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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445125	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE HEALTH AND REHABILITATION CENTER	3391 OLD GETWELL RD MEMPHIS, TN 38118

(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) COMPLETION DATE
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to construct the common wall with the apartment building using 2 hour fire resistant materials. The findings included: Observation of the wall that is shared with the apartment building at the end of 1st Magoffin on 9/6/11 at 11:25 AM, revealed a 4 foot wide by 8 foot tall sheet of plywood covering a section of the wall. The area above the ceiling was open to the deck. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.	K 011	KO11 A 4 hr separation corridor at the subdivision location between apartment building and 1st Magoffin .The facility had remove the panel , upon the Fire Marshall. Block wall will be visible to eye.	9/30/11
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018	K018 (a) The Soiled Utility room door on 1st Meree will be repaired. (b) The fire Door by the soiled utility on 1st Magoffin will be repaired.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9-23-11

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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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain doors protecting corridor openings. The findings included: Observation of the corridor openings on 9/6/11 from 9:20 AM until 3:00 PM revealed the following doors were not being maintained: a. The soiled utility room door on 1st McCree would not latch when closed. b. The fire doors by the soiled utility on 1st Mcgoffan would not latch when closed. c. The dutch door on 1st Mcgoffan would not latch at the lower leaf and there was not an astragal between the meeting of the top and lower leafs of the door. d. The storage room door on 2nd McCree would not close or latch.	K 018	© The Dutch door on 1st Magoffin will be repaired. (d) The storage room on 2nd Mcree will be repaired. Maintenance will monitor all doors monthly and along with Fire Drills.	9/30/2011

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K 018	Continued From page 2 These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/7/11.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain doors in hazardous areas. The findings included: 1. Observations of the clean linen room on 1st McCree on 9/6/11 at 10:05 AM, revealed the door would not latch when closed. 2. Observations of the storage room by resident room 423 on 9/6/11 at 10:25 AM, revealed the door closure was not secured to the door and the door would not latch when closed. These findings were acknowledged by the Administrator and verified by the Maintenance	K 029	K029 (1) The Clean Linen Room Door on 1st McRee will be repaired. (2) The Storage room door by resident room 423 door closures will be repaired	

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K 029	Continued From page 3 Supervisor at the exit conference on 9/7/11.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain a resident room door. The findings included: Observations of resident room 115 on 9/6/11 at 2:24 PM, revealed the door was hard to push open due to the door sticking against the frame. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.	K 038	K038 The facility understand the important of all resident door . Manitenace will check all resident door montly and with all fire drills The resident room 115 door will be repaired	9/30/2011
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain all battery operated exit signs.	K 047	K047 [illegible] Exit / Emergency Lights will be repaired	9/30/2011

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K 047	Continued From page 4 The findings included: Observation of the kitchen on 9/6/11 at 12:35 PM, revealed the combination battery operated exit / emergency light would not come on when the test button was pushed. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.	K 047		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain all fire alarm components according to National Fire Protection Association 72. The findings included: Observation of the facility on 9/6/11 at 2:15 PM, revealed the fire alarm system's remote	K 052	K052 The facility understand how important it is to maintain all fire alarm components to be test according to the National Protection Association 72. On 9/12/2011 Miller Protective Service came out and replaced the panel and test was completed. See attachment.	9/30/2011

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K 052	Continued From page 5 annunciator did not receive or activate a visual or audio signal when the phone lines were disconnected. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.	K 052		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure that 4 of the 23 battery operated smoke detectors had the required clearance from supply air and return vents. The findings included: Observation of the facility's smoke detectors on 9/6/11 from 9:41 AM until 2:30 PM revealed the following: a. Resident room 405's smoke detector was too close to the air supply duct. b. Resident room 407's smoke detector was too close to the air supply duct. c. Resident room 409's smoke detector was too close to the air supply duct. d. The smoke detector in 1st McCree's storage room was to close to the exhaust vent. These findings were acknowledged by the Administrator and verified by the Maintenance	K 054	K054 The facility will relocated all the smoke detectors form all supply air vents . (a) The Smoke Detector in room 405 will be relocated (b) The Smoke Detector will be relocated © The Smoke Detector will be relocated	9/30/2011

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K 054	Continued From page 6 Supervisor at the exit conference on 9/6/11.	K 054		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed to maintain the sprinkler heads. The findings included: Record review on 9/6/11 at 12:45 PM, the annual sprinkler test conducted on 11/3/10 revealed 9 sprinkler heads in the chemical room with paint on the heads and 1 in the store room with paint on the head. The first and second quarter reports of 2011 stated the same deficiency as noted on 11/3/10. The facility did not have a statement from the sprinkler company that the deficiencies had been corrected. The second quarter fire alarm certification report stated 1 deficiency on the sprinkler system. The control valve switch (device 1-45) on the 1st Magoffin floor needed replacing. The facility did not have a statement from the fire alarm or sprinkler contractor stating that the switch had been replaced. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.	K 062	K062 Maintenance will check all sprinkler heads every month	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 066	K066 Staff will be in-services on smoking policy and no smoking sign will be posted in areas where smoking is prohibited.	

