

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>37648</p> <p>Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) form was provided at least two days prior to end of Skilled services for 1 of 3 residents whose Medicare Part A Skilled services were discontinued (Residents #26). In addition, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form 10055, which included appeal rights and liability of payment was provided at least two days prior to a resident's last covered day for 2 of 3 residents whose Medicare Part A services were discontinued and remained in the facility (#26 and #32).</p> <p>Findings:</p> <p>1. Resident #26's NOMNC indicated that the resident's Medicare Part A services would end on 1/25/24 and was signed by residents Guardian on 1/24/24, one day prior to end of skilled services. The medical record lacked evidence that Resident #28's legal guardian was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility.</p> <p>2. Resident #32's Medicare Part A coverage for skilled services ended on 5/16/24. The medical record lacked evidence that Resident #32 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility.</p> <p>On 6/11/24 at 11:43 a.m., during an interview, the Director of Quality and Compliance confirmed the above.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on observation and interview the facility failed to provide maintenance services necessary to maintain a sanitary and comfortable interior on 2 of 3 units observed (100 and 200 units).</p> <p>Findings:</p> <p>During a facility tour on 6/12/24 between 8:31 a.m. and 8:55 a.m , the Director of Operations confirmed the following:</p> <p>100 Unit the following was observed:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] the bathroom had dead bugs/debis in the light fixture -room [ROOM NUMBER] entrance was missing the threshold -room [ROOM NUMBER] had approximately 4 feet section of baseboard trim missing left of the window <p>200 Unit the following was observed:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] the sink was dripping and plugged up causeing pooling water in the sink. -room [ROOM NUMBER] the sink had a steady leak.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	
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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on facility policy, record reviews and interview the facility failed to provide a written Notice of Transfer or Discharge to resident and/or resident representatives for 1 of 6 residents reviewed for hospitalization (Resident #28). In addition, the facility failed to notify the Office of the State Long-Term Care Ombudsman of hospital transfers for 2 of 6 residents reviewed for hospitalization s (Resident's #28 and #2).</p> <p>Findings:</p> <p>Review of facility policy Transfer and Discharge Policy undated, states .Notice of discharge shall be provided to the resident and resident representative: when a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer shall be provided to the resident and resident representative as soon as practicable, A list of resident who transferred out for the facility is provided to the state ombudsman on a monthly basis .</p> <p>1. Resident #28 was admitted on [DATE] with diagnoses to include stage 3 chronic kidney disease. On 6/11/24 Resident #28 was transferred to an acute care hospital for evaluation and was subsequently admitted . Review of Resident #28's clinical record lacked evidence that a written notice of transfer/discharge was provided to the resident and/or resident representative. Further review lacked evidence the facility provided notice of this discharge to Office of the State Long-Term Care Ombudsman.</p> <p>2. Resident #2 was admitted to facility on 5/9/24 with diagnoses to include acute respiratory failure with hypoxia, chronic systolic heart failure, and atrial fibrillation. On 6/1/24 Resident #2 was transferred to an acute care hospital and subsequently admitted . Review of Resident #2's clinical record lacked evidence that a written notice of transfer/discharge was provided to Office of the State Long-Term Care Ombudsman.</p> <p>On 6/11/24 at 11:43 a.m., during an interview, the Director of Nursing confirmed above findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	
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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on facility policy, record review and interview, the facility failed to issue a bed hold notice which included the daily cost of care, to a resident, known family member or legal representative for 1 of 6 sampled residents who had been transferred to the hospital (Residents #28).</p> <p>Finding:</p> <p>Review of facility policy Resident Bed Hold Policy for hospitalization s undated, states Prior to and upon a transfer, written information will be given to the residents and/or the resident representatives that explains in detail: the rights and limitations of the resident regarding bed-holds, The reserve bed payment policy as indicated by the state plan, the facility per diem rate required to hold a bed (non-Medicaid resident), or to hold a bed beyond the state bed-hold period (Medicaid residents).</p> <p>Resident #28 was admitted on [DATE] with diagnoses to include stage 3 chronic kidney disease. On 6/11/24 Resident #28 was transferred to an acute care hospital for evaluation and was subsequently admitted . Review of Resident #28's clinical record lacked evidence that a written notice bed hold was provided to the resident and/or resident representative.</p> <p>On 6/11/24 at 11:44 a.m., during an interview, the Director of Nursing confirmed above findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	
