Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515002	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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. 50551 Based on observation, record review, and interview the Facility failed to reasonably accommodate the needs of Resident #86 by ensuring the call light was in reach. This was a random opportunity for discovery. Facility census: 132. Findings included: a) Resident #86 a) On 02/12/25 at 1:10 PM the resident was observed sitting in wheelchair in her room watching television. She stated that she would like to go to bed and that she was hurting from sitting in the wheelchair. When asked if she could reach her call light, she attempted to and replied no. Her call light was behind her, wrapped around her bedrail. I rang the call light on the opposite side of the room and Nurses Aide (NA) #61 entered the room and acknowledge that resident did not have her call light. She handed call light to her and stated You don't have your light, here you go. NA #61 told her that she would get someone to help and be right back to assist her. She promptly returned with NA #135 and they assisted the resident with her needs using the hoyer lift.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50801 Based on results of State inspection, The facility failed to ensure the most recent survey results were located in prominent areas and readily accessible to residents and public. This deficient practice had the potential to effect more than a limited number of residents. Facility census: 132 Findings include: a) During the resident council meeting on 02/10/25 at 11:30 AM, Resident Council President , (Resident #1), stated she knew there were survey results available for the residents to see but was not sure where they were recently located. Resident #19, #40, and # 64 were also in attendance and stated they did not know survey results were available to them nor where they were located. Based on record review of Section C of the most recent MDS record Residents #1, #19, # 40, and #64 had capacity and were cognitively intact. c) During an interview with theAdministrator, on 2/11/24 at 12:25 PM, she verified the facility failed to post notice of the availability of the results of the most recent survey in prominent areas in the facility and make accessible to all residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50801 Based on resident interview, observation and staff interview the facility failed to ensure the grievance forms were within reach for each resident to enable to file grievance anonymously if they so choose. This was a random opportunity for discovery and was true for Resident #40. Facility Census: 132. Findings Include: a) Resident #40 Upon entrance to the facility on [DATE] an observation found the grievance forms were up too high for residents who could not stand up. If a resident is confined to the wheelchair they are unable to obtain a grievance form without asking staff or others to hand them the form. On 02/11/25 at 11:45 am Resident #40 indicated they were not able to reach the grievance forms nor the box provided to place the grievance forms without standing up from the wheelchair. On 02/11/25 at 11:50 AM, during and interview with Social Worker #147 it was confirmed the resident was unable to reach the forms or the box. She stated, residents could come to my office and ask for a form but resident's would not be able to file it anonymously if they could not stand up.

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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. 50551 Based on record review and staff interview, the facility failed to have residents Pre-Admission Screening and Record Review (PASSAR) reflect a new diagnosis after admission. This is true for one of (1) of six (6) residents reviewed for the care area of PAS-R during the long term care survey process. Resident Identifier: Resident #13. Facility Census 132. Findings included: a) Resident #13 A record review completed on 02/12/25 at 9:14 PM revealed Resident #13's most recent PASSAR dated 04/05/24 included the following: -Section III. MI/MR Assessment, Question 30. Current Diagnosis (check all that apply), was marked a. None. Question 47. The individual has a primary diagnosis of: was marked dementia b) Review of resident's diagnoses list revealed residents primary diagnosis was unspecified psychosis not due to substance or known physiological condition on 02/20/24. She was also given a diagnosis of hallucinations, unspecified on 02/20/24. c) During an interview with Social Worker #147 on 02/12/25 at 2:24 PM, they acknowledged Resident # 13 did not have a PASSAR that reflected her current diagnosis of psychosis or hallucinations.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure the resident's Pre-Admission Screening (PAS) reflected pre-admission diagnoses. This was true for two (2) out of six (6) residents reviewed for the category of PASARR (Pre-Admission Screening and Record Review, during the Long-Term Care Survey Process. Resident identifiers: #125 and #67. Facility census: 132. Findings included: a) Resident #125 A medical record review, completed on 02/11/25 at 9:07 AM, revealed Resident #125 had been admitted to the facility on [DATE] with the following diagnoses: -Bipolar -Major Depression Disorder A PAS, completed on 01/28/25, marked NONE under Section III Question 30 entitled, Current Diagnosis (Check all that apply). Additionally, Section V Question 40 entitled, Major Mental Illness (MI) or Suspected MI was also marked NONE. During an interview on 02/12/25 at 2:24 PM, the Director of Social Services reported that resident's Bipolar and Major Depression Disorder diagnoses had not been captured on the 01/28/25 PAS and a new one had not been completed. 50551 b) A review of Resident #67's medical record on 02/12/25 at 9:20 PM revealed the resident PASSAR dated 12/06/22 included the following: Section III. MI/MR Assessment, Question 30. Current Diagnosis (check all that apply), was marked m. Major Depression. A review of Resident #67's diagnosis list on 02/12/25 at 9:22 PM revealed Resident #67 diagnosis on admission his date of 12/02/21 included bipolar disorder. During an interview on 02/12/25 at 2:26 pm with Social Worker (SW) #147, she acknowledged that resident had a diagnosis of bipolar upon admission and there had been no new PASSAR completed to reflect this upon after admission to this facility.

