STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Crawford Continuing Care Center	1100 Michigan Ave Grayling, MI 49738

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on interview and record review, the facility failed to ensure one Resident (#185) of one resident reviewed for end-of-life care (EOLC) had a care plan and physician's order for terminal care, and appropriate activation of patient advocate/durable power of attorney prior to placing a resident on EOLC. Findings include: Resident #185 (R185) On 2/11/25 at approximately 10:45 AM, Resident R185 was observed in his room with his daughter present. R185's daughter said R185 was admitted to the facility on Thursday (2/6/25) and placed on EOLC on Sunday (2/9/25). R185's medical record was reviewed on 2/12/25 and revealed admission to the facility on [DATE] for skilled therapy services. Physician's orders dated 2/6/25 and 2/7/25 directed R185 receive occupational therapy and physical therapy five times per week. Nurses' progress notes dated 2/6/25 at 5:06 PM, 2/6/25 at 10:26 PM, 2/7/25 at 1:26 PM, and 2/7/25 at 9:58 PM documented R185 was alert and oriented times three (A/O X 3 - a normal level of consciousness and orientation). A progress note dated 2/9/25 at 9:30 AM documented, in part: .Family decided to make resident comfort care . No physician's order for EOLC was in R185's medical record. There was no care plan for EOLC. There were no documented physicians' assessments or statements indicating R185 was incapable of making medical treatment decisions to activate his patient advocate designation. A document Medical Treatment Decisions of Resident was completed and signed by R185 on 2/6/25. The area of the document to elect palliative care or comfort care was blank, indicating R185 did not choose to receive palliative or comfort care when the form was signed on 2/6/25. (continued on next page)

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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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Patient Advocate Designation/Durable Power of Attorney for Healthcare document, signed by R185 on 9/15/24 read, in part: .My patient advocate(s) may only act on my behalf if I am unable to participate in decisions regarding my medical or mental health treatment . The portion of the document for acceptance of patient advocate designation was signed by R185's daughter and read, in part: . This designation shall not become effective unless the individual is unable to participate in medical treatment decisions . The facility's social services director (SS D) was interviewed on 2/12/25 at 2:00 PM. SS D said two physicians were required to assess a resident and document if a resident was incapable of making his own decisions before a durable power of attorney (DPOA) could be activated. SS D confirmed there was no physician documentation of R185 being incapable of making medical treatment decisions. When asked why competency for medical decision-making wasn't completed before activating the POA (power of attorney), SS D said, I don't know how that happened. [R185] should have been assessed [for medical decision-making capability] by two doctors before the family was allowed to make that decision [EOLC]. The Director of Nursing (DON) was interviewed on 2/13/25 at 4:28 PM. The DON confirmed the DPOA for R185 should not have been activated until R185 was assessed by two physicians and declared incapable of making his own medical decisions. The DON said R185's daughter should not have been allowed to place R185 on EOLC until after R185's medical decision-making ability had been assessed by two physicians. The DON confirmed a physician's order and care plan were required for EOLC. The policy Advanced Directives dated as last revised 7/3/24 read, in part: . If a patient loses decision-making capacity and has executed a legally recognized Advance Directive that meets legal requirements: 1. The DPOAH [Durable Power of Attorney for Healthcare] must be activated . If the patient loses decision-making capacity or presents without decision-making capacity, the attending physician and one other physician will complete the activation of the patient advocacy form .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to provide appropriate assessments and documentation warranting the use of a physical restraint for one Resident (#10) of one resident reviewed for restraints, resulting in the potential for feelings of helplessness, agitation, decreased physical functioning and injury. Findings include: Resident #10 (R10) Review of the Minimum Data Set (MDS) assessment, dated 11/26/2024, revealed R10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia and Parkinson's Disease. Further review of the MDS assessment revealed R10 was unable to participate in the Brief Interview for Mental Status (BIMS) and was assessed by staff to have severely impaired cognition. On 2/11/25 at 12:10 p.m., R10 was observed at the nurse's station seated in a reclining wheelchair with the leg rest engaged in the up position. R10 was awake and