STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	**1900 W 1ST STREET , WINSTON-SALEM, North Carolina, 27104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/23/25 through 06/25/25. Event ID# ETCX11. The following intake was investigated NC00231067. 2 of the 4 complaint allegations resulted in deficiency.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		

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 reverse for further 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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F0584 SS = E	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident and staff interviews, the facility failed to maintain walls, floors, baseboards in good condition, and rooms free from debris in 9 resident rooms (Room #220, Room #228, Room #229, Room #311, Room#327, Room #400, Room #402, Room #421, and Room #522) on 6 of 8 resident halls. In addition, the facility failed to maintain floors 3 of 8 halls and a ceiling in 1 of 4 common areas in good condition. The findings included: a. Room #220 was observed on 06/23/25 at 9:46AM. The entrance to the room had dry black and brown raised material on the floor that scraped up with pressure from a shoe. The bathroom floor had visible dirt built up observed. A plastic wrapper and temperature probe were observed on the floor under the bed. During a walk around with the Regional Maintenance Director, Environmental Services (EVS) Director, and the acting Maintenance Director on 06/23/25 at 2:40pm, Room #220 was observed to have the same issues. The EVS Director discussed not being aware of the black and brown raised material or the built-up dirt on the bathroom floor. He explained he did not believe housekeeping had been in the room to clean yet and stated the housekeeping department was short staffed. The EVS Director discussed needing 2 housekeepers per floor and explained right now there was only one housekeeper for the second floor.	F0584		

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F0584 SS = E	Continued from page 2 b. Room #229 was observed on 06/23/25 at 9:51 AM. Heavy buildup of dirt and brown material was noted in all corners and along the baseboards of the bathroom. In the shared bathroom, there was a dark brown stain around the entire toilet base; the seal around the toilet base was absent. Brown material was seen on the wall on and above the commode grab bar. The bathroom wall behind the door had visible splatters of brown & orange matter. Dried green stains were seen around the toilet base bolt. A panel of the privacy curtain between the beds was pulled from the ceiling track and was laying on the floor with brown matter on it. Baseboards in all corners of the room were noted to have brown stains and dirt buildup. On 06/23/25 at 2:44 PM, Room #229 was observed with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. The EVS Director stated that housekeeping had completed cleaning of the room. The EVS Director shared his department was experiencing staffing problems. The Regional Maintenance Director/Environmental Services (EVS) Director stated the facility was working on increasing the number of housekeepers and floor technicians. The EVS Director stated he was unaware of the issues and that housekeeping staff were responsible for ensuring the room was clean, which would include wiping down walls/baseboards when there was visible dirt. He also discussed not being aware of the privacy curtain being on the floor. The EVS Director explained if a privacy curtain fell and/or was dirty, the housekeeper was responsible for letting him know so he could remove the curtain and place it in the laundry. The acting Maintenance Director stated he was unaware of the seal around the base of the toilet missing. He also discussed the lack of maintenance staff but explained a maintenance assistant was to start in a week. c. Room #228 was observed on 06/23/25 at 9:56 AM. The trash can had no liner in place and the bottom of trash can was heavily soiled with a dried brown, orange, and black substance. On 06/23/25 at 2:42 PM, Room #228 was observed with was observed with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. The EVS Director stated that housekeeping had completed the cleaning of the room at the time of the observation. A trash can liner was in place, but the	F0584		

