STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure water temperatures were appropriate. This affected one (Resident #25) of three reviewed for environmental concerns and had the potential to affect all 54 residents in the facility.Findings include:Review of the medical record for Resident #25 revealed an admission date of 07/13/23. Diagnoses included kidney disease, depression, glaucoma, hypertension and irritable bowel syndrome.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact. He required set-up help for eating and oral care and was dependent on staff for toileting, showering, dressing and personal hygiene.Interview on 03/16/26 at 9:08 A.M. with Resident #25 revealed the water in his bathroom sink was never hot.Observation on 03/18/26 at 7:29 A.M. of the sink in Resident #25's room revealed the water reached a temperature of 80 degrees Fahrenheit (F).Interview on 03/18/26 at 9:53 A.M. with Maintenance Director #551 confirmed the water temperature in some of the rooms on the 100-hall, including Resident #25's room, were often not within the required range. He revealed the temperature of 80 degrees F which was obtained was actually warmer than the 50 degrees he often observed. He revealed when the dish washing machine and laundry was being done between the hours of 8:00 A.M. until approximately 2:00 P.M., the water was often not warm. Observation at the time of the interview with Resident #25 revealed he was brushing his teeth at the sink, and he confirmed the water remained cold.Review of the undated facility policy titled Resident Rights revealed residents had the right to a safe, sanitary, and respectful environment which supports their comfort, dignity, and personal wellˆbeing. That included receiving care in a manner which protected privacy, supports personal choices, and ensured access to essential daily needs such as bathing, grooming, and hygiene. Staff would provide care in a safe and secure setting, respond promptly to resident needs, and maintain conditions that uphold the resident's dignity and overall comfort.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plans were comprehensive. This affected three Residents (Residents #2, #11 and #50) of 18 reviewed for care plans and had the potential to affect all 54 residents in the facility. Findings include:1. Review of the medical record for Resident #2 revealed an admission date of 02/20/26. Diagnoses included cerebral infarction, diabetes, dementia, heart disease, depression and kidney disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. He required supervision for eating, substantial to maximum assistance for oral care, personal care and showering and was dependent on staff for toileting. Review of the physician's orders for March 2026 revealed an order for Trazadone (an antidepressant) 50 milligrams (mg) at bedtime. The order began on 03/02/26. There was also an order to monitor for side effects of antidepressants including stiffness of neck, dry mouth, sweating or rashes and weakness. The order began on 02/23/26. Review of the care plan dated 03/02/6 revealed no evidence depression was addressed. 2. Review of the medical record for Resident #50 revealed an admission date of 02/06/26. Diagnoses included sepsis, respiratory failure, heart failure, kidney failure and malnutrition. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. He required set-up help for eating, partial to moderate assistance for oral and personal hygiene, substantial to maximum assistance for showering and was dependent on staff for toileting. He had one Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed; often include undermining and tunneling), two unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) and three unstageable deep tissue injuries (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear). Review of the physicians orders for March 2026 review on an order for wound care to Resident #50's right plantar foot which included cleansing with saline solution, applying a thin layer of hydrogel (gel used to maintain a moist environment) to the black necrotic tissue below the left lateral right great toe and applying Xeroform (gauze designed to maintain a moist environment and protect wounds) to the entire wound, covering it with abdominal dressing (ABD – a thick dressing used for covering large wounds) and Kerlix gauze daily and as needed which began on 02/17/16. There was also an order to encourage the resident to wear Prevalon boots (used to prevent pressure ulcers and keep heels elevated), while in bed which began on 02/06/26 and to float heels and bony prominences while in bed which began on 02/10/26. Review of the care plan dated 02/11/26 revealed Resident #50 had impaired skin integrity. Interventions included completing a skin risk assessment on admission, quarterly and as needed, completing weekly skin checks, encouraging Resident #50 to turn and reposition as needed and providing appropriate offloading mattress and cushioning as applicable. There was no evidence of Prevalon boots or off-loading Resident #50's heels in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/26 at 2:13 P.M. with Registered Nurse (RN) #517 confirmed depression was not addressed in Resident #2's care plan and Resident #50's care plan did not comprehensively address his pressure ulcer risks, interventions and care. 3. Review of Resident #11's medical record revealed an admission date of 01/27/26 with diagnoses including nondisplaced fracture of lateral malleolus of left fibula, unspecified injury of right quadriceps muscle, fascia and tendon, autoimmune thyroiditis, chronic obstructive pulmonary disease and hypertension. A review of Resident #11's comprehensive care plan dated 01/27/26 revealed no care plan was developed to address the Resident's need for medical transportation. Review of the MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Resident #11 required supervision with toileting, moderate assistance with bathing, supervision with upper extremity dressing, moderate assistance with lower extremity dressing and supervision with personal hygiene. An interview with Resident #11 on 03/16/26 at 11:10 A.M. revealed her need for medical transportation to a follow-up appointment with her orthopedic doctor on 03/12/26. The interview further revealed Resident #11's frustration that facility staff failed to schedule and arrange transportation to the follow-up appointment with her doctor on 03/12/26 which caused a delay in her plans to discharge home from the facility. She further stated the appointment was rescheduled for 03/18/26, and she required medical transportation to get to that appointment. Review of the physician's orders for Resident #11 revealed an order dated 03/13/26 for a follow-up appointment on 03/18/26 at 10:00 A.M. for orthopedic post-op visit, and resident requests facility find transportation. An interview with MDS Nurse #517 on 03/18/26 at 2:28 P.M. revealed she was responsible for initial care plans and updates as needed. She further confirmed she did not include Resident #11's need for medical transportation in her comprehensive care plan. Review