IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 25, 2016

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue,
Coeur D'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. De Oro:

On **January 28, 2016**, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

D. Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 11, 2016

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur D'Alene, ID 83814-2403

RECEIVED
FEB 23 2016
FACILITY STANDARDS

Provider #: 135042

Dear Mr. De Oro:

On **January 28, 2016**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 4, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0246 -- S/S: E -- 483.15(e)(1) -- Reasonable Accommodation Of Needs/preferences
F0280 -- S/S: E -- 483.20(d)(3), 483.10(k)(2) - Right To Participate Planning Care-Revise Cp
F0312 -- S/S: E -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 23, 2016**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **November 5, 2015**, following the survey of **October 23, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **April 23, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

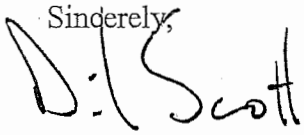
- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **February 23, 2016**. If your request for informal dispute resolution is received after **February 23, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



David Scott, RN, Supervisor
Long Term Care

DJS/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 000}	INITIAL COMMENTS	{F 000}		
	The following deficiencies were cited during the federal recertification and complaint follow-up survey conducted January 27 to January 28, 2015. The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Brad Perry, BSW, LSW, Linda Hukill-Neil, RN Amy Barkley, RN, BSN Abbreviations: None		*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F246** will be corrected as follows:	
{F 246} SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure call lights were accessible for 8 of 12 sample residents (#s 3, 5, 7, 8, 10, 14, 15, and 22) and twenty-three other residents monitored for call light accessibility. This failure created the potential for harm, if the residents' needs were unmet when assistance could not be summoned. Findings included: The facility's call light accessibility audit records,	{F 246}	**1) Correction/s as it relates to the resident/s:** Residents #3,5,7,8,10,14,15 and 22 were provided their call light to be within reach. **2) Action/s taken to protect residents in similar situations:** All residents have their call lights unless care planned otherwise. **3) Measures taken or systems altered to ensure that solutions are sustained:** All staff in serviced on providing call lights to be within reach. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Daily call light audits will be performed to ensure they are within reach. Audits will be done daily, Monday through Friday, for four weeks and weekly thereafter for eight weeks. Audit results will be monitored monthly for three months and presented at QAPI.	

