STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445374

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 08/22/2013

NAME OF PROVIDER OR SUPPLIER
MT PLEASANT HEALTHCARE AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE
904 HIDDEN ACRES DR
MOUNT PLEASANT, TN 38474

(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) COMPLETION DATE

K9999 FINAL OBSERVATIONS K9999

Based on observations, testing, and records review during complaint investigation TN00032333 on 8/22/13, it was determined the facility was in compliance with the Life Safety Code.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 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 requisite to continued program participation.