**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 445451

**NAME OF PROVIDER OR SUPPLIER:**  
**DECATUR COUNTY MANOR**

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 728 KENTUCKY AVE, PARSONS, TN 38363

**DATE SURVEY COMPLETED:** 12/13/2010

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>F9999</td>
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<td><strong>FINAL OBSERVATIONS</strong>\n</td>
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<td>Intakes: TN00025517</td>
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<td>A complaint investigation survey was completed 12/13/10 during the annual survey. No deficiencies were cited related to this complaint investigation.</td>
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</tbody>
</table>

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

**TITLE**

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*V deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

1. 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.

O/RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4FB11

Facility ID: TN2001

If continuation sheet Page 1 of 1