### Statement of Deficiencies and Plan of Correction

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

445165

**Date Survey Completed:**

08/09/2013

### Name of Provider or Supplier

**Highlands of Memphis Health & Rehab**

**Street Address, City, State, Zip Code:**

3549 Norriswood

Memphis, TN 38111

### Summary Statement of Deficiencies

**F9999 Final Observations**

Intakes: TN00031868

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

### Laboratorv 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.