STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075074	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Filosa	13 Hakim St Danbury, CT 06810

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observations, interviews and record review for 1 of 1 sampled residents (Resident #566) reviewed for an indwelling urinary catheter, the facility failed to provide a privacy covering on a urinary collection bag. The findings include: Resident #566's diagnoses include retention of urine, benign prostatic hyperplasia, and Parkinson's disease. The Resident Care Plan dated 7/31/24 identified Resident #566 utilized an indwelling foley catheter. Interventions included enhanced barrier precautions, foley to remain patent, to maintain the foley as ordered in the treatment administration record and to provide education on catheter use. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #566 was severely cognitively impaired, required substantial/moderate assistance for transfers and was dependent for toileting hygiene, bathing, and lower body dressing. Additionally, the MDS identified Resident #566 utilized an indwelling urinary catheter. Observations on 8/1/24 at 10:35 AM identified Resident #566 was in bed with an indwelling urinary catheter, the urinary collection bag was resting on the floor with urine visible in the collection bag, without the benefit of a privacy bag covering the collection bag. Observation on 8/5/24 at 6:26 AM identified Resident #566 was in bed with an indwelling urinary catheter (visible from the hallway), the urinary collection bag was resting on the floor with urine visible in the collection bag, without the benefit of a privacy bag covering the collection bag. Interview and observation with Registered Nurse (RN) #1 on 8/5/24 at 7:40 AM identified that per facility policy the drainage bag should be up off the floor and in a privacy bag. Subsequent to surveyor inquiry, Registered Nurse (RN) #1 placed a privacy covering on Resident #566's urinary collection bag and raised the collection bag off the floor. Interview with the Infection Control Nurse (LPN #5) on 8/7/24 at 10:16 AM identified collection bags should be stored on the bed rail or under wheelchair and in a privacy bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility policy for privacy coverings for urinary collection bags was not provided.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 48950 Based on observations and interviews for resident rooms on the second floor, the facility failed to provide a homelike, clean environment for the 9 of 13 rooms. The findings included: Observation of the second floor during the initial facility tour on 8/1/24 at 12:07 PM identified room [ROOM NUMBER] door and room [ROOM NUMBER] window, room [ROOM NUMBER], room [ROOM NUMBER] door and room [ROOM NUMBER] window, room [ROOM NUMBER] window, room [ROOM NUMBER] door, room [ROOM NUMBER] door and window, room [ROOM NUMBER] door and window, room [ROOM NUMBER] door and window, and room [ROOM NUMBER] door and window were missing a front piece to the facility supplied dresser, which clothing could be seen in the drawers. Interview with Person #1 on 8/5/24 at 12:21 PM identified that the dressers have been missing the front piece for at least 6 months and that she/he told LPN #1. Interview with LPN #1 on 8/5/24 at 12:25 PM identified that the dressers have been an issue and have been broken for a long time. LPN #1 identified that she had informed maintenance of the issues with the resident's dressers, the facility used a call-in voicemail system to report issues and concerns with items needing repair. Interview with the Maintenance Director on 8/5/24 at 12:30 PM identified that he was not aware of any issues with the dressers on the second floor being broken. The Environmental Round logs were reviewed and failed to identify that furniture was on the list of things to check nor were there any maintenance records of furniture needing repair.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51313 Based on interviews, review of the clinical record, and facility documentation for 1 of 5 sampled residents (Resident #47) reviewed for unnecessary medication, the facility failed to accurately transcribe an Advanced Practice Registered Nurse (APRN) medication order. The findings include: Resident #47 diagnosis included vascular dementia with behavioral disturbance, unspecified psychosis, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 was severely cognitively impaired and required supervision with eating, partial assistance with oral hygiene, and was dependent with toileting, upper/lower body dressing, and personal hygiene. Additionally, the MDS identified Resident #47 received antidepressant medication. The Resident Care Plan dated 2/21/24 identified behavioral symptoms. Interventions included providing medications