

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HL100002</b>	(X3) DATE SURVEY COMPLETED  <b>R</b>  <b>12/11/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOSPITAL EAST</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2815 S SEACREST BLVD</b> <b>BOYNTON BEACH, FL 33435</b>	

SUMMARY STATEMENT OF DEFICIENCIES  
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 - INITIAL COMMENTS**

AMENDED

A desk review revisit survey to the 8/27 to 8/30/18 Risk Management Survey at Bethesda Hospital East was conducted on 12/11/18, license # 4452. The citations were found to be corrected at the time of the review.