PRINTED: 11/25/2015
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
	TN3316		11/18/2015

NAME OF PROVIDER OR SUPPLIER: SISKIN HOSPITAL SUBACUTE REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE: ONE SISKIN PLAZA CHATTANOOGA, TN 37403

(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 During the annual licensure survey and complaint investigation number TN37467 completed 11/16/15 to 11/18/15, at Siskin Hospital Subacute Rehab, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000	N 000 No actions required	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President & CEO (X6) DATE: Dec. 10, 2015