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K 066	Continued From page 7 Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to prohibit smoking in non designated areas. The findings included: Observation of the hydro therapy room on 9/6/11 at 12:00 PM, revealed a strong odor of cigarette smoke. The administrative assistant confirmed that the odor came from cigarettes.	K 066		

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K 066	Continued From page 8	K 066		
	This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.			
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104	K104 All mechanical room will be check monthly by the maintenance man and document for penetrations. (See Attachment)	
	This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain smoke barriers. The findings included: 1. Observation of the 1st McCree mechanical room next to the nurse's station on 9/6/11 at 10:00 AM, revealed penetrations above the inside of the door, under the duct work by the door and around the conduits in the wall to the right of the door. 2. Observation of mechanical room 2 on 1st McCree on 9/6/11 at 10:20 AM, revealed penetrations above the inside of the door and a penetration through the wall to the right of the door. These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.			
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K130 A new nurse call system will be put in placed on 1st Magoffin, 2nd Magoffin, 1st Mcree and 2nd Mcree. (SEE ATTACHMENT)	

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K 130	Continued From page 9 This STANDARD is not met as evidenced by: AIA guidelines 10.3.6 Call System A nurse/staff call system shall be provided. 10.3.6.1 General. Alternate technologies may be considered for emergency or nurse call systems. If radio frequency systems are used, consideration shall be given to electromagnetic compatibility between internal and external sources. 10.3.6.2 Patient room call station (1) Each bed location and/or resident shall be provided with a call device. Two call devices serving adjacent beds or residents may be served by one calling station. (2) Calls shall be initiated by a resident activating either a call device attached to a resident's call station or a portable device that sends a call signal to the call station and shall either: (a) Activate a visual signal in the corridor at the resident's door or other appropriate location. In multi-corridor or cluster resident units, additional visual signals shall be installed at corridor intersections; or (b) Activate a pager worn by a staff member, identifying the specific resident and/or room from which the call has been placed. 10.3.6.3 Emergency call system. An emergency call system shall be provided at each resident toilet, bath, sitz bath, and shower room. (1) This system shall be accessible to a resident lying on the floor. Inclusion of a pull cord or portable radio frequency pushbutton will satisfy this standard. (2) The emergency call system shall be designed so that a call activated by a resident will initiate a signal distinct from the regular staff call system	K 130		

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K 130	Continued From page 10 and that can be turned off only at the resident's location. (3) The signal shall activate an annunciator panel or screen at the staff work area or other appropriate location and at other areas defined by the functional program. In addition, the signal shall activate either a visual signal in the corridor at the resident's door or other appropriate location or a staff pager indicating the calling resident's name and/or room location. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the nurse call system in 3 of 4 (1st Magoffin, 2nd Magoffin, 1st McCree and 2nd McCree wings) wings. The findings included: During testing of the nurse call system on 9/6/11 from 10:20 AM until 11:35 AM revealed the following: a. Resident room 120 on 1st Magoffin did not have a nurse call device. b. On 2nd Magoffin resident room 206 bed one, room 210 bed four and room 212 bed 3 nurse call devices would not sound at the nurses station or activate the light above the door. c. Resident room 408 on 1st McCree the nurse call device would not reset. d. The nurse call device in resident room 511 on 2nd McCree would not sound at the nurse's station or activate the light outside the door when manually tested by the certified nurse assistant (CNA). The CNA stated that when a nurse call device was not connected to the outlet in a resident room, all the other rooms would not	K 130		