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F0584 SS = E	Continued from page 3 bottom of the trash can remained heavily soiled with brown, orange, and black substances. The EVS Director stated that housekeepers should clean trash cans before replacing the liner. The assigned housekeeper for Room #228 on 06/23/25 was not available for interview. d. Room #311 was observed on 06/23/25 at10:20 AM. The wall behind the room entry door had 2 holes near the baseboard. Hole #1 measured 6 inches x 3 inches. Hole #2 measured 6 inches x 6 inches and was packed with gauze pads. An approximately 6-inch section of baseboard was observed pulled away from the wall behind bed A. There was a heavy buildup of brown material in all corners of the room. The left entry wall of the bathroom had an approximately 3-inch section of baseboard pulling away from the wall. Above the displaced baseboard was a hole that measured 3 inches x 3 inches (These were measured by the Acting Maintenance Director during group observation rounds in the afternoon.) Brown dried matter was noted on the toilet seat. The toilet base seal was absent with heavy brown staining around the base and heavy buildup of dirt in corners behind the toilet. The wall tile behind the toilet was heavily splattered with dried brown and black matter. The wall by the commode grab bar was splattered with brown material. There was no trash can liners in place for the 2 trash cans and the bottom of both were covered with dried dark brown material with brown splatters to walls of both trash cans. On 06/23/25 at 2:49 PM, the holes in the wall behind the entry door and the left wall of the bathroom in Room #311 were measured by the Acting Maintenance Director. He removed the gauze pads from hole # 1 and stated that he had "no idea why someone put that gauze there". The acting Maintenance Director stated he was unaware of the holes in the wall/baseboards and explained there was a Maintenance Assistant starting next week and that he planned on having the Assistant work on fixing the walls which would include any loose baseboards. The EVS Director stated that the room had been cleaned earlier that day. The brown dried matter on the toilet seat, the absent toilet base seal with heavy brown staining around the base, the heavy buildup of dirt in corners behind the toilet were observed by the group. The wall tile behind the toilet and the wall by the commode grab bar remained splattered with dried brown and black matter. The Regional Maintenance/EVS Director asked the facility's EVS Director if	F0584		

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F0584 SS = E	Continued from page 4 housekeepers cleaned walls as part of their routine cleaning. He replied, "if they see something then yes, they should clean it." Trash can liners were in place for both trash cans but the bottom of both were covered with dark brown material and brown splatters were observed on the walls of both trash cans. The Regional Maintenance/EVS Director shared with the EVS Director that trashcans should be cleaned before replacing liners. The assigned housekeeper for Room #311 on 06/23/25 was not available for interview. e. Room #327 was observed on 06/23/25 at 10:25 AM. Several patches of dried brown matter were noted on the floor between the beds. The entire room floor was sticky and heavy dirt built up was observed in all corners of the room as well as around the air conditioning unit and baseboards. There were dried dark brown raised splatters visible on the wall behind bed B. In the shared bathroom, the wall tiles behind the toilet and the shower curtain were splattered with dried brown matter. On 06/23/25 at 2:44 PM the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS observed in Room #327 several patches of brown, dried matter on the floor between the beds, heavy dirt build up on the floor around the air conditioning unit and baseboards, and dried dark brown, raised splatters on the wall behind bed B. In the shared bathroom, the wall tiles behind the toilet and the shower curtain remained splattered with dried brown matter. The EVS Director did not know if the room had been cleaned yet and he was unaware of the condition of the room. He again discussed the lack of housekeeping staff and stated there was only one housekeeper for the third floor. The EVS Director explained if the housekeeper had already cleaned the room he would have expected the housekeeper to clean the walls, air-conditioning unit, and remove the shower curtain for cleaning. The Regional Director discussed the room needing to be re-cleaned to the facility standards. f. Room 400 was observed on 06/23/25 at 10:02 AM. It was noted that a one-foot section of the baseboard to the left of the air conditioning unit had pulled away from the wall. Black and brown stains were present on the exposed wall behind the baseboard that had pulled	F0584		

