STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	55 Tenth Street Southeast Wells, MN 56097

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (oral care and bathing) was provided for 2 of 2 residents (R26, R80) reviewed for activities of daily living (ADLs) who were dependent on staff for their care. Findings include: R80's facesheet printed on 8/1/24, included diagnoses of chronic kidney disease, fibromyalgia, and anxiety. R80 tested positive for Covid-19 on 7/29/24. R80's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R80 had moderate cognitive impairment, had clear speech, was understood, and could understand. R80 had no behaviors including rejection of care. R80 needed partial/moderate assistance for personal hygiene and was dependent upon staff for bathing. R80's care plan dated 7/24/24, indicated R80 had an ADL self-care deficient; was dependent upon staff for bathing, and required one staff assist for brushing her teeth. The care plan dated 7/15/24, indicated R80 was able to make many day-day decisions. Progress note on 7/19/2024 at 9:46 p.m., indicated staff spoke with R80 regarding her bath schedule and if she wanted a bath that weekend, or if she wanted to wait until Monday (7/22/24), which was her weekly bath day. R80 said she was fine waiting until Monday. (There was no documentation of R80 receiving a bath on Monday 7/22/24, and no documentation of a refusal). During an interview on 7/29/24 at 3:01 p.m., R80 stated no one offered to help her brush her teeth in the morning or at night. R80 stated she was supposed to have a tub bath today, but it had been canceled due to her being in transmission-based precautions (TBP) for Covid-19. R80 stated no one had offered her a bed bath in place of a tub bath. During an observation on 7/31/24 at 7:29 a.m., in R80's room, an electric toothbrush with a pink handle was observed on a dresser under the TV. With permission, writer looked in drawers for toothpaste and/or an emesis basin or small tub with oral care supplies. None was observed in R80's room. There was no toothpaste or oral care supplies in the bathroom either. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation and on 7/31/24 at 7:51 a.m., nursing assistant (NA)-F assisted R80 to the bathroom via a standing lift device. At 8:01 a.m., R80 was assisted back to her recliner. No morning cares were offered, including washing hands and face, or brushing her teeth. During an interview and observation on 7/31/24 at 10:31 a.m., now observed a pink plastic emesis basin in R80's shared bathroom with a facility-provided toothbrush and toothpaste in it and R80's name on the basis. R80 stated she had never seen that before and had not brushed her teeth today. During an interview on 7/31/24 at 10:39 a.m., NA-F stated he did not put the toothbrush and toothpaste in a pink emesis basin in R80's bathroom and did not know who did. NA-F stated he asked R80 if she wanted to brush her teeth, but she said she was too tired. He had not reproached her to ask again. During an interview on 8/01/24 at 9:52 a.m., R80 stated if staff asked her if she wanted to brush her teeth, she would say yes, but didn't know how she would get to the bathroom to brush her teeth. R80 stated no one had asked her if she wanted to brush her teeth and if they did, she would not refuse. R80 stated she still had not had a bath and would like a tub bath. Documentation of oral care and bathing in POC (point of care) in the EMR indicated the following: --Bathing: since admission on 7/5/24, two baths were documented as being given: 1) 7/10/24 (there was a bath sheet completed for this with a nurse skin check), and 2) 7/23/24 (there was no bath sheet completed for this and no nurse skin check). There was one refusal documented on 7/29/24, but no documentation indicating the NA informed the nurse of this. --Oral care was documented multiple times since admission, however R80 stated she had not brushed her teeth since being admitted on [DATE]. In addition, until writer inquired about oral care, there were no oral care supplies in R80's room or bathroom except an electric toothbrush on a dresser under the TV. During a phone interview on 8/01/24 at 11:43 a.m., the director of nursing (DON) stated residents in TBP would receive a bed bath, rather than a shower or tub bath. The DON stated when a resident had a bath, including a bed bath or a shower, it would be documented on a paper bath sheet and scanned into the EMR. Further, whenever a resident had a bath, a nurse did a skin check at the same time and documented it on the bath sheet. In addition, the DON stated oral care was to be offered to resident's morning and night and documented in the EMR. Refusals of a bath or of oral care would be documented in the EMR by the NA; the NA would inform the nurse and the nurse would also document the refusal. The DON was informed that the last documented bath sheet for R80 was on 7/10/24, - 22 days ago. The DON reviewed R80's EMR and stated a bath was documented as being given on 7/23/24, but no bath sheet filled out, therefore the DON was not able to confirm if a bath took place that day. The DON stated if it had, she would have expected a nurse to complete a skin check and document it on the bath sheet. The DON stated R80's next bath day was 7/29/24, and she refused it; however, would still have expected a nurse to do her skin check and document it on the bath sheet, but that had not been done. As a result, the DON was not able to confirm R80 received or was offered a bath after 7/10/24. The DON who was not available on site, stated when she returned, would have more discussion and education with nursing about expectations during a Covid outbreak. 