BELL'S NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
213 HERNDON DRIVE
BELLS, TN 38065

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
213 HERNDON DRIVE
BELLS, TN 38065

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

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TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION
DATE

F 282: 483.20(k)(3)(i) SERVICES BY QUALIFIED
PERSONS/PER CARE PLAN

The services provided or arranged by the facility
must be provided by qualified persons in
accordance with each resident's written plan of
care.

This REQUIREMENT is not met as evidenced by:
Complaint investigation for TN0031834

Based on medical record review and interviews, it
was determined the facility failed to provide
resident transfer with assist of two people in
accordance with the written plan of care for 1 of 6
(Resident #1) sampled residents.

The findings included:

Medical record review for Resident #1
documented an admission date of 11/14/11 and
went to the hospital on 6/11/13 from which she
transferred to another nursing care facility.
Diagnoses included Aftercare Traumatic
Fractured Hip, Symbolic Dysfunction, Paralysis
Agitans, Dementia without Behavior Disturbance,
Depressive Disorder, Osteoporosis, Muscle
weakness general, Hypothyroidism, Dysphagia,
Constipation, Hair Disease, Difficulty Walking,
Urinary Tract Infection and Parkinson's. Resident
#1's Minimal Data Set (MDS) dated 3/28/13
documented the score for the Brief Interview for
Mental Status (BIMS) was 99 which indicated the
resident can communicate but choose not to
participate. The staff completed the interview and
noted both long and short term memory problem
with moderately impaired - decisions poor for
cognitive skills for daily decision making. 

Corrective Action:
1. This facility will ensure that
qualified personnel provide
resident transfers according to
their written plan of care.
2. Resident #1 no longer resides
in the facility. Transfer date:
3. The care plan of each resident
will be reviewed and this
information will be used to further
staff education. Each resident's
individual transfer instructions
will be reviewed with each
respective care giver.

This review will include: where the
specific information is found; the
accuracy of the information; and
the correct performance of the
specified instructions by the
designated care giver. This review
will be conducted by the Director
of Nursing or her Designee.
F 282 Continued From page 1

Resident #1’s MDS dated 6/11/13 documented the score for the BIMS was 0 which indicated Resident #1 had severe impairment in her cognitive status. She also had short term memory problems and was moderately impaired in her cognitive skills for daily decision making.

Review of the care plan dated 3/28/13 documented, "...Falls at risk... Approaches... Transfer: extensive to total assistance of 2..."

During an interview in the activity room, on 10/30/13 at 11:45 AM, certified nursing assistant (CNA) #8 was asked how she transferred Resident #1. CNA #8 stated, "I transferred her from the bed to the geri-chair. The geri-chair scooted a little, so I put her in the recliner and pushed the call light and then put her in the geri-chair..."

During an interview in front of room 320, on 10/30/13 at 3:20 PM, CNA #15 was shown the care plan term, "Transfer: extensive to total assistance of 2." CNA #15 was asked what that meant. CNA #15 replied, "Take two people to transfer with a gait belt... Gait belt goes around waist... Lift resident up and get to chair with the help of another person..."

During an interview in front of room 320, on 10/30/13 at 3:25 PM, CNA #16 was shown the care plan term, "Transfer: extensive to total assistance of 2." CNA #16 was asked what that meant. CNA #16 stated, "...Two sides would transfer a total assist with a gait belt..."

During a telephone interview on 11/1/13 at 2:30 PM, CNA #11 was asked how she transferred Resident #1. CNA #11 stated, "...I picked her up

4. On 11-12-13 and 11-13-13 in-services were conducted by the Director of Nursing and Registered Nurse Supervisors with individual RNs, LPNs and CNA staff for all 3 shifts. In-service included the importance of providing appropriate assistance with transfers in accordance with the residents written care plan. On 11-20-13 a facility wide in-service will be provided by the Director of Nursing and MDS coordinator on the process of determining the amount of assistance required for a resident’s transfer, where this information is found for each resident and the importance of following transfer assistance as noted in the residents plan of care.

5. The Director of Nursing or designee will monitor for compliance with each care giver weekly for 4 weeks, then monthly times 3 months. The findings of these audit results will be reported to the Performance Improvement Committee by the Director of Nursing for effectiveness and determination of compliance.

