

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Bells Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 213 Herndon Drive Bells, TN 38006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on policy review, observation, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions, when food was found opened and undated. The census was 87 with 87 residents receiving a meal tray from the kitchen. The findings include: Review of the facility policy titled, Food Receiving and Storage, revised 11/2018, revealed .Foods shall be received and stored in a manner with safe handling practices.All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date or open date).Other opened containers must be dated and sealed or covered during storage. Observation during the initial tour in the kitchen on 8/11/2025 at 8:50 AM, revealed the following in the walk-in refrigerator: a. 1 gallon of opened and undated mayonnaise b. 1 bag of opened and undated sliced cheese c. 1 gallon of opened and undated pickles Observation during the initial tour in the kitchen in the walk-in freezer on 8/11/2025 at 8:55 AM, revealed a box of single serve ice cream, opened and undated. During observation and interview in the kitchen on 8/12/2025 at 11:03 AM, the Certified Dietary Manager (CDM) confirmed the staff needed more education when the following revealed: a. 1 opened and undated 5-pound container of granulated onions b. 1 opened and undated 16-ounce bottle of imitation banana extract c. 1 opened and undated 16-ounce bottle of pure lemon extract During an interview on 8/11/2025 at 10:00 AM, the CDM confirmed that all items should be dated when opened.		

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.

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

TITLE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to report an injury of unknown origin and an allegation of misappropriation of resident property to the appropriate agencies for 2 of 3 (Resident #78 and #94) sampled residents reviewed for abuse. The findings include: 1. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 10/28/2022, revealed .All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies.The state licensing /certification agency responsible for surveying/ licensing the facility.Immediately is defined as.within two hours of an allegation involving abuse or result in serious bodily injury.within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of the residents.All allegations are thoroughly investigated. The administrator initiates investigations. 2. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypertension, and Chronic Kidney Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #78 had intact cognition. During an interview on 8/12/2025 at 7:56 AM, Resident #78 stated .I have \$42.00 missing. I think my roommate may have gotten it and threw it away .and six pair of pants missing about 2-3 weeks ago. Resident #78 confirmed she reported the missing money to a Certified Nursing Assistant (CNA) and the missing clothing to laundry staff. During an interview on 8/12/2025 at 8:33 AM, CNA G was asked if Resident #78 ever told her that she had money missing. CNA G stated, She [Resident #78] told me it was a dollar out of her drawer but did not know if she misplaced it or if someone took it about 2 weeks ago. CNA G confirmed she told a floor nurse but did not tell any other staff member. During an interview on 8/12/2025 at 8:27 AM, the Administrator was informed that Resident #78 stated she had missing money and thought her roommate may have gotten it. During an interview on 8/13/2025 at 3:10 PM, the Administrator confirmed he had not reported that Resident #78 was missing \$42 dollars to the State Survey Agency or any other agency. 3. Review of the medical record revealed Resident #94 was admitted to the facility on [DATE], with diagnoses including Aphasia, Contracture of Right Wrist and Right Hand, Cerebral Infraction, and Hemiplegia. Review of the quarterly MDS assessment dated [DATE], revealed an interview for mental status could not be conducted due to Resident #94 was severely impaired. Resident #94 was dependent upon staff for toileting, bathing, dressing, hygiene, and transfers. Review of the Nurse's Note dated 7/14/2025 at 1:07 AM, revealed, . Staff reported to this nurse that resident's right arm was discolored/bruised from elbow to wrist. Upon assessment dark red discoloration noted on resident's forearm measuring 24 cm [centimeters] in length by 7 cm in width. Resident denies complaint of pain or discomfort concerning affected area.