**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X]** PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445277

**[X]** MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING __________________

**[X]** DATE SURVEY COMPLETED

07/23/2012

**NAME OF PROVIDER OR SUPPLIER**

MCMINN MEMORIAL NURSING HOME & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

888 HWY 411 NORTH

ETOWAH, TN 37331

**[X]** ID PREFIX TAG

K 000

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**[X]** ID PREFIX TAG

K 000

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

*INITIAL COMMENTS*

During an annual recertification survey on July 23, 2012, the McMinn Memorial Nursing Home was found to be in compliance with the LSC 2000 Health Existing Regulations.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient(s). (See Instructions.) Except for nursing homes, the findings stated above are disclosable 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued pregnant participation.

Laboratory Director's or Provider/Supplier Representative's Signature:

[Signature]

Title:

[Title]

[Date]