Completion Date: 11-22-13
| F 282 | Continued From page 2 with a gait belt and put her back to bed. I didn't know she was a two person assist..."

During an interview by the 300 hall ice machine, on 11/5/13 at 8:45 AM, CNA #17 was shown the care plan term, "Transfer: extensive to total assistance of 2," CNA #17 was asked what that meant. CNA #17 stated, "...if resident can't help at all, use two people lift or use the Hoyer [lift]..."

During an interview in the activity room, on 11/5/13 at 1:55 PM, CNA #6 was asked again to discuss how she transferred Resident #1. CNA #8 stated, "...I had transferred her by myself before if people were busy on the floor. I transferred her by myself at least two times..."

During a discussion in the activity room, with the Director of Nursing (DON) on 11/5/13 at 2:05 PM, the DON stated she could pull up the results of the CNAs' entries into the software of the computer system that would reveal the method of transfer given for Resident #1. The following is the result of that activity:


b. "...6/7/13 10:25 AM Transfer - Transfer ADL - Limited Assistance - 1 person assist..." by CNA #13.

c. "...6/9/13 10:32 AM Transfer - Transfer ADL - Total dependence 1 person assist..." by CNA #13.

The failure to use a two man lift when transferring Resident #1 was not following Resident #1's care plan interventions.
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<thead>
<tr>
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<tbody>
<tr>
<td>F 441</td>
<td><strong>SPREAD, LINENS</strong></td>
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<tr>
<td>SS=D</td>
<td>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</td>
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<td>(a) Infection Control Program</td>
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<td>The facility must establish an Infection Control Program under which it -</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<td>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</td>
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<td>(3) Maintains a record of incidents and corrective actions related to infections.</td>
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<td>(b) Preventing Spread of Infection</td>
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<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<td>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</td>
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<td>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</td>
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<td>(c) Linens</td>
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<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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This REQUIREMENT is not met as evidenced by:

Based on review of "Clinical Nursing Skills by Smith and Duell and Martin", observation and interview, it was determined the facility failed to ensure 1 or 2 Certified Nursing Assistants (CNA) (CNA #10) provided perineal care in a manner to prevent the spread of infection when she failed to change contaminated gloves and wash her hands.

The findings included:

Review of "Clinical Nursing Skills, 5th edition by Smith and Duell and Martin", page 340, documented, "...Gloves Clean, nonsterile gloves are worn when touching... body fluids, secretions, excretions, and contaminated items. Put gloves on just before touching mucous membranes and nonintact skin. Remove gloves immediately after use, and wash hands before touching noncontaminated items and environmental surfaces or giving care to another client. Gloves should be discarded immediately and not reused."

Observations in Resident #6’s room on 10/29/30 at 10:30 AM, CNA #10 performed peri-care for Resident #6. CNA #10 washed her hands and donned gloves. When just about through giving care to the rectal area, Resident #6 had a small bowel movement, which CNA #10 cleaned. After finishing the rectal cleaning, CNA #10, wearing the same gloves, opened and closed the resident's privacy curtain just enough to exit the bedside area and go to the closet area of the room. CNA #10 reached into the closet and got lotion which she brought back to the resident's
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BEELS NURSING AND REHABILITATION CENTER

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>Continued From page 5</td>
<td>bedside after opening and closing the privacy curtains surrounding Resident #6's bed. CNA #10 observed that Resident #6 had had another small bowel movement. CNA #10 used wipes to clean the rectal area, and then applied lotion to Resident #6's buttocks from the lotion bottle she had retrieved from the closet. CNA #10 then put a diaper on one side of Resident #6 and rolled her to the other side. At this point CNA #10 had taken off the glove to her right hand and put on another glove to complete putting on the resident's diaper. CNA #10 failed to remove contaminated gloves and wash hands immediately after giving the peri-care before touching noncontaminated items and environmental surfaces and before resuming pericare.</td>
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<td>During an interview in the activity room on 10/29/12 at 5:15 PM, the director of Nursing (DON) was asked if it was acceptable for the CNA wearing gloves she used to perform pericare, to go the resident's closet, get materials and then bring them back to the bedside and resume pericare to the rectal area. The DON stated, &quot;No.&quot;</td>
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