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

PRINTED: 07/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445125		C 07/09/2012

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
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Intakes: TN00030015 Based on medical record review, observation and interview, it was determined the facility failed to provide scheduled medication as prescribed by the physician for 1 of 7 (Resident #6) sampled residents. The findings included: Medical record review for Resident #6 documented an admission date of 5/4/10 with a readmission date of 9/8/10 with diagnoses of Diabetes Mellitus, Hypertension, Coronary Artery Disease, Cerebrovascular Accident and Chronic Kidney Disease. Review of the physician's recertification orders dated 4/12/12 and 6/5/12 documented, "...LORTAB 5/500 TABLET HYDROCODONE/APAP 5/500 [and 500mg acetaminophen] TAKE 1 TABLET BY MOUTH EVERY 6 HOURS..." with a start date of 1/12/12. Review of the May 2012 Medication Administration Record (MAR) documented the medication was not available on: 5/5/12 12:00	F 309	F 309 To correct and prevent this deficient practice, regarding resident medications, the pharmacy was notified and a corrective collaboration was developed. Fax machine testing was performed on each nursing unit to verify the accuracy of the submission of a medication order. Our policy was updated to include a follow-up phone call to the pharmacy to verify that medication orders were received. Additionally, an in-service was conducted for the nursing staff regarding this update. RECEIVED JUL 24 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Robert L Manthan — Administrator — 7-23-12

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 309	Continued From page 1 PM, 5/20/12 at 12:00 PM, 5/21/12 at 12:00 AM and 6:00 AM and 5/29/12 at 12:00 PM. Review of the June 2012 MAR documented that the medication was not available on: 6/7/12 at 12:00 PM, 6/8/12 at 12:00 PM, 6/16/12 at 12:00 PM, 6/26/12 at 12:00 PM and 6:00 PM and 6/27/12 at 6:00 AM. Review of the May and June 2012 Pain Assessment Records completed by the medication nurse each shift documented that the resident was pain free, therefore, the deficiency did not reach the level of harm. Observations in Resident #6's room on 6/27/12 at 3:20 PM, revealed Nurse #3 completed the wound care as ordered. Nurse #3 communicated with Resident #6 during the procedure, explained the wound care process and assessed her level of pain. Resident #6 tolerated the wound care treatment without indications of pain. During an interview in the conference room on 6/27/12 at 4:45 PM, Nurse #1 was asked why scheduled medication would be unavailable in the medication cart. Nurse #1 stated, "...The sheet [narcotic sign out sheet] the nurses have tells them when to reorder. They should not run out of medications they need..." During an interview in the 2nd Floor Magoffin nurses' station on 6/27/12 at 6:10 PM, Nurse #2 was asked why scheduled medication would be unavailable in the medication cart. Nurse #2 stated, "...It wasn't reordered... the narcotic sheet, half way down the page tells you the drug is due to be reordered..."	F 309	To monitor the corrective action, to insure that this deficient practice will not recur in the future, each on-coming charge nurse will check the previous nurses' narcotic sheets, using the newly developed MEDICATION/NARCOTIC CHECKING FORM, noting meds ordered/date and meds received/date. Completion Date August 3,, 2012 RECEIVED JUL 24 2012	