<table>
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<tr>
<th>Provider/Supply</th>
<th>Identification Number:</th>
<th>Public/Regulatory Code</th>
<th>Date Survey Completed</th>
</tr>
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<tbody>
<tr>
<td>WilMed Nursing Care Center</td>
<td>345423</td>
<td></td>
<td>06/27/2012</td>
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<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
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| F 315 | SS=D | 483.25(c) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | | 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 base and skill validation for providing incontinence care. 
Based on this session, WilMed Organization Human Resources protocol was followed. 
Prior to survey 6/25/12, SDC began reviewing with direct 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 validation. |

Betty Lancerita
Administrator

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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spreading fecal matter from anal area to vagina or urethra (opening to bladder)."

The most recent Significant Change Minimum Data Set (MDS) assessment of 06/29/12 indicated Resident #3 was not cognitively intact. She required total assistance with hygiene and bathing. She was always incontinent of bowel and bladder.

Resident #3’s care plan, last reviewed on 06/04/12, identified problems with needing extensive to total care for activities of daily living (ADL). A problem was also identified with recurrent urinary tract infections (UTI’s). Included in the interventions was to provide prompt incontinent care with the appropriate care front to back.

Resident #3 was observed receiving a bed bath on 06/27/12 beginning at 10:30 AM. Nurse Aide #4 (NA#4) reported that Resident #3 was in the process of having a bowel movement. There were 2 basins of water on the overbed table. NA#4 used the dirty brief to remove a large amount of soft formed stool from the midline crease and anal area. She assisted the resident to roll onto her back and proceeded to provide perineal care. NA#4 announced each step as she provided care. She washed in a front to back motion as she cleansed the groin and the labial areas. She assisted Resident #3 to roll onto her left side. NA#4 used the brief to remove more stool from the buttocks and anal region. She used a wash cloth with soap and water to wipe away the excess stool in a downward motion going from the anal region towards the vaginal region. She announced each time she

revalidation/demonstration. Repeat violation of policy and procedure will result in progressive corrective action. Audit results will be reported in the weekly QIS meetings, and the July and October Quarterly Quality Assurance Meetings.

7/11/12
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|       | wiped downward with the wash cloth to remove stool washing inside the perineum with the stool soiled wash cloth. After several times of wiping downward, NA#4 stated Resident #3 was not finished with her bowel movement and she needed to come back in fifteen minutes to clean her up. She taped a clean brief in place and covered Resident #3 with a sheet. On 06/27/12 at 12:10 PM, NA#4 was back in Resident #3's room to provide incontinent care. She went into the bathroom and wet several wash cloths. She untaped the soiled brief and began to remove stool. NA#4 used a wet wash cloth to wash in a downward motion from the anal area reaching into the perineum to cleanse. Each time she wiped downward there was stool noted on the wash cloth. Resident #3 began to void while she was washing her. She assisted Resident #3 to roll onto her back. NA#4 washed the perineum in a front to back motion and then rolled her onto her left side to finish removing stool. She used several wet wash cloths to remove stool each time going in a downward motion towards the perineal area. She used all of the wet wash cloths so she used disposable wipes. Using the disposable wipes, NA#4 wiped again in a downward motion from the anal region towards the perineum. She placed a clean brief onto Resident #3. NA#4 was interviewed at 12:30PM on 06/27/12 about how she was trained to provide incontinent care. She stated she should have all her supplies together before providing care. She stated she was to use 2 basins to provide a bed bath. NA#4 stated she should wash in a front to back manner. NA#4 stated she should open the
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345423

**Multiple Construction**

**A. Building:**

**B. Wing:**

**C. Date Survey Completed:** 06/27/2012

**Name of Provider or Supplier:** Wilmed Nursing Care Center

**Street Address, City, State, Zip Code:** 1706 South Tarboro Street, Wilson, NC 27893

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Vagina area and cleanse using different parts of the cloth downward. She stated when she was cleansing the back side of a resident, she was taught to wash downward toward the inner thigh/perineal area to remove the stool. When questioned about the procedure observed, she demonstrated using her left hand and wiped from the top of her hand downward. NA#4 stated she should always wash down to make sure she got all of the stool removed. NA#4 then stated she should wash front to back after she washed downward.

The Staff Development Coordinator (SDC) was interviewed about how staff were trained to provide incontinent care on 06/27/2012 at 12:45PM. She stated she had just started inserviceing on prevention of UTI's on 6/25/12. The SDC stated the proper procedure for providing perineal care was demonstrated on dummies and staff were required to demonstrate as well. She stated staff had been instructed to open the labia to wash front to back using different parts of the wash cloth or a clean cloth. When questioned if staff were instructed to wash downward from the anal region towards the perineum, she replied "absolutely not". The SDC stated when cleaning the buttocks/perineal area, staff should always wipe front to back, never back to front. She stated one should not see any staff member washing downward. The SDC commented staff should always wash clean to dirty and not dirty to clean.

During an interview with the Director of Nurses (DON), on 06/27/12 at 1:50 PM, she stated staff were expected to follow the facility's policy and procedure for providing perineal care. She
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<td>Stated staff should always wipe front to back going from clean to dirty. The DON stated staff should not be cleansing dirty to clean contaminating the clean areas.</td>
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