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F0584 SS = E	Continued from page 5 away from the wall. The ceiling above the air conditioning unit had a crumbling and peeling area with two baseball sized round, brown stains observed. A panel of the privacy curtain between the beds was pulled from the ceiling track and it was laying on the floor. The ceiling above the toilet had 2 round brown rings. There was no trash can liner in the trash can and the bottom of the trash can was heavily soiled dark brown matter, and brown splatters were observed to walls of trash can. One broken floor tile was noted on the floor near bed B. On the wall between the beds and approximately at the level of the headboards exposed electrical wires were observed in a square open area that was large enough for a hand to reach the wires located between two call light wall mounts between bed A and bed B. On 06/23/25 at 2:49 PM observations were made in Room #400 along with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. noted the displaced baseboards, the stains on the ceiling in the room and bathroom, the broken floor tile, and the privacy curtain panel laying on the floor. There was no trash can liner in the trash can and the bottom of the trash can was heavily soiled dark brown matter, and brown splatters were observed to walls of trash can. The exposed electrical wires located in a junction box between the two call light wall mounts between bed A and bed B were observed by the Acting Maintenance Director and the Regional Maintenance/EVS Director. The Acting Maintenance Director stated he was not aware of the exposed electrical wires, and broken floor tiles. He stated he was aware of the ceiling tiles and discussed the on-going issue of the pipe leaking. The EVS Director stated he was not aware of the trash can condition or the privacy curtain laying on the floor. The EVS Director confirmed the housekeeper had already cleaned the room today and should have informed him of the privacy curtain as well as cleaned the trash can. g. Room #402 was observed on 06/23/25 at 10:10 AM. An approximately one-foot corner section of baseboard between bed A and the bathroom was observed to be pulled away from wall with an exposed nail visible. The entire room floor had visible scuff marks embedded in the flooring. Above bed A, a baseball sized round brown ring was observed on the ceiling. There was no trash can liners in place in 3 of the 3 trash cans and the bottoms of each had dried thick brown matter with brown splatters to walls of the trash cans. In the shared	F0584		

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F0584 SS = E	Continued from page 6 bathroom, a square cut was seen in the ceiling above the toilet with plumbing pipes visible. A steady flow of water from the ceiling hole was observed and heard. A large gray raised commode seat covered the toilet with a large white bucket on top to collect water and the bucket appeared to be half full. Water was noted on the floor of the entire bathroom extending to the threshold of the bathroom. Several dirty and water saturated towels were on the floor in front of the toilet. A musty smell was noted on entering the bathroom. A resident from Room #402 (Resident #11) was interviewed on 06/23/25 at 10:30 AM. When asked how long the bathroom had been leaking water from the ceiling she said "on and off for 2 months. She stated, "they fix it and it leaks again." When asked how long this instance, she stated "around 2 days." Resident #11 stated due to this leak she must use her wheelchair to go to the unit's shower room to use the commode, even at night due to the current leak which was inconvenient. She stated that the facility had not told her when this leak would be fixed. Review of Resident #11's MDS completed on 06/19/25 revealed that the resident was cognitively intact. An interview was held with the Maintenance Assistant on 06/23/25 at 3:24 PM. He stated he was on call on 06/20/25 when a staff member called him directly on his phone at 10:45 AM and again at 4:02 PM to report that there was flooding from the ceiling in the bathroom of Room #402. He stated he did not come in when he received the calls but told the staff to turn the faucets off in Room #502, directly above Room #402. He explained that he was aware of the problem as the previous maintenance tech had "worked on it". He stated he had ordered the parts to fix the leak a week or two ago but had not received the parts. He explained they typically took 4 to 10 days to ship. He stated that he had not checked the status of the order on 06/23/25. He shared that he had not put a formal work order in the system as of 06/23/25 at 3:24 PM but had communicated the issue verbally in a face-to-face report with the Acting Maintenance Director when he arrived at the facility that morning. 06/23/25 at 1:11 PM, the EVS Director was observed exiting the bathroom in Room #402 with a mop and mop bucket. Observation of the bathroom revealed no water	F0584		

