

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Waters of Sweetwater A Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 978 Hwy 11 South Sweetwater, TN 37874	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100</p> <p>Based on facility policy review, medical record review, review of a facility investigation, and interview the facility failed to prevent physical abuse for 1 resident (Resident #52) of 70 residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse Prevention Program, dated 10/22/2022, revealed .it is the policy of this facility to prevent resident abuse .the facility desires to prevent abuse .by establishing a resident-sensitive and resident-secure environment .</p> <p>Medical record review revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis, Polyneuropathy, and Anxiety.</p> <p>Review of a comprehensive care plan for Resident #52 revised 4/25/2024, revealed .risk for adverse reaction R/T [related to] psychotropic drug use .Chronic pain syndrome .</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment.</p> <p>Review of an Incident Event Note for Resident #52 dated 4/27/2024 at 4:45 PM, revealed .Resident laying in bed, Daughter .at bedside. Resident from across the hall came in and began repeatedly hitting her .She [Resident #52] was using her hands to shield her stomach and he [Resident #272]made contact with her hands also .Offered resident ER [emergency room] evaluation. Resident declined .Resident and daughter feel safe in facility .</p> <p>Review of a Progress Note for Resident #52 dated 4/27/2024 at 4:50 PM, revealed .Charge nurse had just let [left] .[Resident #52] room and heard a scream .[Licensed Practical Nurse (LPN) B] immediately ran back to room and observed [Resident #272] standing over this resident [Resident #52] and that resident [Resident #272] was hitting .[Resident #52]. Nurse immediately removed .resident [Resident #272] from room . assessed this resident [Resident #52] for injury .no injury found .</p> <p>(continued on next page)</p>

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	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review revealed Resident #272 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, Impulse Disorder, and Adjustment Disorder with Anxiety.</p> <p>Review of a comprehensive care plan for Resident #272 dated 2/12/2024, revealed .displays an alteration in cognitive functioning and memory R/T dementia .can be verbally aggressive at times due to his dementia . combative towards staff at night time if he gets startled or more confused . Allow time for resident to understand/respond .has a history of pacing the hallways .has exhibited physical aggression with staff .</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #272 scored a 99 on the BIMS assessment which indicated the resident had severe cognitive impairment.</p> <p>Review of an Incident Event Note for Resident #272 dated 4/27/2024, revealed .Nursing staff had observed resident [Resident #272] going into the resident's [Resident #52] room across the hall .resident [Resident #272] was nude .removed resident [Resident #272] .returned him to his room and assisted him with dressing . Nurse [LPN B] went to across the hall to speak with the resident [Resident #52] .Nurse [LPN B] .was going up hallway .heard a scream .immediately ran back to the room [Resident #52's room] .observed this resident [Resident #272] standing over .punching resident [Resident #52]. Nurse [LPN B] immediately removed this resident [Resident #272] .</p> <p>Review of the facility's investigation for allegations of abuse for Resident #52 and Resident #272 reported on 4/27/2024, revealed .nurse [LPN B] states that she was going up hallway when she heard a scream . immediately ran to .[Resident #52's room] and observed [Resident #272] standing over .[Resident #52] . punching her .actions .immediately removed [Resident #272] from area .had [Certified Nursing Assistant (CNA) C] stay with [Resident #272] .remains on 1:1 supervision .until sent to ER .</p> <p>During an interview on 5/13/2024 at 1:10 PM, Resident #52 stated she remembered the altercation that occurred on 4/27/2024 with Resident #272. Resident #52 stated Resident #272 came into her room to .look around . but could not recall the time. Resident #52 stated her daughter was visiting and had redirected Resident #272 out of the room. Resident #52 stated a .short time later . the CNA (could not recall her name) was providing care to her when Resident #272 opened the door to enter her room. Resident #52 stated Resident #272 was naked and the CNA directed him out of the room. Resident #52 stated after the CNA left the room, Resident #272 entered her room again (time unknown). Resident #52 stated when he entered the room, her daughter told Resident #272 to leave the room. Resident #52 stated Resident #272 walked toward her with closed fists but was unable to recall if Resident #272 hit her. Resident #52 stated she began to scream and the nurse and CNA came back to her