STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155430	A. BUILDING 00 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT ROCHESTER	340 E 18TH STREET ROCHESTER, IN 46975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00435999. Complaint IN00435999 - No deficiencies related to the allegations are cited. Survey dates: June 4, 5, 6, 7 & 10, 2024 Facility number: 000326 Provider number: 155430 AIM number: 100290770 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 1 Medicaid: 17 Other: 10 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/16/2024	F 0000		
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to provide a transfer/discharge form for 2 of 2 residents reviewed for hospitalizations. (Residents 11 & 1) Findings include:	F 0623	We respectfully request consideration for Paper compliance for this survey due to the low number of tags and low scope parity associated with the survey.	06/28/2024

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

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	1. A record review for Resident 11 was completed on 6/6/2024 at 9:49 A.M. Diagnoses included, but were not limited to, sepsis, Alzheimer's disease, and cerebral infarction (stroke). A Nurse's Note, dated 5/28/2024 at 5:59 P.M., indicated Resident 11 refused to eat or drink. She had eaten one bite of pureed food, and refused to swallow which allowed food to run out of her mouth. Vital signs included: blood pressure 100/48 mmHg (millimeters of mercury), pulse 102 beats per minute, respirations 20 per minute, and temperature 98.9 Fahrenheit. The physician was notified, and he indicated the resident's Power of Attorney (POA) wanted Resident 11 sent to the hospital. During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated the transfer/discharge form was part of the "Hospital-ER Transfer Form" under the "Observation" tab of the electronic health record. She indicated the form should have been completed when a resident was transferred from the facility. The form, "Hospital-ER Transfer Form" could not be found in the electronic medical record for Resident 11. 2. A record review for Resident 1 was completed on 6/5/2024 at 10:37 A.M. Diagnoses included, but were not limited to, nondisplaced intertrochanteric fracture of right femur, hemiplegia and hemiparesis following CVA (stroke), and osteoporosis. A Nurse's Note, dated 4/13/2024 at 11:00 P.M., indicated Resident 1 was helped with a transfer when she stumbled and spun around, falling on		F 623 Notice Requirements Before Transfer/Discharge What corrective action will be accomplished for those residents found to be affected by the deficient practice? Residents did not have a negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice. An audit of all residents who have had a hospital – ER transfer and or discharge in the past 90day was completed by the DNS/designee to ensure proper notifications were provided and the notice of transfer/discharge as soon as practicable. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nurses will be re-educated on or before 6/28/2024 by the DNS/designee on the transfer/discharge notices. How the corrective actions will be monitored to ensure the deficient practice will not recur? The DNS/designee will be responsible for the hospital re-admission/transfer QAPI tool	

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	her buttocks. Resident 1 complained of right hip and back pain. The physician was notified, and an order was obtained to send Resident 1 to the emergency department. A Nurse's Note, dated 4/14/2024 at 2:00 A.M., indicated Resident 1 was admitted to the hospital. During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated that the transfer/discharge form was part of the "Hospital-ER Transfer Form" under the "Observation" tab of the electronic health record. She indicated the form should be completed when a resident is transferred from the facility. The form, "Hospital-ER Transfer Form", dated 4/13/2024 at 11:00 P.M., indicated the resident or resident representative was not provided the transfer/discharge form. A form titled, "Notice of Transfer or Discharge" was provided by the Regional Nurse Consultant on 6/10/2024 at 12:49 P.M. A policy was not attached to the form. 3.1-12(a)(6)(A)		weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, and action plan will be developed, Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. The DNS/designee is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to provide the bed hold policy for 2 of 2 residents reviewed for hospitalizations. (Residents 11 & 1) Findings include: 1. A record review for Resident 11 was completed on 6/6/2024 at 9:49 A.M. Diagnoses included, but	F 0625	We respectfully request consideration for Paper compliance for this survey due to the low number of tags and low scope parity associated with the survey. F 625 Notice of Bed Hold Policy	06/28/2024

