STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366196	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Newark South Inc.	17 Forry Street Newark, OH 43055

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52020 Based on record review, policy review and staff interview, the facility failed to ensure advanced directives were clearly reflected in the medical record. This affected one resident (#23) of 16 residents reviewed for advanced directives. The facility census was 44. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included: Alzheimer's Disease, unspecified atrial fibrillation, essential hypertension, hyperlipidemia, anxiety disorder, and depression. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had a Brief Interview of Mental Status (BIMS) score of 0, indicating severe cognitive impairment. Review of electronic medical record for Resident #23 revealed no advance directive documentation in the advance directive section of the medical record. There was no mention of code status, do not resuscitate (DNR) or advance directive in the orders section of Resident #23's electronic medical record or in the care plan for Resident #23. The care plan indicated Resident #23 was a hospice resident as of 01/08/25. Further review of Resident #23's electronic medical record revealed that there was a portable document format (PDF) of Resident #23's Do Not Resuscitate (DNR) order dated 11/27/24 and uploaded five different times between 11/29/2024 and 01/09/25 to three different Resident Document sections: 7000, Pre-Admission Screening and Record Review (PASRR), Further Reviews, Level of Care (LOC), Discharge Summary, and Hospital Records/Admissions. Review of the physical medical record binder for Resident #23 revealed no DNR documentation in the front of the chart or behind the Advance Directive tab. There was a printed face sheet which stated there are no advanced directives selected for this resident. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/13/25 at 9:00 A.M. with Registered Nurse (RN) #606 verified the facility kept advance directives/code status in the front of the resident binders and if there was no DNR document in the front of the physical chart, the resident was a full code (receive all life saving measures in the event of a cardiac or respiratory arrest). When asked if that applied even if the resident was on hospice, RN #23 reiterated that the physical chart is where they keep code status and if the DNR was not there, then that meant that Resident #23 was full code. Interview on 05/14/25 at 3:32 P.M. with the daughter/emergency contact for Resident #23 confirmed her mother's code status of Do Not Resuscitate Comfort Care Arrest (DNR-CC) (in the event of a cardiac or respiratory arrest, the resident is kept comfortable and no life saving measures/cardiopulmonary resuscitation is provided) Review of facility policy titled, Advance Directives updated on 05/01/25 revealed the Director of Nursing (DON) or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care.

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F 0686 Level of Harm - 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** 34298 Based on observation, record review, and interviews, the facility failed to develop and implement a comprehensive, effective and individualized resident centered pressure ulcer prevention and treatment program for Resident #15 to prevent the development of pressure ulcers, to ensure treatments were completed as ordered and to promote timely and optimal healing of pressure ulcers. Actual Harm occurred on 03/17/25 when Resident #15, who was dependent on staff , was assessed to have an unstageable pressure ulcer (the left heel without evidence of interventions being implemented as ordered. The pressure ulcer required manual debridement resulting in the wound classification change to a Stage IV without evidence the physician ordered treatment was implemented for 10 days. This affected one resident (Resident #15) of three residents reviewed for pressure ulcers. Findings include: Review of the medical record revealed Resident #15 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included chronic kidney disease, type 2 diabetes, and displaced fracture of the left lower leg. The clinical admission documentation form dated 01/09/25 revealed Resident #15 was at risk for the development of pressure ulcers. An order dated 01/09/25 revealed skin prep (protective film) to be applied to Resident #15's bilateral heels twice a day. Review of the treatment administration record (TAR) revealed skin prep was applied to Resident #15's heels from 01/09/25 until 05/13/25. A plan of care dated 01/21/25 revealed Resident #15 was at risk for skin breakdown related to impaired mobility, diabetes, edema, friction, shearing, and appliance use. Interventions included pressure re-distribution cushion to wheelchair, assist as needed for turning and positioning in bed and chair, encourage to float heels as tolerated, provide nutritional assessment as ordered, observe wound for any redness, warmth, drainage, odor, and report to the physician as ordered, perform current treatment as ordered, and offloading boots