STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365892	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington House Rehab & Alzheimer's Care Center	2222 Springdale Road Cincinnati, OH 45231

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, review of a facility self-reported incident (SRI), observations, staff interviews, review of personnel files and policy review, the facility failed to ensure a resident was free from physical abuse. This affected one (#15) out of two residents reviewed for abuse. The facility census was 99. Findings include: Record review for Resident #15 revealed the resident was admitted to the facility on [DATE]. Her diagnoses included, hydrocephalus, osteoarthritis, schizo affective disorder, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety disorder, dementia, and essential primary hypertension. Review of the most recent Minimum Data Set (MDS), dated [DATE], revealed Resident #15 had severe cognitive impairment. Further review of the MDS assessment for Resident #15 revealed she required maximum assistance from staff with toileting, bathing, and personal hygiene and was dependent on staff for medication management. Review of Resident #15's behavior care plan initiated on 03/10/23 revealed she was care planned for a behavior problems that included, increased agitation, verbal aggression, refuses care, refuses medication, refuses showers, refuses skin checks, physical aggressive toward staff, refuses to wear incontinence supplies, throws objects at others, refuses to be seen by wound care, refuses to go on appointments, and physical aggression toward other residents. The facility listed the following interventions for Resident #15's behaviors, administer medication as ordered, approach in a calm manner, behavioral health consult as needed, communicate with resident, consult with pastoral, psychological services, support groups, encourage active support by family, minimize potential for disruptive behaviors by offering tasks that divert attention, encourage resident to participate in activities of choice, encourage resident to maintain as much independence and control with depictions making as possible, intervene as necessary to protect the rights and safety of others, minimize potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes, attempt to determine underlying causes, observe and anticipate resident's needs, and encourage resident to express her feelings. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's progress notes dated 04/25/24 as a late entry for 04/24/24 revealed the Administrator received a call from Resident #15's private care giver related to the facility care provided to Resident #15 by the facility staff and will be in a later time to provide more information and a video of the incident. Further review of the progress notes reveled on 04/24/24 the Administrator and Director of Nursing (DON) met with the Resident #15's care manager and she reported concerns of care not being provided in the way the family would prefer. Documentation revealed the family refused to send Resident #15 out for evaluation and treatment until 04/29/24. The family requested Resident #15 to be sent to the emergency department for evaluation and treatment related to the allegation of abuse and falls. Review of hospital records for Resident #15 dated 04/29/24 revealed was seen in the emergency room and was discharged from the hospital with a diagnosis of fall, agitation, and complicated urinary tract infection (UTI). Resident #15 was given a new order for an antibiotic. Review of the facility SRI, revealed the facility opened an investigation regarding physical abuse on 04/24/24 at 1:23 P.M. and closed the report on 04/30/24 at 8:53 P.M. The SRI revealed a personal care giver of Resident #15 called the Administrator on 04/24/24 and reported an allegation of abuse to Resident #15 by two facility State tested Nurse Aides (STNA) #95 and #96 on 04/24/24. The report stated STNA #95 struck Resident #15 with a pillow, held her hands down, and caused Resident #15 to hit her head. As a result of the investigation the facility notified the police and substantiated the allegation of abuse. The investigation revealed Resident #15 was evaluated at the hospital on 04/29/24 and returned with a diagnoses of urinary tract infection. The SRI documented Resident #15 had no injuries or outcome from the incident. Observation on 04/30/24 at 2:08 P.M. of Resident #15 revealed there was no signs of abuse noted. Attempts to interview Resident #15 revealed the resident was not interviewable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/02/24 at 8:57 A.M. with the Administrator, Regional Nurse (RN) #91, and the facility [NAME] President of Risk Management (VPRM) #94 revealed the Administrator reported on 04/24/24 she received a call from Resident #15's personal care giver and she reported she will arrive at the facility and provide information related to care provided to Resident #15 from two STNA's (#95 and #96). The Administrator stated she immediately suspended STNA #95 and #96 and contacted the police department and filed a report. The Administrator stated the personal care giver arrived at the facility around 1:00 P.M. and provided a video of the abuse incident to the facility. The Administrator stated the video revealed the two STNA's (#95 and #96) were rough when they provided personal care to Resident #15. The Administrator confirmed the care provided by STNA #95 and #96 to Resident #15 was not consistent with the facility standards. The Administrator stated Resident #15 is resistive to care and this is care planned for Resident #15. The Administrator stated Resident #15 will swat, hit, kick and try to bite staff when the staff attempt to provide personal care to Resident #15. The Administrator confirmed the facility has provided education to the staff to walk away from the resident's if they are resistive to care and try another care giver or other attempts. The Administrator confirmed STNA #95 and #96 should have left Resident #15 and consulted with other staff members in an attempt to try again if she was resistive to care. The Administrator confirmed the video tape of the care provided to STNA #95 and #96 to Resident #15 appeared as though STNA #95 and #96 had attempted to restrain Resident #15 and had tossed a pillow at Resident #15's head during care. The Administrator confirmed the facility initiated a SRI regarding abuse which was substantiated. The Administrator confirmed STNA #95 and #96 were terminated from employment with the facility due to the incident involving Resident #15. The Administrator confirmed Resident #15 was assessed once the facility became aware of the incident and there was no injuries or outcome from the abuse incident. Observation on 05/02/24 at 11:30 A.M. with the VPRM #94 of the video footage dated 04/24/24 revealed care was being provided to Resident #15 by two STNA's #95 and #96. STNA's #95 and #96 were standing over Resident #15 while providing care. Resident #15 pushed at STNA #95 and #96 and struck out toward the staff members. STNA #95 threw a pillow at the resident, hitting her in the face. Resident #15 pulled the pillow off her face. STNA #95 then picked up a clean incontinence brief and hit the resident in the hand. Resident #15 continued to strike out and tried to bite the staff. STNA #96 stood at the foot of the bed and watched. STNA #95 then held both of Resident #15's hands down on her chest the resident tried to sit forward, and pressure was applied to keep the resident lying down. STNA #95 then put her right hand on the Resident #15's forehead and continued to hold Resident #15's hands down while STNA #96 changed the residents incontinence brief. Review of STNA #95's personnel file revealed the STNA was hired on 12/15/22. STNA #95 was in good standings with the Nurse Aide registry and received resident rights and abuse training. There was no other documented concerns regarding abuse in STNA #95's personnel file. Review of STNA #96's personnel file revealed the STNA was hired on 04/23/23. STNA #96 was in good standings with the Nurse Aide registry and received resident rights and abuse training. There was no other documented concerns regarding abuse in STNA #96's personnel file. Review of the facility policy titled, Ohio Abuse, Neglect & Misappropriation, dated 09/02/16 revealed the intent of the facility to provide resident centered care that meets the psychosocial physical and emotional needs and concerns of the residents. Further review of the facility policy revealed the intent of the facility is prevent the abuse, mistreatment, or neglect of residents.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on record review and staff interview, the facility failed to ensure a valid Preadmission Screening and Resident Review (PASARR) was completed upon admission to the facility. This affected one (#06) out of one resident reviewed for PASARR. The facility census was 99. Findings Include: Record review for Resident #06 revealed he was admitted to the facility on [DATE]. His diagnoses included, diabetes mellitus (DM)2, lymphedema, essential primary hypertension, anxiety disorder, post traumatic stress disorder (PTSD), adjustment disorder, heart failure, major depressive disorder, and chronic kidney disease stage 2. Review of the most recent Minimum Data Set (MDS) assessment, dated 03/13/24, revealed Resident #06 had severely impaired cognition. Further review for the MDS assessment revealed he required maximum assist with toileting and bathing. Review of the PASARR Review for Resident #06 dated 03/13/24 revealed the facility failed to identify Resident #06's mental health diagnoses of major depressive disorder. Interview on 05/02/24 at 8:18 A.M. with the facility Social Worker (SW) #42 confirmed Resident #06's PASARR dated 03/13/24 was not completed correctly and the residents diagnoses of major depressive disorder was not assessed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on record review, staff interviews and policy review, the facility failed to ensure residents with compromised nutrition status were weighed weekly as ordered. This affected three (#70, #33, and #85) of nine residents reviewed for nutrition. The facility census was 99. Findings include: 1. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses including hyperlipidemia, unspecified obesity, major depressive disorder, and generalized anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment completed on 04/11/2024 revealed Resident #70 had severely impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the care plan dated 11/04/2022 revealed Resident #70 had potential for altered nutrition, had weight loss, needs for supplementation, and had inconsistent meal intakes. Interventions included identify resident preferences notify provider/family of unplanned weight loss, obtain daily weights as needed, offer substitutions if meal is declined, provide Med pass supplement twice daily as ordered, and provide assistive devices/assistance/diet as ordered. Review of the medical record revealed Resident #70 had physician orders for regular diet, regular texture with thin liquids. Additionally, Resident #70 had an order for weekly weights dated 02/16/2024. Review of the medical record revealed weights were obtained on 02/05/2024 (176.6 pounds), 03/05/2024 (173.8 pounds), 03/22/2024 (173.5 pounds), and 04/03/2024 (172.0 pounds). During an interview on 05/01/24 at 7:46 A.M. Registered Nurse (RN) #36 verified Resident #70's weekly weights were not being completed as ordered. RN #36 stated it looked like when the order was entered, there was no prompt for weekly weights triggered to document in Resident #70's Medication Administration Record (MAR). During a telephone interview conducted on 05/01/24 at 10:05 A.M. Dietitian #98 confirmed Resident #70's weekly weights were not being done as ordered. 44069 2. Review of the medical record for Resident #33 revealed an admitted [DATE]. Diagnoses included the following: Alzheimer's Disease with early onset, pure hypercholesterolemia, major depressive disorder, moderate protein-calorie malnutrition, orthostatic hypotension, anemia, and anorexia. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was assessed to require supervision for eating, moderate assistance for oral hygiene and transfer, and maximal assistance for toileting, bathing, dressing, personal hygiene, and bed mobility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 08/31/21 revealed Resident #33 had the potential for nutritional problems related to Alzheimer's Disease, hypertension, hypercholesterolemia, major depressive disorder, protein-calorie malnutrition, dysphagia, hyperlipidemia, and anemia. Interventions included administering medications as ordered, identifying resident food and beverage preferences, monitor meal intake, provide assistance with meals as needed, and obtain, monitor, and record weights per facility protocol. Review of the weights documented for Resident #33 revealed a weight of 141 pounds on 02/07/24, 137 pounds on 03/07/24, 122 pounds on 04/05/24, and 127 pounds on 05/01/24. Review of the active physician orders revealed an order dated 02/16/24 for weekly weights. Interview on 05/01/24 at 10:14 A.M. via phone with Registered Dietician #98 confirmed weekly weights were not being obtained as ordered for Resident #33. 3. Review of the medical record for Resident #85 revealed an admitted [DATE]. Diagnoses included the following: dementia, vitamin B 12 deficiency anemia, and unspecified protein-calorie malnutrition. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was assessed to require supervision for eating, oral hygiene, toileting, dressing, personal hygiene, and transfer, moderate assistance for bathing, and was independent for bed mobility. Review of the care plan dated 12/01/23 revealed Resident #85 had the potential for nutritional problems related to dementia, hypertension, mood disorder, vitamin B 12, and unspecified protein-calorie malnutrition. Interventions included identifying resident food and beverage preferences, monitoring meal intake, providing meals per diet order, and providing supplements per order. Review of the active physician orders revealed an order dated 02/16/24 for weekly weights. Review of the weights documented for Resident #85 revealed a weight of 163 pounds on 02/05/24, 164 pounds on 03/05/24, 164 pounds on 03/31/24, 155 pounds on 04/03/24, 154 pounds on 04/30/24, and 164 pounds on 05/01/24. Interview on 05/01/24 at 10:14 A.M. via phone with Registered Dietician #98 confirmed weekly weights were not being obtained as ordered for Resident #85. Review of the undated facility policy titled Resident Height and Weight revealed weights would be obtained monthly or as ordered by the physician or practitioner.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interview and review of medication information, the facility failed to ensure residents were free from unnecessary psychotropic medications when the facility administered antipsychotic medications without an adequate indication of use. This affected two (#66 and #349) of five residents reviewed for unnecessary medications. The facility census was 99. Findings include: 1. Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses of Alzheimer's Disease, dementia with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and malignant neoplasm of unspecified site of right female breast. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 is cognitively impaired and frequently incontinent of bowel and bladder. Resident #66 has no range of motion impairment in upper and lower extremities, requires touch assistance with eating, oral hygiene, toileting, bathing, bed mobility, transfers, and ambulation, and moderate assistance with dressing. Review of hospital documents for Resident #66 revealed a hospital admitted [DATE], with diagnoses of acute encephalopathy, altered mental status, and dementia associated with other underlying disease with behavioral disturbance. Resident #66 was living with a sister in a home environment at the time of hospitalization and had an order written on 12/01/23 for Seroquel 25 milligrams (mg) by mouth three times daily. It was reported on 01/18/24 that Resident #66 had not been taking the medication as ordered while at home. Review of the physician orders revealed Resident #66 had an order written on 01/24/24 for Seroquel (Quetiapine Fumarate) oral tablet 25 mg-give one tablet by mouth three times a day for depression. On 02/23/24, the order was changed to Seroquel (Quetiapine Fumarate) 25 mg-give one tablet by mouth every morning and at bedtime for dementia with behavioral disturbance, psychosis. Interview on 05/02/24 at 10:50 A.M. with Director of Nursing #38 confirmed Resident #66 is being administered Seroquel for a diagnosis of dementia with behavioral disturbance, psychosis which is not a clinically indicated diagnosis. Review of the 2021 [NAME] Pocket Drug Guide for Nurses revealed Seroquel (Quetiapine Fumarate) has a Black Box Warning (BBW) of do not use in elderly patients with dementia related psychosis as there is an increased risk of cardio vascular (CV) mortality, including stroke or myocardial infarction. Further review revealed Seroquel (Quetiapine Fumarate) is indicated for treatment of schizophrenia, manic episodes of bi-polar disorder, depressive episodes of bi-polar disorder, and major depressive disorder. 2. Review of the medical record revealed Resident #349 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia with agitation, anxiety disorder, and hypertension. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #349 is cognitively impaired and occasionally incontinent of bladder and frequently incontinent of bowel. Resident #349 has no range of motion impairment in upper and lower extremities, requires moderate assistance with eating, oral hygiene, and dressing, maximal assistance with toileting and bathing, and supervision with bed mobility and transfers. Review of the physician orders for Resident #349 revealed an order for Risperdal oral tablet 0.5 mg. (Risperidone), give 1 tablet by mouth two times a day for dementia with behavioral disturbance. Review of the hospital documents for Resident #349 revealed an admitted [DATE] to psychiatric services with diagnoses of aggression aggravated, violent behavior, and dementia. It is indicated Resident #349 was receiving Risperdal 0.5 mg. by mouth two times a day for Alzheimer's dementia with behavioral disturbance prior to hospitalization . Review of the medical record for Resident #349 revealed a Consultant Pharmacist Medication Regimen Review dated 04/17/24 with recommendations in reference to a Celexa order. The facility was unable to provide a Consultant Pharmacist Medication Regimen Review for the Risperdal order and the indication for use. Interview on 05/02/24 at 1:47 P.M. with Regional Nurse #93 confirmed the facilities consultant pharmacist did not review the Risperdal order for Resident #349. Interview on 05/02/24 at 10:50 A.M. with Director of Nursing #38 (DON) confirmed Resident #349 is being administered Risperdal for a diagnosis of dementia with behavioral disturbance which is not a clinically indicated diagnosis. Review of the 2021 [NAME] Pocket Drug Guide for Nurses revealed Risperdal (Risperidone) has a Black Box Warning (BBW) of do not use in elderly patients with dementia as there is an increased risk of cardiovascular (CV) mortality and is not approved for this use. Further review revealed Risperdal (Risperidone) is indicated for treatment of schizophrenia, bi-polar 1 disorder, and bi-polar mania.