room to get him out. Resident #52 stated she was not hurt after the altercation and felt safe in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2024 at 10:20 AM, LPN B stated she had been assigned to both residents (Resident #52 and #272) on 4/27/2024 (the day of the resident-to-resident altercation). LPN B stated she observed Resident #272 naked in Resident #52's room (time unknown) and redirected Resident #272 back to his room. LPN B stated she went back up the hall to go to the medication cart and heard a commotion coming from Resident #52's room (time unknown). LPN B stated she went to Resident #52's room and observed Resident #272 standing over Resident #52. LPN B stated she observed Resident #272 with a closed attempting to punch Resident #52 in the stomach. LPN B stated by the time she got to Resident #52, Resident #52's daughter had shielded Resident #52 from being hit by Resident #272. LPN B stated she removed Resident #272 from the room and redirected the resident back to his room across the hall. LPN B stated she had CNA C sit with him until further directives were obtained from management. LPN B stated Resident #52 and Resident #272 had no apparent injuries from the altercation.</p> <p>During an interview on 5/15/2024 at 10:40 AM, CNA C stated she had been assigned to both residents (Resident #52 and Resident #272) on 4/27/2024 (the day of the resident-to-resident altercation). CNA C stated she provided care to Resident #52 in her room (time unknown) when Resident #272 came into the room naked. CNA C stated she redirected Resident #272 back to his room and LPN B helped the resident get dressed. CNA C stated she returned to the room to finish care provisions for Resident #52 and then left the room to get meal trays. CNA C stated she heard yelling coming from Resident #52's room (time unknown) and went to Resident #52's room. CNA C observed Resident #272 standing over Resident #52. CNA C stated it appeared Resident #272 was hitting Resident #52 with a closed fist, in the stomach but could not see directly in front of Resident #272. CNA C stated Resident #52 and Resident #52's daughter (who was at bedside) stated Resident #272 had struck Resident #52 multiple times in the stomach area. CNA C stated LPN B removed Resident #272 from the room and took the resident back to his room across the hall. CNA C stated she sat with Resident #272 until further directives were obtained from management.</p> <p>During an interview on 5/15/2024 at 9:50 AM, the Director of Nursing (DON) stated the resident-to-resident altercation was reported to her on 4/27/2024. The DON stated it was reported Resident #272 hit Resident #52. The DON stated the abuse investigation outcome revealed Resident #272 hit Resident #52, but no injuries were observed to Resident #52 or Resident #272.</p> <p>During an interview on 5/15/2024 at 1:10 PM, Resident #52's daughter stated she had visited the facility when the altercation occurred on 4/27/2024 9(time unknown). Resident #52's daughter stated around 4:00 PM, Resident #272 came into Resident #52's room to .look around . and she had to redirect Resident #272 out of the room. Resident #52's daughter stated approximately 15 minutes later, a staff member was providing care to her mother when Resident #272 opened the door to enter Resident #52's room. Resident #52's daughter stated Resident #272 was naked and the staff member redirected the resident out of the room. Resident #52's daughter stated after the staff member left the room, Resident #272 re-entered the room (time unknown). Resident #52's daughter stated when Resident #272 re-entered the room, she told Resident #272 to leave. Resident #52's daughter stated Resident #272 walked toward Resident #52 and punched the resident in the stomach and hands. Resident #52's daughter stated Resident #52 began to scream, and two staff members came into the room to diffuse the situation. Resident #52's daughter stated Resident #52 was not hurt and felt Resident #52 was safe at the facility.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480</p> <p>Based on facility policy review, medical record review, and interview the facility failed to identify related conditions that requires Level 2 PASRR (Preadmission Screening and Resident Review) evaluation for 1 resident (Resident #50) of 12 residents reviewed for an initial PASRR submission.</p> <p>The findings include:</p> <p>Medical record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), Anxiety, Adjustment Disorder with Depression, and Insomnia.</p> <p>Review of a PASRR for Resident #50 dated 4/4/2023, revealed .Level 1 Form .any or all .mental health conditions that are diagnosed or suspected for this individual now or in the past .No mental health diagnosis is known or suspected .</p> <p>Review of a Psychiatric Nurse Practitioner Note for Resident #50 dated 4/29/2024, revealed, .PSYCHIATRIC HISTORY AND PROBLEMS .Anxiety .PTSD .Depressive Disorder .