while in bed. The boots were to be examined for rough areas or (signs of) wearing (on the boots) and Resident #15's skin was to be examined before and after use of the boots. On 04/02/25 an intervention was added to encourage Resident #15 to wear a pressure-reducing boot to the left foot. Review of the admission Minimum Data Set (MDS) 01/24/25 revealed Resident #15 was cognitively intact and dependent on staff for putting on and taking off footwear and personal hygiene. The assessment revealed the resident had no pressure ulcers but was identified at risk for pressure ulcer development. Review of shower/bathing documentation dated 03/13/25 revealed Resident #15 received a bed bath. No skin impairments were identified. It was documented that Resident #15's skin was checked for dry heels and any red or open areas. On 03/17/25 Resident #15 received a shower. No skin impairments were identified. It was documented that Resident #15's heels were checked for dry heels and any red or open areas. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Treatment Administration Record (TAR) and orders revealed on 03/17/25 Resident #15 had a treatment put in place to cleanse the left heel with normal saline, pat dry, and cover with a foam dressing. There was no skin grid or progress note regarding the area or why the treatment was implemented at that time. An order dated 03/18/25 revealed Resident #15's left heel was to be cleansed with wound cleanser, patted dry, then apply calcium alginate (for moderate to heavily exudating wounds) and apply a border foam dressing daily. Review of the TAR revealed on 03/18/25 and 03/19/25 Resident #15's left heel was cleansed with wound cleanser, patted dry, with calcium alginate and a foam dressing applied. An initial wound evaluation and management note from Wound Physician #900 dated 03/18/25 revealed Resident #15 had a pressure wound identified on 03/17/25 to the left heel. The area was noted to be an unstageable pressure ulcer measured 3.5 centimeters (cm) long, 1.3 cm wide, and 0.2 cm deep with moderate serous (clear, thin, watery fluid) exudate. There was 80 percent thick, adherent, devitalized, necrotic tissue and 20 percent normal skin. An order was given for Mesalt (helps manage heavily discharging wounds) to be applied daily and covered with a gauze island border dressing for 30 days. Recommendations included to off-load wound, reposition per facility protocol, and pressure off-loading boot. The wound was debrided to remove the necrotic tissue and establish the margins of viable tissue. Review of the physician orders revealed no evidence the wound physician's order was written for the Mesalt. The previous treatment continued. The TAR revealed from 03/19/25 to 03/25/25 Resident #15's left heel was cleansed with wound cleanser, patted dry, and calcium alginate and border dressing were applied. A physician order dated 03/19/25 revealed Resident #15 was to wear heel pressure off-loading boots at all times while in bed or in a chair. The order indicated to ensure the boots have an open spot where the heel goes three times a day. A wound physician note dated 03/25/25 by Wound Physician #900 revealed Resident #15 had an unstageable pressure wound to the left heel that measured 1.2 cm long and 1.1 cm wide. The depth was not measurable due to the presence of nonviable tissue and necrosis. No exudate was present. There was 100 percent thick, adherent, devitalized, necrotic tissue. An order was given to apply betadine (topical antiseptic and germicide that can treat or prevent skin infections) to Resident #15's left heel once a day for 30 days. A wound physician note dated 04/01/25 by Wound Physician #900 revealed Resident #15 had an unstageable pressure wound to the left heel that measured 1.5 cm long and 0.8 cm wide. The depth was not measurable due to the presence of nonviable tissue and necrosis. No exudate was present. An order was to continue betadine daily for 23 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound physician note dated 04/08/25 by Wound Physician #900 revealed Resident #15 had a Stage IV (full-thickness skin and tissue loss with exposed muscle, bone, or tendon) pressure wound to the left heel that measured one cm long, 1.3 cm wide, and 0.5 cm deep. There was a moderate amount of serous exudate. There was 100 percent thick, adherent, devitalized, necrotic tissue. The wound was debrided to remove the necrotic tissue and establish the margins of viable tissue. An order was given for Mesalt and bordered dressing to be applied daily for 30 days. A wound management detail report dated 04/15/25 by Assistant Director of Nursing (ADON) #539 who is the facility wound nurse revealed Resident #15 had a Stage IV pressure wound to the left heel that measured one cm long, 1.2 cm wide, and 0.2 cm deep. There was moderate serous exudate with 100 percent granulation. The wound physician would be in to assess the wound on 04/18/25. Review of the TAR revealed skin prep and betadine were the only treatments completed to Resident #15's left heel from 03/26/25 through 04/17/25. A wound physician note dated 04/18/25 by Wound Physician #900 revealed Resident #15 had a Stage IV