STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

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E 000	Initial Comments An unannounced recertification survey was conducted on 11/06/23 through 11/09/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MF3Y11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 11/06/23 through 11/09/23. Event ID # MF3Y11.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to determine whether the self-administration of medications was clinically appropriate for 2 of 2 sampled residents (Resident # 55 and Resident # 37) who were observed to have a medication at bedside. The findings included: 1. Resident #55 was admitted to the facility on 7/19/2019 with diagnoses to include a chronic non-pressure ulcer and gout. A review of the medical record for Resident #55 revealed a physician order dated 9/2/2022 for a multivitamin tablet to be administered daily for wound healing.	F 554	F554 Resident #37 had nasal spray sitting on her bedside table. Resident #55 had multi-vitamins at bedside. Both residents self-administering medications. No self-administration assessment completed and resident #37 did not have and active order for the medication on medication order sheet. #1 Corrective Action for Affected Resident: Medications were immediately removed from both resident□s rooms. The director of nursing completed a self-administration assessment on resident #37. The charge nurse completed a self-administration assessment on resident #55. Primary care	11/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/02/2023

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F 554	Continued From page 1 The most recent quarterly Minimum Data Set assessment dated 10/15/2023 assessed Resident #55 to be cognitively intact. The medical record was reviewed and no assessment for self-administration of medications was in Resident #55's record. There were no physician orders for Resident #55 to self-administer medications, and no care plan that addressed self-administration of medications. Resident #55 was observed on 11/6/2023 at 4:22 PM. A bottle of over-the-counter multivitamin gummies was noted to be on the over the bed table and the bottle appeared to be half full. Resident #55 reported the facility was aware he had multivitamin gummies at the bedside. Another observation of Resident #55 was conducted on 11/7/2023 at 9:33 AM. The multivitamin gummy bottle was reviewed, and the instructions read to take 2 gummies daily. Resident #55 explained he took 2 of the gummies as the directions specified, but he wasn't certain how long he had the multivitamin gummies. During an observation of Resident #55 on 11/8/2023 at 12:21 PM, Medication aide (MA) #1 was interviewed. MA #1 reported she had administered all of Resident #55's medications that date, including his multivitamin tablet. MA #1 reported she was not aware Resident #55 had the multivitamin gummies at his bedside and explained she had not observed the bottle of multivitamin gummies on his over the bed table. MA #1 reported she was not aware Resident #55 was taking the multivitamin in addition to what she administered to him. MA #1 removed the multivitamin gummies from Resident #55's room.	F 554	provider was contacted to ensure resident #37 is capable of self-administering normal saline nasal spray. Primary care provider for resident #55 was contacted to ensure resident is capable of self-administering multi-vitamin. #2 To identify other residents that have the potential to be affected, All residents have the ability to be affected. Director of nursing or designee made a full facility room check of all current residents to ensure no inappropriate medications were being kept by any resident. No other medications were found. #3 To prevent this from recurring: All residents with a Brief Interview for Mental Status (BIMs) score of 12 or higher will be interviewed to determine if they would like to self-administer medications. If a resident wishes to self-administer medications, the resident's primary care provider will be contacted for approval. A self-administration assessment will be completed for all medications requested to be self-administered. The Self administration of that medication will be care planned to reflect so. All nurses and medication aides were in-serviced on self-administration of medication. All new hires will be educated during orientation. Education Completed	

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F 554	Continued From page 2 The Unit Manager (UM) #1 was interviewed on 11/8/2023 at 12:29 PM. UM #1 reported she was not aware Resident #55 had multivitamin gummies at his bedside and was self-administering the multivitamins. UM #1 reported she was not aware Resident #55 did not have an assessment to self-administer medications. The physician (MD) was interviewed on 11/8/2023 at 1:18 PM by phone. The MD explained he was not aware Resident #55 had multivitamin gummies at his bedside and he was administering the gummies in addition to the tablet he was receiving from staff. The MD reported Resident #55 was cognitively capable of managing an over-the-counter multivitamin, however, the facility should have been aware he had it at the bedside, so he was not receiving double medication. The Director of Nursing (DON) was interviewed on 11/9/2023 at 11:55 AM. The DON confirmed that she was not aware Resident #55 had the multivitamin gummies at the bedside, and that she was not aware he did not have an assessment completed to self-administered medications. The DON explained Resident #55 reported to her he was not aware he had to notify the facility nurses if he ordered over-the-counter medications. 2. Resident #37 was admitted to the facility on 4/8/20 with reentry on 10/11/21 from a hospital. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and allergic rhinitis (an allergic reaction causing irritation to the nose).	F 554	11/10/23. #4 To monitor and maintain ongoing compliance: Director of nursing or designee will perform weekly random audits to ensure no medication is at bedside that has not been previously deemed appropriate. Audit will be 10 residents per week for 12 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance Date 11/11/23	