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on [NAME] record review, observations, staff interviews, review of facility documents and policy review, the facility failed to provide resident's with a clean and sanitary environment. This affected four (#06, #10, #48, #80) out of four residents reviewed for the physical environment. The facility census was 99. Findings include: 1. Record review for Resident #06 revealed he was admitted to the facility on [DATE]. His diagnoses included, diabetes mellitus (DM)2, lymphedema, essential primary hypertension, anxiety disorder, adjustment disorder, heart failure, major depressive disorder, and chronic kidney disease stage 2. Review of the most recent Minimum Data Set (MDS) assessment, dated 03/28/24, revealed Resident #06 had severely impaired cognition. Further review for the MDS assessment revealed he required maximum assist with toileting and bathing. Interview and observation on 04/30/24 at 2:30 P.M. with the housekeeper (HK) #90 confirmed she had cleaned Resident #06's room at an earlier time on 04/30/24. HK #90 confirmed the presence of brown splatter up the wall and onto the ceiling. HK #90 confirmed the brown substance all along the floor of the bathroom and dried on the toilet seat and around the toilet. HK #90 stated she thought the unknown brown substance on the toilet seat and around the toilet was feces. HK #90 stated she is unable to clean any brown substance and the task of cleaning unknown brown substances was the nursing staff's job. 2. Record review for Resident #10 revealed he was admitted to the facility on [DATE]. His diagnoses included, asthma, cachexia, osteoarthritis, dementia, and anxiety. Review of Resident #10's most recent MDS assessment, dated 03/11/24, revealed he required assistance from staff with toileting and bathing. Record review for Resident #10 revealed he was severely cognitively impaired. Interview and observation on 04/29/24 at 9:59 A.M. with Housekeeping Manager (HKM) #89 confirmed Resident #10's room had a very strong foul odor. HKM #89 confirmed the presence of brown water and splashed brown substance all around the toilet seat. HKM #89 confirmed Resident #10's toilet seat had several active flying gnats on and around the toilet seat. 3. Record review for Resident #48 revealed she was admitted to the facility on [DATE]. Her diagnoses included, Alzheimer's disease, hyperlipidemia, essential primary hypertension, hypokalemia, anxiety disorder, and major depressive disorder. Review of Resident #48's most recent MDS assessment, dated 03/18/24, revealed she was severely cognitively impaired. Further review of the MDS assessment revealed Resident #48 required assistance from staff with toileting and bathing. Record review for Resident #48 revealed an order for a pressure reducing mattress, dated 10/02/23. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #48's room revealed a mattress was on its side along the wall of the room. Resident #48's bed side table had a sticky substance on the top and splattered down the front. Resident #48's bathroom trash can was soiled and had brown splatter running down the sides of the trash can. Resident #48's toilet seat was dirty, soiled, and had numerous gnats flying around the toilet seat and on the toilet seat. Interview and observation on 04/19/24 at 9:46 A.M. with HKM #89 confirmed Resident #48's room had an extra mattress leaning up on the wall. HKM#48 confirmed that Resident #48 had a sticky substance all over the bed side table and running down the top drawer. HKM #48 confirmed the bathroom trash can had an unknown brown substance running down the bathroom trash can and the toilet had a unknown brown liquid in the toilet bowl. HKM #48 confirmed the soiled toilet seat had gnats flying around the toilet and around the bathroom. 4. Record review for Resident #80 revealed she was admitted to the facility on [DATE]. Her diagnoses included, bipolar disease, anxiety disorder, Alzheimer's disease, essential primary hypertension, dementia, and borderline personality disorder. Review of the most recent MDS assessment, dated 02/23/24, revealed she had impaired cognition. Further review of the MDS assessment revealed Resident #80 required supervision from staff with toileting and bathing. Interview and observation on 04/30/24 at 2:30 P.M. interview with HK #90 confirmed she had cleaned Resident #80's room. HK #90 confirmed the bathroom had a smudged brown substance all around the toilet and on the toilet seat was feces. HK #90 stated she was unable to clean feces from resident's bathrooms. Interview on 04/30/24 at 3:00 P.M. with the Administrator confirmed the housekeeping staff is expected to clean the feces from the toilet, however, nursing staff clean the feces from the floor. Review of the facility control treatments revealed the facility was treated from gnats in the dining area and kitchen area on 12/04/23, 01/15/24, 01/25/24, 02/29/24, 04/16/24, and 04/13/24. Further review of the pest treatments did not reveal any treatments of resident rooms for gnats. Review of the facility policy titled, Pest Control, dated 09/15/21 revealed, the facility will establish a regimented time each month for spraying and to eliminate pests in the facility. Review of the facility in-service policy titled, Seven Step Daily Washroom Cleaning, dated 01/01/200, revealed the policy was created to show housekeeping employees the proper method to sanitize a washroom or bathroom in a long-term care facility. Commodes includes the tank, the seat, the bowl and the base. The policy stated to use a separate rag and a germicide solution and to wipe every area of the commode.