pressure wound to the left heel that measured 1.1 cm long, 1.5 cm wide, and 0.3 cm deep. There was a moderate amount of serous exudate. There was 100 percent thick, adherent, devitalized, necrotic tissue. The wound was improving due to the decreased depth of the wound. An order was given for Mesalt and bordered dressing to be applied daily for 20 days. The TAR revealed from 04/18/25 to 04/24/25 Resident #15's left heel was cleansed with wound cleanser, patted dry, and Mesalt and border dressing were applied daily. A wound physician note dated 04/22/25 by Wound Physician #900 revealed Resident #15 was not seen due to Resident #15 was playing bingo. A wound management detail report dated 04/22/25 by ADON #539 revealed Resident #15 had a Stage IV pressure wound to the left heel that measured one cm long and 1.4 cm wide. There was light serosanguineous exudate with 100 percent necrotic tissue. The wound was calloused/firm with well-defined wound edges. A wound physician note dated 04/29/25 by Wound Physician #900 revealed Resident #15 had a Stage IV pressure wound to the left heel that measured 1.1 cm long, 1.5 cm wide, and 0.3 cm deep. There was a moderate amount of serous exudate. Mesalt and bordered dressing was to be applied daily for nine days. The wound was debrided to remove the necrotic tissue and establish the margins of viable tissue. A wound physician note dated 05/06/25 by Wound Physician #900 revealed Resident #15 had a Stage IV pressure wound to the left heel that measured one cm long, 1.8 cm wide, and 0.3 cm deep. There was a moderate amount of serous (clear) exudate. There was 100 percent thick, adherent, devitalized, necrotic tissue. The wound progress was exacerbated due to the patient being non-compliant with wound care (there was no evidence documented in the medical record the resident was non-compliant with wound care). An order was given for Santyl (enzymatic debriding agent), calcium alginate, and bordered dressing daily for 30 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound management detail report dated 05/06/25 by ADON #539 revealed Resident #15's wound progress was exacerbated due to non-compliance with wound care. However, there was no evidence documented in the medical record to support the resident was non-compliant with wound care. Resident #15 did not like the wound touched. Resident #15 was informed that the care had to be done for the wound. A new order was received for pain medication during bandage changes. A wound physician note dated 05/12/25 by Wound Physician #900 revealed Resident #15 had a Stage IV pressure wound to the left heel that measured 0.8 cm long, 1.8 cm wide, and 0.3 cm deep. There was a moderate amount of serous exudate. There was 30 percent thick, adherent, devitalized, necrotic tissue, 40 percent slough, and 30 percent granulation (a type of new, temporary tissue that forms in the process of wound healing). The treatment of Santyl, calcium alginate, and bordered dressing daily was to continue for 24 days. The wound was debrided to remove the necrotic tissue and establish the margins of viable tissue. An interview on 05/10/25 at 1:35 P.M. with Licensed Practical Nurse (LPN) #520 revealed Resident #15 stated Santyl stung but she mainly jerked her foot because she was ticklish. LPN #520 verified treatments were completed by what populated in the TAR to be completed on her shift. LPN #520 stated Resident #15 was compliant with care and never refused treatments when she worked. An observation on 05/13/25 at 7:41 A.M. revealed Resident #15 was lying in bed with heel boots in place. An observation of the treatment to Resident #15's left heel by ADON #539 revealed the wound was pink and the wound had no signs of infection noted. Resident #15 pulled her left foot back some during the treatment. Resident #15 denied any pain and stated she was ticklish. The treatment included the wound cleansed with wound cleanser, patted dry, Santyl and Mesalt applied to the wound and then covered with foam dressing. The resident denied non-compliance with treatments. On 05/14/25 Resident #15's profile was updated for the Certified Nursing Assistants (CNA) to follow when providing care. The CNAs were to encourage/assist Resident #15 to always wear bilateral offloading boots. Skin checks were to be done prior to application and upon removal of the boots. The CNAs were to ensure Resident #15's boots had an open spot where the heel goes. Prior to 05/14/25, there was no intervention on the resident's profile to direct the CNA to use offloading heel boots. An interview on 05/14/25 at 7:06 A.M. Corporate Registered Nurse (RN) #606 verified the only treatments in place for the Stage IV pressure wound to Resident #15's left heel from 04/08/15 to 04/18/25 was skin prep and betadine. Corporate RN #606 verified Wound Physician #900 had put an order in place on 04/08/25 for Mesalt and bordered dressing to be applied daily for 30 days. An additional interview on 05/14/25 at 8:18 A. M. with Corporate RN #606 verified there was no documentation of Resident #15 being noncompliant with dressing changes and was unsure why Wound Physician #900 documented the wound healing progress was