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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648</p> <p>Based on interviews and record reviews, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 4 of 14 residents that were reviewed for new admissions. (#190, #196, #2 and #28)</p> <p>Findings:</p> <p>1. Resident #190 was admitted to the facility on [DATE]. The hospital discharge summary included information that the resident was admitted with diagnosis of COVID-19, Atrial flutter requiring anticoagulant medication and a Coronary Artery Bypass Graft (CABG) on 5/24/24 which required Epicardial pacing wires. The discharge instructions stated, Epicardial pacing wires: prepped and cut on day of discharge. Instructions: you had temporary epicardial pacing wires placed during surgery and utilized in the post-operative period. These rest on the surface of your heart and allowed us to temporarily control your heart rate. These wires exited the skin just below your ribcage and were cut at the time of discharge. These wires should no longer be visible . Do NOT pull these wires. Incision: Keep your incision dry. No bathing, whirlpool tub, or swimming for 3 weeks. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #190's immediate health and safety needs for the above concerns.</p> <p>2. Resident #196 was admitted to the facility on [DATE]. The hospital discharge summary included information that the resident was admitted with diagnosis of left hip prosthetic joint infection requiring intravenous antibiotics via a peripherally inserted central catheter line. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #160's immediate health and safety needs for the above concerns.</p> <p>On 6/12/24 at approx. 10:55 a.m., during an interview, the above was discussed with the Registered Nurse Admission Coordinator.</p> <p>42531</p> <p>3. Resident #2 was admitted to facility on 5/9/24 with diagnoses to include acute respiratory failure with hypoxia, type 2 diabetes mellitus, chronic systolic heart failure, atrial fibrillation, and malnutrition. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #2's immediate health and safety needs for the above concerns.</p> <p>4. Resident #28 was admitted on [DATE] with diagnoses to include chronic kidney disease stage 3, benign prostatic hyperplasia with lower urinary tract symptoms and history of multiple urinary tract infections requiring use of prophylactic antibiotics. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #28's immediate health and safety needs for the above concerns.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/24 at approximately 11:21 a.m., during and interview, the above was discussed with Director of Nursing</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on facility policy, record reviews and interviews the facility failed to update and/or implement goals and interventions for 2 of 14 care plans reviewed. (Resident's #12 and #29).</p> <p>Findings:</p> <p>Review of facility policy Comprehensive Resident Care Plan undated states It is the policy of Mid Coast Senior Health Center to develop, implement and evaluate a comprehensive care plan for each resident based on a comprehensive assessment of the residents needs . will be developed for each resident to include measurable objectives and timetables based on the Resident Assessment Protocols triggered by the MDS and other assessments . will reflect intermediate steps for each objective if identification of those steps will enhance the resident's ability to meet his/her objectives .will be developed 7 days after the completion of the comprehensive assessment by the interdisciplinary team will be reviewed and updated periodically and as the resident's condition dictates .</p> <p>1. Resident #12 was admitted on [DATE] and has diagnoses to include chronic kidney disease stage 2, congestive heart failure [CHF], Diabetes Mellitus II[DMII], right leg above knee amputation and atrial fibrillation.</p> <p>Review of Resident #12's clinical record revealed his/her last quarterly Minimum Data Set [MDS] was completed on 3/7/24. The most recently signed provider orders dated 4/26/24 revealed the flowing:</p> <p>-Order with start date of 1/18/23 for Blood glucose checks fasting and pm qid [4 times daily]- call provider if BG above 400.</p> <p>-Order with start date of 5/17/23 for insulin Aspart 100 unit/ml solution injection sub-q 8units tid [three times daily] for DMII.</p> <p>-Order with start date of 10/1/22 for insulin Aspart 100 unit/ml solution sub q tid per sliding scale 0730/730 am 1130/1130 am, 1630/430pm sliding scale: 70-150=0 units, 151-199=1 units 200-249=2 units, 250-299=3 units 300-349= 4 units, 350-399=5 units >400 call MD/provider for DMII.