STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meeker Manor Rehabilitation Center, LLC	600 South Davis Avenue Litchfield, MN 55355

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an interdisciplinary team (IDT) assessment was completed to determine whether self-administration of medication was clinically appropriate and safe prior to permitting self-administration of nebulizer treatments, for 1 of 1 resident (R1) reviewed for self-administration of medications.Findings include:R1's comprehensive Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).R1's signed physician orders dated 4/29/26, identified an order for Ipratropium-Albuterol 0.5-2.5 mg/3 mL (milliliters) nebulizer treatments administered three times daily, initiated on 3/25/26.R1's electronic medical record (EMR) identified a physician order initiated on 5/18/26, indicated R1 was permitted to self-administer nebulizer treatments following staff setup. The EMR lacked evidence an interdisciplinary team (IDT) self-administration assessment had been completed prior to implementation of the order to determine whether self-administration of the nebulizer was clinically appropriate and safe.Further R1's EMR lacked evidence an assessment had been completed to determine R1's competency and safety to self-administer the nebulizer medication and treatment. The EMR further failed to identify documentation addressing R1's ability to understand the medication purpose, follow treatment directions, safely operate nebulizer equipment, recognize side effects or adverse reactions, or ensure safe administration and storage of the medication and equipment.During observation on 5/17/26 at 1:27 p.m. R1 was observed with nebulizer equipment and medication available in the resident room.During interview on 5/19/26 at 11:57 a.m. R1 stated nursing staff set up the medication cup for the nebulizer treatment and then left the room while the treatment was running. R1 stated staff later returned to ensure the machine was turned off. Staff cleaned the nebulizer mask after the treatment was completed.During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated she set up the nebulizer treatment and later returned to ensure the machine was no longer running. LPN-A further stated the nebulizer mask was cleaned and placed on a paper towel to air dry.During interview on 5/20/26 at 9:57 a.m. registered nurse (RN)-A stated a self-administration assessment was completed for residents who wished to self-administer medications and then submitted to the provider for review and an order. RN-A confirmed a self-administration assessment had not been completed for R1 and stated the assessment should have been completed to ensure R1 could safely and appropriately self-administer the medication.During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated residents wishing to self-administer medications should have had a full assessment completed to evaluate their ability and competency. The DON stated staff were expected to contact the provider for an order and confirmed the self-administration assessment should have been completed prior to a resident being permitted to self-administer medications.Review of the (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled Self-Administration of Medications, revised 2/2024, identified residents could self-administer medications only after the interdisciplinary team (IDT) determined the practice was clinically appropriate and safe. The policy indicated the IDT was responsible for assessing residents' cognitive and physical abilities and evaluating factors including the resident's ability to understand medication labels and instructions, comprehend the medication's purpose and potential side effects, safely administer medications, and safely store medications. The policy further indicated approval for self-administration was to be documented in the medical record and care plan, periodically reassessed based on changes in condition, and residents determined unable to safely self-administer medications were to receive medication administration from nursing staff.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receiving psychotropic medications were adequately assessed and monitored. Further the facility failed to initiate target behavior monitoring for 1 of 5 residents (R3) reviewed for unnecessary psychotropic medications.Findings include:R3's admission Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking abilities), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (a condition involving excessive worry or fear), and mood affective disorder (a mental health condition affecting mood and emotional state). The MDS further identified R3 received antipsychotic, antidepressant, anticonvulsant, and anticoagulant medications.R3's signed physician orders dated 4/29/26, identified an order dated 04/14/2026 at 12:30 p.m. for Risperidone 0.25 mg (milligram), two tablets by mouth every four hours as needed (PRN) for agitation and paranoia, with a maximum of three PRN doses in 24 hours. Review further identified an order dated 4/14/26 at 2:00 p.m. for Risperidone 0.5 