

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7901</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/20/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALLEN MORGAN HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>177 NORTH HIGHLAND MEMPHIS, TN 38111</b>
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(X4) 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)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: There were no licensure deficiencies cited during the annual survey.</p>	N 002		

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*G. Komer Hanlon*

TITLE  
**ADMINISTRATOR**

(X6) DATE  
**8/27/15**

RECEIVED

**AUG 31 2015**