

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7916</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/04/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICARE HEALTH AND REHABILITATION (</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3391 OLD GETWELL RD MEMPHIS, TN 38118</b>		
(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	
N 002	1200-8-6 No Deficiencies  This Rule is not met as evidenced by: Intakes: TN00029718  No deficiencies cited during this complaint investigation.	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

H1NZ21

If continuation sheet 1 of 1