mg, one tablet by mouth three times a day for paranoia/agitation.R3's electronic medical record (EMR) on 5/18/26, failed to identify documentation an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed upon admission despite R3 being admitted on [DATE] and received antipsychotic medications.R3's EMR lacked evidence target behavior monitoring had been initiated for the antipsychotic medications. The EMR failed to identify measurable target behaviors, including documentation of frequency, duration, severity, precipitating factors, or response to interventions for R3's agitation and paranoia. The facility was unable to demonstrate ongoing monitoring of the effectiveness of Risperidone therapy or the continued need for the medications.R3's EMR further identified an AIMS assessment was completed on 5/18/26 after surveyor request; however, the assessment was not completed upon admission or initiated timely in relation to the start of R3's antipsychotic medications on 4/14/26. The delayed completion did not ensure timely monitoring for potential adverse effects associated with antipsychotic medication use.During interview on 5/20/26 at 9:57 a.m., registered nurse case manager (RN)-A stated residents receiving antipsychotic medications required an AIMS assessment completed, orthostatic blood pressures obtained as ordered, target behavior monitoring initiated, and side effects monitored. RN-A reviewed R3's EMR and stated she had completed the AIMS assessment the other day. RN-A stated the AIMS assessment should have been completed within the first week of admission because it was important to establish the resident's baseline status prior to ongoing antipsychotic use. RN-A further confirmed behavior and side effect monitoring had not been initiated until recently and should have been implemented earlier. RN-A stated monitoring was important, particularly because the facility utilized agency staff, so all staff would be aware of the resident's behaviors, response to medication, and ongoing needs.During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated residents receiving antipsychotic medications required ongoing monitoring to identify changes in condition and determine effectiveness of the medication regimen. The DON stated behavioral monitoring and an AIMS assessment were completed upon admission or initiation of antipsychotic medications. The DON reviewed R3's EMR and confirmed the AIMS assessment was completed on 5/18/26; however, it should have been completed upon admission. The DON further confirmed target behavior monitoring should have been in place for R3 and acknowledged monitoring had not been initiated. The DON stated target behavior monitoring was important to ensure staff understood what behaviors were occurring and to evaluate whether the medications were effective.Review of the facility policy titled Psychotropic Medication Use Policy, revised 5/2025, identified psychotropic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were to be used only when clinically indicated and supported by documented target symptoms and behavioral monitoring. The policy further identified residents receiving antipsychotic medications would receive ongoing monitoring for effectiveness and adverse consequences, including documentation of identified target behaviors and individualized interventions. The policy required target behaviors to be monitored and supported in the clinical record. In addition, the policy identified residents initiated on antipsychotic medications would receive DISCUS or AIMS assessments at baseline, with ongoing monitoring completed thereafter. The policy further identified monitoring for behavioral symptoms and re-evaluation of residents receiving new psychotropic medications or dose changes to assess medication effectiveness and continued need.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement comprehensive, person-centered care plans to address significant medical conditions and medication-related risks, including failure to care plan anticoagulant therapy for 2 of 2 residents (R1 and R3) reviewed for anticoagulant medications, and failure to care plan cardiac conditions, pacemaker presence, and condom catheter use for 1 of 2 residents (R1) reviewed for cardiac care needs.Findings include:R1's comprehensive Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), depression (a mood disorder causing persistent sadness or loss of interest), and presence of a cardiac pacemaker (an implanted device used to regulate heart rhythm). The MDS further identified R1 received anticoagulant medications.R1's signed physician orders dated 4/29/26, indicated Eliquis (apixaban) anticoagulant medication dated 3/12/26, and an order to apply a condom catheter at bedtime (HS) and remove when getting up for the day dated 3/15/26.R1's comprehensive care plan printed 5/20/26, failed to identify interventions or monitoring related to anticoagulant medication use, including bleeding risk, monitoring for adverse effects, or staff awareness of anticoagulant precautions. Further, care plan lacked evidence of interventions related to R1's cardiac conditions, presence of a pacemaker, or use of a condom catheter, including monitoring for skin integrity or resident-specific catheter care preferences.R3's admission Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking abilities), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (a condition involving excessive worry or fear), and mood affective disorder (a mental health condition affecting mood and emotional state). The MDS further identified R3 received anticoagulant medications.R3's signed physician orders dated 5/4/26, indicated an order for Eliquis (apixaban) anticoagulant medication.R3's comprehensive care plan printed 5/19/26, lacked evidence of anticoagulant therapy, bleeding risk precautions, monitoring for adverse effects, or interventions related to anticoagulant medication use.During interview on 5/20/26 at 9:57 a.m. registered nurse case manager (RN)-A stated the care plan was a community effort involving the MDS coordinator, director of nursing (DON), herself, and the other case manager. RN-A stated R1's condom catheter should have been referenced on the care plan to address monitoring for skin integrity and the resident's preferred care needs. RN-A reviewed R1's care plan and confirmed the resident had a pacemaker, and that cardiac conditions had not been addressed on the care plan and should have been. RN-A further confirmed R1's anticoagulant medication had not been addressed on the care plan and should have been. RN-A stated it was important for significant diagnoses, devices, and medications to be care planned, especially because the facility utilized agency staff, so all staff were aware of the resident's care needs. RN-A also reviewed R3's care plan and confirmed anticoagulant therapy had not been addressed and should have been included in the care plan.During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated R1's condom catheter should have been addressed on the care plan for monitoring of output, skin integrity, and signs and symptoms of irritation or infection. The DON stated regular skin checks should have been completed, and drainage bags were expected to be changed weekly, which would have been (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented on the treatment administration record (TAR). The DON stated the catheter was disposable and the care plan was important so staff were aware of the residents' needs and it guided resident care. The DON further stated R1's cardiac conditions and presence of a pacemaker should have been addressed on the care plan so staff were aware of the resident's cardiac history, monitoring needs, and potential complications. The DON stated anticoagulant medications should also have been included in the care plan so staff could monitor for changes and be aware of the residents' conditions and risks associated with anticoagulant use. The DON confirmed anticoagulant therapy had not been addressed on R1's or R3's care plans and should have been included.The facility's policy titled Comprehensive Care Plans, revised 1/25, identified the facility would develop and maintain individualized, person-centered care plans that addressed each resident's diagnoses, medical conditions, physician orders, treatments, devices, medications, and identified risks. The policy further identified care plans were intended to guide staff in the delivery of care, ensure continuity of care between caregivers, and include appropriate monitoring and interventions to address changes in condition, medication-related risks, skin integrity concerns, and specialized medical needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received routine bathing and grooming services necessary to maintain personal hygiene and dignity, including failure to provide scheduled weekly bathing and failure to assist with facial hair grooming for 2 of 6 residents (R2 and R21) reviewed for activities of daily living (ADL) care.Findings include:R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 had intact cognition and required assistance with activities of daily living (ADL)'s. R2's diagnoses included primary generalized osteoarthritis, atrial fibrillation, urinary tract infection (last 30 days), thyroid disorder, depression, chronic pain syndrome, urge incontinence, suicidal ideations, and weakness.R2's care plan printed 5/19/26, identified a self-care deficit related to falls. The care plan identified interventions and goals which included R2 would accept assistance with self-cares and would be dressed, groomed, and bathed per preferences. Interventions included assist of one staff member with dressing, assist of one staff member with grooming, assist of one staff member with bathing, provide assistance with oral cares in the morning, at bedtime, and as needed, and honor dressing and personal hygiene preferences.R2's bathing documentation from 4/1/26 to 5/19/26, identified R2 had scheduled bathing services once weekly. Documentation indicated R2 received a bath on 4/2/26, 4/26/26, 4/30/26, 5/12/26, and 5/15/26. R2 refused a bath on 4/16/26. Further review failed to identify documentation R2 received weekly bathing as scheduled, as the time between some completed baths exceeded one week. The record failed to identify additional refusals or documentation explaining why scheduled bathing services were not completed.During observation and interview on 5/17/26 at 10:41 a.m. R2's hair was standing up and appeared very greasy. R2 had a few long white chin hairs approximately one and a half to two inches in length. During interview, R2 stated she did not get a bath very often due to the facility being short staffed. R2 further stated she did not have access to tweezers, a shaver, or a mirror. R2 stated the chin hairs bothers me and I don't like them at all, and stated, when you notice them others can as well.During observation on 5/18/26 at 4:47 p.m. R2 was sitting at a table in the dining room. R2's hair was messy, standing up, and appeared greasy. R2 continued to have long white hairs present on her chin.During observation on 5/19/26 at 9:11 a.m. R2 was wheeling down the hallway in her wheelchair from the dining room to her room. R2's hair appeared brushed. Long white chin hairs continued to be present.R2's electronic medical record (EMR) failed to provide documentation to indicate grooming assistance had been offered or provided related to facial hair care.R21's comprehensive MDS dated [DATE], indicated intact cognition and required assistance with ADL's, including bathing. R21's diagnoses included cancer, cirrhosis (scarring of the liver that affects liver function), diabetes mellitus (a condition affecting blood sugar regulation), hip fracture (a break in the upper portion of the leg near the hip joint), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).R21's care plan printed 5/19/26, identified a self-care deficit related to femur fracture. The care plan identified goals for the resident to accept assistance with self-cares and to be dressed, groomed, and bathed per preferences. Interventions included occupational therapy (OT) per physician order, follow OT instructions, assist of one staff member with dressing, assist of one staff member with grooming, assist of one staff member with bathing, and provide assistance with oral cares in the morning, at bedtime, and as needed.R21's bathing documentation from 4/14/26 to 5/19/26, indicated bathing services once weekly. R21 refused a bath on 4/16/26 and received baths on 4/20/26, 4/30/26, and 5/12/26. Further review failed to identify documentation R21 received weekly bathing as scheduled, as the time between some completed baths exceeded one week. The record failed to identify additional refusals or documentation explaining why scheduled bathing services were not completed.During interview on 5/17/26 at 12:46 p.m. R21 stated I have been here since middle of April (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and I have yet to have a bath or shower. R21 stated part of the issue was she had a lot of wounds and staff were waiting to get approval from the physician before giving her a shower, but stated that has been a while. R21 further stated she had only had her hair washed once with a shampoo shower cap while in bed.During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated R2 and R21 required assistance with all activities of daily living (ADL's) and stated neither R2 nor R21 refused cares. LPN-A further stated residents were expected to receive at least one bath per week.During interview on 5/20/26 at 9:44 a.m. nursing assistant (NA)-A stated she had never heard that either R2 or R21 refused bathing and stated both residents required assistance with bathing. NA-A further stated if she noticed facial hair on a female resident, she would assist the resident with shaving. NA-A stated both residents should receive a bath weekly.During interview on 5/20/26 at 9:57 a.m. registered nurse (RN)-A stated residents were expected to receive bathing at least once weekly unless they refused, and staff were expected to try to follow resident preferences. RN-A stated R2 would occasionally require a lot of convincing, but staff were generally able to encourage her to participate in care. RN-A stated R2 had previously lived in assisted living and had been very independent. RN-A further stated R2 required assistance with grooming and the facial hair should be shaved. RN-A stated the facility had a facility-owned shaver staff could use and the expectation was staff would assist the resident and address facial hair if noticed by staff. RN-A further stated she would have expected a bath to occur for R2 and R21 between 4/30/26 and 5/12/26. RN-A stated both residents were scheduled for Thursday evening bath days. RN-A stated if a resident refused bathing, the refusal should be documented in the medical record. RN-A further stated bathing schedules were discussed during morning meetings and, if bathing was noted to be overdue by a week, the scheduler would assist on the floor to help ensure additional baths were completed.During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated each resident had their own bathing preferences and staff were expected to ensure those preferences were followed. The