RECEIVED
FEB 23 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas di Gro
TITLE: Executive Director
(X6) DATE: 2-18-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 246}	Continued From page 1 dated 12/30/15 through 1/20/16, documented that call lights were not accessible on 1/4/16 for Resident #3 and four non-sample residents; on 1/5/16 for Residents #5, #22, and eight non-sample residents; 1/6/16 for six non-sample residents; 1/7/16 for Resident #3 and seven non-sample residents; on 1/8/16 for two non-sample residents; on 1/11/16 for Resident #3 and four non-sample residents; on 1/12/16 for four non-sample residents; on 1/13/16 for Residents #7, #14, and six non-sample residents; on 1/14/16 for Residents #10, #14, #15, and nine non-sample residents; on 1/15/16 for Residents #3, #7, and four non-sample residents; on 1/18/16 for five non-sample residents; on 1/19/16 for Resident #14 and two non-sample residents; and on 1/20/16 for Residents #8, #14, and four non-sample residents. On 1/28/16 at 2:00 pm, the Administrator said the call light audits were correct and that call lights were not accessible for the residents documented. The Administrator stated that inaccessible call lights were corrected at the time of the audits.	{F 246}	5) **Date of Compliance:** ~~1/4/16~~ 2-1-16 per phone call c Tom de Oro - Lybold 2-24-16 6) **Person's Responsible** Director of Nursing, IDT, Administrator	
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	{F 280}	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F280** will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** Resident #2, 6, 7, 8, 11, 13 and 15 have had their care plan updated to include adaptive eating equipment used and/or therapy recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 280}	Continued From page 2 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to revise care plans for 7 of 12 (#s 2, 6, 7, 8, 11, 13, & 15) sample residents and 13 other residents. The care plans did not reflect revised adaptive eating equipment used and/or did not reflect therapy recommendations for the residents. This had the potential to result in harm if residents did not receive appropriate care due to a lack of direction in their respective care plans. Findings included: The facility's care plan monitoring audits, dated 1/6/16 and 1/7/16, documented: *Adaptive eating equipment care plans had not been revised for Resident #s 2, 6, 7, 8, 11, 13, 15, and 10 other residents *Therapy recommendations were not included on the care plans for Resident #8 and three other residents On 1/28/16 at 2:00 pm, the Administrator said via telephone that the care plans should have been corrected.	{F 280}	**2) Action/s taken to protect residents in similar situations:** Resident's nutritional care plans have been reviewed and accurately reflect adaptive eating equipment used and/or therapy recommendations. **3) Measures taken or systems altered to ensure that solutions are sustained:** Members of the IDT have been in serviced on effective care planning for adaptive eating equipment as well as therapy recommendations **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of care plans related to adaptive eating equipment and/or therapy recommendations. Additional weekly audits will include review of 24 hour report ensuring any Speech recommendations have appropriate follow through. These audits will be conducted weekly times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. **5) Date of Compliance:** 2/3/16 **6) Person's Responsible** Director of Nursing, Facility Educator, Medical Records	
{F 312} SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	{F 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 312}	Continued From page 3 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure bathing and nail care was consistently provided. This was true for 7 random residents for bathing and 5 random residents for nail care who were reviewed for ADL assistance from 1/6/16 to 1/21/16. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues or unpleasant odors due to not being bathed regularly and/or feet problems due to not having regular nail care. Findings included: The facility's bathing and nail care monitoring audits from 1/6/16 to 1/21/16, documented that residents did not receive bathing as per their choice. Staff documented comments such as, "Didn't have time, will make up, came in late, no shower sheet, had last minute appointment, moved beds," or was left blank. The facility's nail care monitoring audits from 1/6/16 to 1/21/16, documented residents did not receive nail care as care planned. Staff documented comments such as, "Nurse notified and has not been done at all this month." On 1/28/16 at 2:00 pm, the Administrator stated per telephone interview, that the bathing and nail	{F 312}	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F312** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** There were no identified residents related to this citation. **2) Action/s taken to protect residents in similar situations:** All resident residing at the facility have the potential to be affected by the deficient practice related to bathing and nail care. Facility wide audit for bathing preference has been performed. Bathing schedule and care plans have been updated to reflect resident preference. All bathing and nail care is current as per care plan. **3) Measures taken or systems altered to ensure that solutions are sustained:** Education will be provided to nurses and aides on the new bathing schedules that includes resident preferences and nail care. Licensed nurses have been educated on diabetic nail care and frequency. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 312}	Continued From page 4 care audits, conducted as part of the facility's Plan of Correction for deficiencies cited during the re-certification survey, were complete as presented.	{F 312}	Facility will perform daily audits of bathing, nail care, and changing of arm protectors for 4 weeks and then monthly for 8 weeks. Results will be monitored monthly for three months. Any identified deficiencies in this action plan will be corrected at the time of identification. The audits will be presented at Quality Assurance to review for further educational opportunities	
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	{F 441}	**5) Date of Compliance:** 2/3/16 **6) Person's Responsible** Director of Nursing, Facility Educator *"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F441** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** There were not identified residents in this citation. **2) Action/s taken to protect residents in similar situations:** Residents using privacy bags for foley catheters have their privacy bags placed as to not let the bag touch the floor. **3) Measures taken or systems altered to ensure that solutions are sustained:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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
{F 441}	Continued From page 5 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure urinary bags did not come in contact with the floor. This was true for 17 of 112 facility audits from 1/4/16 to 1/12/16. Failure to follow standard infection control measures placed the residents at risk for infections. Findings include: Potter and Perry, Fundamentals of Nursing, eighth edition, (p.1062), documented, "...the [catheter] bag hangs on the bed frame or wheelchair without touching the floor." National Center for Biotechnology Information (NCBI), Long term urinary catheters, March/2012, Nice clinical guidelines, number 139, 10.8.1.1., Recommendations, number 51, "Urinary drainage bags should be positioned below the level of the bladder, and should not be in contact with the floor." The facility's auditing tool, dated 1/4/16 to 1/12/16, documented that urinary privacy bags touched the floor for 17 of 112 observations. On 1/28/16, at 2:00 pm, the Administrator stated via telephone call, "We know we need new bags."	{F 441}	Infection Control policy and procedure for use of privacy bags for foley catheters have been in serviced to staff. Return demonstrations for use of privacy bags for foley's has been completed with staff as appropriate to job duties. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform daily audits of privacy bags. These audits will be conducted daily times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. **5) Date of Compliance:** 2/3/16 **6) Person's Responsible** Director of Nursing, Facility Educator, ICN	