PRINTED: 08/01/2013
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TN5404		07/31/2013

NAME OF PROVIDER OR SUPPLIER: NHC HEALTHCARE, ATHENS

STREET ADDRESS, CITY, STATE, ZIP CODE: 1204 FRYE ST, ATHENS, TN 37303

(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 000	Initial Comments An annual licensure survey and complaint investigation #31383 were completed on July 31, 2013, at NHC Healthcare, Athens. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Hami

TITLE: Administrator

(X6) DATE: 8-12-13

STATE FORM 6899 8OBR11 If continuation sheet 1 of 1

AUG 12 2013