PRINTED: 09/26/2014
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	TN0501		09/23/2014

NAME OF PROVIDER OR SUPPLIER: BLOUNT MEMORIAL TRANS CARE CTR

STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(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
N002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on September 23, 2014, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N002		

vision of Health Care Facilities
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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