

SEP 26 2011

PRINTED: 09/09/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7916	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2011
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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118
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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
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N 831	<p>1200-8-6-.08(1) Building Standards</p> <p>(1) The nursing home must be constructed, arranged and maintained to ensure the safety of the resident.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain a corridors hand rail.</p> <p>The findings included:</p> <p>Observations on 1st McCree on 9/6/11 at 12:35 PM, revealed the handrail between room 420 and room 421 was not secured tightly to the wall.</p> <p>This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 9/6/11.</p>	N 831	<p>N 831 The hand rail identified on 1st McCree was repaired during survey</p>	
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Division of Health Care Facilities

[Signature]
LICENSING DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]
TITLE

(X6) DATE
9-22-11

STATE FORM

6899

N2RD21

If continuation sheet 1 of 1