<table>
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<tr>
<th>F 315</th>
<th>483.25(d) URINARY INCONTINENCE</th>
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<td>SS=0</td>
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Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure an appropriate diagnosis was provided for an indwelling catheter for 1 of 6 (Resident #7) sampled residents with catheters.

The findings included:

- Medical record review for Resident #7 documented readmission of 7/2/09 with diagnoses of Congestive Heart Failure, Urinary Tract Infection and Arterial Occlusive Disease. A physician's order dated 7/2/09 documented, "Foley cath [catheter]...to BSD [bedside drainage]." A nursing note documented the catheter was discontinued on 7/20/09. There was no diagnosis for the justification of the need of a Foley catheter.

During an interview in the Activities office on 10/6/09 at 9:55 AM, Nurse #2 stated, "...kept it [catheter] in for Stage 2...the patient was feeble..."

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<th>F 323</th>
<th>483.25(h) ACCIDENTS AND SUPERVISION</th>
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<th>F 323</th>
<th>483.25(h) Accidents and Supervision</th>
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F315 483.25(d) Urinary Incontinence

- Resident #7 Foley catheter was removed on 7/20/09 following bladder tuning.

- Any resident admitted with a Foley catheter or who receives an order for Foley catheter will be assessed for valid justification.

- No resident will have a Foley catheter without a valid justification.

- The Director of Nursing assessed each resident with indwelling Foley catheter ensuring a valid justification.

- On 10-7-09 all licensed nursing staff was in-serviced regarding Foley catheter justifications.

- Performance Improvement Nurse will audit 100% of Foley catheter orders to ensure valid justifications.

10/7/09
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445463

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 10/06/2009

NAME OF PROVIDER OR SUPPLIER

BELLS NURSING HOME INC

STREET ADDRESS, CITY, STATE, ZIP CODE
280 HERNDON DRIVE
BELLS, TN 38006

F 323 Continued From page 1

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to implement new interventions for falls for 1 of 7 (Resident #8) sampled residents with falls.

The findings included:

Medical record review for Resident #8 documented an admission date of 10/23/08 with diagnoses of Hypertension, Status Post Motor Vehicle Accident 20 years ago resulting in a hip and foot deformity, Arthritis and Seizures.

Resident #8's nursing care plan documented, "...Problem Onset: 01/22/2009 Falls, high risk for... Approaches...Call light: Place call light within reach at all times when in room. Instruct on the purpose and use of call light and verify understanding..." The care plan indicated Resident #8 had a fall on 6/4/09 and 8/14/09. The nursing care plan documented, "6/4/09 Cont. [continue] to instruct on purpose of call light and verify understanding and cont to encourage resdt [resdnt] to use...8/14/09 Cont to keep call light in reach, instruct on the purpose & [and] use of call light and verify understanding." There were no new interventions implemented after Resident #8 fell on 6/4/09 and 8/14/09.

F 323: Resident #8 was reassessed by Fall Management Committee and new intervention was implemented on 10/6/09 to include Physical Therapy assessment. Care plan updated on 10/6/09 to include new intervention.

On 10-7-09 Fall management coordinator reviewed all residents with repeat falls for 2009 to ensure new interventions were in place.

On 10/7/09 and 10/8/09 and 10/9/09 all licensed staff was in-serviced by Director of Nursing of Fall Interventions requirements.

Performance Improvement Nurse will audit residents with falls to ensure new interventions are implemented.

10/9/09
**F 323** Continued From page 2
During an interview in the Activities office on 10/6/09 at 9:45 AM, Nurse #4 confirmed no new interventions had been implemented after the falls.

**F 441: 483.65(a) INFECTION CONTROL**

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility staff failed to follow infection control practices by not cleansing a wound prior to applying a new dressing during 1 of 2 (Resident #7) dressing change observations.

The findings included:
Review of the facility's "Dressing Change" policy documented, "Purpose: ...2. To cleanse a wound... Cleanse the wound with an antiseptic ordered by the physician. Start from either direction and work away from the wound using new gauze with each swipe..."

Medical record review for Resident #7 documented a readmission of 7/2/09 with
**F 441** Continued From page 3


Observations of a dressing change in Resident #7’s room on 10/5/09 at 9:20 AM, revealed Nurse #1 performed a dressing change on Resident #7. After Nurse #1 washed her hands she removed the dressing from Resident #7’s right heel and placed it in a plastic bag. Nurse #1 then removed her gloves, washed her hands and reapplied a pair of gloves. Nurse #1 proceeded to spray the pressure ulcer on Resident #7’s right heel with granulex spray, applied a dressing and wrapped the pressure ulcer with kerlix. Nurse #1 did not cleanse the wound prior to applying the granulex spray and dressing the pressure ulcer.

