STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145944	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Aurora	400 West Sullivan Road Aurora, IL 60506

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41384 Based on observations, interviews and record reviews, the facility failed to treat residents with dignity while providing care. This applies to 2 of 2 residents (R183 and R184) reviewed for dignity in a sample of 24. The findings include: 1. On 03/11/25 at 12:46 PM, V15 (Nurse) was standing over R184 feeding her. On 3/12/25 at 12:37 PM V15 said that she shouldn't have stood over R184 while feeding her because it is a dignity issue. 2. On 03/12/25 at 10:43 AM V15 (Nurse) entered R183's room after knocking. V18 CNA (Certified Nurses' Assistant) and V19 (R183's Daughter) were providing incontinence care for R183 and the curtain was not pulled. R183 was naked from the waist down and could be seen from the hall. On 03/12/25 at 11:33 AM, R183, who's cognition is intact, said that she wants the curtain and the door closed while staff are providing care for her. On 03/12/25 at 11:17 AM V18 CNA (Certified Nurse's Assistant) said that she should have closed R183's curtain to provide privacy. On 03/13/25 at 11:27 AM V2 DON (Director of Nursing) said that V15 should not have been standing over R184 while feeding her, and V18 should have had the curtain pulled while providing incontinence care. V2 said that these things should have been done for dignity. The facility's Privacy and Dignity policy dated 8/16/24 showed that the facility will ensure that the residents' privacy and dignity is respected by the staff at all times. The policy shows that during care that requires prior privacy such as incontinence care, the privacy curtain will be drawn to provide full visual privacy. Door may also be closed to provide additional layer of privacy during care. The policy shows that residents will not be addressed in an undignified manner by staff at all.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46380 Based on observation, interview, and record review, facility failed to implement measures to prevent re-opening of pressure ulcer for a resident with known skin alterations to the right buttocks and coccyx. The facility also failed to then assess, report, and initiate pressure ulcer treatments. This applies to 1 out of 1 (R40) resident reviewed for pressure ulcer in a sample size of 24. The findings include: On 03/11/25 at 02:24 PM, during incontinent care, a wound dressing was noted on R40's right buttock. Multiple open areas were noted on R40's coccyx. R40 did not have any wound dressing on his coccyx. Wound on right buttock appeared red in color with yellow tissue noted around the wound area. Wounds on his coccyx appeared red in color with whitish tissue noted in the wound. R40 appeared frail, unable to fully bend knee and is totally dependent on staff for bed mobility, transfers, and incontinence care. R40 transfers from bed to wheelchair using the mechanical lift. On 3/11/25 at 2:40 PM, V6 (RN-Registered Nurse) provided wound care to R40. V6 measured R40's wounds. Wound on right buttock measured 3.5 cm (centimeters) x 2 cm. Right buttock wound appeared reddish with yellowish areas noted. V6 did not measure the wound's depth. V6 said right buttock wound is a stage 3. V6 measured the cluster wound on R40's coccyx. Wounds on coccyx appeared reddish with yellowish areas noted. Measurement was 6.5 cm x 7 cm and V6 did not measure the depth. V6 said wound on coccyx was stage 3 pressure ulcer. On 3/12/25 at 9:41 AM, R40 was noted sitting on his wheelchair in the resident's lounge area. On 3/12/25 at 11:45 AM, R40 was still sitting on his wheelchair in the resident's lounge area. On 3/12/25 at 11:45 AM, V10 (CNA-Certified Nurse Assistant) said he got R40 up from bed on 3/12/25 around 7:50 AM and R40 has not gone back to bed since that time. On 3/12/25 at 9:55 AM, V6 said she did not document about the wound findings seen on 3/11/25 at 2:40 PM into R40's EHR (Electronic Health Record). She said she did not inform the physician and she did not obtain new treatment orders. She said she informed V3 (ADON-Assistant Director of Nursing/IP- Infection Preventionist/ Wound Care Nurse) of R40's wounds. At 10:11 AM, V3 said V6 informed him of R40's wounds on 3/11/2025. He said he did not assess the wounds and did not inform the physician of wounds. On 3/13/25 at 8:26 AM, V7 (NP- Nurse Practitioner) confirmed she saw R40 on 3/6/2025. She said R40 had MASD (Moisture Associated Skin Damage) on coccyx and right buttocks. She confirmed she does not measure MASD and documented her measurements as 0cm x 0cm x 0cm. She said she will assess R40 later. On 3/13/25 at 12:10 PM, V2 (DON-Director of Nursing) said she expects nurses to call the physician immediately for any skin breakdown and obtain treatment orders. She said she expects nurses to document about findings in