## Division of Health Care Facilities

**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinical Lab Identification Number:**

**TN2101**

**Multiple Construction**

- **A. Building:** 01 - **Main Building 01**
- **B. Wing:**

**Date Survey Completed:** 07/15/2013

---

**Name of Provider or Supplier:** NHC Healthcare, Smithville

**Street Address, City, State, Zip Code:**

825 Fisher Ave P O Box 549
Smithville, TN 37166

---

**ID Prefix Tag**

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary of Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>1200-8-6 No Deficiencies</td>
</tr>
</tbody>
</table>

Based on observations, testing, and records review on 07/15/13, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.

---

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

**Title:**

**Date:** 07/13

---

**State Form:** 8499

**MSDB21**

---

**AUG 08 2013**