

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2011
NAME OF PROVIDER OR SUPPLIER APPALACHIAN CHRISTIAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE 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 An annual licensure survey was completed at Appalachian Christian Village on September 26 - 28, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002		

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TITLE

(X6) DATE

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

STATE FORM

6809

V5XU11

If continuation sheet 1 of 1