| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted from 06/12/23 through 06/15/23. Event ID: 1FSH11. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident and staff interviews the facility failed to honor a resident's | F 561 | The statements included in this plan of correction are not an admission and do | 7/12/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/07/2023

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.

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F 561

Continued From page 1

request to be assisted out of bed for 1 of 1 resident reviewed for choices (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 07/18/20.

Review of Resident #1's annual Minimum Data Set (MDS) assessment dated 05/06/23 revealed the resident was cognitively intact and required extensive assistance of two staff for bed mobility, transfers, dressing and personal hygiene. The MDS indicated it was very important for Resident #1 to do her favorite activities.

Review of a form dated 05/09/23 titled "200 Hall Rounds" indicated 300/Float hall to assist with getting Resident #1 out of the bed. There was no specific time recorded.

The care plan dated 05/10/23 revealed Resident #1 preferred activities that identified with her prior lifestyle. The goal was that Resident #1 would express satisfaction with her daily routine and leisure activities. The interventions included informing the resident of upcoming activities by providing an activity calendar and involving the resident in the activities with shared interests.

An observation and interview were conducted with Resident #1 on 06/12/23 at 11:46 AM. The resident was sitting up in her wheelchair. Resident #1 expressed she was not able to get up as early as she wanted to get up on 06/11/23 and 06/12/23 because there was not a float person on third shift to assist Nurse Aide (NA) #5 in getting her out of the bed. She explained that she was always an early riser and liked to get up

F 561

not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. Any alleged deficiencies cited have or will be completed by the dates indicated.

F561 Self-Determination

The nurse manager conducted an interview with Resident #1 on 6/14/2023 and resident voiced she would like to get up between 5:30AM-6:30AM daily.

Care plan and nursing assistant care guide updated for Resident #1 to reflect resident preference for getting out of bed.

Resident preferences for sleeping and waking schedule will be obtained upon admission and will be communicated to nursing department via the nursing assistant care guide and resident care plan. Nursing assistant care guide and resident care plan will be reviewed and updated with changes in condition and/or changes in resident preference.

To identify others that have the potential to

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|---|---|---|---|---|
| F 561 | Continued From page 2<br>early so that she could have some alone time to drink her coffee and sketch and draw in the café, but when there was not a third nurse aide on third shift she had to stay in the bed until first shift came in to get her out of bed. Resident #1 added, she would like to get up between 5:30 AM and 6:00 AM but since there was not a third shift nurse aide to assist NA #5 over the weekend, she did not get up until after 7:00 AM.<br><br>An interview conducted with Nurse Aide (NA) #5 on 06/13/23 at 11:18 AM confirmed that on 06/10/23 and 06/11/23 third shift she was assigned to the hall where Resident #1 resided and that there was not a third nurse aide assigned as a float during the shifts. The NA explained that Resident #1 was alert and oriented and could voice her wants and needs and the resident requested to get up early both mornings of 06/11/23 and 06/12/23 but because she was the only nurse aide on the resident's hall, she could not get the resident up because she required two persons assist to attend to her. The NA stated Resident #1 had to wait until first shift came on duty so that she could get help in getting the resident up out of bed. NA #5 continued to explain that the resident liked to get up early and go to the café to draw and sketch but she was not always able to do that when there were only two nurse aides for 200 and 300 halls and no float which was what the staffing was this past weekend.<br><br>During an interview with Unit Manager (UM) #1 on 06/14/23 at 11:13 AM she explained that Resident #1 had not given her a specific time that she wanted to get up early in the mornings but informed her that the third shift float aide was supposed to assist in getting her out of the bed. | F 561 | be affected, a 100% audit of all in-house residents with a Brief Interview for Mental Status (BIMS) score of 12 or greater was conducted on 07/07/2023 by administrative nursing staff to ensure sleeping and waking schedules were being honored. All resident care plans and nursing assistant care guides will be reviewed, revised, and updated as needed by 07/12/2023.<br><br>To prevent this from re-occurring a member of the admissions department and/or designee will interview new residents upon admission to the facility to determine desired sleeping and waking schedules. This information will be reviewed by a member of nursing administration and placed on the nursing assistant care guide and the resident care plan for reference. An in-service with the nursing department staff was conducted on 6/30/2023 to re-educate staff on honoring resident choices with a focus on honoring preferred sleeping and waking times. Nursing staff educated to notify supervisor immediately for assistance if resident preferences of assignment cannot be met. Education regarding honoring resident preference is included in new hire orientation.<br><br>To monitor and maintain ongoing compliance the Director of Nursing or designee will ensure any identified | |