[named provider] notified. No new orders. Resident suffers from aphasia and was not able to communicate how injury may have occurred. Previous shift had already left for evening. Staff instructed to use caution when repositioning resident. Review of the Radiology Results Report dated 7/15/2025 at 9:16 AM, revealed Resident #94 had a fracture to the right humerus (upper arm). Review of the [named hospital] ED (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Emergency Department] Triage Notes, dated 7/15/2025 at 1:51 PM, revealed Resident #94 was admitted to the ED with bruising to the right arm and a humoral fracture as evident by an x-ray that was performed at the nursing home. The staff at the facility reported to Emergency Medical Services (EMS) that the bruising was observed on 7/14/2025 and that staff was unsure how the injury occurred because .patient [Resident #94] is bed bound and paralyzed on the right side-right also severely contracted at baseline . During an interview on 8/13/2025 at 8:16 AM, The Regional Nurse Consultant confirmed all injuries of unknown origin should be reported by staff when found. The Regional Nurse Consultant confirmed Resident #94 had an injury of unknown origin on 7/13/2025 and management staff was not made aware until 7/14/2025. During a telephone interview on 8/13/2025 at 9:25 AM, Licensed Practical Nurse (LPN) D confirmed on 7/13/2025 after shift change at 7:20 PM, he was asked to come see a bruise on the right forearm on Resident #94. LPN D described the bruise as dark red from the wrist to the elbow. LPN D confirmed he failed to immediately notify the provider and the DON. During an interview on 8/14/2025 at 3:28 PM, the Administrator confirmed allegations of abuse, injuries of unknown origin, and allegations of misappropriation of resident property, should be reported to the state.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to perform a complete and thorough investigation for 1 of 3 (Resident #94) sampled residents reviewed for allegations of abuse. Resident #94, a severely cognitively impaired, vulnerable resident, dependent on staff for transfers was found with her right arm lodged in the opening of the armrest of the wheelchair on 7/13/2025. Later the same day staff observed bruising from her elbow to her wrist. An x-ray obtained on 7/14/2025 revealed a fracture of the right humerus (upper arm). The findings include: 1. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 10/28/2022, revealed .All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.All allegations are thoroughly investigated. The administrator initiates investigations. Review of the facility policy titled, Accidents and Incidents-Investigating and Reporting, dated 7/2018, revealed .All accidents or incidents involving residents .shall be investigated and reported to the Administrator.The Nurse Supervisor/Charge Nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.The following data.shall be included in the Incident Report form.nature of the injury /illness.bruise, fall.The Nurse Supervisor/Charge Nurse and or the department director or supervisor shall complete an Incident Report form and submit the original to the Director of Nursing Services.The Director of Nursing shall ensure that the Administrator receives a copy of the Incident Report for each occurrence. 2. Review of the medical record revealed Resident #94 was admitted to the facility on [DATE], with diagnoses including Aphasia, Contracture of Right Wrist and Right Hand, Cerebral Infraction, and Hemiplegia and Hemiparesis Affecting Right Dominant Side. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed a brief interview for mental status could not be conducted, the resident was rarely/never understood, and cognitive skills for daily decision making were severely impaired. Resident #94 was dependent upon staff for toileting, bathing, dressing, hygiene, and transfers. Review of the Nurse's Note for Resident #94 dated 7/13/2025 at 10:56 AM, revealed .CNA [Certified Nurse Assistant] came up to the nurse station and stated Resident [#94] just almost slid out of her wheelchair but [CNA B] was able to reposition resident and wheelchair before [Resident #94] slid out completely. Review of the Nurse's Note for Resident #94 dated 7/14/2025 at 1:07 AM, revealed .Staff reported to this nurse [Licensed Practical Nurse (LPN) D] that resident's right arm was discolored/bruised from elbow to wrist. Upon assessment dark red discoloration noted on resident's forearm measuring 24 cm [centimeters] in length by 7 cm in width. Resident denies complaint of pain or discomfort concerning affected area.[Medical Director] notified. No new orders. Resident suffers from aphasia and was not able to communicate how injury may have occurred. Previous shift had already left for evening. Staff instructed to use caution when repositioning resident. The facility was unable to provide an assessment or any other documentation regarding the incident where Resident #94's arm was lodged in the wheelchair during the dayshift on 7/13/2025 or during the evening shift regarding the bruising on the resident's right arm that was found approximately 7:20 PM until 7/14/2025 at 1:07 AM. Review of the undated and signed Employee Investigation Interview Form signed by CNA B revealed, .Date/time of incident 7-13-25 [7/13/2025],[Resident #94] was sliding out of her wheelchair her bedside table was still in