**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **ID**
  - **PREFIX**
  - **TAG**

**NAME OF PROVIDER OR SUPPLIER**

WESTMORELAND CARE & REHAB CTR

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

1559 NEW HIGHWAY 52

WESTMORELAND, TN  37186

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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This facility complies with all requirements reviewed for long term care during the complaint (Complaint #TN00024288) survey conducted on 3/8/10 through 3/9/10. 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.

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

**TITLE**

[X] DATE