the EHR. She said she expects nurses to remind the CNAs to follow the care plan to heal or prevent pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R40's EHR (Electronic Health Record) documents the following: R40's EHR documents original admitted [DATE]. R40 was readmitted to facility on 10/24/24. R40's MDS (Minimum Data Set) dated 12/27/2024 shows he had two stage 3 pressure ulcer that were not present upon admission and he has severely impaired cognitive functions. R40's Braden Scale assessment done on 2/26/25 showed he is at high risk for pressure ulcers. R40's POS (Physician Order Sheet) shows an order dated 1/16/2025 to place patient on the wheelchair not more than two hours with pressure relieving cushion. R40's wound care plan shows an intervention that he should not be on his wheelchair for more than two hours. On 3/12/25, R40's Progress Notes was reviewed. V6 did not document about the re-opened wounds on the right buttocks and coccyx found on 3/11/25. There was no documentation that R40's physician was informed about the re-opened wounds or that treatment orders were obtained. Facility's Wound Care Guidelines (reviewed 1/24/25) stated prevention of skin breakdown includes inspection of the skin every shift with care for signs of breakdown. Policy includes educating clinical staff and developing appropriate treatment plan. It states that the resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers etc.) shall be documented in the resident's clinical records in accordance with the facility's policy and in compliance to current regulatory standards. It is documented to initiate wound care treatment upon identification of the wound with physician's order and to refer to facility's Wound Care Specialist timely for all pressure injuries and/or wounds.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48944 Based on observation, interview, and record review the facility failed to administer enteral feeding as ordered, and failed to change and label enteral feeding tube equipment for residents receiving gastrostomy tube feedings. This applies to 3 out of 4 (R46, R11, and R23) reviewed for enteral feeding in a sample of 24. The findings include: 1. On 3/12/2025 at 11:30 AM, R46 said he was receiving gastrostomy tube (g-tube) feedings. R46's g-tube pump had an opened but unlabeled bottle of Jevity 1.5 that was connected to a bag of water that was dated 3/10/2025 (two days earlier). The feeding's tubing tip was uncovered. On 3/13/2025 at 8:45 AM, R46's g-tube pump was hanging an opened bottle of feeding dated 3/13/2025 without an opened time. The feeding's connected bag of water was dated 3/10/2025 (three days earlier). The feeding's tubing tip was uncovered. At 12:15 PM, V20 (Agency Registered Nurse/RN) said she was going to administer R46's scheduled bolus g-tube feeding via a pump. V20 said she reviewed R46's order and determined she had to administer a total of 200 ml (milliliters). V20 said she believed the feeding bottle was opened and hung by the prior shift at 6 AM. V20 proceeded to connect the feeding tubing to R46's g-tube without priming the tubing. Then the feeding pump stopped to alarm that there was an error with the infusion. V20 then disconnected and primed the feeding tubing. V20 then reconnected R46s to his feeding. V20 started R46's feeding infusion without checking for placement or flushing his tube with water prior. R46's g-tube insertion site did not have a dressing. R46 said his feeding leaked at times and he had a scab that was uncomfortable. V20 said she was unsure if R46's g-tube site required a dressing. At 1:25 PM, V20 said she was going to stop the pump and disconnect R46's g-tube feeding. V20 reviewed the feeding pump and said he received a total of 211 ml of enteral feeding. V20 proceeded to disconnect R46's feeding without flushing his tube with water afterward. R46's Order Summary Report dated 3/13/2025 showed an order for Enteral Feed Order every 6 hours GT Jevity 1.5 at 400ml to run for 2 hrs at 200 ml/hr Bolus feeding 12 am, 6 am, 12 pm, 6 pm Water flush 90 ml before and after each bolus feeding. The report also showed additional orders of every evening shift change feeding set and tubing daily and cleanse enteral tube feeding site with soap and water and apply drain sponge dressing daily every day shift. 