STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365535	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Meadows Post Acute	10540 Fremont Pike Rd Perrysburg, OH 43551

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure resident representatives and physicians were notified of changes in condition. This affected one (#05) of three residents reviewed for changes in condition. The facility census was 83. Review of the medical record for Resident #05 revealed an admission date of 06/14/23. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, Alzheimer's disease with late onset, dementia, hypertension, repeated falls, anemia, peripheral vascular disease, orthopedic aftercare following surgical amputation, Methicillin susceptible staphylococcus aureus infection, occlusion and stenosis of carotid artery, and unstageable pressure ulcer of sacral region, acquired absence of right leg above knee, and protein calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #05 had severe cognitive impairment. The resident had no unhealed pressure ulcers. The resident was at risk for developing pressure ulcers/injuries. The resident used a wheelchair and could not ambulate. The resident required the substantial/maximal assistance of staff for toileting, bathing, bed mobility, and transfers. The resident required set-up assistance for eating. The resident had no significant weight loss.Review of a nurse's note dated 10/05/25 at 2:16 P.M. revealed the resident had a decrease in appetite and fluids were encouraged during rounding. Resident #05 had muscle tremors on the left side along with an elevated heart rate of 122 beats per minute. The on-call physician was notified, and new orders were received for an electrocardiogram (EKG), an x-ray, and laboratory testing including a complete blood count, a complete metabolic panel, an erythrocyte sedimentation rate, C-Reactive protein, and lactate. Review of a physician order dated 10/05/25 revealed an order for an EKG and x-ray of the right ankle.Review of a radiology report dated 10/05/25 and electronically signed at 7:11 P.M. revealed an x-ray of Resident #05's right ankle was completed due to ankle pain. The radiology report noted the study quality was limited by inappropriate technique which reduced sensitivity for subtle fracture, malalignment, and small joint effusion. Further review of the findings revealed no acute fracture or dislocation, no focal soft tissue swelling, soft tissue gas, or foreign body identified.Review of a nurse's note dated 10/06/25 at 12:00 P.M. revealed the resident's family was updated on the orders for the EKG and the x-ray. The family was notified that the resident had refused labs this morning. The resident's family was informed that the nurse practitioner was most likely going to order intravenous fluids. The family was notified about the pending vascular consult and notified the nurse had made several attempts to get the appointment scheduled. Review of a nurse's note dated 10/06/25 at 1:10 P.M. revealed the vascular provider had provided another fax number and the referral information was faxed again. The nurse practitioner gave a verbal order to start intravenous therapy 0.9 percent normal saline at 50 milliliters (ml) per hour. The resident agreed to the treatment. Review of the nurses notes from 10/05/25 through 10/07/25 revealed no documentation the resident's representative was notified of the x-ray results of the right ankle.Review of the nurse's notes, physician orders, and medication administration record (MAR) for 10/06/25 revealed no documentation the resident had received the intravenous fluids per physician orders. There was also no documentation the physician was notified the intravenous fluids had not been administered. Interview on 12/03/25 at 9:07 A.M., Unit Manager Licensed Practical Nurse (UMLPN) #102 verified there was no documentation Resident #05's representative had been notified of the x-ray results for the right ankle. UMLPN #102 verified there was no documentation the IV had been administered per physician orders. Further interview with UMLPN #102 revealed she was unable to obtain IV access. UMLPN #102 verified there was no documentation of the unsuccessful attempt to initiate the IV and no documentation the physician was notified.Review of the policy Change in a Resident' Condition or Status, revised 02/2021, revealed the facility would promptly notify the attending physician of a need to alter the resident's medical treatment. This deficiency represents non-compliance investigated under Complaint Number 2677336.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, resident interview, staff interview, and policy review. The facility failed to ensure surgical wound care was completed per physician orders. This affected one resident (#43) of three residents reviewed for wound care. The facility identified five residents with surgical wounds. The facility census was 83. Review of the medical record for Resident #43 revealed an admission date of 09/10/25 and a readmission date of 10/23/25. Diagnoses included pneumonia, anxiety, and surgical aftercare following surgery of the digestive system.