**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ROUTE**

**STATEMENT OF DEFICIENCIES**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**
  - 445241

- **(X2) MULTIPLE CONSTRUCTION**
  - **A. BUILDING**
  - **B. WING**

- **(X3) DATE SURVEY COMPLETED**
  - C  08/10/2010

**NAME OF PROVIDER OR SUPPLIER**

- **SIGNATURE HEALTHCARE OF MEMPHIS**

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

- **1150 DOVECREST RD**
- **MEMPHIS, TN  38134**

**SUMMARY STATEMENT OF DEFICIENCIES**

- **(X4) ID PREFIX TAG**
- **(X5) ID PREFIX TAG**
- **(X5) COMPLETION DATE**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td></td>
<td>NO regulatory violation was found as a result of this investigation #TN00026481, TN00026361, TN00026338, TN00026316, TN00026272 and TN00026154.</td>
<td>F9999</td>
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</tbody>
</table>

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

**TITLE**

**(X4) DATE**

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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.