STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _______________________________________________________

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

B. WING _______________________________________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

C 04/22/2013

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 DOVECREST RD
MEMPHIS, TN 38134

NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE OF MEMPHIS

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 DOVECREST RD
MEMPHIS, TN 38134

ID PREFIX TAG

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

ID PREFIX TAG

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

ID PREFIX TAG

COMPLETION DATE

F9999 FINAL OBSERVATIONS

Intakes: TN00031419, TN00031533, TN00031537

No regulatory violation was found as a result of this investigation.

F9999

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

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(X4) DATE

(X5) COMPLETION DATE

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.