

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

PRINTED: 06/14/2010  
FORM APPROVED  
OMB NO. 0938-0391

JUL 06 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2010
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NAME OF PROVIDER OR SUPPLIER  <b>AMERICARE HEALTH AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3391 OLD GETWELL RD MEMPHIS, TN 38118</b>
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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) COMPLETION DATE
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the current status of residents for fall interventions or dialysis/fluid restrictions for 2 of 25 (Residents #10 and 12) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #10 documented an admission date of 3/27/01 with diagnoses of Dementia, Seizures, Hypertension, Anemia and Encephalopathy. Review of Resident</p>	F 280	<p>Recognizing that care planning is fundamental to providing necessary care and services, this deficiency will be addressed immediately. To ensure that other residents are not affected by the same problem, the following corrective measures will be implemented.</p> <p>A new tracking instrument (<b>24-HOUR CARE PLAN PROBLEM/INTERVENTION LIST</b>) will be initiated, for the revision of care plans, to reflect the present status of the resident.</p> <p>All licensed nurses will be in-serviced on the tracking instrument by the Quality Care Nurse.</p> <p>The <b>24-HOUR CARE PLAN PROBLEM/INTERVENTION LIST</b> will be generated by a licensed nurse on each nursing unit, listing all problems and /or changes in a resident's condition, and filed in the Office of the Care Plan Coordinator. The MDS Care Plan Coordinator, the Quality Care Nurse, and other interdisciplinary team members will update the resident's Care Plan, as indicated on the List.</p> <p>After completion of the update, the Care Plan Coordinator and the Quality Care Nurse will verify that the Care Plan has been updated.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert L. Prantham</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7-1-10</i>
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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.

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F 280	<p>Continued From page 1</p> <p>#10's nurses' notes documented a fall on 3/19/10 with no injury. Review of the care plan initiated on 4/13/10 did not address interventions put into place after the fall to prevent further falls.</p> <p>2. Review of the facility's "Dialysis Protocol" policy documented, "Client Care Management for all forms of Dialysis...6. Assess arteriovenous (AV) shunt, fistula, or graft for bruit and thrill each shift. 7. Assess for signs of infection (redness, swelling, increased tenderness) and drainage at access site each shift. "</p> <p>Medical record review for Resident #12 documented an admission date of 7/3/06 with diagnoses of Diabetes Mellitus, Congestive Heart Disease, Kidney Failure and Hypertension. Review of Resident #10's physician's order dated 4/1/10 documented, "Fluid restriction 1200 cc/day [cubic centimeters per day] Dialysis on Mon, [Monday] Wed, [Wednesday] Fri, [Friday] @ [at] 1 PM." Review of the care plan dated 4/20/10 documented, "8. Restrict intake of fluids to 1000 cc per day...10. Palpate for thrill over shunt site. 11. Listen for bruit over shunt every." The care plan was not updated to reflect the resident's current status for 1200 cc/day fluid restriction and was not individualized to reflect the facility's policy for checking the shunt every shift.</p>	F 280		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and</p>	F 281	<p>The Director of Nurses will receive a copy of the verification list weekly, for checks of Care Plan updates.</p> <p>AmeriCARE recognizes standards of practice, regarding medications and supplies necessary in providing care and services to our residents. To better monitor those standards, the following will be implemented to correct this deficiency.</p>	6/30/10

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F 281	<p>Continued From page 2</p> <p>interviews, it was determined the facility did not follow their policy for "Expired Medications and Supplies" as evidenced by having expired supplies such as vacutainers, Betadine ointment packets and intravenous catheters stored for usage in 6 of 15 (1st Magoffin medication room, 2nd Magoffin medication room, 1st McRee medication room, 1st McRee crash cart, 1st McRee supply room and 2nd McRee medication room) medication storage areas.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's "Expired Medications and Supplies" policy documented, "...The person who delivers and person who receives supplies and/or medications check for expiration dates. Supplies already in house are checked weekly on Wednesday for expiration dates. If expiration date is before the next check, supplies are removed from stock and replaced..."</li> <li>2. Observations in the 1st Magoffin medication room on 6/8/10 at 4:30 PM, revealed expired blood tubes; intravenous (IV) catheters; and J-Loops stored on shelves.</li> <li>3. Observations in the 2nd Magoffin medication room on 6/8/10 at 10:40 AM, revealed expired IV catheters stored on shelves.</li> <li>4. Observations in the 1st McRee medication room on 6/9/10 at 8:00 AM, revealed expired IV catheters; blood tubes; and Betadine packages stored on shelves.</li> </ol> <p>During an interview in the 1st McRee medication room on 6/9/10 at 8:09 AM, Nurse #3 was asked if the staff used these supplies. Nurse #3 stated</p>	F 281	<p>The existing policy has been revised, by the Director of Nurses, to better facilitate the identification of supplies and medications which have expired, and their removal from all storage areas in the facility.</p> <p>The procedure includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>..Go through every medication/supply storage area in the facility and collect any and all items with expired dates and discard.</li> </ul> <p>Thereafter, these storage areas will be checked monthly by the licensed staff, nurses and the Materials Management Director.</p> <ul style="list-style-type: none"> <li>..The Quality Care Nurse will in-service all staff on the revised "Expired Medication and Supply Policy".</li> <li>..Supplies and medications (with expiration dates), prior to delivery and stocking of each nursing unit supply room will be checked by the Director of Materials Management and recorded in the <b>EXPIRATION LOG</b> as pulled from inventory and marked as "returned" or "destroyed". The Materials Management Director will complete this process monthly. Copies of the <b>EXPIRATION LOG</b> will be forwarded monthly to the Administrator and to the Director of Nurses.</li> <li>..Nursing personnel will check expiration dates on all supplies on all nursing units monthly.</li> </ul>		

