### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

445477

**Date Survey Completed:**

C 02/04/2011

<table>
<thead>
<tr>
<th>Provider/Supplier</th>
<th>Street Address, City, State, Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DICKSON HEALTHCARE CENTER</td>
<td>901 N CHARLOTTE DICKSON, TN 37055</td>
</tr>
</tbody>
</table>

#### 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>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td>FINAL OBSERVATIONS</td>
<td></td>
</tr>
</tbody>
</table>

Complaint investigation on #TN00025416 was conducted on 1/31/11 through 2/2/11, and this facility was found to be in compliance with state and federal regulations reviewed this date for this complaint. See annual survey recertification report.

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**

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