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	were not limited to, sepsis, Alzheimer's disease, and cerebral infarction. A Nurse's Note, dated 5/28/2024 at 5:59 P.M., indicated Resident 11 refused to eat or drink. She had eaten one bite of pureed food and refused to swallow, which allowed food to run out of the her mouth. Vital signs included: blood pressure 100/48 mmHg (millimeters of mercury), pulse 102 beats per minute, respirations 20 per minute, and temperature 98.9 Fahrenheit. The physician was notified, and he indicated the Resident's Power of Attorney (POA) wanted Resident 11 sent to the hospital. During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated that the bed hold policy was part of the "Hospital-ER Transfer Form" under the "Observation" tab of the electronic health record. She indicated the policy should be completed when a resident is transferred or discharged from the facility. The form, "Hospital-ER Transfer Form" could not be found in the electronic medical record for Resident 11. 2. A record review for Resident 1 was completed on 6/5/2024 at 10:37 A.M. Diagnoses included, but were not limited to, nondisplaced intertrochanteric fracture of right femur, hemiplegia and hemiparesis following CVA (stroke), and osteoporosis. A Nurse's Note, dated 4/13/2024 at 11:00 P.M., indicated Resident 1 was helped with a transfer when she stumbled and spun around, falling on her buttocks. Resident 1 complained of right hip and back pain. The physician was notified, and an order was obtained to send Resident 1 to the emergency		Before/Upon Transfer What corrective action will be accomplished for those residents found to be affected by the deficient practice? Residents did not have a negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice. An audit of all residents who have had a hospital – ER transfer and or discharge in the past 90day was completed by the DNS/designee to ensure proper notifications were provided and the notice of transfer/discharge as soon as practicable. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nurses will be re-educated on or before 6/28/2024 by the DNS/designee on the transfer/discharge notices. How the corrective actions will be monitored to ensure the deficient practice will not recur? The DNS/designee will be responsible for the hospital re-admission/transfer QAPI tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is	

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	department. A Nurse's Note, dated 4/14/2024 at 2:00 A.M., indicated Resident 1 was admitted to the hospital. During an interview, on 6/10/2024 at 10:18 A.M., the Director of Nursing (DON) indicated the bed hold policy was part of the "Hospital-ER Transfer Form" under the "Observation" tab of the electronic health record. She indicated the policy should be completed when a resident was transferred or discharged from the facility. The form, "Hospital-ER Transfer Form", dated 4/13/2024 at 11:00 P.M., indicated neither the resident nor the resident's representative was provided with a copy of the bed hold policy. A policy was provided on, 6/10/2024 at 12:49 P.M. by the Regional Nurse Consultant. The policy titled, "Bed Hold", indicated, " ...If a private pay resident leaves the facility for a temporary stay in an acute hospital or elsewhere for a medical therapeutic leave, the resident or resident's responsible party may request the facility to hold open the resident's bed during the absence by paying the full daily rate. If a Medicare/Medicaid resident leaves the facility for a temporary stay in an acute hospital or elsewhere for a medical therapeutic leave, the bed will be held ...2. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave. 3. The Resident's Representative will be informed of the bed hold policy at the time of notification of the transfer. The Resident's Representative will be provided a copy of the bed hold policy. 4. The staff will document the notification to thee resident and resident representative of the bed hold policy on the Emergency Resident Transfer Form ...."		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, and action plan will be developed, Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. The DNS/designee is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	

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F 0695 SS=D Bldg. 00	3.1-12(a)(25)(A) 483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to properly store a Bi-Pap (bi-level positive airway pressure) mask for 1 of 1 resident reviewed for oxygen/respiratory equipment. (Resident 131) Finding includes: A record review for Resident 131 was completed, on 6/5/2024 at 1:08 P.M. Diagnoses included, but were not limited to, pulmonary hypertension, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. During an observation, on 6/4/2024 at 9:35 A.M., Resident 131's Bi-Pap mask was observed on the floor under the bed. A Physician's Order, dated 5/31/2024, indicated Bi-Pap on at bedtime and off upon waking. A Care Plan, dated 6/3/2024, indicated Resident 131 had the potential for impaired gas exchange related to pulmonary hypertension and COPD. The goal indicated Resident 131 would have adequate respiratory functions as evidenced by decreased or absence of dyspnea, improved breath sounds, decreased or absence of shortness of breath, and improved oxygen saturation results. The care plan did not address the use of the Bi-Pap. During an interview, on 6/10/2024 at 10:17 A.M., the Director of Nursing (DON) indicated the	F 0695	We respectfully request consideration for Paper compliance for this survey due to the low number of tags and low scope parity associated with the survey. F 695 Facility failed to properly store a Bi-Pap What corrective action will be accomplished for those residents found to be affected by the deficient practice? Residents did not have a negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? No other resident will be affected by this practice, resident 131 is the only one in the building with a Bi-Pap What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All nurses will be re-educated on properly storing a Bi-Pap by DNS/designee by 6/28/2024 How the corrective actions will be	06/28/2024

