A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445133

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X3) DATE SURVEY COMPLETED

C 09/10/2010

MULTIPLE CONSTRUCTION

A. BUILDING ____________

B. WING _______________

NAME OF PROVIDER OR SUPPLIER

ALLEN MORGAN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

177 NORTH HIGHLAND
MEMPHIS, TN 38111

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

(TITLE)

(X6) DATE

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<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>
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<td>FINAL OBSERVATIONS</td>
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Intakes: TN00026353

A complaint investigation was conducted on 09/07/2010 through 09/08/2010. This investigation consisted of medical record review, observations, and interviews. The facility was in compliance with federal and state regulations. No deficiencies were cited.

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.