DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

JUL 1 3 2012

PRINTED: 06/29/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
Dato, Johnson			A. BUILDING		С			
		345423	B. WING		1	/2012		
NAME OF PROVIDER OR SUPPLIER WILMED NURSING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 SOUTH TARBORO STREET WILSON, NC 27893					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		F 315	F315 The facility will promote care of the incontinent resident by adhering to the facility policy and procedure to provide perineal care in a manner that will not increase the risk of infections and/or skin breakdown. CNA #4's schedule adjusted accordingly. DON and Supervisor interviewed CNA #4 to clarify knowledge		6/28/12 6/29/12		
This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide incontinence care per their policy for 1 of 1 sampled dependent residents (Resident #) whose care was observed. Findings include:		on, record review and staff failed to provide r their policy for 1 of 1 residents (Resident#)		base and skill validat providing incontinence Based on this session, Organization Human Res protocol was followed. Prior to survey 6/25/1 began reviewing with d	care. WilMed ources 2, SDC	7/9/12		
	05/22/12 after hospit encephalopathy secondinary tract infection on an antibiotic for 7 UTI. Cumulative diagnifection (UTI), demonstrated of the process of the provided by the facilistarted 06/25/12, independent of the perineal care was to infections. It was also	admitted to the facility on alization for metabolic ondary to sepsis from a (UTI). She was re-admitted days as treatment for the gnoses included urinary tract entia and hypertension. Dedure for "PERINEAL undated), the client should to back motion. Information ty for an inservice that was icated the purpose of prevent skin breakdown and to noted that staff should tront to back to prevent		care staff perineal care procedure with skills validation. SDC/IC Nurse/Shift Supervisors will conduct 10 total random skills validation with return demonstration by direct care staff monthly for 90 days. Any deviation of performance from the facility's Perineal Care Policy and Procedure will require one-to-one remediation with SDC, followed by skills				
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Facility ID: 923511

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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			M.A. COLUMN TO THE PARTY OF THE	С			
		345423	B. WING 06/2		7/2012		
NAME OF PROVIDER OR SUPPLIER WILMED NURSING CARE CENTER				17	EET ADDRESS, CITY, STATE, ZIP CODE 105 SOUTH TARBORO STREET ILSON, NC 27893		
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F 315	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3	315	revalidation/demonstrat Repeat violation of pol procedure will result i progressive corrective Audit results will be r in the weekly QIS meeti and the July and Octobe Quarterly Quality Assur Meetings.	icy and n action. reported ngs,	7/11/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345423		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			C 06/27/2012		
NAME OF PROVIDER OR SUPPLIER WILMED NURSING CARE CENTER			<u>. • • · · · · · · · · · · · · · · · · · </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 SOUTH TARBORO STREET WILSON, NC 27893			
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F 315	stool washing inside to soiled wash cloth. Af downward, NA#4 start finished with her bowneeded to come backher up. She taped a covered Resident #3 On 06/27/12 at 12:10 Resident #3's room to She went into the bat wash cloths. She unbegan to remove stool cloth to wash in a downanal area reaching in Each time she wiped noted on the wash cloth will eshe was we remove stool on the periarea in a fron rolled her onto her less tool. She used severemove stool each time of the wet wash cloth wipes. Using the disagain in a downward towards the perineum onto Resident #3. NA#4 was interviewed about how she was to use bath. NA#4 stated si	the wash cloth to remove the perineum with the stool ter several times of wiping and Resident #3 was not all movement and she to in fifteen minutes to clean clean brief in place and with a sheet. PM, NA#4 was back in a provide incontinent care, throom and wet several taped the soiled brief and bit. NA#4 used a wet wash wnward motion from the to the perineum to cleanse, downward there was stool bith. Resident #3 began to ashing her. She assisted to back motion and then it side to finish removing aral wet wash cloths to the going in a downward erineal area. She used all as so she used disposable posable wipes, NA#4 wiped motion from the anal region in. She placed a clean brief and to provide incontinent with the state of the provide incontinent incontin	F	315			

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	ROVIDER OR SUPPLIER	3	1:	EET ADDRESS, CITY, STATE, ZIP CODE 705 SOUTH TARBORO STREET VILSON, NC 27893			
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F 315	stated staff should all	ways wipe front to back irty. The DON stated staff ng dirty to clean	F 315				