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F 281	<p>Continued From page 3</p> <p>"...do use if if we don't have any in our IV container..."</p> <p>5. Observations of the 1st McRee crash cart on 6/9/10 at 8:10 AM, revealed expired IV catheters were found.</p> <p>6. Observations of the 1st McRee supply room on 6/9/10 at 8:13 AM, revealed expired IV catheters were found.</p> <p>During an interview in the 1st McRee supply room on 6/9/10 at 8:15 AM, Nurse #3 was asked who checks the expiration dates on supplies. Nurse #3 stated, "...I don't."</p> <p>7. Observations in the 2nd McRee medication room on 6/9/10 at 9:20 AM, revealed expired IV catheters and J Loops stored on shelves.</p>	F 281	<p>..AmeriCARE will request the following services from the contracted pharmacy consultant: "Conduct checks of on-hand supplies and medications, in at least three (3) storage areas (unit nursing supply room, medication room, medication cart, central supply, etc.) and include the results in the Monthly Pharmacy Report, currently distributed to the Director of Nurses and the Administrator.</p>	6/30/10
F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents received the care necessary to enable them to function at their highest practicable physical, mental and psychosocial well-being as evidenced by failure of</p>	F 309	<p>AmeriCARE recognizes the importance of obtaining laboratory services to meet the needs of the residents. To ensure that laboratory services are obtained in a timely manner, the following will be implemented to correct this deficiency.</p>	

