

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0501	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/02/2014
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NAME OF PROVIDER OR SUPPLIER BLOUNT MEMORIAL TRANS CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 000	Initial Comments An annual Licensure survey and investigation of complaints #34380 and #34603 was conducted from September 22, 2014, through October 2, 2014, at Blount Memorial Transitional Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____