alert, attempting to get out of the chair and had both legs hanging off the right side of the leg rest. R10 made no attempt to disengage the leg rest to allow their feet to touch the floor. Further observation revealed an unidentified staff member exit the nurse's station and reposition R10 back into a seated position with his legs positioned on the engaged leg rest. On 2/11/2025 at 4:00 p.m., R10 was observed to be seated in the reclining wheelchair with the leg rest engaged in the up position near the nurse's station. R10 was awake and alert, with his knees bent and feet flat on the leg rest of the chair. On 2/12/2025 at 10:49 a.m., R10 was observed in his room, awake and alert, seated in the reclining wheelchair with the leg rest engaged in the up position. R10 was sitting upright so their back was not in contact with the reclined backrest and had his right leg off the right side of the leg rest and right foot on the floor. R10 made no attempt to disengage and lower the leg rest. On 2/12/25 at 4:27 p.m., R10 was observed to be seated in the reclining wheelchair with the leg rest engaged and up, positioned in hall across from nurse's station. R10 was awake and interacted with this Surveyor by waving. R10 appeared fully awake and alert. During an interview on 2/13/25 at 2:22 p.m., Certified Nursing Assistant (CNA) G was queried as to whether R10 could lower the leg rest of the reclining wheelchair on his own accord. CNA G stated R10 was unable to disengage the leg rest of the chair independently. CNA G stated the mechanism was positioned under the leg rest, and staff had to lower the leg rest and bring the chair back to an upright position for R10. CNA G stated R10 is placed in the reclining wheelchair for safety and to prevent the Resident from falling forward when [R10] gets tired. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 1:39 p.m., the Director of Nursing (DON) reported she was unsure if R10's reclining wheelchair should be considered a restraint. The DON confirmed R10 was unable to lower the leg rest and bring the back rest of the chair to an upright position independently. The DON reported R10 could self-propel in his standard wheelchair and was placed in the reclining wheelchair with the leg rest in the up position when they were exhibiting fidgety behavior. A review of R10's electronic medical record on 2/13/2025 at 1:45 p.m., revealed no documentation of behaviors or restlessness targeted by use of the reclining wheelchair for dates and times observed during the survey. Further review revealed no documentation of regular assessments of the resident while seated in the reclining wheelchair to ensure R10's safety and psychosocial well-being. On 2/13/2025 at 2:59 p.m., the DON reported an assessment was not completed prior to implementing the use of the reclining wheelchair or any time after, to ensure R10 was safe to use the reclining wheelchair or if the Resident could remove themselves from the chair independently. On 2/13/25 at 5:03 p.m., R10 was observed self-propelling in a standard wheelchair down the hall outside their room. R10 was bent forward fidgeting with the legs and wheels of the chair. Further observation revealed CNA G approach R10 and redirect the Resident to the upright position in the chair. R10 was then observed seated in the upright position in the chair. Review of R10's care plan revealed the following: [R10] is at risk for alteration in ADL [Activities of Daily Living] . May use geri chair [reclining wheelchair with leg rest] as needed for comfort/positioning when leaning significantly in w/c (wheelchair). Date initiated 8/25/2024 . is at risk for falls/injury [related to] Parkinson disease with noted tremors, Alzheimer disease with mood disorder/agitation . episodes of incontinence, impaired mobility, no safety awareness, bent/stooped over posture when in w/c and staff are unable to get [NAME] to sit upright as he fights it . will bend over and touch things such as his w/c wheels . [NAME] self-transfers ad lib, unable to understand safety concerns . Reviewed 11/10/24 [NAME] was observed lowering himself to the fall . Reviewed 1/8/25 observed sitting on the floor picking at stuff. Unwitnessed and [NAME] is unable to tell us if he lowered himself to the floor thus coded as fall. [NAME] will remain free from falls/injury [through] next review. Attempt to keep [NAME] upright in his w/c by offering him things to do fiddle with out of the busy box or therapy clips, etc. 10/29/2024. [R10] experiences episodes of exit seeking and attempting to open facility doors, Date Initiated: 9/03/2024 . Review of the undated facility policy titled Restraint Free Environment, revealed the following, in part: Physical Restraint: . Placing a resident in a chair that prevents the resident from rising independently . Behavioral interventions should be used and exhausted prior to the application of a physical restraint . Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptom . Potential negative outcomes should also be explained including, but not limited to: Decline in physical functioning. Decreased muscle condition . Delirium. Agitation . Accidents such as falls, strangulation or entrapment. Loss of autonomy and dignity. Withdrawal or reduces social contact.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to ensure that Medication Regimen Reviews (MRR) were reviewed, addressed by the Physician, and maintained in the clinical record for two Residents (#3, #23) of five residents reviewed for MRR, resulting in the potential for the administration of unnecessary medications and adverse medication side-effects. Findings include: Resident #3 (R3) Review of the Minimum Data Set (MDS) assessment, dated 12/28/2024, revealed R3 was admitted to the facility on [DATE] and had diagnoses including heart failure and dementia. Further review of the MDS assessment revealed R3 scored two out of 15 (2/15) on the Brief Interview for Mental Status (BIMS), indicating R3 had severe cognitive impairment. Review of R3's electronic medical record (EMR) for August 2024 through January 2025, revealed the following: 1/28/2025 Medication Regimen Review . See Report - Lab Request. It was noted there was no previous MRR documentation found in R3's EMR for the period of August 2024 through December 2024. Further review of R3's EMR revealed no pharmacy report or recommendation related to the MRR dated 1/28/2025. On 2/13/2025 at 11:44 a.m., the Director of Nursing (DON) reported she kept paper records for the MRRs prior to contracting with a new pharmacy in January 2025. Review of the monthly paper MRR documentation listing residents reviewed for MRR, provided by the DON, revealed R3's medication regimen was reviewed by the pharmacist for the period between 12/01/2024 and 12/14/2024. Further review of the MRR listing revealed no order for [R3] in handwriting at the bottom of the document. During an interview on 2/13/2025 at 12:14 p.m., the DON reported the no order for R3 written on the MRR documentation meant there were no pharmacy recommendations for R3 during the referenced time period. On 2/13/2025 at 12:36 p.m., a request was made of the DON to provide the pharmacy recommendation referenced in the MRR dated 1/28/2025. On 2/13/2025 at 3:05 p.m., the DON reported during her search for the missing recommendation, she found recommendations for the period between 12/1/2024 through 12/14/2024 and the period between 1/1/2025 through 1/29/2025, were not addressed by her or the physician. The DON stated the recommendations were sent to the attention of nursing staff instead of the provider and the system is not set up to send notifications to her or the providers when addressed to nursing. Review of the missing pharmacy recommendations, provided by the DON at the time of the interview, revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/1/2024 through 12/14/2024: Resident is taking digoxin [drug used to treat heart failure and heart rhythm problems] daily. A digoxin level [blood test to determine how much medication is in the system, to rule out toxicity or inadequate dosing] is due to be obtained to assess. 1/1/2025 through 1/29/2025: Resident is taking digoxin daily. A digoxin level is due to be obtained to assess. Further review of R3's EMR for laboratory results revealed R3's last test for digoxin level was dated 3/27/2024. 49310 Resident #23 (R23) R23 was admitted to the facility on [DATE]. Review of the MDS, dated [DATE], revealed diagnoses of fractures, atrial fibrillation, renal insufficiency, respiratory failure, and others. The MDS documented R23 scored 14/15 on the BIMS, indicating R23 was cognitively intact. The medical record of R23 did not contain MRR recommendations or physician responses to MRR for November 2024 and December 2024. On 2/13/25 at approximately 4:00 PM, the DON was asked for R23's MRR for November 2024 and December 2024. On 2/13/25 at 4:11 PM, the DON reported the MRR for December 2024 was a recommendation by the pharmacist to the physician requesting blood tests on R23. The DON said only one of the recommended blood tests were obtained. The DON said no documentation by the physician was found regarding the reason for declination of the additional blood testing recommendations. A copy of the MRR for December 2024 was requested but not provided by the end of survey. On 2/13/25 at 4:46 PM, The DON said she was unable to locate R23's admission MRR for November 2024. The DON provided a paper document containing a list of residents with MRR activity between 11/1/24 and 11/26/24. The DON said she did not know what recommendations were made by the pharmacist to the physician in November 2024 and the DON stated she was unable to locate any documentation from the physician regarding the MRR. The undated policy Medication Regimen Review read, in part: .The consultant pharmacist will review the drug regimen of all the residents at least monthly and report any observed irregularities in drug use and other drug therapy recommendations to the director of nursing and attending physician . the prescriber's response will be recorded on a copy of the MRR report that shall remain in the facility or in the individual resident's clinical record. Recommendations are acted upon and documented by the facility staff or prescriber . Nursing and physician responses to the consultant pharmacist's observations and recommendations should be recorded in the resident's clinical record or on the consultant's written report and filed in the facility for at least two (2) years .