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F0584 SS = E	Continued from page 7 on the bathroom floor but several dirty and water saturated towels remained on the floor in front of the toilet. No water heard or seen from the open ceiling area above the toilet. When interviewed, the EVS Director stated that due to callouts in his department, he was assigned to Room #402. He explained he had just mopped the water up off the bathroom floor. When asked about the dirty wet towels on the floor the EVS Director stated, "they were left there when someone was trying to clean up the water." The EVS Director left the room leaving the dirty wet towels on the bathroom floor. On 06/23/25 at 3:05 PM Room #402 was observed along with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. The EVS Director stated that the floor had been cleaned but scuff marks were visible in the flooring. The EVS Director stated that the floor and room had been cleaned. He stated he was aware of the issue and was working with the chemical representative to evaluate floor cleaning solution concentrations to address it. There was trash can liners in place in all the trash cans but the bottoms of each had dried thick brown matter with brown splatters to walls of the trash cans. The group observed the square cut in the bathroom ceiling. No dripping water was noted or heard. The Acting Maintenance Director stated that the Maintenance Assistant had instructed the staff to turn off the water and not use the faucets in the room directly above Room #402. A large gray raised commode seat covered the toilet with a large white bucket on top to collect water. The bucket was empty. Several dirty and water saturated towels were on the floor in front of the toilet. A musty smell was noted on entering the bathroom. The Acting Director of Maintenance stated he would ask the Maintenance Assistant to share the status of the leak and the timeline for fixing it. The EVS Director stated above he was assigned the room. h. Room #421 was observed on 06/23/25 at 10:15 AM. Shoe impressions and dirt were observed in the floor wax on the entire room floor. Raised, brown material observed on the left and right walls of the bathroom door. The ceiling above the toilet had an area with paint flaking and a round, brown stain approximately the size of a dinner plate present. There was no trash can liners in place for 2 of 2 trashcans and the bottoms of both cans were heavily soiled with dried dark brown and red matter with brown splatter to the walls of the trash cans.	F0584		

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F0584 SS = E	Continued from page 8 The assigned housekeeper for Room #421 on 06/23/25 was not available for interview. On 06/23/25 at 3:10 PM Room #421 was observed with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. Shoe impressions were present in the floor wax on the entire room floor. The EVS Director stated that the floor and room had been cleaned. He stated he was aware of the issue and was working with the chemical representative to evaluate floor cleaning solution concentrations to address it. Trash can liners were in place for both trashcans, but the bottoms of both cans remained heavily soiled with dried dark brown and red matter with brown splatter to the walls of the trashcans. The Regional Maintenance Director/Environmental Services (EVS) Director and the Acting Maintenance Director noted the ceiling stains and stated the building plumbing was older and leaks were an ongoing issue that was being addressed. i. Room #522 was observed on 06/23/25 at 10:52 AM. The floor was noted to be sticky throughout the entire room. The shared closet area on right when entering the room had a hole just above the floor measuring 9 inches x 9 inches. (Measured by the Acting Maintenance Director during group observation rounds in the afternoon.) The closet shelf was broken and had pulled partially away from the wall of the closet. Under bed B by the headboard were a dinnerplate sized area of gray crumbles, which felt like plastic. In the bathroom a heavy buildup of brown/black material was observed in all corners and brown splatters on the walls behind the toilet and around the commode grab bars. The representatives of Resident #14 in Room #522 were interviewed on 06/23/25 at 10:52 AM. They stated housekeeping did not clean her room daily. They stated that the gray plastic crumbles and dirt under Resident #14's bed had been there "several days." 06/23/25 at 3:15 PM, in Room #522. The Acting Maintenance Director measured the hole in the shared closet and noted the broken closet shelf. The EVS Director, acting Maintenance Director, and Regional Maintenance/EVS Director observed under bed B by the headboard were a dinnerplate sized area of gray crumbles, which felt like plastic. In the bathroom a	F0584		