</p> <p>During an interview on 5/15/2024 at 2:55 PM, the Human Resource Manager (HRM) stated the PASRR dated 4/4/2023 was completed at the hospital prior to Resident #50's admission to the facility. The HRM confirmed the resident had a diagnosis of PTSD and Anxiety when he admitted to the facility, and the facility failed to refer Resident #50 to the state designated authority for a level 2 PASRR evaluation to determine if the resident required specialized services.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49792</p> <p>Based on facility policy review, medical record review, and interview the facility failed to revise a comprehensive care plan for 1 resident (Resident #44) of 19 residents reviewed for care plans.</p> <p>The findings include:</p> <p>Medical record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Congestive Heart Failure, and Diabetes.</p> <p>Review of a comprehensive care plan for Resident #44 dated 12/29/2023, revealed .had a potential for complications related to hemodialysis for diagnosis of stage 5 Chronic Kidney Disease .intervention .[Dialysis Clinic] Dialysis, Monday, Wednesday, Friday; chair time 10:30 AM .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #44 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact and received dialysis (process that removes waste products and excess fluid from the blood).</p> <p>During an interview on 5/14/2024 at 8:04 AM, Resident #44 stated the doctor had reduced her dialysis treatments from 3 times a week to 2 times a week.</p> <p>Review of a facility document for Resident #44 dated 5/9/2024, revealed .Dialysis 2x [times] week .</p> <p>During an interview on 5/14/2024 at 1:22 PM, the Director of Nursing (DON) stated Resident #44 received dialysis treatments at another facility on Mondays and Fridays. The DON also stated the resident used to receive dialysis three times weekly but was decreased to two times weekly .a while ago . The DON confirmed the comprehensive care plan had not been revised to reflect the decrease in dialysis treatments for Resident #44.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49786</p> <p>Based on facility policy review, record review, observation, and interview the facility failed to post accurate staffing information to reflect daily staffing levels and failed to document Registered Nurse (RN) hours.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Guidelines for BIPA (Benefits Improvement and Protection Act) Staffing Posting Requirement, revised 7/24/2023, revealed .SNF's [Skilled Nursing Facilities] must post daily, at the beginning of each shift, the specific shift schedule for the 24-hour period, the number and category of nursing staff employed or contracted by the facility for each 24-hour period, as well as the total number of hours worked by licensed nursing staff .</p> <p>During an observation on 5/13/2024 at 10:10 AM, of the daily nurse staff posting, revealed the staffing information posted reflected staffing for 4/26/2024 and had not been updated to reflect the current staff in the facility on 5/13/2024.</p> <p>Review of the facility's daily nurse staff posting sheets revealed no RN hours had been documented for the following dates: 4/25/2024, 5/8/2024, 5/9/2024, and 5/13/2024.</p> <p>Review of the facility's daily time clock punches revealed:</p> <p>4/25/2024 (Thursday): RN E worked 10.25 hours.</p> <p>5/8/2024 (Wednesday): RN E worked 9 hours.</p> <p>5/9/2024 (Thursday): RN E worked 10.75 hours.</p> <p>5/13/2024 (Monday): RN E worked 9.75 hours.</p> <p>During an interview on 5/15/2024 at 10:30 AM, the Director of Nursing (DON) stated she was responsible for posting the daily staffing sheets and documenting the number of nursing staff on each shift. The DON confirmed the daily staffing sheet had not been posted to reflect the current nursing staff working on 5/13/2024. The DON also confirmed the facility failed to document RN hours on the daily staffing sheet for the following dates 4/25/2024, 5/8/2024, 5/9/2024, and 5/13/2024.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49568</p> <p>Based on facility policy review, observation, and interview the facility failed to ensure food items were sealed properly, which had the potential to affect 69 of 70 residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Food Storage Areas, dated 6/04/2021, revealed .Spice jars should be closed when not in use .opened food should be transferred to an airtight container or zip lock bag .</p> <p>Observation of the food preparation room on 5/13/2024 at 10:30 AM, with the Dietary Manager (DM), revealed the following items were not sealed and open to air:</p> <ul style="list-style-type: none"> One 16-ounce (oz) bottle of garlic powder One 19-oz bottle of onion powder One 42-oz box quick oats 3/4 full <p>During an interview on 5/13/2024 at 10:40 AM, the DM stated dry cereal and dried seasoning are to be fully sealed after use. The DM confirmed the food items had not been stored properly.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>49568</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure garbage and refuse were properly contained in 2 of 2 dumpsters (dumpster A and B).