

Division of Health Care Facilities

PRINTED: 08/06/2015  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN9002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/27/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APPALACHIAN CHRISTIAN VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601</b>
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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
N 000	<p>Initial Comments</p> <p>Complaint investigations #34061, #34597, were completed on July 27, 2015, at Appalachian Christian Village. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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