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F 554	Continued From page 3	F 554		

A review of Resident #37's electronic medical record (EMR) revealed a physician order was received on 11/23/22 for 137 micrograms (mcg) / spray azelastine solution (an antihistamine nasal spray) to be administered as two sprays into each nostril twice daily for allergic rhinitis times one month.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 8/18/23. The MDS assessed Resident #37 to be cognitively intact.

Resident #37's current care plan was reviewed. The resident was not care planned for the self-administration of medications.

A review of the resident's EMR revealed no assessments were completed for the self-administration of medications.
Also, there were no physician orders for Resident #37 to self-administer medications.

An observation was conducted on 11/6/23 at 10:25 AM of Resident #37 as she laid in her bed. At that time, a bottle of azelastine nasal spray was noted to be placed on her bedside tray table within reach of the resident. Upon inquiry, Resident #37 reported she used one spray for each nostril twice daily and had been administering the azelastine nasal spray on her own.

On 11/6/23 at 12:26 PM, a second observation was conducted of the resident in her room. Resident #37 was lying in the bed with the azelastine nasal spray observed on her bedside tray table.

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F 554	Continued From page 4	F 554		

An observation and interview were conducted with the resident on 11/7/23 at 2:35 PM. During the observation, it was noted the resident's azelastine nasal spray was no longer placed on her bedside table. When asked, the resident reported she "gave it (the nasal spray) back" to the hall nurse. Upon further inquiry, Resident #37 stated a nurse had left the nasal spray on her bedside table for the last one and one-half (1 and ½) to two (2) weeks, so she administered it herself. The resident reported she knew she probably should not have the medication, so she gave the nasal spray back to the nurse earlier that morning (11/7/23).

An interview was conducted on 11/8/23 at 11:47 AM with Nurse #1. Nurse #1 was the first shift hall nurse who was assigned to care for Resident #37 on 11/7/23 and 11/8/23. During the interview, an inquiry was made about the azelastine nasal spray the resident reportedly gave to Nurse #1 the morning of 11/7/23. Nurse #1 pulled the nasal spray from the medication cart. She reported that when the resident gave it to her, Resident #37 said she knew she was not supposed to have it. Observation of the nasal spray revealed it was 0.1% azelastine providing 137 mcg per spray. Portions of the pharmacy label placed on the nasal spray appeared worn and the dispensed date was no longer visible on the label. The nurse confirmed this label came from the facility's contracted pharmacy.

A telephone interview was conducted on 11/8/23 at 1:20 PM with the facility's Medical Director (who was also the resident's physician). During the interview, the MD stated he would not want Resident #37 to have a medication such as the azelastine at bedside unless she was assessed

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F 554	Continued From page 5 and care planned for the self-administration of it. An interview was conducted on 11/8/23 at 2:40 PM with the facility's Director of Nursing (DON). At that time, the DON reported the facility had a process that needed to be followed if a resident wished to self-administer a medication. However, she confirmed Resident #37 neither had an order to self-administer a medication nor was she care planned to do so.	F 554		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 calendar days for 1 of 1 resident (Resident #37) reviewed who was identified by the facility as having a significant change in condition. The findings included: Resident #37 was admitted to the facility on	F 637	F637 Resident #37 had a Preadmission Screening Review completed on 4/5/23 due to a change in resident's condition. The residents Pre Admission Screening Review changed from a level I to a level II, however a significant change Minimum Data Set assessment was not completed within the 14 days of the change.	11/28/23

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F 637	Continued From page 6 4/8/20 with reentry on 10/11/21 from a hospital. Her cumulative diagnoses included major depressive disorder. A review of Resident #37's electronic medical record (EMR) included a state Medicaid Uniform Screening Tool (NC MUST) form dated 4/5/23. This form indicated a Preadmission Screening and Resident Review (PASRR) screening was completed on 4/5/23 due to a change in the resident's condition. Resident #37's PASRR number ended with the letter "B," which was indicative of a PASRR Level II determination with no limitation on the timeframe. Determination of a PASRR Level II status was made by an in-depth evaluation. The results of the evaluation were used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Further review of the resident's EMR revealed her care plan included the following area of focus, in part: Resident required a Level II PASRR with no end date. Her diagnoses included major depressive disorder and cerebrovascular disease (Initiated on 4/10/23; Revised on 5/11/23). This area of focus was authored by the facility's Social Worker. Resident #37's EMR also included a significant change Minimum Data Set (MDS) with an Assessment Reference Date (or ARD, which was the last day of the look-back period) of 5/18/23. The MDS assessment reported Resident #37 was determined to have a PASRR Level II status. However, the significant change MDS had an ARD which was 44 days after the resident was determined to have a PASRR Level II status.	F 637	#1 Corrective action of affected resident: A significant change MDS was completed for resident #37 on 5/18/23 #2 To identify other residents that have the potential to be affected, All residents with a significant change in condition and/or a Pre Admission Screening Review level change have the potential to be affected. The minimum data set coordinator reviewed all Pre Admission Screening Review level II's to ensure no other significant changes were missed. The audit was completed on 11/8/23. All negative findings were immediately corrected. #3 To prevent this from recurring: Minimum data set coordinators, social worker and activities director were educated by the regional clinical reimbursement specialist on 11/27/23 for Minimum Data Set accuracy and care plan updates per the Resident Assessment Instrument (RAI) manual. Training included accuracy, care plan updates and significant change requirements. #4 To monitor and maintain ongoing compliance: The director of nursing or designee will perform weekly audits of all Pre	

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F 637	Continued From page 7 An interview was conducted with the facility's Social Worker on 11/7/23 at 3:07 PM. During the interview, the Social Worker reported around April of 2023, she reviewed all residents who had not been screened for a long time to be sure their PASRRs were updated. Resident #37 was one of the residents prompted for a review due to having a gradual change in her mental status. During a follow-up interview conducted on 11/8/23 at 11:10 AM, the Social Worker reported she printed out the NC MUST forms after they were received and put the forms in the Medical Record's box to be scanned into the resident's EMR. When asked, the Social Worker stated she was uncertain as to when she informed the MDS nurses of Resident #37's change to a PASRR Level II status. An interview was conducted on 11/8/23 at 10:30 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, MDS Nurse #1 recalled a PASRR assessment was completed for the facility's residents several months ago and a significant change MDS was initiated if a new Level II determination was made for a resident. She stated this was the case for Resident #37 when her PASRR level changed to a PASRR Level II. Upon review of Resident #37's EMR, MDS Nurse #1 reported the resident's PASRR Level II determination was completed on 4/5/23 and the NC MUST documentation of this change was scanned into her EMR on 4/12/23. She stated the significant change MDS should have been completed within 14 days of when the facility became aware of the resident's PASRR Level II determination. She added, "Its possible we missed it and caught it later." An interview was conducted on 11/8/23 at 2:40	F 637	Admission Screening Reviews received during the week and any reported significant change assessments. Audits will be completed weekly for 12 weeks. The administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Date of Compliance 11/28/23.	

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F 637	Continued From page 8 PM with the facility's Director of Nursing (DON). When asked about the delay in completion of a significant change MDS for Resident #37 after she was determined to be a PASRR Level II, the DON reported there was a communication barrier that delayed the significant change MDS based on her new PASRR determination. She added, "When we realized it, we did the sig [significant] change."	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		11/28/23

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F 657	Continued From page 9 assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review the facility failed to review and revise comprehensive care plans for 2 of 2 residents reviewed for comprehensive care plan review and revision. The resident's care plan must be reviewed after each Minimum Data Set (MDS) assessment time frame and revised based on changing goals, preferences and needs of the resident and in response to current interventions for the resident to meet resident care needs (Residents # 62 and # 75). Findings included: 1.Resident # 62 was re-admitted to the facility on 08/30/23 with diagnosis that included peripheral vascular disease (PVD),cerebral vascular accident (CVA) and muscle weakness. Review of a Resident # 62's care plan revised most recently on 10/12/23 revealed Resident # 62 was at risk for skin breakdown related to decreased mobility, weakness, CVA and bowel incontinence. Resident # 62 preferred to spend most of his time in bed with the goal that Resident # 62 would have no preventable skin breakdown through the next review. Interventions included to provide an air mattress, diet as ordered, monitor for skin breakdown, and encourage frequent repositioning. Review of a quarterly Minimum Data Set assessment dated 10/17/23 revealed Resident # 62 had moderate cognitive impairment, required substantial to maximal assist to roll left and right and Resident # 62 developed a stage three	F 657	F657 Resident # 62's care plan was not updated to reflect the correct stage of pressure ulcer after his minimum data set assessment was completed on 10/17/23. Resident #75 care plan was not updated to reflect resident's placement status after the completion of a quarterly assessment on 8/25/23. #1 Corrective action for affected resident: The care plan for resident #62 was updated by the minimum data set coordinator to reflect current stage of pressure ulcer on 11/7/23. The activities director updated resident #75 care plan on 11/8/23 to reflect the resident's long term care stay status. #2 To identify other residents that have the potential to be affected, All residents have the ability to be affected. The director of nursing or designee conducted an audit of all current residents on 11/8/23 to ensure the current pressure ulcer stage and the current placement status was care planned accurately. No other inaccuracies were identified. #3 To prevent this from recurring: On 11/27/23 the minimum data set coordinators, social worker and activities	

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F 657	Continued From page 10 pressure ulcer of the right buttock. An interview conducted on 11/09/23 at 9:20 AM with MDS Nurse #1 and MDS Nurse #2 revealed that care plans for Resident # 62 were revised as required (the care plan must be reviewed and revised periodically to include services, measurable objectives, measurable time frames and must describe the services required to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well- being). Resident # 62 developed a stage three pressure ulcer of the right buttock and required weekly wound care assessment by the physician and oral supplements to promote wound healing. MDS Nurse #1 and Nurse # 2 revealed the care plan should have been updated with the development of the stage three pressure ulcer of the right buttock. An interview conducted with the Administrator on 11/09/23 at 12:44 PM revealed care plans were to be revised and reviewed to reflect resident status at any time as per the Resident Assessment Manual (RAI). 2. Resident #75 was admitted to the facility on 5/19/23 with a cumulative diagnosis which included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted) and dysphagia (difficulty swallowing) status post gastrostomy tube placement. A gastrostomy tube is a feeding tube placed through the skin and directly into the stomach. A review of Resident #75's electronic medical record (EMR) revealed an admission Minimum	F 657	director were educated by the regional clinical reimbursement specialist. Education included minimum data set and care plan updates per the Resident Assessment Instrument (RAI) manual to include accuracy, care plan updates and significant change requirements. #4 To monitor and maintain ongoing compliance: The director of nursing or designee will perform weekly audits of all residents transitioning from short term care to long term care to ensure care plans are updated to reflect resident's correct placement status. Audits will continue for 12 weeks. The director of nursing or designee will audit wound reports weekly to ensure wounds are care planned accurately. Audits will be conducted for all wounds identified in the report. This audit will continue for 12 weeks. The administrator will report the results of all monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance Date 11/28/23	

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(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
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Data Set (MDS) assessment dated 5/25/23 was completed for the resident. The assessment indicated Resident #75 was receiving skilled rehabilitation (rehab) services which included Speech Therapy, Occupational Therapy, and Physical Therapy.

The resident's care plan included the following area of focus, in part: "[Resident #75] is at the facility for short term placement / rehab d/t [due to] stroke and respiratory failure." This area of focus also included a list of Resident #75's preferred activities and was documented as having been initiated on 5/30/23 with revision on 5/30/23.

Resident #75's most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 8/25/23. The MDS revealed the resident had moderately impaired cognition. The assessment also indicated Resident #75 continued to receive Physical Therapy.

A review of the resident's current care plan revealed it continued to include the following area of focus initiated and revised on 5/30/23: "[Resident #75] is at the facility for short term placement / rehab d/t [due to] stroke and respiratory failure..." Resident #75's current care plan also included a new area of focus initiated on 8/25/23. This new area of focus indicated, "Resident is long term placement at the facility" related to his diagnoses and declining health status.

An interview was conducted with the facility's MDS nurses on 11/8/23 at 10:30 AM. During the interview, MDS Nurse #1 reported Resident #75 initially came into the facility for short-term

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	345269	A. BUILDING _____ B. WING _____	11/09/2023

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rehabilitation. She noted the care plan that indicated he was admitted for short term placement / rehab was authored by the facility's Activities Director on 5/30/23. However, when Resident #75 had his quarterly assessment completed, he was care planned to be a long-term care resident. MDS Nurse #2 stated, "I actually told the Activities Director she needed to change the short-term to long-term in the care plan."

An interview was conducted on 11/8/23 at 2:40 PM with the facility's Director of Nursing (DON). The DON reported each department (such as Activities, Social Work, and Dietary) reviewed and revised their own care plan during the resident's assessment window. She also stated there were morning meetings when the individual departments came together and communicated the care plan components as a whole.

An interview was conducted on 11/9/23 at 8:55 AM with the Activities Director. During the interview, the Activities Director reported she was told about the need to revise her care plan for Resident #75 yesterday (11/8/23) and she stated, "I fixed it." The Activities Director stated the overall activity care plan had not changed. However, the discharge plan for the resident had changed where he was now anticipated to remain at the facility for long-term placement. Upon further inquiry, the Activities Director stated the MDS nurses typically reminded her when an upcoming assessment was due for a resident and of the need to review his/her care plan. The Activities Director reported she must have "missed it" when it came time to review and revise Resident #75's care plan.

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F 690	Continued From page 13	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (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. §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. This REQUIREMENT is not met as evidenced by:	F 690		11/28/23

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F 690	Continued From page 14 Based on observations, staff interviews and record review, the facility failed to keep a urinary catheter bag and/or the catheter tubing from touching the floor to reduce the risk of infection or injury for 1 of 2 residents (Resident #85) reviewed with indwelling urinary catheters. The findings included: Resident #85 was admitted to the facility on 8/24/23. His cumulative diagnoses included obstructive uropathy (a structural or functional obstruction of the urinary tract that impedes the flow of urine). A review of Resident #85's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/13/23. This MDS indicated the resident had intact cognition. He was reported as having an indwelling urinary catheter. The resident's care plan included the following area of focus, in part: The resident requires a chronic urinary catheter related to benign prostatic hyperplasia with lower urinary tract symptoms, and obstructive uropathy. This area of focus was initiated on 8/24/23 with revision on 8/28/23. An initial observation was made on 11/6/23 at 12:14 PM as Resident #85 sitting in a wheelchair in his room while watching television. The resident's urinary catheter bag was observed to be hanging from the right side of his wheelchair's frame. Both the urinary catheter bag and tubing were observed to be touching the floor. On 11/6/23 at 3:00 PM, another observation was conducted of Resident #85 as the resident was	F 690	F690 Resident #85 was observed sitting in his wheel chair with his foley catheter bag and foley catheter tubing touching the floor- placing the resident at risk for infection and/or injury. #1 Corrective action for affected resident: Resident #85's catheter bag and tubing were immediately corrected on 11/7/23. #2 To identify other residents that have the potential to be affected: The Director of Nursing completed an audit of all current residents with catheters and ensured that all catheter drainage bags and tubing were positioned appropriately and not touching the floor. Audit Completed 11/10/23. #3 To prevent this from recurring: The Director of Nursing or designee completed education with all nursing staff on appropriate placement of catheter bags and tubing. All new hires will be educated during orientation. Education completed on 11/27/23. #4 To monitor and maintain ongoing compliance: The director of nursing or designee will complete random audits of residents with a catheter to ensure bag and/or tubing is not touching the floor and is positioned	

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F 690	Continued From page 15 sitting in a wheelchair in his room. The resident's urinary catheter bag was observed to be hanging from the frame of the wheelchair and was positioned approximately ½ inch above the floor. However, a portion of the tubing from the urinary catheter was lying on the floor. An observation made on 9/11/23 at 3:15 PM revealed Resident #85's urinary catheter bag was lying on the floor as it hung from the frame of his wheelchair. The resident's urinary catheter tubing was observed to be slightly off the floor at the time of this observation. On 11/7/23 at 2:30 PM, Resident #85 was observed sitting in a wheelchair in his room watching television. Both the resident's catheter bag and tubing were noted to be on the floor. Upon request and accompanied by Nurse #1, an observation was made on 11/7/23 at 2:43 PM of Resident #85's urinary catheter bag and tubing lying on the floor. When asked if they should be touching the floor, the nurse stated, "No." Nurse #1 was observed as she donned a pair of gloves in preparation to adjust the catheter bag and tubing so they were no longer touching the floor. An interview was conducted on 11/8/23 at 2:40 PM with the facility's Director of Nursing (DON). During the interview, the observations of Resident #85's urinary catheter bag and/or tubing touching the floor were discussed. The DON reported nursing staff knew they needed to keep the resident's urinary catheter bag and tubing off the floor to the best of their ability. She added, "Maybe his should be checked more often."	F 690	appropriately. Audits will be completed for 5 residents 2 times a week for 12 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance Date 11/28/23.	