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K 130	Continued From page 11 work. e. Resident room 521 on 2nd McCree did not have a nurse call device. These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11. 4.1 NURSING FACILITIES 2006 Guidelines for Design and Construction of Health Care Facilities Table 4.1-1 Ventilation Requirements for Areas Affecting Resident Care in Nursing Facilities 1 Air movement Minimum Minimum All air relationship air changes total air exhausted Recirculated Relative Design to adjacent of outdoor changes per directly to by means of humidity 7 temperature 8 Area designation area 2 air per hour 3 hour 4 outdoors 5 room units 6 (%) (degrees F/C) RESIDENT UNITS Resident room - 2- 2 - - -7 70-75 (21-24) Resident unit corridor - - 4 - - -7 - Resident gathering areas - 4 4 - - - - Toilet room In - 10 Yes No - - RESIDENT LIVING AREAS Dining rooms - 2 4 - - - 75 Activity rooms, if provided - 4 6 - - - - Personal services (barber/beauty) In 2 20 Yes No __ __ DIAGNOSTIC AND TREATMENT LOCATIONS Physical therapy In 2 6 - - - 75 (24) Occupational therapy In 2 6 - - - 75 (24) SUPPORT AREAS Soiled workroom or soiled holding In 2 10 Yes No - - Clean workroom or clean holding Out 2 4 - - (Max) 70 75 (24) Bathing rooms In - 10 Yes No - 75 (24) SERVICE AREAS Sterilizer exhaust room In - 10 Yes No - - Linen and trash chute room, if provided In - 10 Yes No - - Laundry, general, if provided - 2 10 Yes No - - Soiled linen sorting and	K 130		

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K 130	Continued From page 12 storage In - 10 Yes No - - Clean linen storage Out - 2 Yes No - - Food preparation facilities - 2 10 Yes Yes - - Dietary warewashing In - 10 Yes Yes - - Dietary storage areas - - 2 Yes No - - Housekeeping rooms In - 10 Yes No - - 1 The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of nursing facilities that directly affect resident care and are determined based on nursing facilities being predominantly "no smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustments. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality, and ASHRAE Handbook-HVAC Applications. Occupational Health and Safety Administration standards and/or National Institute for Occupational Safety and Health criteria require special ventilation requirements for employee health and safety within nursing facilities. 2 Design of the ventilation system shall, insofar as possible, provide that air movement is from "clean to less clean" areas. However, continuous compliance may be impractical with full utilization of some forms of variable air volume and load-shedding systems that may be used for energy conservation. Areas that do require positive and continuous control are noted with "Out" or "In" to indicate the required direction of air movement in relation to the space named. Rate of air movement may, of course, be varied as needed within the limits required for positive control. Where indication of air movement direction is enclosed in parentheses, continuous directional control is required only when the specialized equipment or device is in use or	K 130		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE HEALTH AND REHABILITATION CENTER	3391 OLD GETWELL RD MEMPHIS, TN 38118

(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) COMPLETION DATE
K 130	Continued From page 13 where room use may otherwise compromise the intent of movement from clean to less clean. Air movement for rooms with dashes and nonpatient areas may vary as necessary to satisfy the requirements of those spaces. Additional adjustments may be needed when space is unused or unoccupied and air systems are de-energized or reduced. 3 To satisfy exhaust needs, replacement air from outside is necessary. Table 4.1-1 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. 4 Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed. 5 Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to outside. 6 Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." Isolation rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating or	K 130		

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K 130	Continued From page 14 cooling units such as radiators or convectors shall not be used in special care areas. 7 See 4.1-A10.2.1.2 (2) for additional information. 8 Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable where residents may be undressed and require a warmer environment. Nothing in these Guidelines shall be construed as precluding the use of temperatures lower than those noted when the residents' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide 2 air changes for all resident rooms. The findings included: Observations of resident rooms 110, 111, 115, 120, 121 and 123 on 1st Magoffin on 9/6/11 at 10:35 AM, revealed the heating and cooling units were turned off. There was no other air supply ducts in the rooms.	K 130		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		

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K 147	Continued From page 15 Based on observation, it was determined the facility failed to maintain all electrical wiring and equipment. The findings included: 1. Observation of the 1st McCree storage room on 9/6/11 at 10:10 AM, revealed the ceiling mounted light fixture did not have a protective cover. 2. Observation of the activity room on 1st Magoffin on 9/6/11 at 12:15 PM, revealed the receptacle at the sink was not a ground fault interrupting circuit. 3. Observation of the kitchen on 9/6/11 at 12:25 PM, revealed four ground fault interrupting circuit (GFIC) receptacles would not reset when the test button was pushed. The receptacles were located by the radio, the column with the fire extinguisher, the microwave in the cooking area, and by the time card holders. These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 9/6/11.	K 147	K 147 The protective cover of the ceiling mounted light fixture will be replaced The receptacle at the sink in the activity room was replaced during survey. All receptacles identified will be replaced.	9/30/11 9/30 11