DON stated residents should receive bathing at least once weekly. The DON further stated staff were expected to assist residents with shaving facial hair when needed.Review of the facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy, updated 3/31/23, identified the facility was responsible to provide person-centered care and services that honored and supported each resident's preferences, choices, values, and beliefs. The policy further identified the facility would provide necessary care and services to ensure residents' abilities in activities of daily living (ADL's) did not diminish unless unavoidable due to the resident's clinical condition. The policy identified the facility would provide care and services related to hygiene needs, including bathing, dressing, grooming, and oral care. The policy further identified residents unable to complete ADL's independently would receive necessary services to maintain grooming and personal hygiene.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate care and services were provided for the management of an external urinary catheter system, including failure to obtain physician orders and implement care instructions for cleaning, disinfecting, and changing the condom catheter drainage bag for 1 of 1 resident (R1) reviewed for urinary catheter care.Findings include:R1's comprehensive Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).R1's signed physician orders dated 4/29/26, indicated use of a condom catheter at bedtime. Review of the electronic medical record (EMR) failed to identify physician orders or documented instructions related to cleaning, disinfecting, monitoring, or routine changing of the catheter drainage bag associated with the condom catheter system.During observation on 5/19/26 at 11:57 a.m. R1's catheter drainage bag was observed hanging on the side rail in R1's bathroom. Observation and record review failed to identify documentation the drainage bag was routinely cleaned, disinfected, monitored, or replaced in accordance with accepted standards of practice.During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated R1 used a condom catheter at night that was attached to an overnight drainage bag. LPN-A reviewed the EMR and confirmed there were no physician orders addressing when the drainage bag should have been changed or instructions for cleaning or disinfecting the bag. LPN-A stated staff were expected to follow physician orders and facility protocols related to catheter care and infection prevention practices.During interview on 5/20/26 at 9:57 a.m. registered nurse case manager (RN)-A stated there was an order in the computer for the condom catheter to be applied at bedtime and removed at HS. RN-A stated the drainage bag change schedule should have been included in the physician orders and the bag should have been changed weekly. RN-A reviewed the EMR and confirmed there were no orders related to changing, cleaning, or disinfecting the drainage bag.During interview on 5/20/26 at 10:46 a.m. the director of nursing (DON) stated the facility expected catheter drainage equipment to have clear physician orders and nursing instructions regarding care, cleaning, monitoring, and replacement schedules. The DON stated catheter care should have included monitoring output and assessing for signs and symptoms of irritation or infection, including regular skin checks. The DON further stated drainage bags should have been changed weekly and documented on the treatment administration record (TAR). The DON confirmed the facility was unable to provide evidence orders or documented guidance were in place for R1's condom catheter drainage bag care.The facility policy titled, Condom/External Catheter Care, dated 1/2025, identified male external catheters were used for residents with urinary incontinence and required daily care to maintain cleanliness, safety, and proper functioning. The policy directed staff to remove, dispose of, and replace external catheters every 24 hours and to clean and assess the penis daily for redness, bruising, or open areas that could indicate improper fit or skin breakdown. The policy further instructed staff to practice good hygiene, including handwashing and cleaning of the penis during catheter application and drainage bag emptying, and to ensure proper application techniques to avoid complications and injury.The facility policy titled, Disinfection of Urinary Drainage Bag, revised 12/2023, identified the purpose of the policy was to clean and disinfect urinary drainage bags and prohibit the growth of bacteria. The policy directed staff to cleanse catheter and tubing connection points with an alcohol swab prior to disconnecting the drainage bag, disinfect the drainage (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag daily when removed from the resident, rinse the inside of the bag with 55-65 cc of vinegar, allow the exterior to air dry, and change the drainage bag to a new appliance on bath day. The policy further identified staff were to monitor and record urinary output and maintain appropriate catheter care supplies in the resident room.