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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. 42120 Based on medical record review and interview, the facility failed to ensure each resident had a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial need regarding schizoaffective disorder. This practice affected one (1) of (28) resident's care plans reviewed. Resident identifier: #27. Facility census: 132. Findings included: a) Resident #27 On 02/12/25 a review of Resident #27's) medical records revealed a diagnosis of schizoaffective disorder on admission. A review of the current care plan showed there was no care plan addressing schizoaffective disorder. During an interview on 02/13/25 at 1:55 PM the Director of Nursing (DON) confirmed there was no schizoaffective disorder care plan for Resident #27.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45173 Based on record review and staff interview, the facility failed to revise the care plan regarding an appropriate diagnosis for Resident #128's urinary catheter, antipsychotic medication and behavior monitoring for Resident #90; and the discontinuation of a feeding tube for Resident #86. This was true for three (3) of 32 sampled residents reviewed during the survey process. Resident Identifier: #128, #90 and #86. Facility Census: 132. Findings Include: a) Resident #128 On 02/11/25 at 3:21 PM, a record review was completed for Resident #128. The review found the care plan listed the resident's need for a urinary catheter was personal preference. However, further review of the record found urinary retention as the correct diagnosis for the urinary catheter. On 02/12/25 at 2:22 PM, the Director of Nursing (DON) confirmed the diagnosis for the urinary catheter on the care plan was incorrect. The DON stated, I don't know why that was on the care plan .the reason was urinary retention. b) Resident #90 On 02/12/25 at 8:30 PM, a record review was completed for Resident #90. The review of the care plan found focus areas of antipsychotic medication and behaviors listed. However, on further review the resident was not prescribed an antipsychotic medication nor was he having any type of behaviors. An interview was held with the DON on 02/13/25 at 10:31 AM. The DON stated, he is not taking antipsychotic medication or having behaviors anymore .the care plan should have been updated. c) Resident #86 - Peg tube On 02/12/25 at 11:30 AM, a review of Resident #86's records revealed theresident's care plan addresses peg tube care. Page 7 of the care plan, under the focus category At risk for alteration in skin integrity related to impaired mobility. Interventions for that focus/goal included treatment to peg tube site per orders. Resident #86's current order and diagnosis list did not reveal the resident currently had a peg tube. Per review of discontinued orders it was revealed resident's orders for peg tube was discontinued on 05/18/23. On 02/12/25 at approximately 2:47 PM during an interview with DON and Administrator they both acknowledged the resident did not currently have a peg tube. When asked if peg tube care was listed in her care plan, the Administrator reviewed care plan and acknowledged the care plan stated treatment to peg tube site per orders. 50551

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45173 Based on record review and staff interview, the facility failed to follow physician's orders regarding medication administration, behavior monitoring, pain score, side effects of a antipsychotic, and supplement. This was true of two (2) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifiers: #13 and #58. Facility Census: 132. Findings Include: a) Resident #13 On 02/13/25 at 12:24 PM, a record review was completed for Resident #13. The review found blanks on the 02/2025 Medication Administration Record (MAR). The following is the list of the missed behavior and side effect monitoring: --02/04/25 physically abusive behavior --02/04/25 antianxiety medication side effect tracking --02/04/25 antipsychotic medication side effect tracking --02/04/25 socially inappropriate or disruptive behavior --02/04/25 verbally abuse behavior On 02/13/24 at approximately 2:30 PM, the DON confirmed the missing documentation on 02/04/25. b) Resident #58 On 02/13/25 at 1:00 PM, a record review was completed for Resident #58. The review found blanks on the 09/2024 MAR. The following is the list of the missed medications, behaviors, side effect monitoring, and pain score: --09/21/24 Atorvastatin 40mg (milligram) --09/21/24 Famotidine 20mg --09/21/24 Melatonin 5mg --09/21/24 Metformin 500mg --09/21/24 Seroquel 50mg --09/21/24 Tylenol Extra Strength 500mg-2 tablets --09/21/24 Behavior-refusal of care (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--09/21/24 Depression/Depressive Behaviors --09/21/24 Insomnia/Sleepless Behaviors --09/21/24 Pain score --09/21/24 Antidepressant side effect tracking --09/21/24 Antipsychotics side effect tracking --09/21/24 Socially inappropriate or disruptive behavior --09/21/24 