**STAFF OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>(X) PROVIDER/ SUPPLIER IDENTIFICATION NUMBER</th>
<th>(XII) MULTIPLE CONSTRUCTION NUMBER</th>
<th>(XIII) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>T97402</td>
<td>A BUILDING 01 - MAIN BUILDING 01</td>
<td>05/10/2010</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

CHRISTIAN CARE CENTER OF SPRINGFIELD,

**STREET ADDRESS, CITY, STATE, ZIP CODE**

764 6TH AVENUE EAST
SPRINGFIELD, TN 37172

**ID PREFIX TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** | **PROVIDER'S PLAN OF CORRECTION** | **COMPLETE DATE** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>1200-8-6 No Deficiencies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During the annual licensure survey completed on 6/6/10, this facility was found to be 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 and its referenced publications.

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE**

[Signature]

**STATE FORM**

[Form Number] A21R21

[Completion Page] 1 of 1