### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 445232

**Multiple Construction:**
- A. Building _____________________________
- B. Wing _____________________________

**Date Survey Completed:**
- C 07/15/2010

**Name of Provider or Supplier:**
- Pine Meadows Health Care

**Street Address, City, State, Zip Code:**
- 700 Nuckolls Road
- Bolivar, TN 38008

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td><strong>FINAL OBSERVATIONS</strong> F9999</td>
<td>F9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intakes: TN00025576, TN00025975

A complaint investigation was conducted on 7/12/10 through 7/14/10. The facility was in compliance with federal and state regulations. No deficiencies were cited related to this complaint investigation.

---

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.