During an interview on the West hall on 10/5/09 at 10:50 AM, when asked about cleansing the wound Nurse #1 stated, "I forgot it [to cleanse the wound], I realized it as soon as I threw my stuff in the bag. I was nervous and afraid to say anything."

**F 502** 483.75(j) SS-D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, medical record review...
F 502  Continued From page 4  
and interview, it was determined the facility failed to ensure laboratory (lab) tests were performed in a timely for 3 of 21 (Residents #6, 12 and 13) sampled residents.

The findings included:

1. Review of the facility's "PROTOCOL FOR LAB RESIDENT LAB TEST" documented, "...Write all labs...on calendar at nurses station...Patient Care Coordinator will monitor continually labs and correspond with [named lab] to ensure promptness of collection...[named lab] will fax list to our facility of monthly/scheduled labs. This list is posted at nurses stations and checked for accuracy by the Patient Care Coordinator...

2. Medical record review for Resident #6 documented an admission date of 7/23/01 with diagnoses of Hypokalemia, Peripheral Edema, Depressive Disorder, Acute Paranoid Reaction, Gastroesophageal Reflux Disease, Neuralgia and Parkinson's Disease. A physician's order dated 3/24/09 documented "...Serum K+ [Potassium level] in 2 wk [weeks]..." The facility was unable to provide documentation that the K+ was performed as ordered.

During an interview at the West hall nurses station on 10/5/09 at 10:00 AM, Nurse #3 stated, "...they did not do the order requesting the K+ ordered in two weeks...I checked with lab..."

3. Medical record review for Resident #12 documented an admission date of 9/2/08 with diagnoses of Weakness, Vertigo, Osteoarthritis, Hypertension, Gastroesophageal Reflux Disease, Chronic Bronchitis, Hypokalemia, Diabetes, Hypothyroidism, Congestive Heart Failure and

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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 502</td>
<td>Resident #13 CBC, Protime with INR drawn on 10/5/09 and 10/12/09. Attending physician notified of results on 10/6/09 and 10/13/09.</td>
<td>F 502</td>
<td>On 10/5/09 100% of resident records requiring laboratory blood analysis were audited by licensed nurses ensuring blood work was performed; results were on the medical record and attending physician was notified. On 10-6-09 Policy on laboratory blood analysis was reviewed by Director of Nursing, Assistant Administrator, and Administrator for any needed revisions. On 10/7/09 and 10-14-09 Licensed Nursing staff was in-serviced by Director of Nursing regarding policy on laboratory blood analysis. Performance Improvement Nurse will monitor 20% of resident census monthly x 12 months for timely laboratory blood analysis, documented results on record and notification of attending physician. Results of the audits will be reported to Performance Improvement Committee.</td>
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F 502. Continued From page 5

Left Lower Extremity Deep Vein Thrombosis. A physician's order dated 7/1/09 documented "Weekly Pro-X [prothrombin time] on Mondays..." The facility was unable to provide results of the prothrombin time that was to be done on 8/3/09 and 8/27/09.

During an interview at the West hall nurses station on 10/6/09 at 8:08 AM, Nurse #2 stated, "...8/3/09 [pro-X] was just missed. That one was not on the calender... was marked [Protime] 8/24/09 [on calender] but it was very small [writing]..."

4. Medical record review for Resident #13 documented an admission date of 2/19/08 with diagnoses of Cerebrovascular Accident, Thoracic Aortic Aneurysm, Depression, Hypertension, Status Post Percutaneous Endoscopic Jejunostomy and Alcoholic Psychosis. Review of "Bells Nursing Home Standing Orders" documented, "...Coumadin Tx [treatment] residents are to have a Protome [PT] with INR [International Normalized Ratio]...monthly unless otherwise ordered by the physician..." There was no documentation the PT with INR for April 2009 was done. Review of a 9/23/09 physician's order documented, "...CBC [Complete Blood Count] & [and] Pro-X c [with] INR on 9/28/09..." The facility was unable to provide documentation that the CBC & Pro-X were done as ordered.

During an interview in the Activities office on 10/6/09 at 11:00 AM, Nurse #5 stated, "...it [CBC and Pro-X] was overlooked..."