50761 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's Face Sheet printed on 8/1/24 at 1:13 p.m., included diagnoses of pneumonia, chronic obstructive pulmonary disease (COPD), emphysema, acute and chronic respiratory failure with hypoxia, congestive heart failure, and COVID-19. R26's admission MDS dated [DATE], identified R26 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 13 (Score of 13-15 suggests cognition intact). Further, R26's MDS did not address the level of assistance needed to shower/bathe self, the assessment stated, Not Applicable (NA). Finally, the MDS indicated R26 needed substantial/maximal assistance with personal hygiene, walking was not attempted due to R26's medical condition and/or safety concerns, substantial/maximal assistance to wheel the wheelchair 50 feet in distance, and received hospice cares. R26's care plan printed on 7/30/24, indicated R26 had an ADL self-care performance deficit related to impaired mobility secondary to difficulty breathing from COPD, congestive heart failure (CHF), CKD, benign prostate hyperplasia (BPH), and hypertension. During various observations from 7/29/24 through 8/1/24, R26 remained in quarantine in own room with spouse. R26 noted to be sitting in a wheelchair with a high flow nasal cannula or nebulizer treatment mask on and watching television. R26 was not observed outside the room. R26 had a bathroom with toilet and sink in the room, but no shower or bath tub. Nursing progress note dated 7/30/24, indicated R26 was in a private room with a private bath. All cares have been done in the room and R26 had not left the room. R26 is on isolation precautions and they are being followed. During interview on 7/30/24 at 12:54 p.m., LPN-B stated R26 was supposed to call staff for help to reposition, toilet, hygiene, etc. R26 doesn't always use call light and told staff, I can do it myself. During interview on 7/30/24 at 1:37 p.m., LPN-B stated R26 was seen by Hospice PT and R26 was not to ambulate in the hallway due to hypoxia. R26 is allowed to ambulate and perform ADLs with staff assistance. During interview on 8/01/24 at 8:13 a.m., NA-E stated R26 will have a bath on 8/2/24 since R26 will be out of COVID. R26 received peri-care and washed own face and brushed teeth. During interview on 8/01/24 at 8:16 a.m., LPN-C and NA-E stated COVID quarantine was 10 days. NA-A and NA-E stated 10 days was too long without a bath. During interview on 8/01/24 at 8:18 a.m., NA-E stated COVID residents should be the last residents getting a bath for the day. LPN-C stated last time R26 had a bed bath (not just peri-care) was on 7/25/24. LPN-C stated, 10 days was too long without a bath, especially on hospice. LPN-C, was unaware of policy for bathing residents with COVID. During interview on 8/01/24 at 8:27 a.m., R26 stated they had no bath since being put into quarantine and would like a bath. R26 stated he would like a bath first thing in the morning. R26's spouse was also in the room and confirmed R26 hadn't had a bath since being quarantined. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Hospice Nurse Manager on 8/1/24 at 10:01 a.m., the Hospice Nurse Manager stated no current hospice aides are scheduled due to lack of identified need. During interview on 8/01/24 at 11:36 a.m., DON stated, baths are completed last for residents with an active infection. If it's COVID, no resident can leave room and should be offered a bed bath weekly. Due to strict isolation, residents can't leave their rooms. The DON expected bed baths for COVID residents weekly unless refused. Other hygiene should be done twice daily (brushing teeth) and after incontinent episodes staff are expected to help residents. At 11:39 a.m., DON stated residents on hospice should be bathed more often (even without hospice aides) and expected bed baths to be given if in isolation (COVID). Facility Policies: Resident Showers and Bed Baths both dated 1/2024 reviewed and indicated; It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Further, the Policy Explanation and Compliance Guidelines indicated residents will be provided showers as per request or as per facility schedule protocol and based upon resident safety. No facility policy available for residents with COVID to shower/bathe. Facility Oral Care policy dated 1/2024, indicated it was the practice of the facility to provide oral care to residents to prevent and control plaque associated with oral diseases. The policy outlined the steps to take to assist a resident with oral care. .

