

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number: TN7916
 (Y2) Multiple Construction: A. Building: 01 - MAIN BUILDING 01
 B. Wing: _____
 (Y3) Date of Revisit: 10/4/2011

Name of Facility: AMERICARE HEALTH AND REHABILITATION CENTER
 Street Address, City, State, Zip Code: 3391 OLD GETWELL RD
 MEMPHIS, TN 38118

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|-----------------------|---------------------------------|-----------------|----------------------------|-----------------|----------------------------|
| ID Prefix N0831 | Correction Completed 09/30/2011 | ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ |
| Reg. # 1200-8-6-08(1) | | Reg. # _____ | | Reg. # _____ | |
| LSC _____ | | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ |
| Reg. # _____ | | Reg. # _____ | | Reg. # _____ | |
| LSC _____ | | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ |
| Reg. # _____ | | Reg. # _____ | | Reg. # _____ | |
| LSC _____ | | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ |
| Reg. # _____ | | Reg. # _____ | | Reg. # _____ | |
| LSC _____ | | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ | ID Prefix _____ | Correction Completed _____ |
| Reg. # _____ | | Reg. # _____ | | Reg. # _____ | |
| LSC _____ | | LSC _____ | | LSC _____ | |

Reviewed By: _____ Date: _____ Signature of Surveyor: *Wanda Brown* Date: 10/6/11
 State Agency: _____
 Reviewed By: _____ Date: _____ Signature of Surveyor: _____ Date: _____
 CMS RO: _____

Followup to Survey Completed on: 9/6/2011
 Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO