CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>00</u>			LETED	
		155696	B. W	B. WING			/2024
		11111					
NAME OF	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
BRIDGE	POINTE HEALTH C	CAMPUS		VINCE	NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Ū			F 00	000	The submission of this plan of	f	
	This visit was for the	ne Investigation of Complaint		, , ,	correction does not indicate a		
	IN00423574.	3 1			admission by Bridgepointe He		
	11.00.12007.11				Campus that the findings and		
	Complaint IN00423	3574: Federal/State deficiencies			allegations contained herein a		
	_	ations are cited at F635.			an accurate, true representati		
	l'elated to the dilegi	arons are cited at 1 055.			the quality of care provided, o		
	Unrelated deficience	vy is aited			1		
	Officialed deficient	y is cited.			living environment provided to		
		2 8 2 2024			residents of Bridgepointe Hea		
	Survey dates: Janua	ary 2 & 3, 2024			Campus. The facility recogniz		
					its obligation to provide legally	-	
	Facility number: 00				medically necessary care and	İ	
	Provider number: 1				services to its residents in an		
	AIM number: 2003	74360			economic and efficient manner The facility hereby maintains		
	Census bed type:				in substantial compliance with		
	SNF: 20				requirements of participation		
	SNF/NF: 43				skilled health care facilities. T		
	Residential: 22						
	Total: 85				this end, the plan of correction	1	
	10(a): 83				shall serve as the credible	-11	
					allegation of compliance with		
	Census payor type:				state and federal requirement		
	Medicare: 24				governing the management o		
	Medicaid: 29				facility. The Plan of Correction	1 IS	
	Other: 10				submitted to respond to the		
	Total: 63				allegation of noncompliance of	ited	
	These deficiencies reflect State Findings cited in				during the Complaint Survey		
					conducted January 2-3, 2024		
	accordance with 41	0 IAC 16.2-3.1.			facility respectfully requests fr		
					the department a desk review	for	
	Quality review com	npleted on January 9,2024.			substantial compliance.		
F 0635	483 20(0)						
SS=D	483.20(a)	ian Ordara for Immediate					
Blda. 00	Care	ian Orders for Immediate					
Didd. 00	LUGIE						1

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

At the time each resident is admitted, the

§483.20(a) Admission orders

(X6) DATE

TITLE

Michelle Weber Executive Director 01/21/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: IJTU11 Facility ID: 003237 If continuation sheet Page 1 of 9

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155696 NUMBER STREET ADDRESS, CITY, STATE, ZIP COD 1900 COLLEGE AVE VINCENNES, IN 47591 MAJ DI SIAMMARY STATEMENT OF DESICIENCIE REFERY (EACH DEPTICINCY MUST BE PRECEDED BY PULL TAG IGACII MUST HAVE physician orders for the resident's immediate care. Based on record review and interview, the facility failed to ensure physician orders were obtained and implemented following admission for 1 of 3 diabetic resident's reviewed. A resident with a diagnoses of type II diabetes did not have a physician's order to monitor their blood sugar levels for 7 days following their admission to the facility. (Resident F) Finding includes: During record review on 1/224 at 11:15 A.M., Resident F4 diagnoses included, but was not limited to, type II diabetes mellitus with diabetic chronic kidney disease and type II diabetes mellitus with diabetic chronic kidney disease and type II diabetes mellitus with hyperglycemia. Resident F4 milmission MDS (minimum data set) datad. 11:29/23, indicated that the resident had diabetes mellitus and did not receive insulin. Resident F5 physician orders included, but were not limited to. Irrolicity Pen Injector 1.5 mg (milligrams) per ml (millifiter) für diabetes mellitus type II once a day on Mondays (started I1/22/23, provided discharge medications which included glucose blood test strips with instructions to test 4 times daily before meals and at beltime. Resident F4 blood sugar levels were not documented from the admission date of 11/22/23 through the form the admiss	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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District Companies Distric	NAME OF I	PROVIDER OR SUPPLIEF	8						
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thru 11/29/23, nor was an order obtained for review and interview, the facility			_						
						1			
I monitoring the resident's blood sugar until						- I			
monitoring the resident's blood sugar until failed to ensure physician orders were obtained and implemented			ient s 01000 sugai unui			1			

STATEMENT OF DEFICIENCIES		i '			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
155696			B. WING 01/03/2024				
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					OLLEGE AVE		
BRIDGE	POINTE HEALTH C	AMPUS		VINCE	NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During on intervious	on 1/3/24 at 1:05 P.M., LPN 10			following admission for 1 of 3 diabetic residents reviewed. A		
		esident with a diagnosis of			resident with a diagnosis of ty		
	1	uld have a physician's order			diabetes did not have a	Je II	
		od sugar levels routinely.			physician's order to monitor th	eir	
		Ç ,			blood sugar levels for 7 days		
	On 1/3/24 at 2:15 P	.M., the DON (Director of			following their admission to th	e	
		facility policy titled,			facility. (Resident F)		
	· ·	tandard Operating Procedure),			Plan of Correction:		
		e policy included, "1. Blood			Resident F was not affected.		
	~	shall be completed for the			by the alleged deficient praction	e.	
	resident per the phy	'sician's order"			Resident assessed with no		
	This citation relates	to complaint IN00423574.			findings. Transfer/admission orders reviewed, reconciled, a	nd	
	This citation relates	to complaint 11100423374.			verified with MD. Orders for bl		
	3.1-30(a)				glucose monitoring for Reside		
	2.1 2 0 (w)				have remained in place since		
					11/29/23 and documented		
					appropriately with no adverse		
					effects. Staff were immediatel	y	
					educated on following physicia	ans	
					admission orders and blood		
					glucose monitoring for all diab	etic	
					residents.		
					All residents admitted and		
					residents with a diagnosis of		
					diabetes have the potential to	be	
					affected. Audit completed on		
					resident admissions within las	t 30	
					days to ensure transfer/admis	sion	
					order compliance and for all		
					diabetic residents to ensure b		
					glucose monitoring in place pe	er	
					physicians' orders. Orders		
					reconciled and updated as indicated. RN's/LPN's educated.	_{2d}	
					regarding admission physician	_	
					orders verification process an		
					blood alucose monitoring for	-	

PRINTED: 01/23/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155696		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2024	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS			STREET A 1900 C VINCEI			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	REGELITORY OF		TAG	diabetic residents. 3. As a measure of ongoing compliance, DHS or designed audit transfer/admission order 3 new admissions/readmissions per week for 4 weeks, then 2 admissions/readmissions per week x 4 weeks then 1 new admission/readmission per weeks then 3 admissions/readmissions per month x 3 months. DHS or designee will also audit 3 diable residents to ensure blood sugmonitoring orders in place per physician's orders 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for weeks, then monthly x 3 months.	e will rs for ons new eek x petic par r	
				4. As a quality measure, the DHS or designee will review a findings and corrective action least quarterly and ongoing ur campus achieves one hundre percent compliance in the car Quality Assurance Performan Improvement meetings. The puill be reviewed and updated warranted.	any at ntil d mpus nce olan	

FORM CMS-2567(02-99) Previous Versions Obsolete

483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control

§483.80 Infection Control

The facility must establish and maintain an infection prevention and control program

F 0880

SS=D Bldg. 00

Event ID:

IJTU11

Facility ID: 003237

If continuation sheet

Page 4 of 9

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED	
	155696		B. W	ING _		01/03	/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE		
BRIDGE	POINTE HEALTH C	CAMPUS			NNES, IN 47591		
D. (IDOLI				1 *			1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		de a safe, sanitary and					
		onment and to help prevent					
	· ·	and transmission of					1
	communicable dis	seases and infections.					
	\$402.00/=\ \=======	on provention and souted					
	- , ,	on prevention and control					
	program.	establish an infection					
		establish an infection ontrol program (IPCP) that					
	1 '	minimum, the following					
	elements:	minimum, the following					
	Gorionia.						
	§483.80(a)(1) A s	ystem for preventing,					
	. , , , ,	ing, investigating, and					
		ons and communicable					
		sidents, staff, volunteers,					
		individuals providing					
		contractual arrangement					
	based upon the fa	-					
	-	ing to §483.70(e) and					
	following accepted	d national standards;					
	§483.80(a)(2) Wri	tten standards, policies,					
		or the program, which must					
	include, but are no						
		rveillance designed to					
		communicable diseases or					
		they can spread to other					
	persons in the fac						
		hom possible incidents of					
		sease or infections should					1
	be reported;						
	(iii) Standard and transmission-based						
	I	followed to prevent spread					
	of infections;	. in a lasting a least of the					
	` '	v isolation should be used					
		luding but not limited to:					
	. ,	duration of the isolation,					
	1	he infectious agent or					
	organism involved	a, and	- 1		I		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IJTU11

Facility ID: 003237

If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED		
155696		B. W	NG		01/03/	2024		
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹		1900 C	OLLEGE AVE			
BRIDGE	POINTE HEALTH C	CAMPUS	_	VINCE	NNES, IN 47591			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		t that the isolation should be e possible for the resident						
	under the circums	-						
		nces under which the facility						
	must prohibit emp							
		sease or infected skin						
	lesions from direc	t contact with residents or						
	their food, if direct	t contact will transmit the						
	disease; and							
	. , ,	ene procedures to be						
	1	nvolved in direct resident						
	contact.							
	incidents identified	ystem for recording d under the facility's IPCP e actions taken by the						
		s. andle, store, process, and o as to prevent the spread						
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.							
	review, the facility control practices we observations of care hygiene after removersident's oxygen to allowed to fall to the stepped on during of drainage bag was nobladder, was clippe	on, interview, and record failed to ensure infection ere maintained during 1 of 2 e. Staff failed to complete hand wing their gloves during care, a ubing and nasal cannula were see floor and were repeatedly care, and a resident's catheter ot kept below the resident's d to the side of a waste bin, the floor. (Resident D)	F 08	380	The submission of this plan of correction does not indicate ar admission by Bridgepointe Herodampus that the findings and allegations contained herein at an accurate, true representation the quality of care provided, or living environment provided to residents of Bridgepointe Heal Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an	alth re on of the th	01/29/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IJTU11

Facility ID: 003237

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

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
				UILDING	00	COMPLETED		
155696			B. W	ING		01/03/	2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8			OLLEGE AVE			
BRIDGE	POINTE HEALTH C	CAMPUS			NNES, IN 47591			
(X4) ID	CLIMANA DAZ	STATEMENT OF DEFICIENCIE	ı	ID	<u> </u>		(V5)	
PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
TAG	REGULATORT OR	CESC IDENTIFY INCOMPATION	+	IAG	economic and efficient manne		DATE	
	During an observati	ion on 1/3/24 at 10:15 A.M.,			The facility hereby maintains i			
	-	were performing incontinence			in substantial compliance with			
		. Resident D was receiving			requirements of participation f			
		en via nasal cannula with			skilled health care facilities. To			
		nding from the resident to the			this end, the plan of correction			
		r located on the floor near the			shall serve as the credible	-		
		le providing care, staff			allegation of compliance with	all		
		D's supplemental oxygen and			state and federal requirements			
		annula and tubing to fall to the			governing the management of			
		ident's bed. Throughout the			facility. The Plan of Correction			
		CNA 5 stood on and stepped			submitted to respond to the			
	on the resident's oxy	ygen tubing. Resident D also			allegation of noncompliance c	ited		
	had a urinary cathet	ter with a catheter drainage			during the Complaint Survey			
	bag clipped to the s	ide of his bed. CNA 4			conducted January 2-3, 2024.	The		
	provided catheter ca	are and perineal care to			facility respectfully requests from	om		
	Resident D, then as	sisted the resident to turn			the department a desk review	for		
	towards CNA 5 to r	remove a small amount of BM			substantial compliance.			
	(bowel movement)	from the resident's buttocks.			F880 D Infection Prevention &	<u>L</u>		
	-	h CNA 4 and CNA 5 removed			<u>Control</u>			
	-	not perform hand hygiene.			This REQUIREMENT is not m	et		
	•	ed the resident's room to retrieve			as evidenced by: Based on			
	-	e hallway just outside Resident			observation, interview, and re			
	•	roceeded to lift Resident D from			review, the facility failed to en			
		theter drainage bag was given			infection control practices wer	е		
		ld during the transfer to his			maintained during 1 of 2			
		ging in the Hoyer lift, Resident			observations of care. Staff fail	ed to		
		ront of his face and holding on			complete hand hygiene after			
		positioned above the			removing their gloves during of			
		As CNA 4 lowered Resident D			a resident's oxygen tubing and			
		NA 5 placed her hand on			nasal cannula were allowed to			
		ad. Staff then clipped Resident			to the floor and were repeated	-		
		ge bag to the side of a waste the recliner. Staff then			stepped on during care, and a			
		ent's nasal cannula without			resident's catheter drainage b	•		
		a or wiping the tubing.			was not kept below the reside bladder, was clipped to the side			
	cicannig the canfilling	a or wiping the tubing.			• • •			
	During an interview	y on 1/3/24 at 11:00 A.M., QMA			a waste bin, and was resting of	ווע		
		dent's nasal cannula and			the floor. (Resident D) Plan of Correction:			
		ld be wrapped up and placed			Resident D was not affected	od		
	oxygen tubing shou	na oe wrappea up ana piacea			i. Resident D was not allecte	- u		

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155696	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2024			
BRIDGE	ROVIDER OR SUPPLIER	AMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 1900 COLLEGE AVE VINCENNES, IN 47591					
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR in bag on a table or QMA 8 indicated castay below the level be resting on the floperform hand hygic and after removing On 1/3/24 at 2:05 P Nursing) supplied a Hygiene, dated 1/18 "Purpose: Effective incidence of healthd Handwashing may a decontaminating has ituations: After the DON also prove Catheter Care, dated included, "To preveurinary tract 4. The held or positione prevent the urine in from flowing back in the state of the summary tract 4. The held or positione prevent the urine in from flowing back in the state of the summary tract 4. The held or positione prevent the urine in from flowing back in the state of the summary tract 4. The held or positione prevent the urine in from flowing back in the summary tract 4. The held or positione prevent the urine in from flowing back in the summary tract 4. The held or positione prevent the urine in from flowing back in the summary tract 4. The summary tract	EXAMPUS STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION night stand when not in use. Atheter drainage bags should of the bladder and should not sor, and that staff should ne prior to donning gloves gloves. J.M., the DON (Director of facility policy titled, Hand 3/23. The policy included, hand hygiene reduces the care-associated infections 3. also be used for routinely nds in the following clinical	1900 C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) by the alleged deficient practice Resident assessed with no findings or adverse effects not Resident D's oxygen tubing was immediately discarded and replaced with new tubing and cannula. Resident D's foley catheter bag was immediately removed from the side of the trans. The catheter bag was replaced with a new bag and positioned below the level of bladder, ensuring the tubing we not touching the floor. CNA #4 and CNA #5 immediately educated related to hand hygic oxygen tubing care and maintenance, and catheter bas placement and care. Resident monitored for any signs or symptoms of infection with no findings. 2. All residents have the potent to be affected. All residents wo oxygen audited for appropriate placement of oxygen tubing ar all residents with catheters audited to ensure appropriate placement of catheter bag. Oxygen tubing and catheters is replaced and placed properly in the placement of catheter bag.	ee. ed. as rash as 4 ene, g D ential ith end pags			
				indicated. Nursing staff educated on infection control including hygiene, oxygen tubing care a maintenance, and urinary cathological bag placement and care. 3. As a measure of ongoing compliance, the DHS or design will 1) monitor 5 staff members	nand nd neter nee			

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

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155696		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIE			1900 C	ADDRESS, CITY, STATE, ZIP COD OLLEGE AVE NNES, IN 47591			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
					hand hygiene 5 times per week 4 weeks, 3 times per week for weeks, weekly for 4 weeks, the monthly for 3 months; 2) audit residents with oxygen for propplacement of tubing 5 times per week for 4 weeks, times per week for 4 weeks, weekly for 4 weeks, then mon x 3 months; 3) audit 3 residen with urinary catheters for propplacement of catheter bag 5 tiper week for 4 weeks, 3 times week for 4 weeks, weekly for weeks, then monthly for 3 months.	thly ts eer mes		
					4. As a quality measure, the DHS or designee will review a findings and corrective action least quarterly and ongoing ur campus achieves one hundre percent compliance in the can Quality Assurance Performan Improvement meetings. The p will be reviewed and updated warranted.	at at d npus ce olan		

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