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F0584 SS = E	Continued from page 9 heavy buildup of brown/black material was observed in all corners and brown splatters on the walls behind the toilet and around the commode grab bars. The Acting Maintenance Director was unaware of the maintenance issues in Room #522. The Director of EVS stated that the room had been cleaned that day. He discussed not being aware of the issues in the room but would have expected the housekeeper to sweep under bed B and clean all surfaces in the bathroom that had visible dirt. j. On 06/23/25 at 09:30 AM and 2:30 PM the second-floor dayroom ceiling directly above air conditioning unit had two large, circular, brown rings. k. On 06/23/25 at 09:35 AM and 2:30 PM the second-floor metal threshold plates bolted to the floor on both hallways had heavy dirt buildup. l. On 06/23/25 at 10:45 AM and 2:43 PM the third-floor metal threshold plates bolted to the floor on the hallway had heavy dirt buildup. m. On 06/23/25 at 10:50 AM and 3:30 PM the fourth-floor metal threshold plates bolted to the floor on the hallway had heavy dirt buildup. On 06/23/25 at 3:25 PM, following the group walking rounds, a group interview was conducted with the Regional Maintenance Director/Environmental Services (EVS) Director, the Acting Maintenance Director, and the Director of EVS. The Acting Maintenance Director stated he was aware of the wall damage to the bathroom ceiling in Room #402 and the bathroom wall holes but not to entry room walls in Room #311 and Room #522. The Acting Maintenance Director stated that he spent a lot of his time trying to fix walls in the facility when it was brought to his attention. He stated he had been told of the pipe leak in Room #402 by the Maintenance Assistant in the AM of 06/23/25 but he had not observed it himself before the group walking rounds. He offered to bring the Maintenance Assistant in to share the progress of repairs for Room #402. The Acting Maintenance Director stated that he was unaware of the baseboard issues in rooms of Rooms #311, #400, and #522 and the exposed electrical wires in room of Room #400. The Acting Maintenance Director stated that the expectations for staff were to report missing or loose baseboards, wall damage, leaks, or any other damage/issues through the electronic tracking system.	F0584		

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F0584 SS = E	Continued from page 10 The Regional Maintenance Director/Environmental Services (EVS) Director stated that he, the Acting Maintenance Director, and the Director of EVS all received immediate notification of issues on their phone app of work order system once staff entered a work order request. The Regional Maintenance/EVS Director and the Acting Maintenance Director stated they had not received notification of the issues in Room #402 on their phone. On 06/23/25 at 3:35 PM. during the group interview, the Director of EVS stated that he was unaware of the floor, wall, and room cleanliness concerns for Room #220, #228, Room #429, Room #400, Room #402, Room #311, Room #327, and Room #522 and the dirt on the metal thresholds on the hallways of the second, third and fourth floors. The Director of EVS explained that the assigned housekeeper should wipe down any high touch areas, dust, clean the bathroom, empty trashcans, and sweep/mop the floor of each resident room daily. He stated that he and a floor technician were responsible for carpet cleaning and buffing and cleaning corners of rooms and bathrooms throughout the facility. The Director of EVS stated if the housekeeper saw spillage or dirt on the walls/doors they were responsible for cleaning the area. He shared that he was responsible for training the EVS staff in how to clean rooms and floors. The Director of EVS stated the rooms observed were not cleaned to expectations. The Director of EVS stated that he did routine rounds to look for issues "several times a week." On 06/23/25 at 3:35 PM. The Maintenance Assistant explained he and the Acting Maintenance Director relied heavily on housekeeping and nursing assistants to complete work orders in the computerized tracking system. The Maintenance Assistant stated he was unaware of the holes in any of the walls other than the ceiling in Room #402 because no one had entered the issue into the computerized system. He explained that anyone can enter an issue into the computerized system which then sends an alert to his phone. The Maintenance Assistant stated once an issue had been fixed, he logged into the computerized system and marked the issue as completed. The Maintenance Assistant stated that he did not do routine rounds to look for issues. The Administrator was interviewed on 06/23/25 at 3:50 PM. She stated it was her expectation that staff report missing or loose baseboards, items in disrepair in resident rooms, and water leaks in resident rooms. She	F0584		

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F0584 SS = E	Continued from page 11 stated that this could be done through the electronic tracking system or directly to the Maintenance Assistant. She was aware of ceiling stains and the water leak in Room #402 but had not observed the room herself. The Administrator stated she was not aware of any of the floor and wall issues in Room #311 and #522, and the exposed electrical wires in room of Room #400 but the facility was in the process of hiring additional environmental services staff and hoped to have an additional full-time maintenance staff soon.	F0584		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff	F0690		

