PRINTED: 11/23/2015
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: 01 - MAIN BUILDING 01 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 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 11/18/2015, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 002	N 002 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

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