exacerbated due to Resident #15 being non-compliant with wound care. Lastly, she verified there was no information regarding the offloading boot to the resident's heels or left heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview on 05/19/25 at 9:49 A.M. with Wound Physician #900 revealed an order would have been changed from betadine to Mesalt based on the amount of exudate. Wound Physician #900 stated he did not believe the wound would have gotten worse not using the Mesalt and bordered dressing but verified the wound could have become more macerated (the occurrence of skin softening and breaking down due to prolonged exposure to moisture). Wound Physician #900 stated he documented the exacerbation of the wound was due to Resident #15 non-compliance with wearing offloading boots (which the resident was dependent on staff for application of). Email correspondence on 05/19/25 at 8:42 A.M. with Corporate RN #606 verified there was an order for the heel protectors for Resident #15 on 03/19/25 which was updated on 05/14/25. Corporate RN #606 verified there was no documentation of heel protectors being used or refused from the time the heel protectors were care planned on 01/21/25 and initially ordered on 03/19/25. An interview on 05/19/25 at 12:55 P.M. ADON #539 revealed she did rounds with Wound Physician #900. ADON #539 verified she usually put the new orders from Wound Physician #900 in the computer but the orders from 04/08/25 were not put in the computer and she doesn't know what happened. ADON #539 verified the only orders from 04/08/25 to 04/18/25 to Resident #15's left heel was skin prep and betadine.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, interview, and record review, the facility failed to ensure safe oxygen administration practices were implemented. This affected one resident (Resident #13) of eleven receiving oxygen in the facility. The facility census was 44. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included asthma, dysphagia, dyspnea, dependence on supplemental oxygen, and obstructive sleep apnea. Review of physician orders dated 11/19/24 revealed the resident was to receive continuous oxygen at two liters per minute via nasal cannula due to oxygen dependence. Review of minimum data set (MDS) 3.0 assessment dated [DATE] showed Resident #13 scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. The resident's respiratory treatments included oxygen therapy and a non-invasive mechanical ventilator. Review of a care plan dated 03/14/24 revealed Resident #13 exhibited hoarding behaviors. The care goal was for the resident to avoid harming self or others during daily care and activities. Interventions included encouraging communication between the resident and family regarding care and behavioral strategies, and notifying the physician of any new or escalating behaviors or safety concerns. Observation on 05/12/25 at 11:10 A.M. revealed various clothing items and plastic cups surrounding all sides of the oxygen concentrator. The machine was not powered on at the time, but the intake air vent was partially obstructed by clothing packed underneath the bed and around the concentrator. Observation on 05/13/25 at 7:42 A.M. revealed Resident #13 was seated in her recliner, approximately one foot from the oxygen concentrator (brand: Respironics). Surrounding all sides of the device were cardboard boxes containing clothing, trash, and plastic cups. The concentrator was in use, with items partially blocking the intake vent, at this time the concentrator was not alarming. Observation and interview on 05/13/25 at 10:34 A.M. with Licensed Practical Nurse (LPN) #519 confirmed the presence of numerous items surrounding the active oxygen concentrator which included partial occlusion. LPN #519 acknowledged the resident's hoarding behaviors and noted concerns about maintaining a safe room environment. She confirmed the resident consistently used the concentrator while in her room or recliner, doing so in an unsafe manner. Interview on 05/14/25 at 4:50 P.M. with corporate nurse #606 confirmed the oxygen concentrator air intake should be unobstructed during usage, if the machine was not functioning properly, it would alarm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Respironics Everflo user manual revealed a warning indicating potential harm to the patient or operator if the device is not used properly. It emphasizes that the concentrator requires unobstructed ventilation, with intake ports located at the rear base and side. The manual advises keeping the device six to twelve inches away from walls, furniture, or curtains to ensure adequate airflow.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, interview, and policy review, the facility failed to ensure medication parameters were followed for Resident #15 and failed to ensure Resident #20 receive d an appropriate antibiotic for a urinary tract infection. This affected two residents (Resident #15 and #20) of six residents reviewed for unnecessary medications. Facility census was 44. Findings include: 1. Review of the medical record revealed Resident #15 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection, chronic kidney disease, extended-spectrum beta-lactamases (ESBL), and type 2 diabetes. On 02/24/25, Resident #15 was ordered midodrine (to treat low blood pressure) 10 milligram (mg) every six hours and to hold for a systolic blood pressure (top number of the blood pressure reading) greater than 130 millimeters of mercury (mmHg). Review of the medication administration record (MAR) revealed midodrine was held due to low blood pressure/outside of parameters on: 04/01/25 at 4:00 A.M. A blood pressure was not recorded. 