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the physician orders dated 11/18/25 revealed the resident had a surgical wound to the right upper quadrant mid abdomen. The orders were to cleanse the wound with wound cleanser, pat dry, apply skin prep to the skin surrounding the wound, apply the antibacterial dressing and foam, change three times per week on Tuesdays, Thursdays, and Saturdays, and as needed. Review of the nurses' notes from 11/21/25 through 11/25/25 revealed no documentation the resident had refused wound care. Review of the Treatment Administration Record (TAR) dated 11/01/25 through 11/25/25 revealed the wound care treatment to the abdomen had been documented as completed on 11/22/25. Interview on 11/25/25 at 1:25 P.M., Resident #43 revealed the facility had not completed the wound care to her surgical wound since the previous week. Resident #43 revealed she had asked the nurse to change the dressing on Saturday 11/22/25 but the nurse never returned to complete the dressing change. Resident #43 also revealed she had to request every week for dressing for her PICC (Peripherally Inserted Central Catheter) line to be changed or it would not have gotten done.Observation on 11/25/25 at 1:25 P.M. of Resident #43's abdominal wound dressing revealed the dressing was dated 11/20/25. Interview on 11/25/25 at 1:36 P.M., the Assistant Director of Nursing (ADON) #114 verified the wound dressing was dated 11/20/25 and the wound treatment had not been completed on 11/22/25 as documented. ADON #114 revealed she would find someone to change the wound dressing. Review of the facility policy Wound Care, revised 10/2010, revealed wound care would be provided per physician orders and the dated and time the wound care was given would be documented in the medical record. This deficiency represents non-compliance investigated under Complaint Number 2677336.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of wound care provider documentation, review of hospital documentation, staff interview, family interview, nurse practitioner interview, review of the National Pressure Injury Advisory Panel 2025 guidelines, and review of facility policies, the facility failed to provide a timely assessment, ongoing monitoring, and interventions to prevent the development of a pressure ulcer for Resident #05, who was known to have arterial and venous insufficiency, and who was identified at risk for pressure ulcers. This resulted in Immediate Jeopardy and serious physical harm, injuries, and/or negative health outcome on 09/07/25 when Resident #05 was found with an unstageable pressure ulcer to the right malleolus (ankle) underneath an ankle monitoring device. The unstageable pressure ulcer was not accurately assessed, and no interventions were initiated. On 09/08/25 the wound was assessed as an unstageable pressure ulcer and an intervention for wound treatment was to elevate the extremity. There were no interventions documented regarding the frequency of monitoring Resident #05's skin under the ankle monitor and no documentation that the ankle monitor had been removed. There was no documentation of an investigation regarding Resident 05's unstageable pressure ulcer to determine causative factors of the wound development or need to change pressure reduction interventions. Furthermore, Resident #05's nutritional status was not reassessed with the change in condition. Resident #05's wound began deteriorating on 09/25/25 with signs of infection. Wound Nurse Practitioner (WNP) #700 ordered offloading heel boots, a wound culture, and a vascular consult. There was no documentation of the offloading heel boots being implemented. The resident's wound culture was not obtained until 10/06/25. On 10/05/25 the resident began experiencing a decline in condition and laboratory testing was ordered. The laboratory was unable to obtain vascular access, and the resident refused a second attempt. On 10/06/25 the resident was ordered intravenous fluids which were not administered. Additionally, the vascular consult was not obtained prior to the resident discharging per family request to the hospital on [DATE]. On 10/06/25, Resident #05 was admitted to the hospital and diagnosed with a wound infection, septic arthritis of the right ankle, osteomyelitis of the fibula due to Staphylococcus aureus, and was hypoglycemic with an extremely low blood sugar of 26 milligrams per deciliter (mg/dL) and required 15 grams of oral glucose. Resident #05 also required intravenous antibiotics, wound debridement, and negative pressure wound therapy (wound vac). Resident #05 was diagnosed with moderate to severe stenosis of the right lower extremity and an above the right knee amputation was performed on 10/17/25. This affected one (#05) of four residents reviewed for pressure ulcers. The facility identified 10 residents with pressure ulcers. The facility census was 83.On 12/03/25 at 4:31 P.M., the Administrator, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) #114 were notified that the Immediate Jeopardy began on 09/07/25 at approximately 10:30 A.M. when Resident #05 was found with an unstageable pressure ulcer to the right ankle from an ankle monitoring device with no documented interventions regarding the skin monitoring under the ankle monitor and no documentation the ankle monitor had been removed. Also, there was no documentation in the medical record of an immediate wound assessment and no investigation of the causative factors of the wound development or the need to change pressure reduction interventions. Furthermore, Resident #05's nutritional status was not reassessed with the change in condition. Resident #05's wound began deteriorating on 09/25/25 with signs of infection. WNP #700 ordered offloading heel boots, a wound culture, and a vascular consult. There was no documentation in the medical record that the offloading heel boot intervention was implemented, and the resident's wound culture was not obtained until 10/06/25. On 10/05/25 the resident began experiencing a decline in condition and laboratory testing was ordered. The laboratory was unable to obtain vascular access, and the resident refused a second attempt. On 10/06/25 the resident was ordered intravenous fluids which were not administered, and the provider was not notified of the intravenous fluids not being administered. Additionally, the vascular consult was not obtained prior to the resident discharging, per family request, to the hospital on [DATE]. On 10/06/25 the resident was admitted to the hospital and diagnosed with a wound infection, septic arthritis of the right ankle, osteomyelitis of the fibula due to Staphylococcus aureus and was hypoglycemic with an extremely low blood sugar of 26 milligrams per deciliter (mg/dL) requiring 15 grams of oral glucose. The resident required intravenous antibiotics, wound debridement, and negative pressure wound therapy (wound vac). Resident #05 was diagnosed with moderate to severe stenosis of the right lower extremity and an above the right knee amputation was

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of bowel records, staff interview, and policy review, the facility failed to ensure bowel movements were accurately documented and failed to ensure the bowel protocol was followed when a resident was without a bowel movement for greater than three days. Additionally, the facility failed to timely complete a bowel assessment for a resident with a known history of constipation who had no documented bowel movements for six days. This affected one (#74) of three residents reviewed for bowel and bladder. The facility census was 83. Review of the medical record for Resident #74 revealed an admission date of 02/17/22. Diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, type two diabetes mellitus, chronic kidney disease, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was always incontinent of bowel and frequently incontinent of bladder. The resident was dependent on staff for all activities of daily living. Review of the care plan revealed the resident was at risk for constipation due to decreased mobility, and frequent pain medication use. Interventions included administering medications per physician orders, monitoring for medication side effect and reporting changes and complications of constipation. Review of the physician orders for Resident #74 revealed an order dated 05/06/25 for Dulcolax suppository ten milligrams daily, an order dated 10/11/25 for Linzess, 72 micrograms daily for chronic constipation, and an order for Metamucil, two capsules daily for chronic constipation. Further review of the physician orders revealed orders dated 06/11/25 for sennoside-docusate tablet 8.6-50 mg tablet three times per day, and orders dated 06/11/25 for Miralax 17 grams four times a day for constipation, and an order dated 05/05/25 for a mineral oil enema as needed up to twice weekly for constipation.Review of the Medication Administration Record (MAR) dated 11/01/25 through 11/20/25 revealed the scheduled routine bowel medications had been administered per physician orders. the resident refused the Dulcolax suppository ten times, refused the sennoside-docusate four times, and refused the Miralax 46 times. The as needed mineral oil enema was never administered. Review of the bowel task documentation completed by the Certified Nursing Assistants dated 11/15/25 through 11/20/25 revealed the resident had no bowel movements from 11/15/25 through 11/20/25. Review of the progress notes dated 11/15/25 through 11/20/25 revealed there was no documentation the physician was notified of the resident not having a bowel movement. There was no documentation the resident was assessed for bowel sounds prior to 11/20/25. There was no documentation the resident was provided with additional interventions or medications to assist with bowel movements. There was no documentation the resident had been educated regarding refusals of bowel medications. Review of a nurse's note dated 11/20/25 at 11:49 A.M. revealed the resident had a declinein condition with increased pain in his bottom, drooling, and greenish phlegm. The nurse practitioner was notified.Review of a nurses note dated 11/20/25 at 1:13 P.M. revealed the resident was evaluated by the nurse practitioner with new orders for STAT labs. The resident was agreeable with the treatment plan. The resident's representative called 911 and the resident was sent to the hospital. Review of the bowel alert report dated 11/15/25 through 11/20/25 revealed Resident #74 had triggered an alert for no bowel movement on 11/16/25, 11/17/25, 11/18/25, 11/19/25, and 11/20/25. Review of the hospital documentation dated 11/20/25 through 11/25/25, provided by the facility, revealed no documentation the resident had a bowel blockage. The resident was admitted to the hospital with diagnoses including acute respiratory failure and pneumonia.Interview on 11/25/25 at 11:52 A.M., Licensed Practical Nurse (LPN) #103 revealed the facility tracked resident bowel movements. LPN #103 revealed a resident would be added the no bowel movement list after three days. LPN #103 revealed Resident #74 had received a lot of bowel medications. LPN #103 revealed if a resident had not had a bowel movement in three days then the nurse practitioner would be notified. LPN #103 revealed Resident #74 has had several x-rays in the past to check for blockages. Interview on 11/25/25 at 12:00 P.M., LPN #122 revealed Resident #74 was not feeling well and the nurse practitioner had ordered some laboratory testing which the resident was agreeable with. LPN #122 revealed she had went to lunch and when she returned another nurse had stated the resident was not looking good. LPN #122 revealed she had went to notify the nurse practitioner but the resident's family member had requested the resident be sent to the hospital. LPN #122 revealed there was no time to assess the resident as the nurse practitioner was already in the room and then emergency medical services had arrived. LPN #122 revealed the unit managers provided a bowel list each morning and the nurse practitioner was notified

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, resident interview, family interview, and policy review revealed the facility failed to ensure medical documentation was complete and accurate. This affected two (#5, #51) of three residents reviewed for clinical documentation and had the potential to affect all residents. The facility census was 83. 1. Review of the medical record for Resident #05 revealed an admission date of 06/14/23. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, Alzheimer's disease with late onset, dementia, hypertension, repeated falls, anemia, peripheral vascular disease, orthopedic aftercare following surgical amputation, Methicillin susceptible staphylococcus aureus infection, occlusion and stenosis of carotid artery, and unstageable pressure ulcer of sacral region, acquired absence of right leg above knee, and protein calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #05 had severe cognitive impairment. The resident required the substantial/maximal assistance of staff for toileting, bathing, bed mobility, and transfers. Review of the plan of care initiated 06/16/23 revealed the resident had impaired cognitive function, wandered, and was an elopement risk due to impaired safety awareness. Interventions included an ankle monitor to the left leg. Staff were to document wandering behavior and were to check function of ankle monitor daily and placement every shift. Further review of the care plan revealed there was no care plan in place for edema or interventions for compression stockings. Review of a physician order dated 02/23/24 revealed to check the ankle monitoring device function daily and placement of ankle monitoring device to the left ankle every shift. Review of a physician order dated 02/23/24 revealed a second order to check placement of the ankle monitoring device each shift and check function daily with no specified location of the device. The orders for the ankle monitoring device were discontinued on 10/08/25. Review of a physician order dated 06/24/24 revealed the resident was ordered knee high compression stockings, staff were to apply in the morning and then remove at bedtime for lower extremity edema, as tolerated. The order for the compression stockings was discontinued on 10/08/25.Review of an incident report dated 09/07/25 at 10:30 A. M. revealed the resident was found with a wound to the right ankle. Further review of the incident report revealed the resident's ankle monitor was on the right leg. Review of the progress notes and Treatment Administration Record (TAR) dated 08/01/25 through 10/05/25 revealed no documentation the resident had refused the compression stockings. Staff documented daily the compression stockings were applied in the morning and removed at bedtime. Further review of the TAR revealed staff were documenting the ankle monitor to the left leg was checked for placement and function every shift. There was no documentation the ankle monitor had been moved to the right leg. Review of a late entry nurse's note dated 10/07/25 at 7:30 P. M. revealed the resident was transported to the hospital. Review of the hospital documentation dated 10/06/25 revealed the resident was admitted to the hospital on [DATE] around 8:16 P.M. Interview on 12/01/25 at 2:30 P.M., Unit Manager Licensed Practical Nurse (UMLPN) #102 revealed Resident #05 no longer wore an ankle monitor. UMLPN #102 revealed the resident used to wear an ankle monitor on the right leg. UMLPN #102 reviewed the resident's medical record and verified the resident had two separate physician orders for documenting function and placement of the ankle monitor. The first order noted no location of the ankle monitor, and the second order noted the ankle monitor on the left ankle. UMLPN #102 verified staff had documented completing both orders. UMLPN #102 revealed staff should have checked both ankles and then clarified the order and the correct location of the ankle monitor. Further interview on 12/01/25 at 3:52 P.M., UMLPN #102 revealed she could not say with 100 percent certainty if Resident #05's ankle monitor was on the right leg. Additional interview with UMLPN #102 revealed the nurse's note dated 10/07/25 stating the resident was admitted to the hospital had been documented on the incorrect date on 10/07/25. UMLPN #102 verified the resident was transferred to the hospital on [DATE].Interview on 12/01/25 at 4:52 P.M., LPN #116 revealed being notified on 09/07/25 by Certified Nursing Assistant (CNA) #130 of a wound found on Resident #05's right ankle. LPN #116 revealed a risk assessment had been completed noting the ankle monitor was on the right ankle. LPN #116 revealed moving the ankle monitor up higher on the resident's right leg. LPN #116 revealed he was only aware of the ankle monitor being in place on the right ankle. LPN #116 revealed he was unaware there were two separate physician orders for monitoring placement and function of the ankle monitor with one noting the left ankle and the other with no specified location.Interview on 12/02/25 at 8:07 A.M., Certified Nursing Assistant (CNA) #130 revealed Resident #05

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure enhanced barrier precautions were maintained during wound care. This affected one (#05) of four residents reviewed for wound care. The facility identified 29 residents with enhanced barrier precautions. The facility census was 83. Review of the medical record for Resident #05 revealed an admission date of 06/14/23. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, Alzheimer's disease with late onset, dementia, hypertension, repeated falls, anemia, peripheral vascular disease, orthopedic aftercare following surgical amputation, Methicillin susceptible staphylococcus aureus infection, occlusion and stenosis of carotid artery, and unstageable pressure ulcer of sacral region, acquired absence of right leg above knee, and protein calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #05 had severe cognitive impairment. The resident was at risk for developing pressure ulcers/injuries. The resident used a wheelchair and could not ambulate. The resident required the substantial/maximal assistance of staff for toileting, bathing, bed mobility, and transfers. Review of a physician order dated 10/21/25 revealed the resident was ordered enhanced barrier precautions for high contact resident care including wound care.Review of a nurse ' s note dated 10/21/25 at 2:00 P.M. revealed Resident #05 had returned from the hospital on [DATE] and a second skin check was completed. The resident had an above the knee amputation of the right leg with the incision well approximated with 16 sutures. The resident had an unstageable pressure ulcer to the coccyx, and unstageable pressure ulcer to the left heel, a deep tissue injury of the left lateral foot and left malleolus. Observation on 11/25/25 at 2:00 P. M. of Resident #05 revealed a sign outside the resident ' s door indicating the resident required enhanced barrier precautions (gown and gloves) when providing high contact care. Licensed Practical Nurse (LPN) #103 and the Unit Manager Licensed Practical Nurse (UMLPN) #102 provided wound care treatment for the resident ' s unstageable sacral wound per physician orders. LPN #103 and UMLPN #102 had not donned a gown prior to providing wound care for the resident. The uniform tops of both LPN #103 and UMLPN #102 touched the resident while turning and repositioning the resident during wound care. Interview on 11/25/25 at 2:16 P.M., LPN #103 and UMLPN #102 verified the resident required enhanced barrier precautions during wound care. LPN #103 and UMLPN #102 verified they had not worn gowns while providing wound care for the resident. Review of the facility policy Enhanced Barrier Precautions, revised 03/2024, revealed enhanced barrier precautions (EBPs) were utilized to reduce the transmission of multidrug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities including wound care.