STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365394	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Adams Lane	1856 Adams Lane Zanesville, OH 43701

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff and resident interviews, and record review the facility failed to provide reasonable accommodation of needs and preferences when a bedside chair, a bedside nightstand, and a call light were not within reach. This affected one of 108 residents (#26). The facility census was 108. Findings Include: Record review revealed Resident #26 had an admitted [DATE] with diagnoses including: Type two diabetes, displaced intertrochanteric fracture of left femur, cervical disc degeneration, coronary artery bypass graft without angina, chronic atrial fibrillation, systolic congestive heart failure, muscle wasting multiple sites, posthemorrhagic anemia, Alzheimer's disease, major depressive disorder, dementia without behavioral disturbance, unsteadiness on feet, abnormalities of gait and mobility, hyperlipidemia, hypertension, venous insufficiency, cognitive communication deficit, wrist drop left wrist, lymphedema, hypertension, urinary tract infection, full incontinence of feces, urinary incontinence, retention of urine, cardiac pacemaker, and history of covid-19. Interview and observation on 02/10/25 at 7:39 P.M. with Resident #26 confirmed that he would prefer to get out of bed and sit in a chair to watch television, and would like to be able to access his personal belongings without requiring staff assistance to do so. At the time of the interview, observation revealed no bedside chair or bedside nightstand in the room for Resident #26. A bedside table was observed on the wall opposite of the foot of the bed and out of reach. Personal belongings were on the floor beside the bed stored in shopping bags and were out of reach. Observation on 02/11/25 at 9:13 A.M. revealed the call light for Resident #26 hanging off the right side of the bed out of his reach. Resident #26 attempted to retrieve the call light unassisted and was unable to do so. Interview on 02/11/25 at 9:18 A.M. with Licensed Practical Nurse (LPN) #280 confirmed that the call light for Resident #26 was hanging off the right side of the bed out of reach. LPN #280 confirmed that Resident #26 was unable to retrieve the call light, and required staff assistance to do so. Interview on 02/13/25 at 8:37 A.M. with Staff #305 confirmed that the facility did not provide bedside chairs for residents and if residents wanted a bedside chair, resident's families were responsible to provide them. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365394	A. Building B. Wing	02/19/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/25 at 9:16 A.M. with Activities Staff #246 confirmed that Resident #26 enjoyed watching television in his room and in the common areas as one of his independent activities. Activities Staff #246 confirmed that Resident #26 did not have access to a bedside chair in his room. Review of the activities care plan for Resident #26 with a revision date of 02/11/24 revealed Resident #26 enjoyed Independent, self- directed leisure time activities, and functioned at an independent level in his leisure pursuits. Resident #26 was alert and oriented and able to express his needs, desires and opinions, and frequently engaged in the following leisure pursuits: Watching TV, listening to music, reading magazines, and visits with staff and other residents. Review of the activities of daily living (ADL) care plan for Resident #26 with a revision date of 02/11/24 revealed the resident requires extensive to total assist for most all care due to impaired mobility, impaired cognition, impaired balance and overall decline in functional status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on record review, observation, staff and resident interviews, the facility failed to provide a safe, clean, comfortable and homelike environment for two residents which allowed them to use their personal belongings to the extent possible This affected three residents (#33, #40, #75) of 108 residents residing in the facility. The census was 108. Findings Include: 1. Record review revealed Resident #40 had an admitted [DATE] with diagnoses including: Cerebral infarction, dysphagia, influenza, chronic obstructive pulmonary disease, morbid obesity, diverticulosis, muscle wasting and atrophy, intervertebral disc degeneration of the lumbar region, type two diabetes mellitus, chronic respiratory failure with hypoxia, major depressive disorder, cardiac pacemaker, voice and resonance disorder, low back pain, abnormalities of gait and mobility, anemia, hyperlipidemia, anxiety disorder, left bundle branch block, constipation, gastroesophageal reflux disease, difficulty in walking, history of covid-19, urge incontinence, venous thrombosis and embolism, hypertension, abnormal posture, and unsteadiness on feet. Observation on 02/11/25 at 9:26 A.M. revealed the following items on the bathroom sink: Mouthwash, shampoo, toothbrush, toothpaste, shave cream, surgical mask, comb, disposable razors, denture cup, and denture adhesive. None of the items were labeled for ownership. Interview with Resident #40 on 02/11/25 at 9:26 A.M. confirmed that the bathroom is shared between three residents and the sink was always a big mess. Resident #40 confirmed that she didn't store or use her personal toiletries in the bathroom, she used her toiletries at her bedside table each day because the sink was not clean. Interview on 02/11/25 at 9:59 A.M. with Certified Nurse Aide (CNA) #295 confirmed the bathroom is shared between two resident rooms or three residents, and that the items on the bathroom sink were unlabeled for ownership and should not be laying out on the bathroom sink. CNA #295 was unable to confirm which items belonged to which of the three residents who shared the bathroom. 2. Record review revealed Resident #75 had an admitted [DATE] with diagnoses including: Chronic Kidney Disease stage three, sacrolitis, major depressive disorder, exudative age-related macular degeneration left eye, atherosclerosis of aorta, spondylosis without myelopathy or radiculopathy, pruritus, hypertension, anxiety disorder, osteoporosis, hypercholesterolemia, bilateral primary osteoarthritis of knee, and neuralgia and neuritis unspecified. Observation on 02/11/25 at 10:21 A.M. revealed the following items on the bathroom sink: Body wash, lotion, a basin with a toothbrush, toothpaste, a loose toothbrush, dentures in a cup covered with water and without a lid, body spray, deodorant, an electric toothbrush (uncovered) and plugged in. None of the items were labeled for ownership. A pair of pants and a pair of underwear with a soiled incontinence pad in them were on the bathroom floor, and the pants appeared to be wet. Also on the floor was a bag of incontinence briefs unlabeled for ownership with another pair of pants sitting on top of it. (continued on next page)

