

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
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)
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	N 002	

Division of Health Care Facilities

Coni R. Cochran
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
11/23/11

STATE FORM

6500

COHL21

If continuation sheet 1 of 1