A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445139

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

DATE SURVEY COMPLETED: 11/17/2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE
141 N MCLEAN
MEMPHIS, TN 38104

NAME OF PROVIDER OR SUPPLIER
SIGNATURE HEALTHCARE AT ST PETER VILLA

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

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

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F9999 FINAL OBSERVATIONS

Intakes: TN00023527, TN00024108, TN00024114

This institution complies with all requirements for participation for long term care facilities investigated during this complaint survey.

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

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.