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F0690 SS = D	Continued from page 12 interviews, the facility failed to keep a urinary catheter drainage bag from touching the floor to reduce the risk of infection for 1 of 1 resident reviewed for urinary catheter (Resident #6). Findings included: Resident #6 was admitted to the facility on 02/25/25. His related diagnoses included overactive bladder and neuromuscular dysfunction of bladder. The admission Minimum Data Set (MDS) assessment dated 03/04/25 indicated Resident #6 was moderately cognitively impaired with no behaviors. He was documented on the MDS as having an indwelling urinary catheter. Resident #6 had a care plan dated 03/11/25 for a suprapubic catheter due to neurogenic bladder (bladder doesn't empty or store urine properly due to nerve damage or dysfunction). The care plan interventions included positioning the catheter bag and tubing below the level of the bladder and away from entrance room door, checking for tubing kinks each shift. Record review revealed Resident #6 had a urinary tract infection (UTI) on 4/17/25. On 06/23/25 at 10:00 am Resident #6 was observed in his room in bed. He had an indwelling suprapubic urinary catheter connected to a bedside urine drainage bag. The bedside drainage bag was observed positioned below bladder level but unsecured and laying directly on the floor. The urine bag appeared to be half full. A follow up observation was conducted on 06/23/25 at 2:20 pm of Resident #6's suprapubic urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level but on the floor. The urine drainage bag appeared to be full. An interview and observation were conducted with Nurse Aide (NA) #1 on 06/23/25 at 2:20 pm who confirmed that she was assigned to Resident #6 on 06/23/25. NA #1 stated catheter care consisted of putting the drainage bag below the level of the bladder, not putting the bag	F0690		

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F0690 SS = D	Continued from page 13 on the bed, and securing it to the bedframe to keep it off the floor. NA #1 was accompanied to Resident #6's room and she confirmed Resident #6's urine drainage bag was lying on the floor. NA #1 attempted to hang the urine drainage bag back onto the bed frame but stated the hook for the bag was not able to be attached onto the bed frame. She stated that the nurse had been notified at beginning of shift when NA #1 observed in on the floor and determined it could not be attached to the bed frame. She stated that she would go now to obtain a privacy bag that would allow the urinary drainage bag to be attached to Resident #6's bed frame. When asked why she did not obtain a privacy bag earlier she stated, "I didn't think about it." An interview was conducted with Nurse #1 on 06/23/25 at 2:25 pm. Nurse #1 stated she was the assigned nurse for Resident #6. Nurse #1 indicated she was told by the assigned NA the hook for Resident #6's urinary drainage bag would not attach to the bed frame and so the urine drainage bag was on the floor when she assumed the assignment that morning at 7:15 am. Nurse #1 confirmed she was aware the drainage bag had been on the floor all day and stated she meant to change the drainage bag to a drainage bag that would be able to attach to Resident #6's bed frame but had not "had the time." An interview was conducted with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 06/24/25 at 4:10 pm. The IP/SDC stated urinary catheter drainage bags, and the drainage valve should be kept off the floor because of germs and to prevent contamination. The IP/SDC shared that urinary catheter bags should be hung on the side of the bed below the level of the bladder when a resident was in bed and the drainage valve should be secured. She stated that staff were provided with this training during the new hire process and during the facility's annual competency training. An interview was conducted with the Director of Nursing (DON) on 06/24/25 at 8:45 am. The DON stated that urinary catheter drainage bags should not be on the floor for infection control reasons. She stated the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor. An interview was conducted with the Administrator on 06/24/25 at 8:45 am. The Administrator reported that	F0690		

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F0690 SS = D	Continued from page 14 urinary catheter drainage bags should not be on the floor for infection control reasons. She stated the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor. The Administrator stated she did not know why staff had not fixed or changed out resident #6's drainage bag when they were aware of the issue.	F0690		