PRINTED: 02/02/2017
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
	TN3314		01/19/2017

NAME OF PROVIDER OR SUPPLIER: CONSULATE HEALTH CARE OF CHATTANOOG

STREET ADDRESS, CITY, STATE, ZIP CODE: 8249 STANDIFER GAP ROAD, CHATTANOOGA, TN 37421

(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 A Licensure survey and investigation of complaints #39706, # 40137, #40236, #40293, #40321, ##40385, #39812, and #40386, were completed on January 19, 2017, at Consulate Health Care of Chattanooga. No health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: EXECUTIVE DIRECTOR (X6) DATE: 2/10/17