2. On 3/11/2025 at 10:00 AM, R11's g-tube pump was hanging an open bottle of Jevity 1.5 dated 3/10/2025 without an open time. The feeding's connected bag of water and tubing was not dated. The feeding's tubing tip was uncovered. On 3/13/2025 at 8:45 AM, R11's g-tube pump was hanging an open bottle of feeding dated 3/13/2025 without an open time. The feeding's tubing tip was uncovered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Oder Summary Report dated 3/13/2025 did not show orders for instructions on changing his enteral feeding equipment (set and tubing) and providing care to his g-tube insertion site. 3. On 3/11/2025 at 10:40 AM, R23 said he was receiving g-tube feedings. R23 had an open g-tube feeding bottle of Jevity 1.5 dated 3/11/2025 without an open time. On 3/13/2025 at 9:50 AM, V8 (Registered Dietician) said she reviews and enters enteral feeding orders to ensure residents are receiving their required nutritional g-tube feedings. V8 said enteral feeding bottles are required to be labeled before being hung, with the resident's name, feeding instructions, open date, and time opened. V8 said enteral feeding sets (water bags) and tubing were for one-time use and should be discarded after 24 hours. V8 said it is recommended that when a new feeding bottle is started, a new set of equipment should also be started to ensure safe administration of enteral feedings. The facility's Enteral Tube Feeding Care policy dated 7/26/2024, said 1. Nurse to check in the POS/MAR the order for enteral feeding interventions .c. Rate d. Duration .3. Check that Feeding bag is properly labeled to include: a. Resident's name b. Formula (if it is not a closed system) and rate of feeding administration c. Date and time feeding was started .5. Flush the enteral tube with 15 to 30 cc of water before starting the enteral feeding and after stopping the enteral feeding to ensure that enteral formula in the enteral tubing is pushed to the stomach. 6. Change feeding bags daily and PRN. Use new enteral tubing daily and PRN every time a new feeding bag is started .8. Enteral tube stoma care: Site must be cleaned and covered with a dry gauze daily.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48944 Based on observation, interview, and record review the facility failed to change a resident's PICC (Peripherally Inserted Central Catheter) line dressing as ordered. This applies to 1 out of 3 residents (R51) reviewed for central intravenous (IV) lines in a sample of 24. The findings include: On 3/11/2025 at 10:45 AM, R51 said he was receiving IV antibiotic infusions for his right foot wound infection. R51 had an intravascular (IV) central catheter to his left upper arm. R51's IV catheter had a transparent dressing dated 3/03/2025 (eight days earlier). The right lower corner of R51's transparent PICC line dressing was loose and no longer adherent to his skin. At 11:10 AM V9 (Registered Nurse/RN) said she was going to infuse R51's scheduled IV antibiotic. V9 initiated R51's IV infusion and failed to assess the dressing's integrity. On 3/13/2025 at 10:25 AM V3 (Assistant Director of Nursing/ADON) said central catheter dressings should be changed every 7 days and as needed (PRN) for infection control and prevention. V3 said nurses should assess PICC line dressings every shift to ensure their integrity and if compromised they should be changed. R51's Order Summary Report dated 3/13/2025 showed a 2/12/2025 order for Change PICC line dressing every night shift every Sunday and as needed. R51's ETAR (Electronic Treatment Administration Record) for March 2025 showed documentation that R51's scheduled PICC dressing was not completed on 3/09/2025 (Sunday). The facility's Intravenous Therapy policy dated 1/03/2025, said It is the facility's policy to ensure that intravenous policy and procedure are compliant to federal standard of care. 1. All IV access will be assessed by the nurse .2. Dressing Change .c. All central line dressing (PICC lines, single and multi-lumen central catheters inserted in subclavian, jugular, or inguinal area) will be changed every 7 days and prn.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46380 Based on observation, interview, and record review the facility failed to properly secure resident medications. This applies to 5 out of 5 residents (R15, R22, R24, R40, R43) reviewed for medications in a sample of 24. The findings include: 1. On 3/11/2025 at 10:17 AM and 3/12/2025 at 12:22 PM, a medication cup with 2 capsules of fish oil and 1 capsule of turmeric was observed on R43's bed side table. She said she usually takes the medication when her tummy feels better because she had hyperacidity. R43 said nurses usually leave the medication there so she can take it when she wants to. Review of R43's POS (Physician Order Sheet) shows order for fish oil and turmeric but there are no orders for resident to self-administer medication and medication to stay at the bedside. On 3/13/25 at 12:10 PM, V2 said there are no residents with orders for medication to stay at the bedside, no orders to self-administer medication. She said she expects nurses to take unlabeled medication from resident rooms. She said if a resident wants to take medication, nurses should ask order from physician. 2. On 3/11/2025 at 10:12 AM, a tube of unlabeled Calmoseptine ointment was observed on R15's nightstand. Review of R15's POS showed there was no order for medication, medication to stay at bedside and there was no order for resident to self-administer medication. 