front of her .her stroke arm was not in normal position . Review of the undated and signed Employee Investigation Interview Form signed by CNA E revealed, .Date/time of incident 7-13-25 [7/13/2025] 7:20 pm [PM],[Resident #94],in bed.came in Sunday at 7:00 PM, Check resident at 7:20 PM notice large bruise on Right arm, had not Did [done] any care at that time, notified the nurse. Review of the Nurse Practitioner (NP) Note dated 7/14/2025 at 3:25 PM, revealed (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Patient [Resident #94] complaints of spontaneous ecchymoses [bruising]. This has been noted for one to two days.bruising is on her right upper arm. She slid down in chair this weekend.orders given for right humerus x-ray. Review of the Nurse's Note for Resident #94 dated 7/14/2025 at 4:56 PM, revealed .[NP] in facility on this date for visit with resident regarding follow up on bruising to right upper arm.orders as follows obtained X-ray of right humerus. Review of the Radiology Results Report for Resident #94 dated 7/15/2025 at 9:16 AM, revealed HUMERUS.Acute appearing fracture of the surgical neck as noted. Review of the Nurse's Note for Resident #94 dated 7/15/2025 at 12:58 PM, revealed .[NP] reviewed right humerus x-ray results obtained on 7/15/25 [2025]. New orders.Transfer to [named hospital] on this date for possible surgical neck fracture.Bruising remains to right upper arm related to incident of sliding down in chair over the weekend. Review of the (Named Hospital) Emergency Department (ED) Triage Notes dated 7/15/2025, revealed .Patient [Resident #94] presents.from [Named nursing home] for right arm bruising and humoral fracture. Staff advised EMS [Emergency Medical Service] that they noticed the bruising yesterday and performed an X-ray which resulted .with noted fracture. Staff advised that they are unsure how the patient sustained this injury as patient is bed bound and paralyzed on the right side-right also severely contracted at baseline. Review of the signed witness statement by CNA B dated 7/15/2025, revealed .resident [#94] was sliding out of her wheelchair. she had her contracted arm in the opening of the wheelchair by [the] armrest. with her feet on the wheels of bedside table, [her] left arm was extended cross [across] her bed rail.we got her back into the wheelchair.Brought resident out to the charge nurse and reported what happened, left resident [#94] at nurse station . During a telephone interview on 8/12/2025 at 2:18 PM, Licensed Practical Nurse (LPN) C stated she was told by CNA B, on 7/13/2025, at approximately 11:00 AM, that Resident #94 had slid down in the wheelchair. LPN C confirmed she failed to assess the resident, failed to complete an incident report, failed to report the incident to administration and the oncoming staff, and failed to obtain witness statements. During a telephone interview on 8/12/2025 at 2:51 PM, CNA B told this surveyor that Resident #94 was found during the morning of 7/13/2025 with her contracted right arm lodged in the opening under the armrest of the wheelchair. CNA B confirmed she did not write a witness statement on the day of the incident. During an interview on 8/13/2025 at 8:16 AM, the Regional Nurse Consultant acknowledged that the management staff were not notified of the bruise on Resident #94's forearm until 7/14/2025. The Regional Nurse Consultant stated the nurse should have reported the bruises to the Director of Nursing (DON) when it was found on 7/13/2025 at 7:20 PM, as an injury of unknown origin. The Regional Nurse Consultant stated an injury of unknown origin should be reported to the DON and the Administrator at the time it was discovered, it should be reported to the State Survey Agency when it was discovered. The Regional Nurse Consultant agreed that Resident #94 should have been assessed, the incident documented, and an incident report completed when the resident was found with her right arm ledged in the opening under the armrest of the wheelchair. During a telephone interview on 8/13/2025 at 9:25 AM, LPN D confirmed he failed to immediately notify the provider and the DON when the bruises were found. During a telephone interview on 8/14/2025at 12:06 PM, CNA E stated on 7/13/2025 at approximately 7:20 PM, she observed a purple-colored bruise on Resident #94's right forearm and upper right arm. During a telephone interview on 8/14/2025 at 3:35 PM, the NP agreed that when staff observe bruising, they should report their findings. The NP was asked do you know what caused the bruise (on Resident #94's arm). The NP stated .we had discussed [Resident #94] had slid down in wheelchair. The NP confirmed she was not notified until 7/14/2025 of the bruising found on 7/13/2025. The facility failed to complete an incident report, failed to report the injury to management staff and the provider when the injury was found on 7/13/2025 at approximately 7:20 PM, and failed to complete a thorough investigation of Resident #94's fractured humerus.		