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Trash Disposal, dated 2/27/2020, revealed .dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents .will ensure the dumpster lids are closed .no trash is on the ground surrounding the dumpsters .</p> <p>Observation of the outside dumpster area on 5/13/2024 at 10:40 AM, with the Dietary Manager (DM), revealed 2 dumpsters present for waste disposal. The entry doors on both sides of Dumpster A and B were open. The area around dumpster A and B had multiple disposable gloves, 2 broken office chairs, and 2 ripped mattresses on the ground surrounding both dumpsters.</p> <p>During an interview on 5/13/2024 at 10:50 AM, the DM confirmed the dumpster area had not been maintained in a sanitary condition.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49792</p> <p>Based on facility policy review, medical record review, and interviews, the facility failed to obtain an updated physician order for 1 resident (Resident #44) of 19 residents reviewed for Physician's Orders.</p> <p>The findings include:</p> <p>Medical record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Congestive Heart Failure, and Diabetes.</p> <p>Review of the Physician's Orders for Resident #44 dated 12/27/2023, revealed .Hemodialysis on Monday, Wednesday and Friday .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #44 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact and received dialysis (process that removes waste products and excess fluid from the blood).</p> <p>During an interview on 5/14/2024 at 8:04 AM, Resident #44 stated the doctor had changed her dialysis days from 3 times a week to 2 times a week.</p> <p>Review of a facility document for Resident #44 dated 5/9/2024, revealed .Dialysis 2x [times] week .</p> <p>During an interview on 5/14/2024 at 1:22 PM, the Director of Nursing (DON) stated Resident #44 received dialysis treatments on Mondays and Fridays. The DON also stated the resident used to receive dialysis three times weekly but was decreased to two times weekly .a while ago . The DON confirmed the facility failed to obtain a new Physician's Order to reflect the decrease in dialysis treatments for Resident #44.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480</p> <p>Based on facility policy review, medical record review, observation, and interviews the facility failed to follow infection control practices during medication administration for 2 residents (Resident #63 and Resident #35) of 4 residents observed for medication administration.</p> <p>The findings include:</p> <p>Medical record review revealed Resident #63 was admitted to the facility on [DATE] with diagnoses including Need for Personal Assistance with Personal Care, Obstructive and Reflux Uropathy, and Elevated [NAME] Blood Cell Count.</p> <p>During an observation of medication administration on 5/14/2024 at 8:30 AM, RN A exited a resident's room without washing or sanitizing the hands. Further observation revealed RN A donned a pair of gloves and prepared medications for Resident #63. The resident's door revealed a sign STOP .ENCHANCED BARRIER PRECAUTIONS .EVERYONE MUST .Clean their hands, including before entering . RN A entered Resident #63's room wearing the same pair of gloves, did not remove the gloves, and did not wash or sanitize the hands prior to entering the room.</p> <p>During an interview on 5/14/2024 at 8:35 AM, RN A confirmed she failed to wash or sanitize the hands after exiting a resident's room, she donned a pair of gloves, and prepared Resident #63's medications. RN A also confirmed Resident #63 was on enhanced barrier precautions, she failed to remove the soiled gloves, and failed to perform hand hygiene prior to entering Resident #63's room.</p> <p>Medical record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Chronic Pain Syndrome, Legal Blindness, Weakness, and Reduced Mobility.</p> <p>During an observation of medication administration on 5/14/2024 at 8:40 AM, RN A sanitized the hands and prepared medications for Resident #35. Further observation showed RN A dropped 1 tablet of Oxycodone [medication used to treat pain] 10/325 mg (milligram) on the surface of the medication cart. RN A donned clean gloves, picked up the tablet, and placed the tablet in a medication cup. RN A continued to prepare the remaining scheduled medications for Resident #35, placed the medications in the same medication cup, and administered the medications to the resident.</p> <p>During an interview on 5/14/2024 at 8:46 AM, RN A confirmed she dropped the Oxycodone 10/325 mg tablet on top of the medication cart and confirmed the medication should have been discarded and not administered to Resident #35.</p> <p>During an interview on 5/15/2024 at 1:55 PM, the Director of Nursing (DON) confirmed RN A did not follow standard precautions with hand hygiene and the facility infection control practices during medication administration.</p>		