3. On 3/11/2025 at 10:27 AM, a bottle of unlabeled TUMS Antacid 72 chews observed on R22's nightstand on the right side of her bed. The bottle was half empty. Review of R22's POS showed there was no order for medication, medication to stay at bedside and there was no order for resident to self-administer medication. 4. On 3/11/2025 at 10:52 AM, a bottle of Antifungal powder- Miconazole nitrate 2% powder was seen on R24's nightstand. On 3/13/25 at 12:10 PM, V2 (DON-Director of Nursing) said R24 is unable to apply it to herself. Review of R24's POS showed an order for antifungal powder. There was no order for medication to stay at the bedside, and no order that R24 to self-administer medication. 5. On 3/11/2025 at 11:12 AM, a bottle of unlabeled Docusate Sodium 50 mg observed on top of R40's drawers. Review of R40's POS showed there was no orders for Docusate Sodium, no orders for medication to stay at the bedside, and no orders for resident to self- administer medication. Facility's Policy on Medication Storage, Labeling, and Disposal dated and revised 8/16/24 documents that medications should be stored safely under appropriate environmental controls and medications will be secured in a locked storage area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Policy on Self-Administration of Medication dated 12/3/15 and revised on 6/6/24 documents resident may store the medication at bedside if there is a physician order to keep it at bedside.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41384 Based on observation, interview and record review, the facility failed to follow their planned menu resulting in lunch entrees being served to residents with inadequate protein. This applies to all 78 residents in the facility receiving General, Low Concentrated Sweets, No Added Salt, Pureed, and Mechanical Soft diets at the facility. The findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated 3/14/25 documents that the total census was 79 residents. The facility's Order Listing Report of 3/12/25 showed 1 NPO (nothing by mouth) resident. The facility's Daily Spreadsheet, dated Week 1 Wednesday, shows residents with General, Mechanical Soft, Pureed, No Added Salt, Low Concentrated Sweets all received either regular, ground or pureed portions of ham. The spread sheet shows each resident receiving the ham were to be served the equivalent of a 3-ounce portion of ham. On 3/12/25 at 11:50 AM, V24 (Cook) was observed plating food for a regular diet, and she placed one slice of ham on the plate. On 3/12/25 at 11:58 am V17 (Dietary Director) weighed 2 slices of ham from 2 different lunch trays and each slice of ham weighed 2 ounces. V17 said that he does not have a slicer to cut meat and because of that he is unable to cut an accurate amount of protein to serve to the residents. On 3/12/25 at 12:15 PM V8 (Dietician) said that the ham is to be 3 ounces served weight. V8 said that if this is not done, residents will not be getting enough protein and that can cause malnourishment or prevent wound healing. V8 said that the facility needs a slicer to get an accurate amount and portion size of protein to meet the requirements. The facility's kitchen policy with revised date of 8/16/2024 showed that all food items in the menu and recipe will be followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41384 Based on observation, interview, and record review the facility failed to implement transmission-based precautions for a resident with an acute contagious gastrointestinal infection and adhere to enhanced-barrier precautions. This applies to 6 out 6 residents (R184, R183, R65, R51, R46, and R40) reviewed for infection control in a sample of 24. The findings include: 1. On 3/11/25 at 12:06 PM there was no isolation sign on the door to R183 & R184 shared room. R183 was in her wheelchair very upset saying that she has had 3 bowel movements in her brief since she was in physical therapy, and nobody has come to change her brief. R183 said that she has been having diarrhea for the last week. On 3/12/25 at 11:08 AM, CNA (Certified Nurse's Assistant) said that R183 has been having loose stools for at least the last four days. On 3/13/25 at 11:27 AM, V2 DON (Director of Nursing) said that R183 has had loose stools for about a week and that R183 was started on antibiotics on Friday 3/7/25 for pneumonia and the antibiotics can cause loose stools and C diff (acute contagious gastrointestinal infection). V2 said that the facility moved R184 out of the room with R183 on 3/11/25 around 11 PM because of the loose stools they suspected R183 had C-Diff. R183's electronic health record showed that her mental cognition is intact. R183's 3/10/25 physician's order at 2:53 PM showed, obtain stool for C-DIFF and on 3/11/25 physician's order shows strict contact isolation (C-Diff). R183's 3/7/25 physician's order showed amoxicillin-Pot Clavulanate (Antibiotic) tablet 875-125mg every 12 hours for 10 days. The start date was 3/7/25 and the end date was 3/17/25. R183's Follow up Question report of 3/1/25 - 3/13/25 showed that R183 started having loose stools on 3/4/25 and continued through 3/13/25 with a total of 17 recorded episodes of loose stools in 10 days. R183's 3/1/25 - 3/31/25 EMAR (electronic Medication Administration Record) showed an order on 3/10/25 at 5pm to obtain stool sample for C-DIFF, and the sample was obtained on 3/11/25 at 5:44 am. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Control policy with the revised date of 2/10/25 shows, if the resident with infection needs transmission-based precaution, the facility will provide the transmission-based precaution setup required. If the resident needs to be quarantined, the facility will also provide the set up similar to the setup for isolation room. A sign will be provided outside the room of the resident on a transmission-based precaution indicating the type of precaution contact, droplet, or EBP (enhance barrier precaution). The facility shall comply with infection control recommendations provided by the IDPH (Illinois Department of Public Health) or certified local health department, including but not limited to testing plan, infection control assessment, training or other measures designed to reduce incidence of infection. Contact precautions intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment. Examples of infectious organisms requiring contact precautions are C-Diff, scabies, norovirus, etc. and are outlined in CDC (Center for Disease Control) appendix A (Type and Duration of Precautions Recommended for Selected Infections and Conditions) a. Single room is required. If not available cohorting with a resident with the same organism may be done. 46380 2. On 3/11/25 at 1:05 PM, V4 (CNA-Certified Nurse Assistant) and V5 (CNA) provided incontinent care to R40. R40 had an EBP (Enhance Barrier Precaution) signage on his door and had a PPE (Personal Protective Equipment) bin by his door. V4 and V5 provided care using only gloves and surgical mask. On 3/11/25 at 1:20 PM, V6 (RN-Registered Nurse) was observed providing wound care to R40. She was assisted by V4. R40 had open wounds on his right buttock and coccyx. V4 and V6 were only wearing gloves and surgical mask throughout wound care. On 3/13/25 at 12:10 PM, V2 (DON-Director of Nursing) said residents with open wounds are put on EBP. She said when providing care to residents with wounds, staff are expected to wear gown, gloves, and mask. She said this is to prevent infection and cross contamination. 48944 3. On 3/11/2025 at 11:10 AM, R51's room door had an Enhanced Barrier Precautions (EBP) sign. The sign instructed staff to wear gloves and gown when providing high-contact care activities. V9 (Registered Nurse/RN) said she was going to infuse R51's scheduled IV (intravenous) antibiotic via his left upper arm PICC (Peripherally Inserted Central Catheter) line. V9 was wearing gloves but not a gown when she administered R51's IV infusion. R51's care plan said he required the implementation of EBP due to his surgical wound and PICC line initiated on 2/21/2025. The care plan's goal was to prevent the spread of infection. 4. On 3/13/2025 at 12:05 PM, R46's room door had an EBP sign. V20 (Agency RN) said she was changing R46's gastrostomy tube y-connector port. V20 was wearing gloves but not a gown. V20 then proceeded to infuse R46's scheduled bolus gastrostomy tube feeding. R46's care plan said he required the implementation of EBP due to his g-tube for nutrition initiated on 1/21/2025. The care plan's goal was to prevent the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145944	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Aurora	400 West Sullivan Road Aurora, IL 60506

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 3/13/2025 at 1:10 PM, R65's room door had an EBP sign. V20 (Agency RN) said she was going to infuse R65's scheduled bolus gastrotomy tube feeding. V20 donned gloves but failed to don a gown. R65's care plan said she required the implementation of EBP due to her g-tube for enteral nutrition and her open right toe wound initiated on 5/01/2024. The care plan's goal was to prevent the spread of infection. On 3/12/2025 at 9:40 AM, V3 (Infection Preventionist/IP Nurse) said staff was expected to don proper PPE (Personal Protective Equipment) when providing high-contact care activities to residents under EBP including central lines, feeding tubes, and wound care. V3 said EBP practices were implemeted to prevent the spread of infections and protect residents and staff. The facility's policy titled Enhanced Barrier Precautions dated 7/26/2024, said The facility will use Enhanced Barrier Precautions (EBP) to reduce transmission of multi-drug resistant organisms in the nursing homes. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDROs as well as residents with wounds and/or indwelling medical devices.