as ordered with physician discussion regarding dose revision and effect as needed. A Psychiatric progress note dated 4/17/24 written by APRN #1, identified that she was asked to evaluate Resident #47 for behavioral disturbances, restlessness, eating poorly, and trying to climb out of bed at night when his behaviors become acute. An order from APRN #1 dated 4/17/24 directed to discontinue Trazodone (a medication to treat depression) 50 milligrams (mg) at bedtime and start Trazodone 75 mg at bedtime. APRN #2 (medical APRN) entered an order in the electronic chart for Trazodone 25 mg at bedtime to start 4/17/24 (despite APRN #1 writing order for 75 mg). A nurse's note written by LPN #4 dated 4/17/24 at 8:48 PM identified an order written by APRN #1 that Trazodone was decreased to 25 mg at bedtime, despite APRN #1 writing an order for Trazodone for 75 mg (APRN #1's handwritten order was misinterpreted by LPN #4 to read 25 mg instead of 75 mg). Nursing notes dated 4/23/24 at 6:57 AM, identified extreme restlessness on the night shift; with Resident #47 removing his/her dry brief and soaker pad from the bed and urinating on the bed and clothes four times during the night. Additionally, the nursing notes identified Resident #47 had both legs over the side of the bed. Resident #47 wanted to check the roster, and staff unable to redirect the resident with offers of food or conversation, the resident did not sleep all shift. Nursing notes dated 4/24/24 at 7:17 AM, identified Resident #47 was restless all shift, again removing his/her brief and urinating on the linens on the floor three times during the night. Resident #47 had his/her legs over the positioning pillow and wanted to go to the theatre. Offers of food and fluids did not decrease restlessness. On 4/25/24 a progress note written by APRN #2 identified that Resident #47 had a recent reduction in two of his/her medications and that his/her restlessness had increased at night. APRN #2 recommendation at that time was to increase the Trazodone to 50 mg from 25 mg (despite the psychiatric APRN #1 originally writing order for Trazodone 75 mg on 4/17/24). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 8/6/24 at 2:00 PM identified that Psychiatric APRN #1 did not enter orders in the electronic chart but wrote her orders on paper. LPN #5 stated that LPN #4 (who no longer works at the facility) transcribed the orders incorrectly into the electronic chart. Interview with APRN #1 on 8/6/24 at 2:20 PM identified that she was unable to write orders in the electronic chart, but she communicated with nursing staff regarding the medication changes and the reason for the increase in dosage from 50 mg to 75 mg.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on interviews, review of the clinical record, and facility policy, for 1 of 2 residents (Resident #36) reviewed for pressure ulcers, the facility failed to ensure an alternating pressure mattress (APM) was set at the appropriate setting according to the physician's orders. The findings include: Resident #36's diagnoses included congestive heart failure, hypertension, unspecified protein calorie malnutrition and muscle weakness. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was moderately cognitively impaired, and was dependent on staff with bed mobility, transfers, and ambulation. In addition, Resident #36 was frequently incontinent of urine and bowel and was at risk of developing pressure ulcers. Physician's order dated 7/24/24 directed an alternating pressure mattress (APM) with air loss at a weight setting of 165 pounds and to check placement and inflation each shift. The Resident Care Plan dated 8/1/24 identified Resident #36 was at risk for skin breakdown due to decreased mobility, and incontinence. Interventions included an alternating pressure air mattress, following skin care protocol using preventive measures when indicated, offloading heels while in bed, and providing treatments as ordered. A physician progress note dated 8/2/24 identified Resident #36 with a 1.5 centimeter (cm) by 1.0 cm dark purple area with a small superficial opening on the coccyx. The physician identified the area as a new deep tissue injury possibly developed when Resident #36's APM deflated accidentally as reported by the nursing staff. Observation on 8/6/24 at 10:00 AM and 8/7/24 at 9:00 AM identified that Resident #36's APM was set at 200 pounds. Review of Resident #36's clinical record identified that staff was signing off the APM setting of 165 pounds. Observation and interview with the Wound Advanced Practice Nurse (APRN #3) and wound Nurse (RN #3) on 8/7/24 at 9:10 AM identified that the APM was set at 200 pounds instead of 165 pounds (per the physician's order). The Wound APRN further stated that an APM setting of 200 pounds could negatively affect the healing of the wound for Resident #36. In addition, APRN #3 stated that the physician order should have been followed for a setting at 165 pounds. Subsequent to surveyor inquiry, the APM setting was adjusted by APRN #3 to reflect Resident #36's weight of 165 pounds. Interview with the RN #4 on 8/7/24 at 9:20 AM identified that the Charge Nurse on the unit was responsible for checking the placement and inflation of the APM each shift and as needed. RN #4 stated that she had not yet made her rounds for the day shift and could not explain the reason the APM was not set at the correct setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facilities Pressure Reducing Mattress policy identified, in part, that residents with an identified pressure area will be provided with an alternating pressure air mattress when appropriate and the APM will be checked for placement and inflation each shift and as needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, interviews, review of the clinical record, and facility policy for 1 of 1 sampled resident (Resident #11) reviewed for range of motion (ROM), the facility failed ensure a device was applied for hand contractures. The findings include: Resident #11's diagnoses included Alzheimer's disease, poly osteoarthritis abnormal posture, and contractures of right/left hands. A Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #11 had a short/long term memory problem and upper/lower extremity limited ROM/impaired on both sides. Additionally, the MDS identified Resident #11 required maximal assistance with eating and was dependent with oral hygiene, toilet use, shower/bathing and upper/lower body dressing. An Occupational Therapy (OT) evaluation and plan of treatment dated 1/17/24 indicated Resident #11 had impaired ROM to the right upper extremity (elbow, wrist, hand, thumb, index finger, middle finger, ring finger and little finger), additionally, impaired ROM to the left upper extremity (wrist, hand, thumb, index finger, middle finger, ring finger, and little finger). There was functional limitation present due to contracture and Resident #11's ability to express ideas, wants and ability to understand others was rarely or never understood. A physician's order dated 5/15/24 directed Resident #11 to have a [NAME] guard applied to the right hand daily for contracture management, remove for hand hygiene to be completed as needed every shift. Additionally, Resident #11 was to wear a rolled cloth to left hand daily, to remove for hand hygiene as needed every shift, ROM with morning and evening care every day and evening shift. The Resident Care Plan dated 7/10/24 identified functional deficits related to comorbidities and health conditions resulting in potential of low endurance and deconditioned state. Interventions included applying a rolled cloth to left hand as tolerated, transfer with assist of 2 with Hoyer lift and no ambulation at this time. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 was cognitively impaired with both short- and long-term memory problem, required total assistance with all activities of daily living (ADLS) and functional limitation in range of motion on both sides to both upper and lower extremities. An OT note dated 7/31/24 identified Resident #11 initially made facial expressions of pain when the therapist touched his/her right-hand and was initially guarded but tolerated ROM and minimal touching of his/her right hand, additionally he/she tolerated rolled up gauze in both hands. Nursing made aware. Observations on 8/1/24 at 10:33 AM, identified Resident #11 sleeping with hands in fists, without the benefit of cloth rolls in the hands. At 11:55 AM Resident #11 was up in the wheelchair sleeping with his/her neck leaning to right side and was moved into dining room by staff without the benefit of repositioning. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 8/2/24 at 11:22 AM identified Resident #11 was up in the wheelchair without the benefit of a rolled cloth to the left hand. Interview with OT #1 identified that Resident #11 does not tolerate [NAME] guard in his/her right hand and should have a soft cloth hand rolls in his/her hands. An OT note date 8/2/24 identified Resident #11 gentle stretching to bilateral hands to decrease contractures to open hands for good hygiene care. Discussed with nursing that resident is unable to tolerate [NAME] guards and to continue to use soft cloth at this time. Observation on 8/5/24 at 10:33 AM identified Resident #11 sleeping with hands in fists without the benefits of cloth hand rolls. Observation on 8/6/24 at 11:55 AM identified Resident #11 was up in the wheelchair with his/her hands in a fist, without the benefits of cloth hand rolls or a palm guard. Observation on 8/6/24 at 12:16 PM identified Resident #11 in the dining room, handwashing was being provided for lunch, Resident #11 grimacing