**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
WESTMORELAND CARE & REHAB CTR

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1559 NEW HIGHWAY 52
WESTMORELAND, TN 37186

<table>
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F9999</td>
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<td><strong>FINAL OBSERVATIONS</strong></td>
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Intakes: TN00024260

A complaint investigation was conducted on 3/8/10 through 3/10/10. This investigation consisted of observations and interviews. The facility was in compliance with federal and state regulations. 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.

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

**TITLE**

**DATE**

(X4) ID PREFIX TAG

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
03/10/2010

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
445342

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

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: VGM311
Facility ID: TN8307
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