Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN4709	A. BUILDING _____ B. WING _____	C 04/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During complaint investigation of #29563 conducted on April 9, 2012, at NHC Healthcare, Ft. Sanders, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE