STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225750	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masconomet Rehabilitation and Healthcare Center	123 High Street Topsfield, MA 01983

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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 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. Based on observation and interview, the facility failed to store and handle food in accordance with professional standards for food service safety, potentially putting the residents at risk for foodborne illness. Specifically, the facility failed to:1. Ensure that food was stored, labeled, and dated properly, and that food/beverages were not expired; and2. Ensure staff did not handle ready-to-eat food with contaminated gloves. Findings include:1. Review of the facility's policy titled, Food Receiving and Storage, dated November 2022, indicated but was not limited to the following:-All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).-Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or discarded.-Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits, vegetables, and other ready-to-eat foods to prevent meat juices from dripping onto these foods.-Foods and snacks kept on nursing units: beverages are dated when opened and discarded after twenty-four (24) hours. Review of the facility's policy titled, Food Preparation and Service, dated November 2022, indicated but was not limited to the following:- Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food means food that requires time/temperature control for safety to limit the growth of pathogens (i.e., bacterial or viral organisms capable of causing a disease or toxin formation). Examples of PHF/TCS foods include ground beef, poultry, chicken, seafood (fish or shellfish), cut melon, unpasteurized eggs, milk, yogurt and cottage cheese.-Cross-contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods.-Appropriate measures are used to prevent cross-contamination. These include: storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigerator. During a walk through in the main kitchen walk-in refrigerator on 3/10/26 at 7:39 A.M., the following was observed:-Two bins of onions stored on the bottom shelf, both of which contained multiple yellow onions covered with a green and white substance resembling mold.-A case of raw bacon stored on the middle shelf above a case of milk.-An opened blue bag of hard-boiled eggs, loosely secured by a piece of plastic wrap, directly exposed to air. -Eight loaves of baked sweet bread on a sheet pan, undated and directly exposed to air. During a walk through in the main kitchen dry storage area on 3/10/26 at 7:51 A.M., the following was observed:-A case of nectar-thick tea packets with a use by date of 10/23/25. During an observation on 3/10/26 at 8:05 A.M., the reach-in refrigerator contained the following food items:-A container of egg salad, halfway full, dated 3/2/26.-A container of chicken salad, halfway full, dated 3/7/26. During an observation on 3/11/26 at 8:23 A.M., the first-floor nourishment kitchen refrigerator contained the following:-A carton of Lactaid milk, opened and halfway full, with a best by date of 1/26/26 and no opened date. -A bottle of Thick and Easy nectar-thick apple juice, opened and halfway full, with a best by date of 1/22/26 and no opened date. During an interview on 3/11/26 at 7:50 A.M., the Food Service Director (FSD) said all food/beverage items should be marked with a received date and opened date. The FSD said staff inspect and rotate foods in the main kitchen at least twice weekly; she would expect moldy or rotten food items to be discarded immediately and would also notify the vendor. The FSD said raw bacon should not be stored over milk and all foods should be covered due to cross-contamination risks. In addition, the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	FSD said the facility policy is to discard opened/prepared foods after two days, and that the egg salad and chicken salad in the reach-in refrigerator should have already been discarded. The FSD said that residents are at increased risk of foodborne illness if food/beverages are not stored, dated, or labeled properly. During a follow-up interview on 3/11/26 at 8:51 A.M., the FSD said dietary staff are responsible for checking the nourishment kitchens at least twice daily at 5:30 A.M., and 2:30 P.M., which would include discarding any items past their best by, use by, or expiration dates. The FSD said nursing staff are responsible for dating any opened beverages in the nourishment kitchens and she has provided education to nursing staff about dating/labeling. 2. Review of the facility's policy titled, Food Preparation and Service, dated November 2022, indicated the following:-Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned.-Gloves are worn when handling food directly and changed between tasks. On 3/10/26 at 7:59 A.M., the surveyor observed the breakfast line in the main kitchen and made the following observation:-The cook touched the oven handle with gloved hands, potentially contaminating his gloves, removed a whole quiche by flipping it from the aluminum pan into his gloved hands, held the quiche to slice it into pieces, and placed the pieces of quiche onto resident plates. With the same contaminated gloves, the cook then proceeded to directly handle multiple pieces of ready-to-eat toast while placing them on resident plates. On 3/11/26 at 7:46 A.M., the surveyor and the FSD observed the breakfast line in the main kitchen and made the following observation:-The cook grabbed shelled eggs from a carton with gloved hands, cracked the eggs directly into a pan on the stove, touched the handle of the pan to move the eggs, and then touched the handle of the steamer to retrieve a pan of ready-to-eat pancakes, potentially contaminating his gloves. With the same contaminated gloves, the cook then proceeded to directly handle multiple pancakes while placing them on resident plates. During an interview on 3/11/26 at 7:50 A.M., the FSD said her expectation is that dietary staff should use a utensil or glove when touching ready-to-eat food, and should change gloves when they are contaminated, such as after touching equipment handles or raw eggs. The FSD said she does not do regular food handling education with her staff.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interview, the facility failed to ensure one Resident's (#91) hand roll was in place as ordered by the physician, out of a total sample of 26 residents. Findings include:Review of the policy titled Resident Mobility and Range of Motion, dated as revised July 2017, indicated:2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion). 6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and will be consistent with state laws and practice acts. 8. Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs. Resident #91 was admitted to the facility in November 2024 and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left dominant side. Review of Resident #91's most recent Minimum Data Set (MDS) assessment, dated 12/30/25, indicated that on the Brief Interview for Mental Status exam Resident #91 scored 10 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #91 had functional limitations in range of motion on both upper extremities and was dependent on staff for Activities of Daily Living (ADLs). Review of Resident #91's active Physician's Orders indicated:-Hand roll to left hand at all times, may remove for ADLs. Inspect skin every shift, start date 4/1/25. Review of Resident #91's active care plans indicated:-An ADL care plan, dated as revised 5/16/25, indicating Resident #91 is dependent on staff for all ADLs. -A chronic pain care plan that includes the following intervention: Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain, start date 6/4/25. Further review of Resident #91's care plans failed to indicate the hand roll as an intervention, including the refusal of the hand roll or removal of the hand roll by Resident #91. Review of an outpatient therapy note, dated 6/23/25, indicated Resident #91 was seen due to severe contracture to his/her LUE (left upper extremity) and RLE (right lower extremity). Review of the most recent Nursing Quarterly Assessment, dated 12/25/25, indicated that Resident #91 experienced pain during movement and care due to the presence of contractures. During an observation and interview on 3/10/26 at 8:48 A.M., the surveyor observed Resident #91 in bed. The surveyor observed Resident #91's left hand to be contracted and there was no hand roll in place or observed in the vicinity. Resident #91 said he/she is supposed to wear a brace on his/her left hand/arm at night but that they didn't put it on last night because he/she didn't ask for it. On 3/11/26 at 7:22 A.M., the surveyor observed Resident #91 in bed asleep. There was no hand roll in place. During an observation and interview on 3/11/26 at 8:50 A.M., the surveyor observed Resident #91 in bed, with no hand roll in place. Resident #91 said that his/her hand hurts when the staff put in the hand roll, but that once it is in it feels good. Resident #91 said that he/she often forgets to ask staff to put the hand roll in and that they do not put it in unless he/she asks. On 3/11/26 at 10:22 A.M., the surveyor observed Resident #91 in bed asleep. There was no hand roll in place. On 3/12/26 at 7:37 A.M., the surveyor observed Resident #91 in bed asleep. There was no hand roll in place. During an interview on 3/12/26 at 8:40 A.M., Certified Nursing Assistant (CNA) #2 said that Resident #91 is dependent for ADL care. CNA #2 said that she was not aware that Resident #91 has an order for a hand roll but that is something that the nurse would be responsible for. During an interview on 3/12/26 at 8:42 A.M., Nurse #5 said that Resident #91 is supposed to have the hand roll in at all times except when staff provide care. He said that despite Resident #91's pain, if you are gentle, you are able to slowly get the roll in place. Nurse #5 said that Resident #91 does not refuse the hand roll and if he/she did the nurses would write a note. During an interview on 3/12/26 at 8:53 A.M., the Director of Nursing said that Resident #91's hand roll should be in place, and it is the expectation that the nurses document if refused.

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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. Based on observations, record review, and interviews, for one Resident (#77), out of 26 sampled residents, the facility failed to provide an environment free of accidents and hazards to prevent injury. Specifically, for Resident #77, who has a history of repeated falls, the facility failed to ensure fall mats were in place as ordered by the physician. Findings include:Review of the facility's policy titled Falls and Fall Risk, Managing, dated as revised March 2018, indicated:Resident-Centered Approaches to Managing Falls and Fall Risk.1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Resident #77 was admitted to the facility in November 2024 and has diagnoses that include dementia, anxiety disorder, and repeated falls. Review of Resident #77's most recent Minimum Data Set (MDS) assessment, dated 2/12/26, indicated on the Brief Interview for Mental Status exam Resident #77 scored 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #77 was dependent on staff for Activities of Daily Living (ADL). Review of Resident #77's active Physician's Orders indicated the following order: Safety floor mats next to bed while patient is in bed, check placement every shift, start date 4/1/25. Review of Resident #77's Functional Ability Assessment, dated 2/12/26, indicated that Resident #77 was dependent on staff for ADLs. Review of Resident #77's Falls Care Plan indicated I am at risk for falls r/t (related to) Impaired balance and mobility, poor safety awareness, use of psychotropic medications, visual impairment, dated as revised 12/1/25. Interventions include:-Fall Mats placed to Bilateral sides of bed, start date 2/17/26. Resident #77's care plan failed to indicate refusal or removal of the fall mat(s). Review of Resident #77's falls Kardex (resident specific care instructions and needs) indicated the following interventions:-Fall Mats at bedside. Review of Resident #77's March 2026 clinical progress notes failed to indicate refusal or removal of the fall mat(s). Review of Resident #77's accident and incident report provided by the facility indicated that Resident #77 sustained an unwitnessed fall in his/her room on 2/17/26. According to the investigation, Resident #77 was found on the fall mat beside his/her bed. On 3/10/26 at 9:04 A.M. and 10:07 A.M., the surveyor observed Resident #77 in bed. The fall mats were not in place beside the bed but rather leaning against a wall. On 3/11/26 at 8:35 A.M. and 10:23 A.M., the surveyor observed Resident #77 in bed. There was a fall mat on right side of bed, but the left side fall mat was observed folded up and leaning against a wall. During an interview on 3/12/26 at 8:29 A.M., Certified Nursing Assistant (CNA) #1 said Resident #77 requires total assist with ADLs. CNA #1 said that Resident #77 is easily redirected if he/she has behaviors and does not move the fall mat. CNA #1 said that whenever Resident #77 is in bed, the fall mats should be in place. She said that if the mats are moved while care is provided, staff are expected to put them back in place afterward. During an interview on 3/12/26 at 8:32 A.M., Nurse #5 said that Resident #77 requires total care. Nurse #5 said that Resident #77's fall mats should be in place whenever he/she is in bed. Nurse #5 said that if the staff move the mats when providing care or feeding the Resident the mats should be put back in place when the care is complete. During an interview on 3/12/26 at 8:53 A.M., the Director of Nursing said that the fall mats should be in place whenever Resident #77 is in bed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, and in accordance with physician's orders were provided for two Residents (#67 and #112), out of a total sample of 26 residents. Specifically, the facility failed: 1. For Resident #67, to ensure Oxygen was administered in accordance with the physician's order; and 2. For Resident #112, to ensure Oxygen was administered according to the physician's orders, nebulizer (a medical device that converts liquid medication into a fine, breathable mist for direct inhalation into the lungs through a mask or mouthpiece) tubing was dated, and a nebulizer mask was stored appropriately. Findings include: Review of the facility's policy titled Oxygen Administration, dated October 2010, indicated the following: -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. -Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. 1. Resident #67 was admitted to the facility in February 2026 with diagnoses including idiopathic pulmonary fibrosis (a chronic, progressive lung disease characterized by scarring of lung tissue), pneumonia, and acute respiratory failure with hypoxia (low oxygen levels). Review of Resident #67's most recent Minimum Data Set (MDS) assessment, dated 2/11/26, indicated that Resident #67 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of 15. The MDS further indicated that the Resident received continuous oxygen therapy and required assistance from staff for activities of daily living. During an observation with interview on 3/10/26 at 10:16 A.M., the surveyor observed Resident #67 sitting in a wheelchair wearing an oxygen nasal canula (a flexible tube with two small prongs inserted into the nostrils to deliver supplemental Oxygen). The oxygen concentrator was set to 3 liters per minute. The Resident said his/her baseline setting is 2 liters per minute. On 3/11/26 at 7:04 A.M., the surveyor observed Resident #67 lying in bed wearing an oxygen nasal cannula. The oxygen concentrator was set to 3 liters per minute. On 3/11/26 at 8:48 A.M., the surveyor observed Resident #67 lying in bed wearing an oxygen nasal cannula. The oxygen concentrator was set to 3 liters per minute. During an observation with interview on 3/11/26 at 11:00 A.M., the surveyor observed Resident #67 sitting in a wheelchair wearing an oxygen nasal cannula. The oxygen concentrator was set to 2.5 liters per minute. The Resident said his/her oxygen was set to 3 liters per minute earlier that day, but he/she thought the setting was too high, so staff decreased it to 2.5 liters per minute. Review of Resident #67's active Physician's Orders indicated: Oxygen continuous via nasal cannula at 2 liters per minute, every shift continuous (14 hours or greater per day continuous), start date 2/9/26. Review of Resident #67's Respiratory Care Plan, last revised 2/24/26, indicated the following intervention: Oxygen a/o (as ordered). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's most recent laboratory results, dated 3/3/26, indicated an elevated carbon dioxide level of 35 milliequivalents per liter (normal range: 22-29 milliequivalents per liter). During an interview on 3/11/26 at 11:03 A.M., Nurse #4 said Oxygen orders should be followed as prescribed by the physician. Nurse #4 said Resident #67 has not had any change in respiratory status or increased difficulty breathing that would necessitate an oxygen concentrator setting above the ordered 2 liters per minute. Nurse #4 said a resident with a diagnosis of acute respiratory failure with hypoxia should not have oxygen levels more than ordered secondary to the risk of carbon dioxide retention. During an interview on 3/11/26 at 1:29 P.M., the Director of Nursing (DON) said Oxygen orders should be followed as prescribed by the physician and that a resident with a diagnosis of acute respiratory failure with hypoxia should not have oxygen levels more than ordered secondary to the risk of carbon dioxide retention. The DON said she would expect Resident #67's oxygen concentrator to be set at 2 liters per minute in accordance with the physician's order. 2. Resident #112 was admitted to the facility in February 2026 with diagnoses including chronic respiratory failure with hypoxia. Review of Resident #112's most recent MDS assessment, dated 3/3/26, indicated the Resident scored 15 out of 15 on the BIMS exam indicating he/she was cognitively intact. The MDS further indicated that the Resident was on oxygen therapy. On 3/10/26 at 10:49 A.M., the surveyor observed Resident #112 wearing an oxygen nasal cannula, the oxygen concentrator was set to 3 liters. The Resident said he/she should be on 2 liters of Oxygen. The Resident further said he/she does not adjust the settings of the Oxygen. A nebulizer machine was noted on top of the Resident's drawer, the tubing was undated, and the mask was next to a plastic food container, a glass vase, and a box of gloves. On 3/11/26 at 7:07 A.M., the surveyor observed Resident #112 wearing an oxygen nasal cannula, the oxygen concentrator was set to 3 liters. A nebulizer machine was noted on top of the Resident's drawer, the tubing was undated, and the mask was next to a plastic food container, a glass vase, and a box of gloves. On 3/11/26 at 10:38 A.M., the surveyor observed Resident #112 wearing an oxygen nasal cannula, the oxygen concentrator was set to 3 liters. The Resident was also inhaling medication via the nebulizer mask. The surveyor asked Nurse #2 who was standing at the doorway to the Resident's room to look at the oxygen setting. Nurse #2 removed the Resident's nebulizer mask and confirmed the oxygen concentrator was set to 3 liters. The Nurse then placed the nebulizer mask on top of the Resident's drawer. Review of the current Physician's Orders indicated the following: -Date 3/4/26: Oxygen PRN (as needed) via (N/C) at (2) Liters Per Minute- to keep O2 sats above 90% as needed for if O2 sats are under 90% apply O2. [sic] -Date 3/4/26: Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML3 ml inhale orally via nebulizer two times a day for Respiratory Treatments & compliance until 3/14/26 11:26 Supplementary Documentation Codes Pre and Post Tx Lung Sounds C = ClearO = Other (see progress note) Pre and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post Tx - P, R and O2 Sat results MNS - Enter the number of minutes of nurse time for the medication administration.