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	365394	A. Building B. Wing	02/19/2025

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Continuing Healthcare at Adams Lane	1856 Adams Lane Zanesville, OH 43701

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 10:21 A.M. with Resident #75 confirmed the bathroom was shared between two resident rooms, for a total of four residents and stated the other residents in the next room were disrespectful for leaving their things on the sink. Resident #75 confirmed that she kept her personal toiletries in a basket and used the toiletries in her room because the bathroom and the bathroom sink were not clean. Interview on 02/11/25 at 10:40 A.M. with Licensed Practical Nurse (LPN) #270 confirmed that the bathroom was shared between two resident rooms, or four residents and that soiled clothing shouldn't be on the bathroom floor, and unlabeled items shouldn't be on the bathroom sink. LPN #270 was unable to confirm which items on the sink belonged to which of the four residents who shared the bathroom. 3. Review of Resident #33's medical record revealed an admitted [DATE] and diagnoses including chronic obstructive pulmonary disease, diabetes, peripheral vascular disease, and hypertension. Review of Resident #33's quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 13, indicating the resident was cognitively intact. further review of the MDS revealed Resident #33 was independent with toileting tasks and was occasionally incontinent of urine. An observation made on 02/11/25 at 11:29 A.M. revealed Resident #33's bathroom had a strong odor and dirty linen was noted to be on the floor around the front of the toilet. A second observation made on 02/13/25 at 4:20 P.M. revealed the odor continued and a towel was on the floor in front of the toilet. In an interview on 02/13/25 at 4:20 P.M. Licensed Practical Nurse (LPN) #206 verified there was an odor in the bathroom and removed the towel from the floor in front of the toilet. LPN #206 stated the Certified Nurses Aides had put the towel down to soak up urine from the floor but the should have removed the towel after the task was completed.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review and staff interview, the facility failed to ensure written information prior to transfer to the hospital of the bed hold notice. This affected three residents (#61, #71 and #106) of three residents reviewed for hospitalization . The census was 108. Findings included: 1. Review of Resident #71's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included diabetes, encephalopathy, Down's syndrome, dysphagia, chronic kidney disease, and high blood pressure. Review of the quarterly minimum data set assessment (MDS) dated [DATE] revealed his cognition was not intact (BIM's-3). He required setup or clean-up assistance with oral hygiene, is dependent upon staff for toileting, dressing and personal hygiene and substantial/maximal assistance for shower bathing. The resident has an indwelling urinary catheter and is frequently incontinent of bowel. Review of the nursing progress notes revealed on 12/26/24 at 11:54 P.M. Resident #71 was mouth breathing, and an oxygen face mask was put on the resident. Monitored oxygen, it was at 70% again. Increased oxygen to 4 liters (L), and his oxygen would not go above 88% on 4L. Resident #71 was sent to the hospital and admitted on [DATE]. On 12/29/24 at 1:39 P.M. Resident #71 was readmitted to the facility from the hospital. Further review revealed Resident #71 has a Guardian/Resident Representative. Review of the bed hold notice revealed it was was not signed until after Resident #71 returned to the facility on [DATE]. This was verified during interview with the Director of Nursing on 02/18/25 at 3:38 P.M. 50538 2. Review of Resident #61's medical record revealed an admitted [DATE] and a reentry date of 12/02/24. Further review revealed diagnoses including chronic obstructive pulmonary disease, diabetes, obstructive uropathy, anxiety, paranoid schizophrenia, major depressive disorder, and extrapyramidal and movement disorder. Review of the annual minimum data set (MDS) dated [DATE] revealed Resident #61 had a brief interview for mental status (BIMS) score of 13 indicating the resident was cognitively intact. Further review of the MDS revealed Resident #61 wore a hearing aide, was able to understand person to person communication and was able to make himself understood during person to person communication. Review of Resident # 61's progress note dated 11/28/24 at 1:17 PM revealed Resident #61 was having pain and swelling to his lower extremities. Further review of Resident #61's progress notes on 11/28/24 at 2:28 PM revealed Resident #61 requested to go to the emergency room because of the pain. Review of Resident #61's progress note dated 12/02/24 at 3:07 PM revealed Resident #61 returned to the facility after completing his hospital course of treatment. (continued on next page)

