STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ____________________________
B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345423
B. MULTIPLE CONSTRUCTION
C. DATE SURVEY COMPLETED: 03/16/2016

NAME OF PROVIDER OR SUPPLIER
WILSON REHABILITATION AND NURSING CENTER

ADDRESS, CITY, STATE, ZIP CODE
1705 SOUTH TARBORO STREET
WILSON, NC  27893

SUMMARY STATEMENT OF DEFICIENCIES
(FIELD IDENTIFICATION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  PREFIX  TAG
F 315  SS=D

DEFICIENCY
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.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews the facility failed to collect and send a urine sample for 1 of 1 sampled residents (Resident #94) who had physician orders for a urinalysis with culture and sensitivity due to suspicion of a urinary tract infection (UTI). Findings included:

Resident #94's Admission Minimum Data Set (MDS) dated 12/16/15 revealed she was admitted to the facility on 12/09/15 with diagnoses of muscle weakness, pneumonia and respiratory failure. Resident #94 was moderately cognitively impaired.

Review of the Nurses Additional Notes dated 03/04/16 revealed Resident #94 was disoriented to place, time, and others. Resident #94 was attempting to pack up her roommate's belongings. Reorientation was provided but Resident #94's disorientation continued. A new order for a UA C&S (urinalysis with culture and sensitivity) was received from the physician to rule out a UTI because of Resident #94's increased confusion.

Review of the Physician's Telephone Orders dated 03/04/16 revealed an order for UA C&S due

F315 The facility will ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections.

The facility will collect and send a urine sample for Resident #94 per physician order.

UA for C&S for Resident #94 was collected and sent to laboratory on 3/16/16. MD notified and order received to report results.

For Resident #94, report for sample showing no growth was received and reported to physician on 3/17/16.

For all other residents, 11-7 pm Nursing staff began on 3/17/2016 reconciling all resident lab orders from 3/4/16 to 3/16/16 with completion of reconciliation on 3/22/16. No trends identified.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

DATE
04/05/2016

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 patient. (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.

Electronic Signature 04/05/2016

Facility ID: 923511
Event ID: 08VL11
If continuation sheet Page 1 of 3
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING**

**B. WING**

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>The facility will provide in-services on UTI prevention, appropriate peri-care and assessment for s/sx of UTI for direct nursing care staff. General and annual education for direct nursing care staff will occur on assessment of s/sxs &amp; prevention of UTI and peri-care.</td>
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11-7 pm Supervisor or designee will perform weekly audit reconciliation of pink copy of MD order, lab requisition sheet and lab calendar, printed record of results and documentation of MD notification x 3 months. Monthly peri-care audits will be completed x 3 months.

DON will report results of audits quarterly at the QAPI team meeting x 6 months.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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**NAME OF PROVIDER OR SUPPLIER**

WILSON REHABILITATION AND NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1705 SOUTH TARBORO STREET

WILSON, NC 27893

**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>unable to collect the urine sample he ordered he would expect to be notified so he could decide if an empiric antibiotic should be started or if just monitoring was needed. In an interview on 03/16/16 at 3:50 PM the Director of Nursing (DON) indicated it was her expectation that urine samples be collected and sent for testing as ordered. She indicated if the nurse was unable to collect the sample it should have been passed on in report and written on the Communication Log. The DON stated the order was missed and it was unacceptable that it had happened.</td>
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