[sic] -Date 2/24/26: Respiratory Bag Change: Change and date bag every night shifts every Thu. [sic] Review of the Resident's Oxygen Therapy Care Plan, date initiated 2/25/26, indicated the Resident has Oxygen with an intervention of Oxygen as ordered. During an interview on 3/11/26 at 10:40 A.M., Nurse #2 said the Resident should be on Oxygen at 2 Liters per minute and that the nebulizer tubing should be dated weekly and the mask stored in a respiratory bag for infection control. During an interview on 3/11/26 at 10:46 A.M., Unit Manager #1 said Oxygen should be administered as ordered, nebulizer tubing is changed weekly, and masks are stored in the respiratory plastic bags. During an interview on 3/11/26 at 1:30 P.M., the DON said Oxygen should be administered at the ordered setting, nebulizer tubing is changed weekly and dated, and nebulizer masks should be stored in the respiratory bag. She further said when Oxygen is administered at the wrong setting it could lead to the Resident retaining carbon dioxide which could be dangerous.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were dated once opened according to manufacturer's guidelines in one of three medication carts observed. Findings include:Review of the facility's policy titled ?Medication Labeling and Storage', revised February 2023, indicated:-Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.-Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration. On 3/11/26 at 6:55 A.M., the surveyor and Nurse #1 observed the following in the Gould unit medication cart:-One Fluticasone Furoate inhaler, opened and undated.-Spiriva Handihaler inhaler, opened and undated.-Ipratropium Bromide nasal solution, opened and undated.-Liquid protein supplement, opened and undated. During an interview on 3/11/26 at 7:05 A.M., Nurse #1 said the medications should have been dated when they were opened. During an interview on 3/11/26 at 7:15 A.M., Unit Manager #1 said medications should have been dated when they were opened. During an interview on 3/11/26 at 1:34 P.M., the Director of Nursing said the medications with shortened expiration should be dated when opened.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interviews, the facility failed to ensure transmission-based precautions were followed to prevent the spread of infections for one Resident (#7), out of 26 total sampled residents. Specifically, the facility failed to ensure staff implemented enhanced barrier precautions for Resident #7, who had a chronic stage three pressure ulcer. Findings include:Review of the facility's policy titled 'Enhanced Barrier Precautions', revised 2/5/25, indicated:-It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.-Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g. chronic wounds such as pressure ulcers). -Implementation of Enhanced Barrier Precautions: PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities.-High-contact care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing brief or assisting with toileting, wound care: any skin opening requiring a dressing. Resident #7 was admitted to the facility in February 2024 with diagnoses including malnutrition and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/14/26, indicated Resident #7 had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. The MDS also indicated Resident #7 had a stage three pressure ulcer. Review of Resident #7's medical record indicated a diagnosis of pressure ulcer of left heel, stage 3 with an onset date of 8/4/25, which was greater than seven months ago. Review of Resident #7's Physician's Order and plan of care, dated 3/1/26-3/12/26, failed to indicate the need for enhanced barrier precautions. On 3/10/26 at 8:18 A.M. and 1:43 P.M., 3/11/26 at 7:20 A.M. and 10:48 A.M., and 3/12/26 at 7:09 A.M. and 10:25 A.M., the surveyor observed no sign that indicated the need for any precautions or precaution cart at Resident #7's doorway. On 3/11/26 at 10:49 A.M., the surveyor observed Certified Nurse Assistant (CNA) #3 assisting Resident #7 with morning care. CNA #3 said he was washing Resident #7 up and getting him/her dressed for the day. CNA #3 was not wearing a precaution gown. There was no sign that indicated the need for any precautions or precaution cart at Resident #7's doorway at this time. On 3/12/26 at 10:26 A.M., the surveyor observed Nurse #7 and Unit Manager #2 remove a soiled wound dressing and apply a new wound dressing to Resident #7's left heel. Both nurses said this was a chronic stage three pressure ulcer that Resident #7 had for more than six months, maybe even a year. Neither nurse wore a precaution gown during wound care. There was no sign that indicated the need for any precautions or precaution cart at Resident #7's doorway at this time. During a follow-up interview on 3/12/26 at 10:41 A.M., Nurse #7 said Unit Manager #2 said Resident #7 was not currently on enhanced barrier precautions. Both Nurse #7 and Unit Manager #2 were unaware chronic wounds required enhanced barrier precautions. During an interview on 3/12/26 at 10:55 A.M., the Director of Nursing (DON) said she was unaware chronic wounds required enhanced barrier precautions. During an interview on 3/12/26 at 11:12 A.M., the Infection Control Nurse said chronic wounds over three to five months require enhanced barrier precautions, including use of a precaution gown while performing high-contact activities. The Infection Control Nurse said she was unaware Resident #7 had a chronic stage three pressure ulcer for over seven months, but he/she should have had enhanced barrier precautions implemented but did not.