

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

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

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445530                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>08/26/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Waters of Bristol A Rehabilitation and Nursing                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2830 Highway 394<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, review of the medical record, observations, and interviews, the facility failed to ensure appropriate hand hygiene was completed during medication administration on 1 of 3 medication carts observed for medication administration. The findings include: Review of the facility's policy titled, Handwashing/Hand Hygiene, revised 8/2014, revealed .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .use an alcohol-based hand rub or soap and water for the following situations: before and after direct contact with residents .before preparing or handling medications . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, and Adult Failure to Thrive. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #11 revised 6/17/2024, revealed the resident had a self-care deficit and required staff assistance with activities of daily living and care. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, and Hypertension. Review of a quarterly MDS assessment dated [DATE], revealed Resident #83 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #83 revised 6/10/2025, revealed the resident had a self-care deficit and required staff assistance with activities of daily living and care. During an observation on 8/25/2025 at 8:10 AM, revealed Licensed Practical Nurse (LPN) A had prepared Resident #11's medications for administration and failed to perform hand hygiene after touching the medication cart, multiple medication drawers, and the medication cart keys located in her pocket. LPN A walked into Resident #11's room from the hallway and administered medications to Resident #11. Further observation revealed LPN A gave Resident #11 a drink of water while touching the resident's straw, the bedside table, and the bed remote. LPN A exited Resident #11's room and did not perform hand hygiene. Continued observation revealed LPN A walked to the nurses' station, touched multiple notebooks to include the telephone, then walked back to the medication cart to start preparing Resident #83's medication for administration. LPN A touched the medication cart keys located in her pocket, touched multiple medication drawers, and touched multiple medication packages. LPN A went into Resident #83's room, administered medications to Resident #83, and failed to perform hand hygiene before or after administering the medications. During an interview on 8/25/2025 at 8:21 AM, LPN A stated hand hygiene should be completed before and after direct contact with the resident or resident surfaces. LPN A confirmed she failed to complete hand hygiene before and after administering medications to Resident #11 and Resident #83. During an interview on 8/26/2025 at 11:15 AM, the Director of Nursing confirmed hand hygiene should be completed before and after contact with the resident and resident surfaces during medication administration.</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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|