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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** 42073 Based on interview and document review, the facility failed to implement the bowel movement (BM) protocol for 1 of 1 resident (R8) reviewed for constipation. Findings include: R8's facesheet printed on 8/1/24, included diagnoses of congestive heart failure, kidney failure, and diabetes. R8's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R8 had severe cognitive impairment, had clear speech, was understood, and could understand. R8 was dependent upon staff for toileting and was frequently incontinent of bowel and bladder. R8's physician order dated 6/7/23, included milk of magnesia oral suspension; give 30 millimeters (ml) by mouth every 24 hours as needed for constipation per standing orders. R8's standing orders (orders nursing staff can initiate independently) dated 2/16/24, included: --Day 2, if no BM, give milk of magnesia 30 ml orally every day as needed for constipation. --Day 3, if no BM, give Dulcolax suppository every day as needed for constipation. --Day 4, if no BM, administer Fleets enema per rectum one time. If no results, call medical provider. R8's care plan dated 6/15/24, indicated staff were to monitor R8 for constipation due to being on an antidepressant. According to point of care (POC) nursing assistant (NA) documentation in the electronic medical record (EMR), R8 went multiple days without a BM: --7/26/24, through 7/30/24, (5 days). R8 received milk of magnesia on 7/30/24 (day 5). During an interview on 7/31/24 at 7:56 a.m., licensed practical nurse (LPN)-C stated there was a bell alert icon in the EMR that alerted nursing staff if a resident went longer than 48 hours without a BM, and then standing orders should be initiated for constipation. LPN-C stated she also looked at POC BM documentation in the EMR to observe frequency of BM's. During an interview on 8/1/24 at 9:42 a.m., when asked, LPN-A was not aware of how to look up a residents BMs, nor was she familiar with the bell alert icon. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 8/1/24 at 11:43 a.m., the director of nursing (DON) was informed of the number of days R8 had gone without a BM. The DON stated R8 relied on staff to toilet him, so nursing staff documented when he had a BM. The DON stated resident BMs were monitored to prevent constipation and hard stools. The DON stated she expected nursing staff to be aware and utilize a medication from his standing orders to prevent constipation. A policy regarding management of bowel elimination was requested and not received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50761 Based on observation, interview, and document review the facility failed to follow the appropriate food preparation safety requirements for thawing frozen meat to reduce and/or prevent the risk of food borne illness. This had the potential to affected 25 of 25 residents who obtained their meals from the kitchen. Findings include: During observation on 7/31/24 at 11:31 a.m., oven roasted turkey breast and a pork product were individually vacuum sealed in a plastic wrap being thawed together in the middle section of a three section sink for the next day meal. While the meat was being thawed in a water bath, no continuous running cold water observed to minimize/prevent food borne illness. During interview on 7/31/24 12:04 p.m., Dietary aide-A stated staff training was completed at the facility and dietary aide-A was taught that a cold-water bath was an appropriate technique to thaw frozen meat. This technique and facility training were confirmed with the dietary manager. U.S. Food and Drug Administration ' s (FDA) Food Code 2022 Chapter 3 indicates: 3-501.13 Thawing. TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 41 degrees F or less or (B) Completely submerged under running water: (1) At a water temperature of 70 degrees F or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 41 degrees F. (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 41 degrees F, for more than 4 hours including; (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking, or (b) The time it takes under refrigeration to lower the FOOD temperature to 41 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview and document review, the facility failed to perform hand hygiene during cares, clean lift equipment after use, ensure 1 of 1 staff were fit-tested with N95 masks prior to entering COVID positive resident room, and adhere to EBP (enhanced barrier precautions) for 1 of 1 residents (R2). This had the potential to impact 25 residents residing in the facility. Findings include: R2's quarterly MDS assessment dated [DATE], indicated R2 was cognitively intact, dependent on staff for transfers, dressing, hygiene, and toilet use, and had diagnoses of neurogenic bladder (loss of bladder control due to nerve damage), dementia, and heart failure. R2's care plan revised 4/8/24, indicated R2 was transferred with a mechanical lift for all transfers and was on EBP due to an indwelling urinary catheter. During an observation on 8/1/24 at 9:07 a.m., nursing assistant (NA)-B was exiting R2's room and entering R1's room. No hand hygiene was observed. At 9:11 a.m., NA-B was observed exiting R1's room and returning to R2's room. No hand hygiene was observed. On 8/1/24 at 9:11 a.m., NA-B was observed entering R2's room without putting on a gown or gloves. NA-B closed the door to R2's room. A sign on R2's door indicated the need for gown and gloves when assisting R2 with dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care (catheter), and wound care. On 8/1/24 at 9:25 a.m., NA-B exited R2's room. NA-B confirmed she assisted R2 with a bed bath and verified she did not wear a gown for the task. NA-B stated she was not familiar with R2 and this was her first day working at the facility. NA-B stated she saw the sign for EBP and the cart with supplies and personal protective equipment (PPE) outside the door but had not seen other staff using gowns or gloves, so did not think she needed to. NA-B verified she should have used PPE when assisting R2 and further stated she should have completed hand hygiene when going from R2's room to R1's room and back again. On 8/1/24 at 9:28 a.m., NA-B and NA-A entered R2's room with a mechanical lift. Neither NA-B or NA-A were observed putting on a gown or gloves prior to entering the room. A sign remained on the door to R2's room indicating the need for EBP and a cart with gowns, gloves, and hand sanitizer was outside R2's door. On 8/1/24 at 9:34 a.m., NA-A removed a mechanical lift from R2's room and pushed it to the nurse's station. NA-A was not observed sanitizing the mechanical lift. NA-A then left the area. No other observation of lift sanitation was observed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/1/24 from 9:34 a.m. to 9:48 a.m., NA-A confirmed she had assisted NA-B with transferring R2 into her wheelchair. NA-A stated she did not wear a gown when assisting R2 and further stated we never gown up for that here. NA-A reviewed the sign on R2's door and confirmed she should have worn a gown and gloves when transferring R2. NA-B exited R2's room with a bag containing a soiled brief. NA-B confirmed she completed a brief change, hygiene, and transferred R2 into her wheelchair. NA-B verified she did not wear a gown when assisting R2 and again verified she saw the sign on the door and the cart outside the room and should have worn a gown. On 8/1/24 at 9:48 a.m., NA-B exited R2's room. NA-B confirmed the mechanical lift NA-A walked out with had not been sanitized in R2's room after use. NA-B then took the mechanical lift from the nurse's station for use with another unknown resident. NA-B was not observed sanitizing the lift. NA-B confirmed she thought the lift had been sanitized after use since it was at the nurse's station. NA-B stated lifts should be sanitized immediately after use to avoid spreading germs to other residents. On 8/1/24 at 9:54 a.m., licensed practical nurse (LPN)-A stated NA-B and NA-A should have used EBP when assisting R2 with bathing, hygiene, changing of brief, and transferring. LPN-A further stated she would expect hand hygiene when leaving a resident room and prior to entering a resident room. LPN-A also stated she would expect mechanical lifts to be sanitized immediately after use and leaving a mechanical lift at the nurse's station without sanitizing it could increase spread of infection. During an interview on 8/2/24 at 9:30 a.m., RN-A was informed of findings related to lack of PPE worn in EBP rooms. RN-A stated it was her expectation staff adhere to EBP as indicated on the signs posted on resident doors. RN-A stated NA-A had received training on EBP precautions in August 2023. NA-B who was agency staff, had just started at the facility and had not received formal orientation including EBP training. 42073 During observation on 7/30/24 at 8:52 a.m., TMA-A, entered R13's room and did not perform hand hygiene prior to entering. On 7/30/24 at 9:06 a.m., TMA-A exited R13's room and did not perform hand hygiene. At 9:07 a.m., TMA-A stated the facility policy was to perform hand hygiene on entrance and exit of resident rooms. TMA-A stated she should have performed hand hygiene prior to entering and exiting R13's room. During an observation on 7/31/24 at 7:51 a.m., NA-F was observed in R80's room who was in TBP for Covid, with a standing mechanical lift taking R80 to the bathroom. NA-F had on full PPE, including an N95 mask. NA-F who was agency staff stated he had not been fit-tested for the brand of N95 masks used at the facility. During a phone interview on 8/2/24 at 11:23 a.m., with the director of long-term care (DLTC) for the nursing staffing agency of which NA-F was employed, the administrator and RN-A, DLTC stated the agency did not do N95 fit training. 50761 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 7/29/24 at 5:01 p.m., NA-D exited R2's room with a stand lift (mechanical device used for transferring), placed the stand back in the storage area near the east hallway nursing station without cleaning it and walked away. NA- D was asked if the lift was cleaned, NA-D confirmed the stand should have been cleaned right away after resident use because other staff would not know if it was cleaned. During continuous observation on 7/30/24 at 8:33 a.m. to 8:48 a.m., NA-C, exited R14's room with the stand, placed it at the end of the west hallway and did not clean it after use. Before entering R23's room on 7/30/24 at 8:48 a.m., TMA-A who was orientating NA-C stated the stand was cleaned . Although this was not observed during the observation . During an interview on 8/2/24 at 9:30 a.m., RN-A stated NA-A had training on cleaning lifts in August 2023. NA-B who was agency staff, had just started at the facility and had not received formal orientation including disinfecting lifts after use. During a telephone interview on 8/02/24 at 11:31 a.m., the director of nursing (DON) was informed of the infection prevention and control findings. The DON stated she expected all residents rooms to be thoroughly cleaned, including residents in TBP, and stated leadership would address whose responsibility it was to clean TBP rooms and provide appropriate training as needed. Further, the DON stated staff were expected to follow facility policies for hand hygiene, cleaning and disinfecting equipment, and wearing proper PPE for residents in EBP. The DON stated the facility would need to figure out how to onboard agency staff who needed fit-testing for N95 masks and would work with RN-A on that. Facility Handwashing/Hand Hygiene policy dated August 2015, indicated the facility considered hand hygiene the primary means to prevent the spread of infection. All personal were trained; all personnel follow handwashing/hand hygiene procedures and use alcohol-based hand rub for the following examples: before and after direct contact with residents, contact with skin, blood or body fluids, handling dressings, before and after entering isolation precaution settings. Facility Environmental Services/Housekeeping/Laundry policy dated 2019, indicated housekeeping surfaces required regular cleaning and removal of soil and dust. Disinfectant/detergents were used for environmental surface cleaning, but the actual physical removal of microorganisms and soil by wiping or scrubbing was probably as important. High touch surfaces included beds, bed rails, bedside table, call button, call button in bathroom, closet handles, light switch, TV remote and trash can. Facility Equipment and Supplies Used During Isolation policy with review date of 5/2024, indicated nursing would notify environmental services regarding equipment that needs sanitization after use in the care of an individual with isolation precautions. Environmental services and/or nursing would be responsible for cleaning and sanitizing equipment before it is return to designated storage areas. Facility Cleaning and Disinfection of Resident Care Items and Equipment policy dated July 2014, indicated resident-care equipment would be cleaned and disinfected according to CDC recommendations. Durable medical equipment would be cleaned and sanitized before reused by another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Infection Prevention and Control Program policy with reviewed date of 5/24/24, indicated all staff receive training relevant to their specific roles and responsibilities, including policies and procedures related to their job function. Staff would demonstrate competence relevant to infection control practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	55 Tenth Street Southeast Wells, MN 56097

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42073 Based on observation and interview and record review, the facility failed to clean resident rooms for (R80, R22, R24, R26, R18) who were on transmission-based precautions (TBP) timely and maintain an environment in good repair affecting 12 residents who used the west unit tub room. Findings include: During an interview on 7/30/24 at 8:59 a.m., housekeeper (H)-A stated housekeeping did not clean rooms of residents in TBP and stated nursing staff was supposed to clean those rooms. During an interview on 7/30/24 at 10:16 a.m., environmental services director (EVSD) stated neither housekeeping nor nursing cleaned the rooms of residents who were in TBP. EVSD stated nursing brought out the garbage and did a quick visual of the room, but did not clean toilets, floors, or high touch surfaces. If a room really needed cleaning, EVSD stated nursing would let housekeeping know and housekeeping would don PPE (personal protective equipment) and clean the room. During an observation on 7/31/24 at 7:29 a.m., R80 who was in TBP , shared an adjoining bathroom with another resident who was in TBP. In the bathroom, the toilet had a commode with arm rests positioned over the toilet. The white commode splash guard was splattered with a brown substance . During an interview and observation and on 7/31/24 at 7:51 a.m., nursing assistant (NA)-F assisted R80 to the bathroom using a standing lift device. During an observation on 7/31/24 at 8:51 a.m., R24 and R26's who were both in TBP shared a bathroom. The toilet had a commode with arm rests positioned over the toilet. The light gray commode splash guard was splattered with a brown substance and the back of the toilet seat was smudged with what looked like feces. The two over the bed tables used by R24 and R26 were soiled and dirty smeared and had greasy looking spots. During an interview on 7/31/24 at 8:49 a.m., nursing assistant (NA)-F stated housekeeping updated them that morning NA's were supposed to clean the rooms of residents in TBP. NA-F admitted he had not received training to properly clean a room of a resident in TBP, nor had he been informed of what cleaning supplies to use and where they were located. During an interview on 7/31/24 at 9:08 a.m., NA-A stated she cared for residents in TBP and stated NA's were supposed to take out the trash and clean the toilet. NA-A stated she had not been trained on how to properly clean a toilet, had no instructions to follow and did not know what cleaning products to use. During an interview on 7/31/24 at 11:05 a.m., the administrator was informed of the condition of soiled toilets in rooms of residents in TBP. The administrator stated it was not acceptable to have toilets in that condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/2/24 on 9:30 a.m. registered nurse (RN)-A infection preventionist wasn't sure who was responsible for cleaning TBP resident rooms RN-A acknowledged the rooms and the shared bathrooms needed regular cleaning and disinfecting. During an observation on 7/31/24 at 9:01 a.m., the flooring in the tub room on the west unit was noted to be in disrepair. The original flooring visible around the perimeter of the room was made up of small, square blue/gray tiles in various sizes. Some of the tiles at the foot end of the tub appear to have been removed and gray paint had been applied over the section of the flooring directly around the tub. At the foot end of the tub where a resident would enter and exit the tub and where their feet would rest, the flooring was wet due to residents having been bathed. The paint in this approximate 3 x 3-foot area, had chipped and/or had been scraped away, exposing the missing tile and concrete, leaving an unclean, uneven surface for resident's feet. During an interview on 7/31/24 at 1:17 p.m., the environmental services director (EVSD) was informed of the observation. EVSD stated he was aware of the condition of the flooring with missing paint and had not gotten around to re-painting it. EVSD acknowledged the condition, and may be difficult to properly clean the floor. During an interview on 7/31/24 at 1:23 p.m., housekeeper (H)-A stated she mopped the floor in the tub room and was aware the paint was flaking off. H-A could not recall if she had brought it to EVSD's attention. On 8/1/24 at 9:45 a.m., a policy on facility upkeep and maintenance was requested and EVSD stated they did not have one.