</p> <p>-Order with a start date of 1/21/23 for apixaban 5mg tablet by mouth 1 tab bid for DVT [deep vein thrombosis] prophylaxis</p> <p>-Order with start date of 3/22/24 for torsemide 20 mg tablet by mouth .2 tablet/40mg 8am for CHF.</p> <p>-Order with start date of 4/4/24 for ipratropium-albuterol 0.5mg/3ml -2.5 mg/3ml solution inhalation 1 vail tid prn for dyspnea.</p> <p>Review of Resident #12's care plan updated 5/31/24 lacked evidence of goals and interventions for the above diagnoses.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/11/24 at 12:21 p.m. during a review of Resident #12's care plan, the Director of Nursing confirmed the above finding.</p> <p>44049</p> <p>2. On 6/10/24 at 9:47 a.m., in an interview with the Resident #29's representative, [he/she] stated, The doctor has told me how to massage [his/her] leg because now that [he/she] is on Hospice they may not cover continued Physical Therapy (PT) for [him/her].</p> <p>On 6/11/24 at 12:15 p.m. in an interview with the charge nurse, she confirmed that the edema is not in the care plan stating, that she has documentation in the resident's clinical record that shows on 6/5/24, 6/6/24, and 6/8/24 she elevated the resident's legs higher than the resident's heart to attempt to reduce the edema in the resident's left leg . I am not sure why it is not on the care plan.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44049</p> <p>Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the floor stand mixer, floor stand fan, and the small countertop mixer. Freezer #7 contained unlabeled and undated items for 2 of 2 observations. Additionally, the dry storage room floor was not maintained in clean and sanitary manner, there is no temperature log for the dish machine, and the Mere Point Unit Freezer contained the ice scoop in with the ice for 1 of 3 days of survey.</p> <p>Findings:</p> <p>On 6/10/24 at 8:10 a.m., during the initial tour of the kitchen with the cook and again on 6/12/24 at 8:00 a.m., during a kitchen tour with the Director of Facilities Operations, the following findings were observed and confirmed:</p> <ol style="list-style-type: none"> 1- Observed that the facility lacks a log for the dish machine. The cook stated, we are supposed to have a log for that, but I do not know where it is. In an interview, the Kitchen Coordinator and a Diet Aide, that run the dish machine, both stated in the instructions for running the dish machine that they must observe the temperature gauge and see that it rises to the correct temperature. 2- Observation of the dry storage room to have food on the floor i.e. packets of peanut butter, crackers and an energy bar. 3- Observation of the large floor mounted mixer to have stuck on dried food on mixer. At this time, the cook stated that she had not used the machine for 2 days. 4- Observation of the floor mounted fan to have a light to moderate covering of dirt like debris on fan with some long strands of dust like debris blowing in the air. 5- Observation of the small countertop mixer with dried food/debris on the side and the stand. No staff member could say when that machine was last used. 6- Observation of Kitchen Freezer #7 containing a package of Frozen French Fries with no label or date, an open bag of Hash browns with no date, and two packages of log shaped food with no label and no date. <p>On 6/12/24 at 8:35 a.m. in the Mere Point Unit Kitchen, during observation of breakfast, surveyor noted the ice scoop in the ice bin of the freezer compartment of fridge. At this time, the kitchen staff member confirmed the ice scoop should not be stored in the ice bin.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Mid Coast Senior Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Baribeau Drive Brunswick, ME 04011	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on observations and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to urinary collection devices for 3 of 3 days of survey on 2 of 3 units (100 and 200 Units).</p> <p>Findings:</p> <p>Observations of 100 Unit revealed the following:</p> <ul style="list-style-type: none"> -On 6/10/24 at 9:48 a.m., and 6/11/24 at 7:25 a.m., observations of room [ROOM NUMBER] bathroom revealed uncovered commode bucket on floor, available for use. -On 6/10/24 at 9:25 a.m., observation of room [ROOM NUMBER] bathroom revealed uncovered commode bucket on the floor with bed pan stored inside, available for use. <p>Observations of 200 unit revealed the following:</p> <ul style="list-style-type: none"> -On 6/11/24 at 8:14 a.m. and 3:09 p.m., and on 6/12/24 at 8:04 a.m., observations of room [ROOM NUMBER] bathroom revealed an uncovered commode bucket on bathroom floor, available for use. - On 6/11/24 at 8:21 a.m., and 3:13 p.m., observations of room [ROOM NUMBER] bathroom revealed an uncovered commode bucket on floor, available for use. -On 6/12/24 at 8:16 a.m. 2 surveyors observed room [ROOM NUMBER] bathroom containing uncovered commode bucket on floor and urinal drainage bag hanging over the hand railing containing approximately 250 ccs yellow liquid. <p>During a facility tour on 6/12/24 at 9:00 a.m., the above findings were confirmed with the Director of Operations.</p>