04/04/25 at 4:00 A.M. for a blood pressure of 112/64 mmHg 04/07/25 at 10:00 P.M. for a blood pressure of 112/60 mmHg 04/08/25 at 4:00 A.M. for a blood pressure of 108/62 mmHg 04/12/25 at 10:00 P.M. for a blood pressure of 116/58 mmHg 04/13/25 at 4:00 A.M. for a blood pressure of 108/56 mmHg 04/14/25 at 4:00 A.M. for a blood pressure of 112/73 mmHg 04/18/25 at 4:00 A.M. for a blood pressure of 118/62 mmHg 04/19/25 at 4:00 A.M. for a blood pressure of 120/64 mmHg 04/26/25 at 10:00 P.M. for a blood pressure of 110/66 mmHg 04/27/25 at 4:00 A.M. for a blood pressure of 108/50 mmHg 04/28/25 at 10:00 P.M. for a blood pressure of 88/54 mmHg 05/01/25 at 10:00 P.M. for a blood pressure of 112/66 mmHg (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/02/25 at 4:00 A.M. for a blood pressure of 108/56 mmHg 05/05/25 at 10:00 P.M. for a blood pressure of 112/62 mmHg 05/08/25 at 10:00 P.M. for a blood pressure of 113/78 mmHg 05/09/25 at 4:00 A.M. for a blood pressure of 112/68 mmHg 05/11/25 at 4:00 A.M. for a blood pressure of 116/58 mmHg 05/11/25 at 4:00 P.M. for a blood pressure of 118/72 mmHg An interview on 05/14/25 at 3:28 P.M. Regional Registered Nurse (RN) #606 verified Resident #15's midodrine was held when the systolic blood pressure was less than 130 mmHg. Regional RN #606 verified midodrine was administered to treat low blood pressure and should be held when systolic blood pressure was greater than 130 mmHg. 2. Review of the medical record revealed Resident #20 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included sepsis, cerebral infarction, chronic respiratory failure, hemiplegia and hemiparesis, tracheostomy, aphasia, acute kidney, obstructive reflux, Alzheimer's disease, anxiety disorder, altered mental status, and dysphagia. The quarterly MDS dated [DATE] revealed Resident #20 had cognitive impairment. A progress note dated 03/02/25 at 9:15 A.M. revealed Resident #20 returned from the hospital with new orders for Keflex (antibiotic) 500 mg four times a day seven days for a urinary tract infection. On 03/02/25, Resident #20 was ordered Keflex. Review of the medication administration record revealed Resident #20 received Keflex from 03/02/25 at 12:00 P.M. through 03/08/25 at 6:00 P.M. Further review of the medical record revealed Resident #20 was not ordered another antibiotic. Review of hospital urinalysis with culture and sensitivity dated 03/05/25 revealed Resident #20's urine had greater than 100,000 colony-forming units per milliliter (cfu/ml) pseudomonas aeruginosa and enterococcus faecalis and was not susceptible to Keflex. An interview on 05/14/25 at 3:28 P.M. with Regional RN #606 verified Resident #20's urinalysis with culture and sensitivity was not received until Resident #20 had been started on Keflex. Regional RN #606 also verified Keflex was continued despite the urine culture indicating the bacteria was not susceptible to Keflex. The Antibiotic Stewardship Program policy updated 11/2019 revealed when prescribing antimicrobials the physician/prescriber should select a antimicrobial with organism susceptibility. When a culture and sensitivity is ordered, it should be performed before the initiation of an antimicrobial. The culture and sensitivity results should be communicated to the physician/prescribed as soon as available to determine if current antimicrobial therapy is continued, modified, or discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366196	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Newark South Inc.	17 Forry Street Newark, OH 43055

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50538 Based on observation, interview and record review the facility failed to provide a clean and sanitary environment. This affected one resident (Resident #194) of three residents reviewed for environment. The facility census was 44. Findings include: Review of Resident #194's medical record revealed an admitted [DATE] and diagnoses including malignant neoplasm of the prostate, secondary malignant neoplasm of the bladder, secondary neoplasm of the bone, and Alzheimer's disease. Further review revealed Resident #194 was receiving hospice services. An observation on 05/12/25 at 12:01 P.M. revealed Resident #194 was lying in bed, on his right side, with his eyes closed. The bed was positioned with the left side and the foot of the bed against the walls. Further observation revealed a bag containing a soiled incontinence brief was noted on the floor, at the foot of the resident's bed. In an interview on 05/12/25 at 12:01 P.M. Regional Registered Nurse (RN) #606 confirmed a bag containing a soiled incontinence brief was on the floor and should have been thrown away.