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F 309	<p>Continued From page 4</p> <p>the facility staff to follow up on results of an X-ray report in a timely manner for 1 of 25 (Resident #12) sampled residents which resulted in actual harm when Resident #12 sustained a fractured finger. The facility failed to obtain orders for hospice and dialysis care for 2 of 6 (Residents #4 and 23) sampled residents receiving hospice or dialysis. The facility failed to follow physician's orders for treatments and medications for 2 of 25 (Residents #16 and 19) sampled residents.</p> <p>The finding included:</p> <p>1. Medical record review for Resident #12 documented an admission date of 7/3/06 with diagnoses of Diabetes Mellitus, Congestive Heart Disease, Kidney Failure and Hypertension. A physician's order dated 5/11/10 documented, "X-ray (l) [Left] hand." The physician's progress notes dated 5/11/10 documented, "...Pain/swelling (L) middle finger of ? etiology... L finger...mod [moderate] pain, [decreased] ROM [range of motion], 2- [to] 3+ [plus] swelling &amp; [and] edema (whole finger)... Pain/swell (L) finger R/O [rule out] Gout... R/O Injury... monitor swelling." A physician's order dated 6/3/10 documented, "Check on pt's [patients] x-ray report of middle (L) finger- He [Resident #12] says it was done." Medical record review revealed no x-ray report in the record. Review of the Nurses Notes for May, 2010 documented a weekly summary dated 5/8/10 and 5/22/10 with no documentation of the resident's injury, that the x-ray was done or results of the x-ray.</p> <p>Observations outside Resident #12's room on 6/8/10 at 8:10 AM, revealed Resident #12 sitting in a wheelchair. Resident #12 raised his left hand and the left middle finger (3rd digit) was observed</p>	F 309	<p>AmeriCARE presently utilizes an existing tracking tool (<b>DIAGNOSTIC TRACKING TOOL</b>) for Laboratory/Radiology and other Diagnostic Studies. In addition, The 11-7 Nurse, utilizing the <b>24-HOUR CHART AUDIT TOOL</b>, will review all charts, medication and treatment records for compliance, during the preceding twenty-four (24) hour period. All licensed staff will be in-serviced on the use of the <b>24-HOUR CHART AUDIT TOOL</b> by the Quality Care Nurse.</p> <p>The Quality Care Nurse will follow-up weekly on all items listed on the report.</p> <p>The physician will be notified by licensed staff of the results within forty-eight (48) hours of the procedure.</p>	
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F 309	<p>Continued From page 5</p> <p>to be swollen. Resident #12 stated he was okay but his finger hurt.</p> <p>During an interview in the conference room on 6/9/10 at 7:40 AM, the Director of Nursing (DON) presented an x-ray report dated 5/13/10 which documented, "There is a fracture at the distal middle phalanx of the 3rd digit and there appears to be some diffuse soft tissue swelling of the 3rd digit." The DON stated, "There is no report, we got it yesterday. No investigation was done. I'm investigating it now. We have a Diagnostic Study Log on each floor. It [the request for the x-ray] was not put on the log." At 10:36 AM, the DON again verified that there had been no follow-up on the x-ray prior to the State Surveyor asking for the report.</p> <p>The facility failed to follow up on the initial physician's order for x-ray ordered on 5/11/10 for 23 days. The physician again asked for the report on 6/3/10 and the facility did not follow up on the second physician's order regarding the x-ray until asked by the State Surveyor on 6/8/10 (total of 28 days). The failure to assess the resident for injury, failure to notify the physician of the positive x-ray report of a fractured finger and the resident stating his finger hurt, resulted in actual harm to Resident #12.</p> <p>2. Medical record review for Resident #4 documented an admission date of 1/16/00 with diagnoses of Diabetes, Anoxic Brain Damage, Hypertension and Cerebral Vascular Accident. Review of the care plan dated 5/6/10 documented the resident was receiving hospice due to a terminal brain injury. Review of the current signed physician recertification orders for May, 2010 revealed no documentation the resident was to</p>	F 309	<p>The Quality Care Nurse will then submit the completed form to the Director of Nurses, who will conduct weekly checks to assure that orders have been carried out.</p> <p>AmeriCARE recognizes the importance of follow-up activity regarding orders for on-going services. To ensure that this activity is properly documented, the following will be implemented to correct this deficiency.</p>	

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F 309	<p>Continued From page 6 receive Hospice care.</p> <p>3. Medical record review for Resident #16 documented an admission date of 10/20/09 with diagnoses of Dementia, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus and Hypertension. A physician's order dated 4/10/10 documented, "Bactroban oint [ointment] for lac [laceration] on face &amp; abrasion." There was no documentation on the treatment record that the Bactroban had been applied as ordered by the physician from 4/10/10 through 4/30/10.</p> <p>During an interview at the 2nd Magoffin nurses station on 6/9/10 at 10:50 AM, Nurse #1 stated, "No, I don't find where we did them [applied the Bactroban ointment] on the MAR's [medication administration records]."</p> <p>4. Review of the facility's "Dialysis Protocol" policy documented, "Client Care Management for all forms of Dialysis: ...6. Assess arteriovenous (AV) shunt, fistula, or graft for bruit and thrill each shift. 7. Assess for signs of infection (redness, swelling, increased tenderness) and drainage at access site each shift."</p> <p>Medical record review for Resident #19 documented an admission date of 4/22/10 with diagnoses of Diabetes Mellitus and End Stage Renal Disease. Review of the May and June, 2010 MARs revealed no documentation that Resident #19's Vas Cath (dialysis access) or maturing fistula (dialysis access) had been assess each shift.</p> <p>During an interview in the conference room on 6/8/10 at 4:00 PM, the DON stated the nurses were suppose to document on the MARs about</p>	F 309	<p>All recertifications are checked by the unit nurse. Also, the in-house RN, on a monthly basis, will review the MONTHLY RECERTIFICATIONS for appropriate orders for all on-going services. An additional check for these services will be confirmed by the Pharmacy Consultant, as part of the Monthly Pharmacy Report filed with the Director of Nurses and the Administrator.</p> <p>The Hospice Nurse will review the MONTHLY RECERTIFICATIONS to confirm that the order for Hospice Services is continued on the document. The Hospice Nurse will then submit a report to the Director of Nurses that appropriate orders are present on the recertifications.</p> <p>AmeriCARE recognizes the importance of proper execution of orders, medications, and treatments, as requested by the physician. To ensure proper care of the resident, the following will be implemented to correct this deficiency.</p> <p>The Quality Care Nurse will in-service all licensed nurses on the <b>24-HOUR CHART AUDIT TOOL</b>.</p> <p>The 11-7 Nurse, utilizing the <b>24-HOUR CHART AUDIT TOOL</b>, will review all charts, medication and treatment records for compliance, during the preceding twenty-four (24) hour period.</p> <p>After completing the <b>24-HOUR CHART AUDIT</b>, the 11-7 Nurse will submit the results to the Quality Care Nurse.</p>	
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F 309	Continued From page 7 the access.  Resident #19's physician's order dated 5/3/10 documented, "Metoprolol 100 mg [milligrams] PO [by mouth] BID [twice a day]." Review of the June, 2010 MAR documented Resident #19 received Metoprolol 100 mg at 9:00 AM from June 1st through June 8th, but did not receive the 4:00 PM dose for any of those days.  5. Closed medical record review for Resident #23 documented an admission date of 8/6/09 with a discharge date of 12/29/09 with diagnoses of Diabetes Mellitus and End Stage Renal Disease. Review of the Minimum Data Set signed 8/19/09 documented the resident was receiving dialysis. Review of the physician recertification orders signed 12/2/09 revealed no physician's order for dialysis care.	F 309	The Quality Care Nurse will confirm that all physician's orders, medications, and treatments were carried out.  The 24-HOUR CHART AUDIT TOOL will be submitted to the Director of Nurses weekly, to assure compliance.  Understanding that appropriate documentation is essential in providing care to our residents, this deficiency will be addressed immediately.  AmeriCARE will begin to document dialysis access on the MAR. All licensed nurses will be in-serviced by the Quality Care Nurse, on the procedure. Any omissions from the MAR will be reflected on the 24-HOUR CHART AUDIT summary, completed by the 11-7 Nurse.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the	F 431	The Dialysis Policy was revised by the Director of Nurses on 6/14/2010 to reflect changes in documentation procedures.  AmeriCARE supports the highest standards for the storage and disposition of drugs and biologicals  To address this deficiency, all licensed nurses will be in-serviced by the Pharmacy Nurse Consultant, on procedures which make certain that medications are stored in locked compartments at all times.	6/30/10