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	Bi-Pap mask should be stored in a respiratory bag when not in use. A policy was provided on, 6/102024 at 12:49 P.M. by the Regional Nurse Consultant. The policy titled, "Bi-Level Therapy". The policy did not address the storage of the mask when not in use. 3.1-47(a)(6)		monitored to ensure the deficient practice will not recur? The DNS/designee will be responsible for the completion of the QAPI tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, and action plan will be developed to ensure compliance and disciplinary action taken as needed. The DNS/designee is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	
F 0730 SS=E Bldg. 00	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service Based on interview and record review the facility failed to ensure performance evaluations were completed annually for 4 of 4 employee files reviewed. (CNA 3, CNA 4, CNA 7 & CNA 8) Findings include: 1. During an interview on 6/10/2024 at 10:05 A.M., CNA 3 indicated "they (the facility) do not do competencies every year or evaluations." 2. During an interview on 6/10/2024 at 11:01 A.M., CNA 4 indicated she had not received a performance evaluation since she started working here (at the facility).	F 0730	We respectfully request consideration for paper compliance for this survey due to the low number of tags and low scope parity associated with the survey. F730 It is the policy of Hickory Creek Rochester to do an annual performance evaluation What corrective action will be accomplished for those residents found to be affected by the deficient practice?	06/28/2024

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	3. During an interview on 6/10/2024 at 1:23 P.M.,the Business Office manager indicated "they (the facility) used to do them (competency evaluations) but when the new company took over they gave out the raises in January and they just didn't get done, but we are starting it back again." 4. During an interview on 6/10/2024 at 1:29 P.M., the Administrator indicated "she and the Director of Nursing complete them and they should be done every year. There were some that were done, but there was a lot of turn over and she did not think they were all done." The employee file for CNA 3 was reviewed on 6/10/2024 at 1:36 P.M. CNA 3 was hired on 2/8/2023. No annual performance evaluation was located in the file. The employee file for CNA 4 was reviewed on 6/10/2024 at 1:38 P.M. CNA 4 was hired on 4/17/2023. No annual performance evaluation was located in the file. The employee file for CNA 7 was reviewed on 6/10/2024 at 1:40 P.M. CNA 7 was hired on 8/11/2017. No annual performance evaluation was located in the file. The employee file for CNA 8 was reviewed on 6/10/2024 at 1:43 P.M. CNA 8 was hired on 9/22/2019. No annual performance evaluation was located in the file. During an interview on 6/20/2024 at 1:45 P.M., the Business Office Manger indicated the performance evaluations should be done every year.		No resident was affected by this deficient practice. The ED/designee will do monthly checks to see who needs their annual performance evaluation done. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice. ED/designee will do regular in-service education. The facility will complete a performance review of every nurse aide at least once every 12 months, and provide education based on the outcome of the reviews. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? An audit will be completed by the ED/designee monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur? The ED/designee will bring the results of the audit tool to the monthly QAA Committee meeting for further review The ED/designee is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	

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	During an interview on 6/10/2024 at 1:46 P.M., the Administrator indicated she did not have a policy regarding the performance evaluations. 3.1-14(h)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure kitchen equipment were in good working condition in 1 of 1 kitchen reviewed. Finding includes: During a kitchen tour with the Dietary Manager on 6/4/2024 at 9:26 A.M., the following was observed: -broken seals to both doors of the freezer. -broken seals to both doors on 2 refrigerators. During an interview on 6/4/2024 at 9:45 A.M., the Dietary Manager indicated the seals needed to be fixed. On 6/10/2024 at 1:36 P.M., the Regional Nurse Consultant provided the policy titled,"Kitchen Safety Guidelines", dated 4/2024, and indicated the policy was the one currently used by the facility. The policy indicated"...2. All employees will report defective equipment, unsafe condition,acts, or safety hazards to the supervisor and/or the maintenance department... 13. The maintenance department is responsible for routine inspections and repair of fans, vents and equipment.... 3.1-21(i)(3)	F 0812	RE: IDR for F812 (F): We agree that the seals were cracked for the freezer and refrigerators, due to normal wear and tear over time. The seals have been replaced for the freezer and refrigerators. We would argue that despite these seals being cracked, the food being stored in these areas was safe as the temperatures for the freezer and refrigerators were always within range before and during the survey. We will attach temperature logs for the freezer and refrigerators that will verify this claim. The surveyor saw that the temperatures were within range for the freezer and refrigerators, and the temperatures were never in question. The temperatures were not mentioned in 2567 verbiage as being a concern for this deficiency. As a result of the temperatures being within range at all times, there was no risk to any residents since the food was frozen and/or stored in a safe and acceptable temperature range at all times. We respectfully request that the scope and severity for	07/05/2024

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			F812 be reduced from the F level, to a D level scope and severity rating. F812: We respectfully request consideration for paper compliance for this survey due to the low number of tags and low scope parity associated with the survey. F812 It is the policy of Hickory Creek Rochester to ensure that food safety requirements are met such as food procurement store/prepare/serve. What corrective action will be accomplished for those residents found to be affected by the deficient practice? DM will conduct an in-service by 06/28/2024 for all staff to report defective equipment, unsafe condition, acts, or safety hazards to the supervisor and/ or the maintenance department. The Dietary Manager will perform a safety audit weekly for 30 days and monthly thereafter. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? No residents were harmed due to the broken seals on the	

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			freezer/refrigerators, there are daily checks to monitor temperatures that are done, and they were always in range. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? An audit will be completed by the DM weekly for 4 weeks and then monthly thereafter. How the corrective actions will be monitored to ensure the deficient practice will not recur? The DM will bring the results of the audit tool to the monthly QAA Committee meeting for review The DM is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure proper infection control practices were implemented related to Enhanced Barrier Precautions (EBP) for 1 of 4 residents reviewed for EBP; failed to follow infection control practices when completing a blood sugar check for 1 of 1 resident reviewed for blood sugar assessments and failed to complete changing gloves and hand washing during catheter care for 1 of 1 resident observed for urinary catheter care. (Resident 28, QMA 2, CNA 5, Resident 23) Findings include:	F 0880	We respectfully request consideration for Paper compliance for this survey due to the low number of tags and low scope parity associated with the survey. F 880 Facility failed to ensure proper infection control What corrective action will be accomplished for those residents found to be affected by the deficient practice?	06/28/2024

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	1. During an interview on 6/5/2024 at 8:27 A.M., Resident 28 indicated he went to dialysis 3 times a week. There was no signage and or indication the resident was to be in EBP isolation. The record for Resident 28 was reviewed on 6/6/2024 at 9:58 A.M. Diagnoses included, but were not limited to: cellulitis to the right leg, diabetes type 2, and end stage renal disease. A current Care plan, dated 5/7/2024 at 3:46 P.M., indicated the resident was receiving hemodialysis and was at risk for complications such as fluid imbalance, bleeding or infection due to a right jugular perma catheter. During an interview on 6/10/2024 at 10:05 A.M., CNA 3 indicated they had "3 residents on EBP". Resident 28 was not named. During an interview on 6/10/2024 at 10:27 A.M., the Director of Nursing indicted the "resident had a porta cath" (implanted port). The Regional Nurse Consultant indicated "yes that is an indwelling catheter." 2. During an observation of a blood sugar check, on 6/6/2024 at 12:11 P.M.,with QMA 2, the following was observed: QMA 2 placed the glucometer (a device for obtaining a blood sugar level) on the bedside table without placing a barrier first. She then donned gloves. QMA 2 wiped the residents' finger with an alcohol pad, then with an opened hand fanned the area that had just been cleansed. She then obtained a blood sample. QMA 2 exited the resident's room with her gloves on, and went to the medication cart. She removed the gloves		Residents did not have a negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents residing in the facility have potential to be affected. the Infection Preventionist (IP) or designee will educate all staff regarding Infection control policy. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A root Cause Analysis was conducted by the IP with input from the facility MD,ED,and DNS to identify the root cause and develop solutions/systemic changes to address the root cause. The IP will provide education and training to the IDT and all staff of changes. How the corrective actions will be monitored to ensure the deficient practice will not recur? The IP/designee will complete daily observational rounds through the facility covering all shifts and days of the week to ensure staff are practicing appropriate infection control practices and compliance. The facility will review, update, and make changes as needed. The DNS/designee will be responsible for the completion of the QAPI tool weekly times 4	

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	155430	A. BUILDING 00 B. WING	06/10/2024

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	and threw away her trash. During an interview on 6/6/2024 at 11:56 A.M., QMA 2 indicated she "should have used a barrier, not fanned the area, and removed her gloves prior to coming out of the room". 3. During an interview on 6/4/2024 at 9:46 A.M., Resident 6 indicated she had 2 catheters. The record for Resident 6 was reviewed on 6/5/2024 at 10:43 A.M. Resident 6's diagnoses included, but were not limited to Multiple Sclerosis, pressure ulcers stage 4 sacral region, left buttocks, right buttocks, and neuromuscular dysfunction of bladder. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/28/2024, indicated the resident required total assist of 2 staff for bed mobility, transfers, and toilet use. A Care Plan, dated 5/6/2024, indicated the resident required a suprapubic (SP) urinary catheter and also had a Foley indwelling catheter due to: diagnosis of neuromuscular dysfunction of bladder. The resident had an indwelling Foley catheter placed upon return to the facility due to leakage of the SP catheter to keep urine off of her wounds to her bottom. On 6/7/2024 at 1:40 P.M., CNA 5 was observed to provide catheter care to Resident 6. The aide put her supplies on the over-the-bed table. She then washed her hands, applied a gown and gloves and filled the water basins with water. She then completed the washing, rinsing and drying of the catheter tube and the peri area. With the same gloves on, CNA 5 then rearranged the residents legs, moved a pillow, used the bed controls and		weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, and action plan will be developed to ensure compliance and disciplinary action taken as needed. The DNS/designee is responsible for the implementation and monitoring of this plan. Date of compliance: June 28, 2024	

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	then rearranged the sheet over the resident. During an interview, on 6/7/2024 at 2:02 P.M., CNA 5 indicated she knew she should have washed her hands and changed her gloves after completing peri and catheter care. 4. During an observation on 6/4/2024 at 11:11 A.M., Resident 13 was observed to have an urinary catheter drainage tube with a large amount of sediment in the tubing. The record for Resident 13 was reviewed on 6/5/2024 at 2:36 P.M. Resident 13's diagnoses included, but were not limited to: diabetes, neuromuscular dysfunction of bladder, and intellectual disabilities. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/22/2024, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, and extensive assist for 2 staff for toilet use, and had an indwelling urinary catheter. A current Care Plan, dated 5/4/2023, indicated the resident required an indwelling urinary catheter due to neuromuscular dysfunction of the bladder. Interventions included,, but were not limited to: Do not allow the tubing or any part of the drainage system to touch the floor. Store the collection bag inside a protective dignity pouch. During an observation, on 6/6/2024 at 10:29 A.M., Resident 13's catheter drainage bag was uncovered with the catheter tubing on the floor. During an observation, on 6/6/2024 at 12: 15 P.M., Resident 13's catheter tubing was on the floor.			

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	During an observation, on 06/6/2024 at 1:14 P.M., Resident 13's catheter tubing was on the floor. During an observation, on 6/6/2024 at 3:16 P.M., Resident 13's catheter tubing was on the floor. During an observation, on 6/7/2024 at 2:06 P.M., Resident 13's catheter tubing was on the floor. During an interview, on 6/7/2024 at 3:25 P.M., the Director of Nursing indicated the catheter tubing should have been off the floor. During an observation, on 6/10/2024 at 10:16 A.M., Resident 13's catheter tubing was on the floor. On 6/10/2024 at 1:36 P.M., the Regional Nurse Consultant provided the policy tithed,"Shared Glucometer Cleaning and Disinfecting", dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated"... 2. Throughout thee procedure, perform appropriate hand hygiene. c. Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other residents...." On 6/10/024 at 1:36 P.M., the Regional Nurse Consultant provided a "Skills Competency-Title:Catheter Care (Urinary)", dated 5/2023, and indicated the policy was the one currently used by the facility. The policy indicated...17. Remove gloves. 18. Perform hand hygiene. 19. Dispose of soiled linen properly. 20. Perform hand hygiene...." On 6/10/2024 at 1:30 P.M. the Regional Nurse Consultant provided the policy titled,"Bowel and Bladder Program", dated 5/2019. The policy did not address the catheter tubing and or drainage			

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	bag placement.			