### Statement of Deficiencies and Plan of Correction

**Provider/Supplement/CLIA Identification Number:**

445030

**Multiple Construction**

- **Building:** __________
- **Wing:** ______________________

**Date Survey Completed:**

09/06/2011

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### Laboratory Director's or Provider/Supplement Representative's Signature

**Name of Provider or Supplier:**

NHC Healthcare, Hillview

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

2710 Trotwood Ave

Columbia, TN 38401

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### Summary Statement of Deficiencies

**ID Tag:**

**Prefix:**

**Tag:**

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td></td>
<td></td>
<td><strong>FINAL OBSERVATIONS</strong></td>
<td>F9999</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intakes: TN00027228, TN00028065

No regulatory violation was found as a result of this complaint survey.

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**Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.**

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

**Title**

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**Date**