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F 431	Continued From page 8 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined 1 of 5 (Nurse #2) medication nurses failed to ensure medications were stored in locked compartments at all times.  The findings included:  Observations and an interview in room 214 on 6/7/10 at 9:48 AM, Nurse #2 stated, "I made a mess, I should have gotten a towel, I'm going to get one now." Nurse #2 left the room, leaving four medications on the overbed table unattended.	F 431	The Pharmacy Nurse Consultant will also instruct and test the Quality Care Nurse and other designated nurses on proper medication storage. The above nurses, once approved by the Nurse Consultant, will in turn, provide med pass reviews to other staff nurses, with emphasis on accurate medication storage  The Pharmacy Nurse Consultant will provide a list of in-serviced/trained staff nurses to the Director of Nurses.  All agency nursing personnel will be in-serviced by the Quality Care Nurse on proper medication storage, prior to accepting an assignment at the facility. Only agency nurses who have attended the in-service program are eligible for assignment at AmeriCARE	7/15/10.
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE  The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.  This REQUIREMENT is not met as evidenced	F 454	Life Safety-Smoke Detectors  The Building Services Staff installed new batteries in the defective smoke detectors noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2010
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NAME OF PROVIDER OR SUPPLIER  AMERICARE HEALTH AND REHABILITATION CENTER	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) COMPLETION DATE
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F 454	<p>Continued From page 9</p> <p>by: Based on policy review, observation and interview, it was determined the facility failed to maintain the safety of residents, personnel and the public by failing to replace the batteries in the smoke detectors for 4 of 93 (Rooms #105, 115 and 402 and 422) resident rooms.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy documented, "It's the policy of [named facility] to check all smoke detector by the 1st of every month."</li> <li>2. Observations in room 105 on 6/7/10 at 10:05 AM, the smoke detector was beeping.</li> <li>3. Observations in room 115 on 6/7/10 at 9:15 AM, revealed the smoke detector was beeping.</li> <li>4. Observations in room 402 on 6/7/10 at 10:30 AM, on 6/8/10 at 8:30 AM and 6/9/10 at 9:00 AM, revealed the smoke detector was beeping.</li> <li>5. Observations in room 422 on 6/9/10 at 9:00 AM, revealed the smoke detector was beeping.</li> <li>6. During an interview beside room 402 on 6/9/10 at 8:55 AM, the Maintenance Manager was asked when the smoke detector were checked in the resident rooms. The Maintenance Manager stated, "Once a month."</li> </ol>	F 454	Smoke detectors in every resident's room will be checked by the Building Services Director, during the first working week of each month, and batteries replaced, as warranted.	6/30/10
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