

PRINTED: 07/29/2010  
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>TN9002                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____                                | (X3) DATE SURVEY COMPLETED<br><br>07/27/2010 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>APPALACHIAN CHRISTIAN VILLAGE |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2012 SHERWOOD DRIVE<br>JOHNSON CITY, TN 37601 |   |  |
| (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 002   | 1200-8-6 No Deficiencies<br><br>There were no life safety code deficiencies noted on the day of this annual survey.    | N 002  |   |  |

Division of Health Care Facilities

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

STATE FORM

TITLE

*Administrator*

(X6) DATE

8/4/10

6799

4LYK21

If continuation sheet 1 of 1