Wandering/elopement behavior --09/21/24 2.0 Supplement On 02/13/24 at approximately 2:30 PM, the DON confirmed the missing documentation on 09/21/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50801 The facility failed to provide an environment that was free from accident hazards over which it had control. This was a random opportunity for discovery. Water temperatures were found to be above 120 degrees Fahrenheit (F). This deficient practice had the potential to negatively effect more than a limited number of residents. Facility census: 132. Findings included: a) State Operations Manual Appendix PP Review of the State Operations Manual Appendix PP found in the interpretive guidelines for F689 the following concern regarding water temperatures: - Water temperature of 124 degrees Fahrenheit will cause a 3rd degree burn in 3 minutes. - Water temperature of 120 degrees Fahrenheit will cause a 3rd degree burn in 5 minutes. - Burns can occur even at water temperatures below those identified, depending on an individual's condition and the length of exposure. -Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black. b) On 02/09/25 at 1:13 PM, the water temperature of the sink in room [ROOM NUMBER] was tested by surveyors feeling very hot. Surveyors requested the water temperatures be tested via thermometer. Maintenance Supervisor #73 tested the water temperature was tested by inserting the stem of the thermometer into the stream of running water, so that the sensor was fully immersed. A water temperature of 126 degrees Fahrenheit was reached. c) Water Temperatures in Shower Rooms Date and Time - Shower room wing 1 had a water temperature of 126 degrees Fahrenheit. - Shower room wing 2 had a water temperature of 121.6 degrees Fahrenheit. - Shower room wing 7 had a water temperature of 122.5 degrees Fahrenheit. d) During an interview with Maintenance Supervisor #73, on 02/09/25 at 1:21 PM, He stated the water temperatures were tested on ce every week. He said the temperatures averaged around 113 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Number of Residents that go to the shower rooms by wings: Wing 1 - 20 of 20 Wing 2 - 16 of 18 Wing 7 - 20 of 21 f) During an interview, on 02/09/25 at 3:10 PM, the Nursing Home Administrator confirmed that the maintenance director would ensure all water temperatures would be 110 degrees Fahrenheit or below.

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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** 45173 Based on observation, record review and staff interview, the facility failed to date insulin upon opening for Resident #3 and dispose of expired insulin for Resident #18. These were random opportunities for discovery. Resident Identifiers: #3 and #18. Facility Census: 132. Findings Include: a) Medication Cart 800 wing On [DATE] at 1:00 PM, a tour of the medication cart on the 800 wing was completed. The tour found Resident #3's insulin glargine not dated upon opening and Resident #18's Novolog insulin expired on [DATE] after 28 days from opening. Registered Nurse (RN) #119 confirmed the insulin glargine was not dated upon opening and the Novolog insulin was expired. b) Facility policy On [DATE] at 2:30 PM, a review of the facility policy was completed. The facility policy, entitled Medication Labeling and Storage, under the section entitled Medication Labeling section 5 states, Multi-dose vials that have been opened or accessed are dated and discarded within 28 days . On [DATE] at 3:30 PM, the Director of Nursing (DON) was notified and confirmed the insulin should be dated upon opening and discarded after 28 days.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43340 Based on observation, staff interview, and food tray temperatures the facility failed to serve food to residents that was at an appetizing temperature. This failed practice was true for one (1) of two (2) wings tested for food tray temperatures throughout the Long-Term Care Survey Process. Facility census: 132. Findings included: a) Wing 1 Lunch Time Meal Observation During an observation on 02/12/25 at 12:53 PM, it was noted that a food truck was brought out of the kitchen with all resident lunch trays for residents on the 100 Wing. Staff members immediately began to deliver the trays to the residents' rooms. At 1:03 PM, when four (4) trays were left on the food truck, the Surveyor requested that CNA #135 select one tray that would be served last. CNA #135 selected Resident #45's tray and stated that she was actually getting ready to go out to eat with her family member and would not need her lunch tray. Registered Nurse (RN) #62 was asked to call the kitchen and ask them to come to the wing in order to temp the last tray on the food cart. On 02/12/25 at 1:07 PM, Dietary Aide #300 tested the temperature of Resident #45's lunch tray with the following results: -Hamburger: 116.5 degrees Fahrenheit (F) -Carrots: 112.2 degrees F -Ham: 104.0 degrees F Dietary Aide #300 agreed the food temperatures obtained were not considered to be the appropriate