and crying out, pulling hand away. LPN #2 observed the resident's behavior, administered scheduled Tylenol and placed a call to APRN #4 for as needed medication for pain. Observation 8/6/24 at 1:50 PM identified Resident #11 in the room sleeping in a wheelchair without the benefit of a cloth hand roll in his/her hands, or palm guard. Observation on 8/7/24 at 9:27 AM identified Resident #11 lying in bed without the benefit of cloth handrolls in his/her hands. Observation on 8/7/24 at 10:01 AM with the DNS identified that cloth hand rolls were not in Resident #11's hands. In an interview, clinical record review and review of the Treatment Administration Record with the DNS on 8/7/24 at 10:01 AM failed to reflect documentation identifying resident refusals for the cloth hand rolls, except on 8/3/24. Subsequent to surveyor observations, a physician order was obtained to discontinue the palm guard on 8/6/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on interviews, review of the clinical record, and facility policy for 1 of 4 residents (Resident #47) reviewed for nutrition, the facility failed to document the percentage of supplements consumed in regard to significant weight loss. The findings include: Resident #47's diagnoses included left sided hemiplegia and hemiparesis (muscle weakness) following a cerebral infarction, dysphagia, and dementia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 was severely cognitively impaired and required supervision or touch assistance with eating, partial/moderate assistance with oral hygiene, and was dependent with personal hygiene. Additionally, Resident #47's MDS identified no significant weight loss at that time. The Resident Care Plan dated 12/8/23 identified a nutritional concern due to a cerebral vascular accident, hemiplegia and hemiparesis, dysphagia, and dementia. Interventions included to provide a one person assist with meals, give large portions, juice supplement as ordered, and to monitor appetite daily. A review of Resident #47's weights identified that Resident #47 weighed 129.3 pounds (lbs) on 1/1/24. A Dietitian's note dated 2/2/24 identified Resident #47 weighed 119 lbs (Resident #47 had a 10.3 lb/7.9% weight loss in one month) and that there was a significant decrease in weight. The Dietitian recommended that the house juice supplement be increased from twice daily to three times daily. A physician's order dated 2/2/24 directed to give a house juice supplement of 177 milliliters (ml) three times a day. Resident #47's weights were 121 lbs on 3/1/24, 115 lbs on 4/1/24, 114.2 lbs on 5/3/24, and 109 lb on 6/5/24 (a 12 lb/9.9% weight loss in 3 months). A Dietitian's note dated 6/19/24 identified Resident #47 was seen by the physician due to progressive weight loss. The Dietitian recommended that the house juice supplement be increased from three to four times daily. A physician's order dated 6/19/24 directed to give a house juice supplement four times a day. A review of Resident #47's weights identified that Resident #47 weighed 107 lbs. on 6/21/24 (which indicated a 22.3 lbs/17.2% weight loss in less than 6 months). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with the Dietitian on 8/6/24 at 12:12 PM identified that tracking consumption of the house supplement was not documented since the supplement was ordered on 2/2/24 and would be documented on the Electronic Medication Administration Record (EMAR). Additionally, the house supplement was not transcribed into the EMAR to include the ml amount consumed. Although the nurse aides document total daily fluid intake on the intake record, it does not delineate the amount of nutritional supplement consumed. Interview and clinical record review with LPN #1 on 8/6/24 at 1:42 PM identified that nurses provide residents nutritional supplements and document it was given on the EMAR. Additionally, LPN #1 identified that the consumption amount of the house supplement was not being documented on the EMAR for Resident #47. LPN #1 further indicated that Resident #47 would typically only drink about half or a quarter of the house supplement, and not drink the whole supplement at a time. Interview with the Dietitian on 8/6/24 at 1:46 PM identified that with tracking of the house supplement consumption, along with checking labs and completing closer weight monitoring, she would be able to further evaluate Resident #47's diet needs. Additionally, the Dietitian indicated that there was a high calorie gelatin that could be added to Resident #47's diet order. Subsequent to surveyor inquiry, the order for the house juice supplement was changed by the Dietitian on 8/6/24 to consume 90 ml four times a day and to document the ml actually consumed on the EMAR. Additionally, the Dietitian collaborated with the Advanced Practice Registered Nurse to have lab work ordered and recommended weight monitoring weekly for 6 weeks, then monthly. Review of the Use of Nutritional Supplements policy dated 4/23 directed, in part, that supplement orders are transcribed on the EMAR. The ml of the supplement consumed by the resident is charted on the EMAR. The Dietitian should complete periodic reassessments of the need for continuation of supplemental feeding. 50250

