**Division of Health Care Facilities**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Provider/Supplier/CLA Identification Number</th>
<th>Multiple Construction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1) PROVIDER/SUPPLIER/CLA</td>
<td>TN3701</td>
<td>A. Building 01 - Main Building 01</td>
<td>03/15/2011</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier**

CHURCH HILL CARE & REHAB CTR

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

701 WEST MAIN BLVD
CHURCH HILL, TN 37642

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Complete Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>1200-8-6 No Deficiencies</td>
<td>N 002</td>
<td></td>
</tr>
</tbody>
</table>

There were no life safety code deficiencies noted on the day of this annual licensure survey.

**Division of Health Care Facilities**

**Laboratory Director's or Provider/Suppler's Representative's Signature**

**State Form**

6200 D8K121

**Title**

3/25/11

**Date**

3/25/2011