## Division of Health Care Facilities

### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/Clinic Identification Number</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN3701</td>
<td></td>
<td>01/08/2014</td>
</tr>
</tbody>
</table>

### Name of Provider or Supplier

**CHURCH HILL CARE & REHAB CTR**

**701 WEST MAIN BLVD**

**CHURCH HILL, TN 37042**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>1200-8-6</td>
<td>No Deficiencies</td>
</tr>
</tbody>
</table>

During the Licensure survey and complaint investigation number 32977, conducted on January 6-9, 2014, at Church Hill Care & Rehab Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.

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**Division of Health Care Facilities**

**Laboratory Directors or Provider/Supplier Representative's Signature**

**Title**

**Date**

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**State Form**

**N71F11**