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to ensure documentation of target behaviors/symptoms with attempted use of non-pharmacological interventions prior to the administration of as needed (prn) anti-anxiety medication for two Residents (#3, #10) of five residents reviewed for unnecessary medications, resulting in the potential for adverse side effects and decreased quality of life. Findings include: Resident #3 (R3) Review of the Minimum Data Set (MDS) assessment, dated 12/28/2024, revealed R3 was admitted to the facility on [DATE] with diagnoses including dementia and depression. Further review of the MDS assessment revealed R3 scored two out of 15 (2/15) on the Brief Interview for Mental Status (BIMS), indicating R3 had severe cognitive impairment. Review of R3's February 2025 Medication Administration Record (MAR) revealed the following order: Lorazepam [controlled drug used to treat anxiety] Tablet 0.5 MG [milligram]. Give 1 tablet by mouth every 8 hours as needed for anxiety. Start Date: 01/20/2024. Further review of R3's February 2025 MAR revealed lorazepam 0.5 mg was administered on the following dates/times: 2/1/2025 at 7:39 p.m., no behavior or symptom documented. 2/2/2025 at 3:51 a.m., no behavior or symptom documented. 2/2/2025 at 6:36 p.m., restless/anxiety. 2/3/2025 at 7:59 a.m., no behavior or symptom documented. 2/5/2025 at 1:40 a.m., no behavior or symptom documented. 2/9/2025 at 7:35 p.m., no behavior or symptom documented. The electronic medical record (EMR), including progress notes, behavior notes, assessments, miscellaneous documents, February 2025 MAR and Treatment Administration Record (TAR), for R3 were reviewed. No specific resident behaviors targeted by the administration of as needed lorazepam 0.5 mg were documented. No documentation of non-pharmacological interventions to coincide with the administration of the lorazepam 0.5 mg were referenced. Review of R3's care plan revealed the following, in part: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[R3] is at risk for alteration in mood and/or adverse responses [related to diagnosis] depression . continual yelling out help me, help me, feed me, feed me, and is becoming louder and angrier with his yelling/demands, swearing more, unable to redirect/calm . [R3] is more vocal, obstinate and difficult to redirect . Interventions: . Attempt to redirect [R3] with snack/coffee, short conversation, Date Initiated: 1/10/2025 . Provide therapeutic listening, calm reassurance and support, Date Initiated: 4/24/2024 . During an interview on 2/13/25 at 1:41 p.m., the Director of Nursing (DON) reported the symptoms of anxiety and behaviors were a new sign of cognitive decline for R3. The DON reported staff had been attempting new interventions, including the administration of the as needed lorazepam 0.5 mg to address R3's behaviors. When asked if the implementation of non-pharmacological interventions was expected prior to the administration of the as needed lorazepam, the DON stated the expectation was to have all target behaviors documented in the EMR, along with non-pharmacological interventions attempted and failed prior to administration of any as needed lorazepam to allow for changes to be made to the resident's care plan and medication regimen, when warranted. Resident #10 (R10) Review of the MDS assessment, dated 11/26/2024, revealed R10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia and Parkinson's Disease. Further review of R10's MDS assessment revealed the Resident was unable to participate in the BIMS and was assessed by staff to have severely impaired cognition. Review of R10's February 2025 MAR revealed the following order: Lorazepam Tablet 1 MG. Give 1 mg by mouth every 12 hours as needed for anxiety related to dementia in other diseases classified elsewhere, unspecified severity, with agitation. Start Date: 1/14/2025 0600 [6:00 a.m.]. Further review of R10's February 2025 MAR revealed as needed doses of lorazepam 1 mg were administered as follows: 2/1/2025 at 10:59 p.m., Push at, attempting to swat at staff, yelling, trying to climb out of chair. 2/2/2025 at 7:29 p.m., anxiety. 2/3/2025 at 8:20 p.m., resident agitated. 2/5/2025 at 1:01 a.m., Was behavior observed? Yes. It was noted in review of the 2/5/2025 administration note, no specific behaviors were documented. The electronic medical record (EMR), including progress notes, behavior notes, assessments, miscellaneous documents, February 2025 MAR and Treatment Administration Record (TAR) for R10 were reviewed. No documentation of non-pharmacological interventions prior to the administration of the lorazepam 1 mg were referenced. Review of R10's care plan revealed the following, in part: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[R10] has [diagnosis] of Alzheimer's disease with mood disorder and agitation . Episodes of [R10] grabbing onto staff's hands/ arms while trying to assist him and not letting go with a firm grip on staff . episodes of yelling out for [spouse] and yelling at staff . Interventions: . If refusing cares/uncooperative/aggressive with cares, stop/wait and reapproach, Date Initiated: 9/03/2024. Provide therapeutic listening and calm conversation to minimize stimulation and provide [R10] with a chance to relax/calm down, observe for alteration in mood and/or adverse responses and report/document accordingly, Date Initiated: 8/25/2024. Review of the undated facility policy titled Behavioral Health Services, revealed the following, in part: Non-Pharmacological Intervention refers to approaches to care that do not involve medications, generally directed toward stabilizing and/or improving a resident's mental, physical, and psychosocial well-being . Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated. Review of the undated facility policy titled Behavior and Symptom Management, revealed the following, in part: Interventions will be monitored frequently to determine effectiveness. Nonpharmacological interventions must be tried and documented in the clinical record before administering medication and/or increases made to resident's psychotropic medication regime whenever possible .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49310 Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures to ensure a safe and sanitary environment for five Residents (#5, #10, #23, #15, and #13) of eight residents reviewed for infection prevention and control. Findings include: Resident #5 (R5 On 2/11/25 at 1:43 PM, R5 was observed with a urinary catheter drainage bag dragging on the floor beneath her wheelchair. There was no barrier beneath the drainage bag. R5's catheter drainage tubing was observed dragging on the floor beneath the wheelchair on 2/12/25 at 8:12 AM and 2/12/25 at 10:33 AM. Resident #10 (R10) On 2/11/25 at 1:13 PM, R10 was observed in a reclining geriatric care in the hallway. A plastic drinking cup with a straw was on the floor without a barrier beneath it next to R10's chair. At approximately 1:30 PM, Registered Nurse (RN) B picked up the cup from the floor and placed it on a mobile overbed table next to R10's chair. RN B did not sanitize the cup or obtain a clean cup of fluid for R10. Resident #23 (R23) R23 was diagnosed with Influenza A on 2/11/25. A review of R23's medical record on 2/13/25 revealed R23 did not have an infection care plan providing staff with interventions and direction to prevent the spread of Influenza. On 2/11/25 at 2:17 PM, Certified Nurse Aide (CNA) J was observed exiting R23's room and placing two bags of soiled linen on the floor in the hallway outside of R23's room. CNA J was asked if bags of soiled linen were typically placed on the floor. CNA J said bags of soiled linen should be taken to the soiled utility room and placed in soiled linen barrels to be taken to laundry. Resident #13 (R13)/Resident #15 (R15) On 2/11/25 at 12:31 PM, CNA I was observed sitting at a table with R15 sitting on the right side of CNA I and R13 sitting on left side of CNA I. CNA I was wearing examination gloves while simultaneously feeding R13 and R15. After providing approximately five forkfuls of food to each resident, CNA I removed the gloves and put on another pair of examination gloves without washing or sanitizing her hands. A clear plastic refuse bag containing clean and folded cloth clothing protectors was observed on the floor in the middle of the dining room on 2/11/25 at 1:15 PM. CNA J was asked the typical location to place the bag of clothing protectors. CNA J picked up the bag of clothing protectors from the middle of the dining room and placed the bag on the floor against the wall in the dining room next to a housekeeping cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Crawford Continuing Care Center	1100 Michigan Ave Grayling, MI 49738

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on 2/13/25 at 4:10 PM. The DON said staff is expected to sanitize their hands between glove changes, and bags of linen should not be placed on the floor. The DON said staff should never place a drinking cup on the floor. The DON said a cup on the floor should be taken to the kitchen for appropriate cleaning and R10 should have been provided with a clean cup of fluids. The DON said urinary catheter drainage bags and tubing should never sit on the floor without a barrier. The DON confirmed flu interventions and precautions are required to be included in a resident's care plan. The undated policy Indwelling Urinary Catheter Care read, in part: . Never place urine collection bag on an unclean surface, such as the floor. This minimizes the potential for contamination . The policy Infection Control Surveillance and Outbreak Policy dated as last revised 6/27/24 read, in part: . Environmental rounds are conducted to assess the overall environmental risks of infection .