## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 445118

**State of Arkansas, Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**OCT NO. 0938-0391**

**Printed:** 02/03/2012

**Form Approved:**

**Multiple Construction B. Wing _____________________________**

**Name of Provider or Supplier:** Ashton Place Health & Rehab Center

**Street Address, City, State, Zip Code:** 3030 Walnut Grove Rd, Memphis, TN 38111

### Summary Statement of Deficiencies

**ID:** F9999  **Final Observations**

Complaint investigations numbers TN00022576, TN00022677, TN00022699, TN00022727, TN00022904, TN00022910 and TN00022980 were conducted on 5/26/09 through 5/27/09, and this facility was found to be in compliance with state and federal regulations.

### Provider's Plan of Correction

**ID:** F9999  **Final Observations**

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.

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

**Date:**

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**Event ID:** ITUD11  **Facility ID:** TN6007  **If continuation sheet Page:** 1 of 1