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 50179 Based on observations, interviews, review of facility documentation, and facility policy for medication storage, the facility failed to ensure storage of a vaccine in the refrigerator per CDC guidelines. The findings include: On 8/5/24 at 11:35 AM, observation of the 2nd floor medication cart identified a Covid-19 vaccine (Spike vac) with Resident #38's name attached was stored unrefrigerated in the cart. Interview with LPN #5 on 8/5/24 at 11:44 AM identified that the vaccine should be refrigerated and not stored in the medication cart. LPN #5 removed the vaccine and discarded it in a sharp ' s container. Interview with Pharmacist #1 on 8/6/24 at 2:20 PM identified that the Covid-19 vaccine was to be stored in the refrigerator until it was to be used and it should be taken out of the refrigerator an hour prior to administration. Spike vac vaccine should not be stored unrefrigerated for a long period of time because the efficacy of the vaccine will decrease. Documentation of receipt of vaccine was dated 5/3/24 and signed by LPN #3. Interview with LPN #3 on 8/7/24 at 11:44 AM identified she received the vaccine however she did not recall what she did with the vaccine upon receipt. Review of the policy for medication storage directed, in part, refrigerated medications must be stored in a separate medication refrigerator with temperature maintained at 36 F to 46 F and vaccines shall be stored in compliance with CDC guidelines and the manufacturer ' s specifications.

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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** 51102 Based on observations, interviews and record review for 1 of 3 residents (Resident #566) reviewed for infection control, the facility failed to ensure the urinary collection bag was maintained off the floor. Resident #566's diagnoses include retention of urine, benign prostatic hyperplasia, and Parkinson's disease. The Resident Care Plan dated 7/31/24 identified Resident #566 utilized an indwelling foley catheter. Interventions included enhanced barrier precautions, foley to remain patent, to maintain the foley as ordered in the treatment administration record and to provide education on catheter use. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #566 was severely cognitively impaired, required substantial/moderate assistance for transfers and was dependent for toileting hygiene, bathing, and lower body dressing. Additionally, the MDS identified Resident #566 utilized an indwelling urinary catheter. Observations on 8/1/24 at 10:35 AM and 8/5/24 at 6:26 AM identified Resident #566 was lying in bed with the urinary drainage collection bag resting on the floor with urine visible in the collection bag. Interview and observation of Resident #566 with Registered Nurse (RN) #1 on 8/5/24 at 7:40 AM identified that per facility policy the drainage bag should not be resting on the floor. Subsequent to surveyor inquiry, Registered Nurse (RN) #1 raised the collection bag so it was not resting on the floor. Observation of Resident #566 on 8/6/24 at 11:55 AM identified he/she was sitting in a wheelchair in the hallway with the urinary collection bag in a privacy bag located under the wheelchair and resting on the floor. Further observation at that time identified Nurse Aide (NA #1) pushing Resident #566 in the wheelchair in the hallway with the urinary drainage bag dragging on floor. Interview and observation with NA #2 in the presence of NA #1 on 8/6/24 at 11:55 AM identified that the drainage bag was dragging on the floor because there was no other place to secure the bag without it touching the floor. Subsequent to surveyor inquiry, NA #2 reported to the surveyor that the drainage bag was raised off the floor. Interview with the Infection Control Nurse (LPN #5) on 8/7/24 at 10:16 AM identified that collection bags should be kept off the floor, by being stored on the bed rail or under the wheelchair in a privacy bag. However, if the collection bag was in a privacy bag, then it was alright because the privacy bag acted as a barrier. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075074	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Filosa	13 Hakim St Danbury, CT 06810

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Urinary Catheter Policy dated March 2024 directed to keep the collection bag below the level of the bladder and not place the urinary collection bag on the floor.