

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Waters of Bristol A Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 Highway 394 Blountville, TN 37617	

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 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** 50216</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure appropriate hand hygiene was completed during wound care for 1 (Resident #81) of 3 residents observed for wound care.</p> <p>Review of the facility's policy titled, Dressing Change - Clean, dated 1/2024 revealed .To protect wounds . prevent infection, and promote healing .All dressings will be done using clean technique, unless otherwise ordered sterile by the physician .Procedure .Perform proper hand hygiene .Put on clean gloves .remove and discard gloves. Perform proper hand hygiene .Put on clean gloves .Remove and discard gloves .perform proper hand hygiene .</p> <p>Medical record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart Disease, Congestive Heart Failure, and Chronic Bronchitis.</p> <p>Review of a comprehensive care plan dated 2/29/2024, revealed Resident #81 had a Stage 3 pressure ulcer to the sacrum.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #81 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #81 had a Stage 3 pressure ulcer.</p> <p>Review of the Physician's Orders for Resident #81 dated 6/3/2024, revealed .Cleanse wound to sacrum with wound cleanser and pat dry. Apply collagen powder [specialized protein powder to aid in wound healing] to wound bed and cover with [specialized dressing] .one time a day .</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 6/11/2024 at 8:50 AM, revealed Licensed Practical Nurse (LPN) A set up the supplies needed for wound care administration, cleaned the hands with hand sanitizer, and put on gloves. LPN A removed the soiled dressing from Resident #81's sacrum and placed the soiled dressing into a garbage bag. LPN A proceeded to clean the sacral wound with gauze pads and wound cleansing spray. Continued observation revealed LPN A finished cleaning the pressure wound, applied the collagen powder to the wound bed, and covered the wound with a clean dressing. Further observation revealed Resident #81's sacral pressure wound did not show any signs or symptoms of infection during wound care. LPN A picked a marker up from the floor and dated the clean dressing applied to Resident #81's sacral pressure wound with the marker. LPN A removed the soiled gloves and went into the bathroom to wash the hands. LPN A confirmed she did not change her gloves or wash her hands after removing the soiled dressing and before applying the clean dressing. LPN A stated she should have completed appropriate hand hygiene and put on clean gloves before applying the clean dressing.</p> <p>During an interview on 6/12/2024 at 1:00 PM, the Infection Preventionist (IP) stated the facility protocol was the gloves are to be changed when going from dirty to clean. IP stated LPN A had received re-education on the dressing change protocol.</p>		