### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

**Mission Convalescent Home**

**Street Address, City, State, Zip Code:**

118 Glass St

Jackson, TN 38301

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>(X3) ID Prefix Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
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**Final Observations:**

Intakes: TN00026788, TN00027121

This facility complies with all requirements for participation for long term care facilities investigate during this complaint survey.

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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.