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|---|---|---|---|---|
| F 561 | Continued From page 3<br>The UM continued to explain that she had educated the staff that when they work short, they needed to focus on providing the basic needs of all the residents. She stated she was not aware that there were only two nurse aides for the long-term care side for third shift over the weekend and if she had known she would have come into work herself to work the hall.<br><br>An interview conducted with the Director of Nursing on 06/14/23 at 11:39 AM revealed she had a lot of staff to get the residents up in the morning, but Nurse Aide #6 was usually assigned to float, and the NA was on vacation the weekend of 06/10/23 and 06/11/23.<br><br>During an interview with the Administrator on 06/14/23 at 1:28 PM she expressed that it was not an unreasonable request for Resident #1 to be gotten out of bed when she requested. | F 561 | sleeping and waking preferences are being honored by completing random weekly audits. Results of these audits will be documented for 5 residents per week x 4 weeks, then for 3 residents per week x 4 weeks, and then for 2 residents per week x 4 weeks. Any concerns identified during these audits will be addressed immediately and reported to the Quality Assurance Committee for 3 months. After 3 months of audits are completed, the Quality Assurance Committee will then determine if further action is needed.<br><br>Completion Date 07/12/23 | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident, and staff interviews the facility failed to provide routine incontinence care to a resident before his breakfast meal was served to him for 1 of 2 residents reviewed for activities of daily living (Resident #143).<br><br>The findings included: | F 677 | F677 ADL Care Provided for Dependent Residents<br><br>On 6/14/23 the care plan and nursing assistant care guide was updated for Resident #143 to reflect Activities of Daily Living (ADL) care needs for incontinence.<br><br>To identify others that have the potential to | 6/30/23 |

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|---|---|---|---|---|
| F 677 | Continued From page 4<br>Resident #143 was admitted to the facility on 05/30/23 with diagnoses that included paraplegia, neurogenic bladder, and others.<br><br>Review of a comprehensive admission Minimum Data Set (MDS) assessment dated 06/06/23 revealed that Resident #143 was cognitively intact, required extensive assistance with bed mobility was frequently incontinent of bowel and had an indwelling catheter during the assessment reference period.<br><br>An observation and interview were conducted with Resident #143 on 06/12/23 at 8:30 AM. Resident #143 was resting on an air mattress, covered with a sheet and was alert and verbal. Resident #143 proceeded to grab the right-side grab bar on his bed and turn over, pulled the sheet back. His brief was not in place and was stuck between Resident #143's knees, there was a ball of feces laying under his bottom along with other fecal matter in the area. No offensive odors were noted durnig the observation. The bottom sheet and top sheet were soiled with a brown dried substance. Resident #143 added that he was waiting for his breakfast to come so he could eat.<br><br>An observation and interview were conducted with Resident #143 on 06/12/23 at 10:12 AM. Resident #143 remained in bed and indicated that the staff had not been in to check on him and had not provided care to him. He stated that he had eaten breakfast and it was good.<br><br>An observation and interview were conducted with Resident #143 on 06/12/23 at 11:06 AM. Resident #143 remained in bed and was alert and verbal. He stated that the staff had not been in to | F 677 | be affected, a 100% audit was conducted by administrative nursing staff of all in-house residents to determine level of continence/incontinence. All resident care plans and nursing assistant care guides were reviewed, revised, and updated with any changes needed on 6/15/23.<br><br>All nursing department staff were in-serviced by 6/30/23 by administrative nursing regarding meeting the needs of dependent residents. The importance of prompt 2-hour care rounds was included in this in-service. All newly hired staff responsible for providing incontinence care for residents will receive this education during orientation.<br><br>To prevent this from re-occurring, all residents will be assessed by licensed nursing staff upon admission to determine level of continence/incontinence. The interdisciplinary team (IDT) will review new admissions to ensure Activities of Daily Living (ADL) care needs are documented appropriately; this will be communicated to the nursing department via nursing assistant care guide and resident care plan.<br><br>To monitor and maintain ongoing compliance, the Director of Nursing or designee will review documented continence/incontinence levels and ensure accuracy on nursing assistant care guide and resident care plan for 5 residents weekly x 4 weeks, then 3 | |

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| F 677 | Continued From page 5<br>check or change him. Resident #143 stated, "do I need to be changed?" he explained, "I am a paraplegic and don't have any feeling there." Resident #143 was told that yes, he was soiled and needed to be cleaned up and he was observed to turn his call light on. Resident #143 again grabbed the right-side grab bar and turned over his brief remained between his knees and the ball of fecal matter remained under him.<br><br>Nurse Aide (NA) #1 was interviewed on 06/12/23 at 11:07 AM. NA #1 confirmed that she was taking care of Resident #143. She stated that she had been in his room earlier on the shift to check on him but had not provided any care to him since coming on her shift at 7:00 AM. NA #1 was notified that Resident #143 had turned his call light on because he was soiled and needed to be cleaned up. NA #1 stated that she would find some help and get him cleaned up.<br><br>An observation of NA #1 and NA #2 providing incontinent care to Resident #143 was observed on 06/12/23 at 11:09 AM. NA #1 and NA #2 were observed to turn Resident #143 onto his right side and remove his top sheet exposing the brief that was still between his knees and the ball of fecal matter remained under him. NA #1 and NA #2 used soap and water to clean Resident #143's peri area and also removed the soiled linen and replaced it with clean linen. When they were finished providing incontinent care, they covered Resident #143 with a top sheet and exited the room.<br><br>A follow up interview was conducted with NA #1 on 06/12/23 at 12:47 PM and again confirmed she was caring for Resident #143. She stated that when she arrived for her shift at 7:00 AM, | F 677 | residents weekly x 4 weeks, and then for 1 resident weekly x 4 weeks. Any concerns identified during these audits will be addressed immediately and reported to the Quality Assurance Committee for 3 months. After 3 months of audits are completed, the Quality Assurance Committee will then determine if further action is needed.<br><br>Completion Date 6/30/23 | |

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| F 677 | Continued From page 6<br>she had not gotten any report. NA #1 stated that normally any one of the staff members that were working the unit would get report from the previous shift. NA #1 stated she "did not get a chance to check" Resident #143 that morning because it was Monday morning and there was a lot going on. She added "normally he would tell us if he needed" incontinent care. She again confirmed that the first time she provide incontinent care to Resident #143 on 06/12/23 was at 11:09 AM.<br><br>Nurse #1 was interviewed on 06/13/23 at 9:07 AM and confirmed that she was working Resident #143's unit on 06/12/23. She added that Resident #143 was not able to tell the staff all the time if he was soiled but the NAs should be checking him for incontinent issues during their regular rounds.<br><br>The Director of Nursing (DON) was interviewed on 06/13/23 at 5:03 PM who stated that Resident #143 should have been checked for incontinent issues and provided incontinent care before being served his breakfast meal. | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent | F 686 | | 7/12/23 |

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|---|---|---|---|---|
| F 686 | Continued From page 7<br>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident, staff, and Wound Provider interviews the facility failed to keep a Stage 4 pressure ulcer covered and free from contamination of fecal matter for 1 of 4 residents reviewed for pressure ulcers (Resident #143).<br><br>The findings included:<br><br>Resident #143 was admitted to the facility on 05/30/23 with diagnoses that included paraplegia, open wound of left buttock and others.<br><br>Review of an Admission skin assessment dated 05/31/23 written by the Wound Nurse read in part, "pressure ulcer noted to left ischium (8.5x5.2 with undermining of 4.4cm @12 o'clock and 2.3 cm @ 6 o'clock). Orders in place to clean left ischium (hip area) with soap and water, apply barrier cream to peri wound, pack wound bed with Dakin's (bleach substance used to clean wounds) moistened gauze and cover with padded dressing twice a day."<br><br>Review of a comprehensive admission Minimum Data Set (MDS) assessment dated 06/06/23 revealed that Resident #143 was cognitively intact, required extensive assistance with bed mobility and had one stage 4 pressure ulcer that was present on admission. The MDS also revealed that Resident #143 received pressure ulcer care, was frequently incontinent of bowel and had an indwelling catheter during the assessment reference period. | F 686 | F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>An interview was conducted with Resident #143 on 6/14/23. It was determined that although the resident is alert and oriented, he was unable to notify staff when his wound dressing is not in place due to lack of sensation to his peri-area related to diagnosis of paraplegia. Nursing assistant care guide and resident care plan updated to reflect need to check the dressings to his hip and buttocks to ensure they are clean, dry, and intact.<br><br>A 100% audit of all residents with documented wound care orders was conducted on 6/14/23 and a member of administrative nursing ensured all wound dressings were clean, dry, and intact. All residents with wound care orders will be reviewed, and nursing assistant care guides and resident care plans will be reviewed, revised, and updated with any needed revisions by 7/12/23.<br><br>All nursing department staff were in-serviced by 6/30/23 on wound care policies. Nursing assistants were educated to notify wound care nurse or unit nurse immediately if dressing is not clean, dry, and intact. All newly hired staff responsible for providing care for residents will receive this education during | |

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| F 686 | Continued From page 8<br><br>Review of a physician order dated 06/08/23 read, clean wound to left ischium with soap and water, apply barrier cream to wound boarder, then dampen kerlix (rolled gauze) with Dakin's solution and pack into wound bed. Cover with foam dressing change daily and as needed.<br><br>Review of the Medication Administration Record (MAR) dated June 2023 revealed that Resident #143 wound care had been provided daily as ordered.<br><br>An observation and interview were conducted with Resident #143 on 06/12/23 at 8:30 AM. Resident #143 was resting on an air mattress, covered with a sheet and was alert and verbal. Resident #143 stated that while at home he developed a wound to his left hip area and because "I would not stay off it of the wound got bigger and got infected" and required a hospitalization. Resident #143 proceeded to grab the right-side grab bar on his bed and turn over, pulled the sheet back exposing a large gaping hole on his left ischium. His brief was not in place and was stuck between Resident #143's knees, there was a ball of feces laying under his bottom along with other fecal matter in the area. The bottom sheet and top sheet were soiled with brown and pink substances. No stool was visible in the gaping hole wound which was pink with some patchy areas of grey dead tissue. Resident #143 stated that he had told the staff that his dressing needed to be replaced but stated he had not learned the staff's names yet so was not sure who he had told. Resident #143 added that he was waiting for his breakfast to come so he could eat. | F 686 | orientation.<br><br>To prevent this from re-occurring, Director of Nursing or designee will complete weekly audits to ensure that residents with wound dressing orders have dressings in place that are clean, dry, and intact. Results of these audits will be documented for 5 residents per week x 4 weeks, then for 3 residents per week x 4 weeks, and then for 2 residents per week x 4 weeks. Any concerns identified during these audits will be addressed immediately and reported to the Quality Assurance Committee for 3 months. After 3 months of audits are completed, the Quality Assurance Committee will then determine if further action is needed.<br><br>Completion Date 7/12/23 | |

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|---|---|---|---|---|
| F 686 | Continued From page 9 | F 686 | | |

An observation and interview were conducted with Resident #143 on 06/12/23 at 10:12 AM. Resident #143 remained in bed and indicated that the staff had not been in to redress his wounds or check on him.

An observation and interview were conducted with Resident #143 on 06/12/23 at 11:06 AM. Resident #143 remained in bed and was alert and verbal. He stated that his wound had not been redressed yet and the staff had not been into check or change him. Resident #143 stated, "do I need to be changed?" he explained, "I am a paraplegic and don't have any feeling there." Resident #143 was told that yes, he was soiled and needed to be cleaned up and he was observed to turn his call light on. Resident #143 again grabbed the right-side grab bar and turned over and exposing a very large gaping hole to his left ischium, his brief remained between his knees and the ball of fecal matter remained under him.

Nurse Aide (NA) #1 was interviewed on 06/12/23 at 11:07 AM. NA #1 confirmed that she was taking care of Resident #143. She stated that she had been in his room earlier on the shift to check on him but had not provided any care to him since coming on her shift at 7:00 AM. NA #1 was notified that Resident #143 had turned his call light on because he was soiled and needed to be cleaned up. NA #1 stated that she would find some help and get him cleaned up.

An observation of NA #1 and NA #2 providing incontinent care to Resident #143 was observed on 06/12/23 at 11:09 AM. NA #1 and NA #2 were observed to turn Resident #143 onto his right side and remove his top sheet exposing his wound

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 686 | | F 686 | | |

Continued From page 10
and brief that was still between his knees. As they cleaned Resident #143 the dressing that had been over Resident #143's left ischium was found stuck to his right buttock area and was discarded by NA #1 and NA #2. NA #1 stated that she would go and let the Wound Nurse know that his dressing needed to be changed as soon as they finished the care. NA #1 and NA #2 used soap and water to clean Resident #143's peri area and also removed the soiled linen and replaced it with clean linen. When they were finished providing incontinent care, they covered Resident #143 with a top sheet and NA #1 stated she was going to find the Wound Nurse and let her know that his dressing needed to be replaced.

A follow up interview was conducted with NA #1 on 06/12/23 at 12:47 PM and again confirmed she was caring for Resident #143. She stated that when she arrived for her shift at 7:00 AM, she had not gotten any report. NA #1 stated that normally any one of the staff members that were working the unit would get report from the previous shift. NA #1 stated she "did not get a chance to check" Resident #143 that morning because it was Monday morning and there was a lot going on. She added "normally he would tell us if he needed" incontinent care. She again confirmed that the first time she provide incontinent care to Resident #143 on 06/12/23 was at 11:09 AM.

An observation and interview were conducted with Resident #143 on 06/12/23 at 1:47 PM. Resident #143 was dressed and in his wheelchair at bedside. He stated that someone had come and replaced his wound dressing around 12:30 PM and then he had gone down to the therapy room for his therapy session.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 686 | Continued From page 11 | F 686 | | |

Nurse #1 was interviewed on 06/13/23 at 9:07 AM and confirmed that she was working Resident #143's unit on 06/12/23. She stated that she had completed his admission to the facility, and he had since completed his intravenous antibiotics for a wound infection that he was prescribed from the hospital. She stated that on most days the Wound Nurse completed Resident #143's wound care but if the Wound Nurse was off or unavailable, she could certainly do the care. Nurse #1 added that if the dressing was soiled in between routine wound care, she would be responsible for changing it at that time. Nurse #1 stated that no one had informed her yesterday (06/12/23) that Resident #143's dressing was off, or she would have gone and replaced the dressing or called the Wound Nurse to replace the dressing. She added that Resident #143 was not able to tell the staff all the time if he was soiled but the NAs checked him for incontinent issues during their regular rounds.

The Wound Nurse was interviewed on 06/13/23 at 9:30 AM who confirmed that Resident #143 had a wound to his left ischium that was treated on a daily basis. She stated that yesterday (06/12/23) she had completed Resident #143's wound care around lunch time after NA #1 notified her that Resident #143's dressing needed to be replaced. The Wound Nurse stated she was not aware prior to that, that Resident #143's dressing was off. She stated that from 8:30 AM to 12:30 PM "was a long time for the wound to be exposed to stool" and if someone would have notified her sooner, she certainly would have immediately gone and completed the wound care. The Wound Nurse stated if the any wound dressing became dislodged or soiled, she would

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 686 | Continued From page 12<br>expect it to be replaced as soon as possible.<br><br>The Director of Nursing (DON) was interviewed on 06/13/23 at 5:03 PM who stated that Resident #143 should have been checked for incontinent issues before breakfast, provided incontinent care and immediately let the nurse or Wound Nurse know that the dressing was off and needed to be replaced.<br><br>The Wound Provider was interviewed via phone on 06/15/23 at 12:26 PM who confirmed that he had evaluated Resident #143 today 06/15/23 and measured his wound. He stated that comparing today measurements with last week measurements there was no change to the wound in size. He stated that it definitely was no worse but appeared stable and had no overt signs of infection. He stated that wound had good pink tissue with some yellow slough which he had debrided (removed). The Wound Provider stated that there was always a concern for wounds in that area to be covered and kept clean of fecal matter and urine. He stated that the dressings they used were pretty good about keeping feces and urine out of the wound and they should be in place at all times except when removed to clean and place a new dressing. | F 686 | | |
| F 690 SS=E | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. | F 690 | | 6/30/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 690 | Continued From page 13<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews, the facility failed to anchor a Resident's indwelling urinary catheter tubing (Resident #53) to prevent pulling and trauma and failed to change the drainage sponge as ordered around a Resident's suprapubic stoma (an artificial opening in the skin) where the suprapubic urinary catheter was inserted (Resident #19). This was for 2 of 3 residents (Resident #53 and #19) who were reviewed for | F 690 | F690 Bowel/Bladder Incontinence, Catheter, UTI<br><br>A catheter securement device was placed on Resident #53 on 6/13/2023.<br><br>A catheter securement device was placed on Resident #19 on 6/13/2023. | |

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|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|

F 690

Continued From page 14
urinary catheters.

The findings include:

1. Resident #53 was admitted to the facility on 03/31/18 with diagnoses that included obstructive uropathy requiring a urinary catheter.

Review of Resident #53's care plan dated 04/16/23 indicated the resident required an indwelling urinary catheter related to obstructive uropathy. The goal to manage the catheter appropriately as to not exhibit signs of urinary tract infection and urethral trauma would be attained by utilizing interventions such as: avoiding obstructions in the drainage system, position catheter bag below the level of the bladder, change catheter as ordered by the physician and assess the drainage every shift. There was no care plan that addressed Resident #53 refused an anchoring device to be applied to the catheter tubing to prevent pulling or trauma.

Review of Resident #53's quarterly Minimum Data Set (MDS) assessment dated 04/13/23 revealed the resident was cognitively intact and had an indwelling urinary catheter.

Review of Resident #53's physician orders dated 11/30/21 revealed urinary catheter to bedside drainage for obstructive uropathy.

On 06/12/23 at 8:48 AM an observation was made of Resident #53's urinary catheter tubing extending from the right side of the resident's brief and connecting to the drainage bag which was hung on the bedframe on the right side of the bed. There was no anchoring device in place. The resident was sleeping during the observation.

F 690

Catheter securement devices were checked for placement on all residents with an ordered catheter on 6/13/2023. Any missing catheter securement devices were replaced immediately.

To identify others that have the potential to be affected, a 100% audit of all residents with documented catheters was completed on 06/15/2023. All care plans and nursing assistant care guides were reviewed, revised and updated by 06/20/2023.

To prevent this from re-occurring, all nursing staff were educated by administrative nursing on the facility□s urinary device policy by 6/30/23. Education on the facility□s urinary device protocol will be provided to newly hired nursing staff during orientation.

To monitor and maintain ongoing compliance the Director of Nursing or designee will complete random weekly audits to ensure catheter securement devices are in place for residents with catheters ordered. Results of these audits will be documented for 5 residents per week x 4 weeks, then for 3 residents per week x 4 weeks, and then for 1 resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 690 | Continued From page 15<br><br>On 06/13/23 at 8:57 AM during an observation and interview with Resident #53 the resident was lying in bed eating breakfast. The resident was asked if she had an anchoring device in place on her urinary catheter tubing and she lifted her bed linen from both sides of her brief and stated "no, why, should I have"? There was no anchoring device in place.<br><br>On 06/13/23 at 10:09 AM An observation was made of Resident #53 accompanied by Nurse Aide (NA) #3 who was frequently assigned to care for the resident. The NA asked the resident if she could see if she had an anchoring device in place then observed that there was no anchoring device applied to Resident #53's catheter tubing.<br><br>An interview was conducted with Nurse Aide #3 on 06/13/23 at 10:09 AM. The NA explained that she was not aware that Resident #3 did not have an anchoring device in place but that she was pretty sure there should be one in place to prevent pulling and trauma. The NA stated she would obtain one and place it on the Resident #53.<br><br>During an interview with Nurse #2 on 06/13/23 at 3:54 PM the Nurse confirmed she was responsible for Resident #53 for that shift. The Nurse explained that all residents who have urinary catheters should have anchoring devices in place to prevent from pulling and trauma. She continued to explain that when she conducted a resident's full body assessment, she made sure they were wearing one if they had a urinary catheter, but she had not had to complete one on Resident #53 yet, so she did not know if she had one in place or not. The Nurse reported that no | F 690 | per week x 4 weeks. Any concerns identified during these audits will be addressed immediately and reported to the Quality Assurance Committee for 3 months. After 3 months of audits are completed, the Quality Assurance Committee will then determine if further action is needed.<br><br>Completion Date 6/30/2023 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ____<br>B. WING ____ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WILKESBORO HEALTH AND REHABILITATION** | **204 OLD BRICKYARD ROAD**<br>**NORTH WILKESBORO, NC 28659** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 16 | F 690 | | |

one had reported to her that the Resident did not have one in place.

The Director of Nursing (DON) was interviewed on 06/13/23 at 5:18 PM who explained anchoring devices were utilized with urinary catheters but Resident #53 would often refuse the stabilizing device.

During an observation and interview with Resident #53 on 06/13/23 at 5:48 PM it was noted that the resident had an anchoring device on her right thigh. The resident stated they came in and put it on her yesterday or today and that she did not mind wearing it, but she did not know what it was for. The resident also commented she could not tell that she was wearing it unless she looked at it and saw it was there.

On 06/14/23 at 9:30 AM an observation was made of Resident #53 who continued to wear the anchoring device on her right thigh. The Resident commented "look it is still there."

During an interview with the Administrator on 06/14/23 at 1:14 PM she expressed she expected the staff to apply the stabilizing band on Resident #53.

2. Resident #19 was admitted to the facility on 01/03/23 with diagnoses that included chronic neurogenic bladder.

Review of Resident #19's physician orders revealed: an order dated 01/03/23 for a suprapubic urinary catheter to bedside drainage and an order dated 01/04/23 to cleanse the suprapubic catheter site with saline and apply a drainage sponge every day.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 690 | Continued From page 17<br><br>The significant change Minimum Data Set (MDS) assessment dated 05/03/23 revealed Resident #19's cognition was moderately impaired and required a suprapubic catheter.<br><br>Review of Resident #19's care plan dated 05/08/23 indicated the Resident required a suprapubic catheter related to chronic neurogenic bladder. The goal the suprapubic catheter care would be managed appropriately as evidence by no exhibiting obstruction, signs of infection or trauma would be attained by utilizing interventions such as: assessing drainage, provide catheter care, manipulate tubing as little as possible, keep catheter bag below level of bladder and report complications.<br><br>Review of Resident #53's Treatment Administration Record (TAR) from 06/2023 indicated the treatment of cleansing and changing the drainage sponge to the Resident's suprapubic site was last completed on 06/12/23 by the Wound Nurse.<br><br>On 06/13/23 at 2:08 PM an observation was made of Resident #19's suprapubic stoma accompanied by Nurse Aide (NA) #4. The NA revealed the drainage sponge on the suprapubic stoma was dated 06/11/23. The drainage sponge contained a moderate amount of greenish brown drainage and had a foul odor.<br><br>An interview was conducted with the Wound Nurse on 06/13/23 at 2:15 PM who explained she worked Monday through Friday and was responsible for doing all treatments in the facility which included changing the drainage sponges on the suprapubic catheters. She stated the last | F 690 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 690 | Continued From page 18 | F 690 | | |

time she changed the drainage sponge on Resident #19's suprapubic stoma was yesterday (06/12/23).

On 06/13/23 at 2:20 PM accompanied the Wound Nurse to perform a dressing change on Resident #19's suprapubic drainage sponge. Before the Wound Nurse removed the resident's dressing the resident informedher that the area was itching and when she scratched it, she had blood on her fingers. The Nurse lowered the resident's brief to expose the old drainage sponge and noted it was dated 06/11/23 and had a moderate amount of greenish brown drainage as well as streaks of blood on the drainage sponge. The foul odor was more prominent after the old dressing was removed. The Wound Nurse cleansed the stoma area and replaced a new drainage sponge as ordered.

An interview was conducted with the Wound Nurse on 06/13/23 at 2:44 PM who explained the amount of drainage and bloody streaks on the old dressing was typical of the condition of the dressings she removes during the treatments and the odor was typical as well. The Nurse stated she had no explanation of why the old dressing was dated 06/11/23 because she thought she did the treatment on Resident #19 on 06/12/23.

An interview was conducted with the Director of Nursing (DON) on 06/14/23 at 11:51 AM who explained that Resident #19 was relatively new to the facility as a long-term care resident, and she contacted her previous care takers about the condition of her suprapubic stoma drainage. She continued to explain that the drainage was an issue with them as well and they had to increase the dressing changes to twice a day and that may

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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| F 690 | Continued From page 19<br>be what the facility had to do as well. The DON indicated she expected the dressing changes to be changed as the physician ordered one time a day. | F 690 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, | F 867 | | 6/26/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 20 | F 867 | | |

including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 867 | Continued From page 21 | F 867 | | |

Continued From page 21

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

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| | 345401 | A. BUILDING ______ B. WING ______ | 06/15/2023 |

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|---|---|---|---|---|
| F 867 | Continued From page 22<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following a focused infection control survey on 11/12/20 a focused infection control and complaint survey on 1/29/21, and the recertification and complaint survey conducted on 12/02/21. This failure was for two deficiencies originally cited in the area of Infection Control (F880) and Quality of Care (F686) that were subsequently recited on the current recertification survey of 06/15/23. The repeat deficiencies during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F880: Based on observation, record review and interviews the facility failed to perform hand hygiene and change gloves after removing a soiled dressing and before cleansing a resident's suprapubic stoma (an artificial opening through the abdomen to the bladder) site for 1 of 1 resident (Resident #19) reviewed for dressing change.<br><br>During the focus infection control survey of 11/12/20 the facility failed to implement their infection control policies and the CDC guidelines when staff did not don full Personal Protective Equipment (PPE) including gloves and in a resident rooms, failed to sanitize a multi-use | F 867 | F867 QAPI/QAA Improvement Activities<br><br>Deficiency Corrected<br><br>The facility Quality assessment and Assurance Committee failed to implement procedures and monitor the interventions facility put in place following a focused infection control survey on 11/12/2020, a focused infection control and complaint survey conducted on 1/29/2021 and the recertification and complaint survey conducted on 12/02/21 in the areas of Infection Control and Quality of Care.<br><br>A plan of correction for F880 cited during the Focused Infection Control Survey 11/12/2020 and for F880 focused infection control and complaint survey conducted on 1/29/2021 and for F686 cited during the recertification and complaint survey on 12/02/2021 were submitted to CMS and accepted with follow up and return to compliance visits. Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout | |

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|---|---|---|---|---|

F 867

Continued From page 23

stethoscope between residents and failed to perform hand hygiene after cleaning environmental surfaces in a resident room for 3 of 3 residents on enhanced droplet precautions on the Covid-19 quarantine hall. These failures in infection control practices occurred during a Covid-19 pandemic.

During the focused infection control and complaint survey of 1/29/21 the facility failed to implement their infection control policies when facility staff members failed to don and doff Personal Protective Equipment (PPE), perform hand hygiene before entering or after contact with objects in resident's rooms who were under enhanced droplet isolation precautions and disinfect reusable equipment between residents on the general population halls (Resident #1, #2) for 2 of 5 staff observed for infection control practices. The failures in infection control practices occurred during a global COVID-19 pandemic. A total of 28 residents and 2 staff members were confirmed positive for COVID-19 as of 01/27/21.

F686: Based on observations, record review, resident, staff, and Wound Provider interviews the facility failed to keep a Stage 4 pressure ulcer covered and free from contamination of fecal matter for 1 of 4 residents reviewed for pressure ulcers (Resident #143).

During the recertification and complaint survey of 12/02/21 the facility failed to identify and assess a change in a resident skin condition for 1 of 3 residents reviewed for pressure ulcers resulting in the development of an unstageable deep tissue injury to the resident's sacral area.

F 867

the monitoring period and were discontinued.

The Administrator initiated an in-service to all administrative staff on June 26, 2023, regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education.

The QAPI Committee will review the compliance audits for F880 and F686 to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved

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| WILKESBORO HEALTH AND REHABILITATION | 204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659 |

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|---|---|---|---|---|
| F 867 | Continued From page 24<br>The Administrator was interviewed on 06/13/23 at 5:33 PM and stated that she had been at the facility since March 2023 and had met at least twice with the QA committee. She stated they met monthly and all department heads, some direct care staff, and the Medical Director all attended their meetings. She stated that each department head brought their own reports specific to their department and they would discuss any items that needed to be discussed. On a monthly basis the QA committee discussed wounds and infection control along with a list of other topics. The Administrator felt like the facility was moving in the right direction and were very productive in the QA meetings. The Administrator stated that they would look at the newly identified infection control issues and pressure ulcer issues and identify new ways and strategies to achieve and maintain compliance. | F 867 | three months of consistent compliance.<br><br>The Administrator will be responsible for the plan of correction.<br><br>Date of Completion 6/26/2023 | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | | 7/12/23 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 25<br>and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which 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; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | | |

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|---|---|---|---|---|

F 880

Continued From page 26

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews the facility failed to perform hand hygiene and change gloves after removing a soiled dressing and before cleansing a resident's suprapubic stoma (an artificial opening through the abdomen to the bladder) site for 1 of 1 resident (Resident #19) reviewed for dressing change.

The finding included:

Review of an undated policy titled "Wound Care" revealed Policy: Provide wound care for the purpose of healing and decreasing the potential for nosocomial infections. Procedure: 9. Put on exam glove and loosen tape and remove dressing. 10. Pull glove over dressing and discard. 11. Perform hand hygiene. 12. Wear gloves for new or deep wounds, wounds which bleed, when physically touching the wound .... 13. Cleanse wounds with saline unless otherwise indicated.

On 06/13/23 at 2:20 PM a treatment observation was made of a dressing change on Resident #19's suprapubic catheter stoma by the Wound Nurse. The Nurse assembled the supplies for the ordered dressing change and explained the

F 880

F880 Infection Prevention & Control

On 6/13/23 he wound care nurse was reeducated by Director of Nursing on best practices regarding infection control during wound care.

Resident #19 was not adversely affected regarding deficient practice.

To identify others that have the potential to be affected, administrative nursing staff will conduct a 100% audit of all residents receiving wound care by 7/12/23 to ensure that proper hand hygiene is completed during the procedure.

To prevent this from re-occurring, administrative nursing staff completed in-servicing for all nursing department staff by 6/30/2023 on proper infection control practice during wound care. Education on proper infection control during wound care will continue to be provided to newly hired nursing staff during orientation.

To monitor and maintain ongoing

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|---|---|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 27<br>procedure to Resident #19 who responded that she was glad because it had been itching and when she scratched it, she had blood on her fingers. The Nurse sanitized her hands and applied clean gloves then removed the old drainage sponge dressing which had a moderate amount of greenish brown drainage that contained bloody streaks had a foul odor. The Wound Nurse threw the soiled drainage sponge in a cup that she utilized for a trash receptacle. The Nurse then picked up the saline gauze and proceeded to cleanse the drainage and blood from the area around the stoma and threw the gauze in the trash cup. She then removed her dirty gloves and sanitized her hands before she applied a new drainage sponge dressing around the stoma.<br><br>An interview conducted with the Wound Nurse on 06/13/23 at 2:44 PM revealed the Nurse explained that she knew she did not remove her gloves, sanitize her hands and apply a new pair of gloves after she removed the dirty dressing and before she cleansed the drainage from the stoma. She stated she was nervous.<br><br>An interview was conducted on 06/13/23 at 4:07 PM with the Assistant Director of Nursing (ADON) who also served as the Infection Control Nurse. The Nurse explained that the Wound Nurse rounded with the Wound Care Provider on a weekly basis, and she had not received any feedback regarding a lack of proper wound care technique performed by the Wound Nurse. The ADON continued to explain that the Director of Nursing had observed the Wound Nurse during wound treatments, but she did not know how often. Regardless, the ADON stated the Wound Nurse should have removed her gloves, sanitized | F 880 | compliance, the Director of Nursing or designee will complete weekly audits to ensure proper infection control practice is used during wound care. Results of these audits will be documented for 5 residents per week x 4 weeks, then for 3 residents per week x 4 weeks, and then for 2 residents per week x 4 weeks. Each week□s observations will include at least one observation of the wound care nurse completing wound care. Any concerns identified during these audits will be addressed immediately and reported to the Quality Assurance Committee for 3 months. After 3 months of audits are completed, the Quality Assurance Committee will then determine if further action is needed.<br><br>Completion Date 07/12/23 | |

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|---|---|---|---|---|
| F 880 | Continued From page 28<br>her hands and donned a new pair of gloves after she removed the old drainage sponge and before she cleansed the stoma area.<br><br>On 06/13/23 at 5:22 PM during an interview with the Director of Nursing (DON) she explained that she had observed the Wound Nurse during wound treatments, and she did get nervous but even so the Wound Nurse should have removed her dirty gloves and donned a fresh pair of gloves before she cleansed the stoma site. | F 880 | | |