desired temperature for the point of delivery to the residents. Dietary Aide #300 stated temperatures should be 120 degrees F or above for all hot food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation, staff interview, and equipment manual review the facility failed to keep the ice machine in safe operating condition. This had the potential to affect all Residents who get their nutrition from the kitchen, and residents who attend food related activities. Facility Census: 132. Findings Included: a) Ice Machines On 02/13/25 at 12:40 PM a tour with the Maintenance Director found the ice machines located in the Kitchen area had a drainpipe running on the floor to a drain. Nutrition rooms on units one (1) and three (3) had no required air gap on the ice machine drains. The drainpipes were touching the drains. Continued tour found unit one (1), five (5) and six (6) had no required filter on the ice machines. On 02/13/25 throughout the tour, the Maintenance Director confirmed the drainpipes should not be touching the floor or drain and all the ice machines should have a filter.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 43340 Based on record review and staff interview, the facility failed to provide an accurate and complete medical record for seven (7) of 32 residents. Resident identifiers: #3, #17, #280, #128, #123, #71 and #75. Facility Census: 132. Findings Include: a) Resident #3 On [DATE] at 9:18 AM, a record review was completed for Resident #3. The review found the [NAME] Virginia (WV) Physicians Orders for Scope of Treatment (POST) was incomplete. The resident's signature under section E was not dated. On [DATE] at 2:21 PM, the Director of Nursing was notified and confirmed the resident's signature was not dated. b) Resident #17 On [DATE] at 9:30 AM, a record review was completed for Resident #17. The review found the WV POST form under section B had both selective treatments and comfort-focused treatments selected. The directions under section B specify pick one (1). On [DATE] at 2:21 PM, the DON was notified and confirmed both choices were selected and only one (1) should have been selected. c) Resident #280 On [DATE] at 10:30 AM, a record review was completed for Resident #280. The review found a verbal/telephone consent was obtained form the Medical Power of Attorney (MPOA) on [DATE]. The guidance states to receive the MPOA's signature in a reasonable amount of time. On [DATE] at 2:21 PM, the DON was notified and confirmed the MPOA's signature should have been obtained. d) Resident #128 On [DATE] at 1:00 PM, a record review was completed for Resident #128. The review found the transfer form was completed on [DATE] at 8:00 AM but was dated for [DATE] at 12:30 PM. On [DATE] at 2:21 PM, the DON was notified and confirmed the date on the transfer form was incorrect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Resident #71 A record review, completed on [DATE] at 10:50 AM, revealed a POST form with the following details: -CPR -Full Treatment -No Artificial Means of Nutrition The POST form was signed by Resident #71 but was not dated. During an interview on [DATE] at 02:19 PM, the DON confirmed the POST had not be dated by resident and could not be considered legally valid. f) Resident #123 A record review, completed on [DATE] at 11:00 AM, revealed a POST form with the following details: -CPR -Full Treatment -Provide Feeding through New or Existing Surgically-Placed Tubes The POST form was signed by Resident #123 but was not dated. During an interview on [DATE] at 2:18 PM, the DON confirmed the PAS had not be dated by resident and could not be considered legally valid. g) Resident #75 A record review of dialysis care revealed Resident #75's Physician orders for no blood draws / injections / blood pressures from right vascath arm. A medical record review found documentation of blood pressures being obtained in the right arm. During an interview on [DATE] at about 9:10 AM Resident #75 stated, he would not allow anyone to take blood pressures from his right arm. He stated, he protects his right arm. 45173

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

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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 - Few	Provide and implement an infection prevention and control program. 45173 Based on observation, and staff interview, the facility failed to maintain an appropriate infection control program for foley catheter care. This was a random opportunity for discovery. Resident Identifier: 85. Facility Census: 132. Findings Include: a) Resident #85 On 02/10/25 at 12:46 PM, an observation of Resident #85's urinary catheter drainage bag touched the floor. On 02/10/25 at 12:48 PM, Nurse Aide (NA) #163 confirmed the drainage bag was touching the floor. NA #163 stated, let me raise the bed .it shouldn't be touching the floor. On 02/10/25 at approximately 2:00 PM, the Director of Nursing (DON) was notified. The DON confirmed the urinary catheter drainage bag should not be touching the floor.