**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

A. **BUILDING __________________________**  
B. **WING __________________________**

**(X2) MULTIPLE CONSTRUCTION**

**(X3) DATE SURVEY COMPLETED**

**C 09/20/2013**

**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN HEALTH AND REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

500 HICKORY HOLLOW TERRACE  
ANTIOCH, TN  37013

**DATE SURVEY COMPLETED**

**(X3) DATE SURVEY COMPLETED**

**A. BUILDING __________________________**  
B. **WING __________________________**

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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F9999</td>
<td>FINAL OBSERVATIONS</td>
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Intakes: TN00031472

This facility is in compliance with 42 CFR Part 483, Subpart (B), Requirements for Long Term Care investigated during this complaint survey.

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

**TITLE**

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.