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	365394	A. Building B. Wing	02/19/2025

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility Notice of Bed Hold Policy revealed the notice, given to the resident to allow him to decide if he wanted to hold his bed so that he could return from the hospital to the same room and bed, was to cover Resident #61's hospital stay that started on 11/28/24 and ended on 12/02/24. Further review of the Notice of Bed Hold Policy revealed it was signed by Resident #61 on 12/03/24. In an interview on 02/18/25 at 3:38 P.M. the Director of Nursing (DON) verified the Notice of Bed Hold Policy was signed on 12/03/24 after Resident #61's return to the facility. Review of the Notice of Bed Hold Policy (undated) revealed it was to be signed by the resident upon discharge to the hospital or if the resident was unable to sign verbal notification from the resident or resident's representative was to be documented. 51074 3. Review of the medical record for Resident #106 revealed an admitted [DATE]. Diagnoses include acute on chronic respiratory failure, chronic diastolic heart failure, chronic obstructive pulmonary disease, bacterial pneumonia, depression, diabetes mellitus, type two, diabetic peripheral neuropathy, acute on chronic anemia and Upper GI bleed. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 indicating intact cognition. The resident required minimal assistance for all activities of daily living. Review of the transfer form dated 11/06/24 revealed Resident #106 had a change in condition and was sent to the hospital. Review of the notice of bed hold letter revealed the letter was not signed by the resident until 11/19/24 on her return to facility. On 02/19/25 at 7:40 A.M., interview with Assistant Director of Nursing (ADON) #283 verified the bed hold letter dated 11/06/24 was not signed by the resident until 11/19/24. Further interview verified the letters are to be signed acknowledging the facility bed hold policy.

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	365394	A. Building B. Wing	02/19/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review and staff interview, the facility failed to ensure pre-admission screening and resident reviews (PASSAR) were accurately completed. This affected one resident (#43) of two review for PASSAR accuracy. The census was 108. Findings include: Review of Resident #43's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included Ogilvie syndrome (acute colonic pseudo-obstruction, is the acute dilatation of the colon in the absence of any mechanical obstruction), colostomy, gastrostomy, nausea and vomiting, schizoaffective disorder , depression and anxiety. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact. He required partial/moderate assistance for oral hygiene, personal hygiene, and turning and repositioning, dependent for toileting and substantial/maximal assist for showers/bathing, lower body dressing and application of footwear. Resident #43 had an indwelling catheter and a colostomy. Receives antipsychotic's and antidepressants. Review of the PASSAR dated 07/28/24 failed to identify Schizoaffective disorder, depression and anxiety. Mood disorder was the only thing identified under indication of serious mental illness. On 02/13/25 3:26 P.M. interview with Social Worker Designee #311 verified the depression, schizoaffective disorder and anxiety were not included on the PASSAR and a new one had not been completed.

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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** 50538 Based on record review and interview the facility failed to develop and implement a comprehensive person centered care plan for diuretic medication for Resident #60. This affected one resident (#60) of five residents sampled for unnecessary medications. The facility census was 108. Findings include: Review of Resident #60's medical record revealed an admitted [DATE] and a reentry date of 01/13/22. Further review revealed diagnoses including malignant neoplasm of overlapping sites of rectum, anus and anal canal, secondary malignant neoplasm of large intestine and rectum, diabetes, chronic respiratory failure, morbid obesity, heart failure, and hypertension. Review of Resident #60's quarterly minimum data set (MDS) dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 15 indicating that she is cognitively intact. Further review of the MDS revealed Resident #60 was receiving diuretic medication. Review of Resident #60's physician's orders revealed an order with a start date of 04/02/24 for furosemide 40 mg give one tablet in the morning for heart failure. Review of Resident #60's plan of care revealed no care plan for diuretic medication. In an interview on 02/18/25 at 4:34 P.M. MDS nurse Licensed Practical Nurse (LPN) #350 verified there was not a diuretic medication care plan in Resident #60's plan of care.

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	365394	A. Building B. Wing	02/19/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, staff interview and review of facility policy and procedure, the facility failed to ensure medications were locked against unauthorized access. This had the potential to affect one resident (#97) of 10 residents on the 200 hallway identified as cognitively impaired and independently mobile. The census was 108. Findings include: Observation on 02/12/25 at 10:39 A.M. revealed the medication cart in the hallway unlocked outside of room [ROOM NUMBER]-A with the door closed and no nurse in attendance of the cart. At 10:41 A.M. Registered Nurse #251 came out from the room and verified during interview she had left the medication cart unlocked and unattended in the hallway. Review of the facility Medication Storage policy and procedure (dated 04/18 and updated 01/03/25) revealed compartment (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, medical record review, and staff interview the facility failed to maintain infection control with urinary catheters. This affected one resident (#3) of four residents reviewed for urinary catheters. The census was 108. Findings include Review of Resident #3's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, morbid obesity, heart failure, diabetes, atrial fibrillation, major depression, chronic kidney disease and anxiety. Review of the admission minimum data set (MDS) dated [DATE] revealed her cognition was intact. She required set up or clean-up assistance for eating, oral hygiene, is dependent for toileting, and substantial/maximal assistance with shower/bathing, partial/moderate assistance for personal hygiene, dressing and turning and repositioning. The resident had a urinary catheter and was frequently incontinent of bowel. On 02/11/25 at 11:47 A.M. observation revealed the urinary catheter tubing was observed on the floor. At 12:05 P.M. the urinary catheter tubing remained on the floor. At 12:07 P.M. interview with Registered Nurse (RN) #251 verified the urinary catheter tubing was on the floor. On 02/11/25 at 12:41 P.M. Licensed Practical Nurse (LPN) Supervisor #277 revealed she had changed the resident's urinary catheter bag and tubing. On 02/12/25 at 10:38 A.M. observation revealed Resident #3 revealed she was up in the wheelchair with therapy staff in her room. The resident's urinary catheter tubing was observed on floor and the bag was in a wash basin. On 02/13/25 at 2:57 P.M. Resident #3 was observed up in her wheelchair, with her urinary catheter tubing on the floor, red colored sediment in tubing . On 02/13/25 at 3:03 P.M. interview with LPN #233 verified the urinary catheter tubing was on the floor