

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7940</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>02 - ALLENBROOKE NURSING &amp; REHAB CENTER</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALLENBROOKE NURSING AND REHABILITATI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3933 ALLENBROOKE COVE MEMPHIS, TN 38118</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 met as evidenced by: Intakes: TN00033989</p> <p>During the investigation completed on 6/26/14, this facility was found to be in compliance with the reviewed requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-08-06, Standards for Nursing Homes.</p>	N 002		

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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