

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/13/2025
NAME OF PROVIDER OR SUPPLIER  Wilson Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Downing St SW Wilson, NC 27893	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49159</p> <p>Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 2 of 4 residents (Resident #86 and Resident #13) reviewed with urinary catheters.</p> <p>The findings included:</p> <p>1. Resident #86 was admitted to the facility on [DATE] with diagnoses that included retention of urine, benign prostatic hyperplasia (a non-cancerous condition that causes the prostate gland to enlarge), and obstructive and reflux uropathy (urinary tract conditions that occur when urine can't flow normally).</p> <p>An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 was moderately cognitively impaired. The assessment indicated Resident #86 was dependent upon staff for all his activities of daily living (ADL). Resident #86 was coded for an indwelling catheter.</p> <p>Resident #86's care plan dated 11/2/24 revealed focus areas for catheter care and at risk for infection.</p> <p>An initial observation was conducted on 1/6/25 at 10:40 AM of Resident #86. He was observed lying in his bed. His urinary catheter bag was inside a blue privacy bag and was hanging off the bed frame on the resident's left side of the bed resting on the floor.</p> <p>Additional observations of Resident #86 were conducted on 1/6/25 at 11:27 AM and 2:33 PM. Resident #86's urinary catheter bag remained inside a blue privacy bag and was hanging off the bed frame on the resident's left side of the bed resting on the floor.</p> <p>An interview was conducted on 1/6/25 at 2:37 PM with Nurse #1. She stated the urinary catheter bag was in the privacy bag.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/8/25 at 1:59 PM. She stated her expectation was that urinary catheter bags were kept off the floor to prevent infection.</p> <p>(continued on next page)</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 REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Infection Preventionist (IP) on 1/9/25 at 10:22 AM. She stated the blue privacy bag was on the urine bag itself and served as a layer of protection between the urine collection bag and the floor to prevent infection.</p> <p>An interview was conducted on 1/9/25 at 11:01 AM with the Administrator. He stated the urinary catheter bag should not touch the ground and if it did, it was changed out immediately to prevent infection.</p> <p>On 1/10/25 at 12:04 PM, the Administrator provided documentation from the manufacturer of the urinary catheter bag utilized for Resident #86 that indicated the catheter bag had an anti-reflux chamber that prevents urine from flowing back into the bladder, which can reduce the risk of infection.</p> <p>49502</p> <p>2.Resident #13 was readmitted to the facility on [DATE] with diagnoses which included congestive heart failure, recurrent urinary tract infections (UTI), and neuromuscular dysfunction of the bladder.</p> <p>A quarterly Minimum Data set (MDS) dated [DATE] revealed Resident #13 was cognitively intact. She was dependent upon staff for toileting hygiene and was incontinent of urine.</p> <p>Resident #13's care plan dated 11/15/24 revealed a focus for bladder incontinence with a history of urinary tract infections (UTIs).</p> <p>Physician orders revealed Resident #13 had an order to insert an indwelling urinary catheter on 1/3/25 for urinary retention. An additional review of physician orders revealed the indwelling urinary catheter was discontinued on 1/6/25.</p> <p>An initial observation was conducted on 1/6/25 at 11:40 am of Resident #13 as she was lying in her bed. A urinary catheter bag inside a privacy bag was observed to be hanging off the bed frame on the resident's right side of the bed. The entire bottom of the privacy bag was resting on the floor.</p> <p>An additional observation was conducted on 1/6/25 at 12:25 pm, Resident #13's urinary catheter bag was inside a privacy bag and was observed to be hanging off the bedframe on the resident's right side of the bed. The entire bottom of the privacy bag was resting on the floor.</p> <p>In an interview with Nurse #3 on 1/7/25 at 9:15 am, she stated she was the hall nurse assigned to care for Resident #13. Nurse #3 was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, It shouldn't touch the floor to prevent infection.</p> <p>During an interview with Nurse Aide (NA) #2 on 1/8/25 at 8:47 am, she stated the catheter bag and tubing should not be on the floor to reduce the risk of infection.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/8/25 at 1:59 PM. She stated her expectation was that urinary catheter bags were kept off the floor to prevent infection.</p> <p>An interview was conducted with the Infection Preventionist (IP) on 1/9/25 at 10:22 AM. She stated the blue privacy bag was on the urine bag itself and served as a layer of protection between the urine collection bag and the floor to prevent infection.</p> <p>(continued on next page)</p>		

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