of the facility's undated policy titled Plan of Care Overview revealed the facility would provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents and included the provision of services to enable the resident to live with dignity and supported the resident's goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 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 record review, interview and facility policy review, the facility failed to provide transportation to medical appointments as needed for Resident #11. This affected one resident (#11) of one resident who was investigated for transportation needs. The facility census was 54.Findings include:Review of Resident #11's medical record revealed an admission date of 01/27/26 with diagnoses including nondisplaced fracture of lateral malleolus of left fibula, unspecified injury of right quadriceps muscle, fascia and tendon, autoimmune thyroiditis, chronic obstructive pulmonary disease and hypertension.Review of Resident #11's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Resident #11 required supervision with toileting, moderate assistance with bathing, supervision with upper extremity dressing, moderate assistance with lower extremity dressing and supervision with personal hygiene.Review of physician's orders for Resident #11 revealed an order for a follow-up appointment on 03/12/26 at 2:30 P.M. for an orthopedic post-op visit.An interview with Resident #11 on 03/16/26 at 11:10 A.M. revealed her need for medical transportation to a follow-up appointment with her orthopedic doctor 03/12/26. The interview further revealed Resident #11's frustration that facility staff failed to schedule and arrange transportation to the follow-up appointment with her doctor on 03/12/26 which caused a delay in her plans to discharge home from the facility. She further stated the appointment was rescheduled for 03/18/26, and she required medical transportation to get to that appointment.An interview with Assistant Director of Nursing (ADON) #577 on 03/18/26 at 11:44 A.M. revealed she was responsible for arranging transportation to medical appointments for residents in the facility. She reported that when residents were admitted with orders for follow-up appointments or when they returned from appointments with orders for future appointments, the floor nurse was expected to put paperwork in her mailbox to notify her transportation was needed. She went on to say she was never notified about an appointment for Resident #11 on 03/12/26, and transportation was never arranged. She further stated she knew the resident and her family were upset that appointment had to be rescheduled. Review of the facility's undated policy titled Resident Transportation revealed the facility would provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents and the facility would assist the resident in making transportation arrangements to and from the source of any needed service, such as dental visits, or physician visits in the event the resident requires such assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 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** Based on record review, observation, interview and facility policy review, the facility failed to ensure pressure reducing interventions were in place as ordered by the physician for Resident #50. This affected one resident (#50) of three residents reviewed for pressure ulcers and had the potential to affect five additional residents (#4, #5, #16, #62 and #64) identified by the facility with pressure ulcers. The facility census was 54. Findings include:Review of the medical record for Resident #50 revealed an admission date of 02/06/26. Diagnoses included sepsis, respiratory failure, heart failure, kidney failure and malnutrition.Review of the comprehensive MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. He required set-up help for eating, partial to moderate assistance for oral and personal hygiene, substantial to maximum assistance for showering and was dependent on staff for toileting. He had one Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed; often include undermining and tunneling), two unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) and three unstageable deep tissue injuries (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear).Review of the care plan dated 02/11/26 revealed Resident #50 had impaired skin integrity. Interventions included completing a skin risk assessment on admission, quarterly and as needed, completing weekly skin checks, encouraging Resident #50 to turn and reposition as needed and providing appropriate offloading mattress and cushioning as applicable. There was no evidence of Prevalon boots or offloading Resident #50's heels in the care plan.Review of the physicians orders for March 2026 review on an order for wound care to Resident #50's right plantar foot which included cleansing with saline solution, applying a thin layer of hydrogel (gel used to maintain a moist environment) to the black necrotic tissue below the left lateral right great toe and applying Xeroform (gauze designed to maintain a moist environment and protect wounds) to the entire wound, covering it with abdominal dressing (ABD - a thick dressing used for covering large wounds) and Kerlix gauze daily and as needed which began on 02/17/16. There was also an order to encourage the resident to wear Prevalon boots (used to prevent pressure ulcers and keep heels elevated), while in bed which began on 02/06/26 and to float heels and bony prominences while in bed which began on 02/10/26.Review of the wound assessment report dated 03/10/26 revealed the wound to Resident #50's right plantar foot measured six centimeters (cm) long by 15 cm wide and 0.10 cm deep. It was identified as unstageable, acquired on 02/06/26 and improving with delayed wound closure. It had 20% epithelial tissue appearing as new, light pink tissue migrating from the wound edges, 20% granulation tissue characterized by a moist, red, vascular appearance and 10% slough presenting as moist, yellow, non-viable tissue loosely adherent to the wound surface. The remaining 50% consisted of eschar, noted as firm, dry, black necrotic tissue covering half of the wound bed. No tunneling or undermining was described. Treatment was to cleanse with normal saline, apply a thin layer of hydrogel to the black necrotic tissue below the lateral right great toe, Xeroform, ABD and Kerlix gauze with offloading daily and as needed. Resident #50's left lateral heel measured 0.70 cm long by 0.60 cm wide and 0.10 cm deep. It was identified as unstageable, acquired on 02/06/26 and improving without complications. It has 100% slough with the wound edges attached. Treatment was to cleanse with normal saline, Skin Prep (creates a protective barrier), leave open to air and offload.Observation on 03/17/26 at 6:39 A.M. revealed Resident #50 was lying in bed, awake, his feet were uncovered. No Prevalon boots were observed in place, and his heels were not elevated. Resident #50 revealed he came to the facility with boots to help manage his heel pressure ulcers but did not believe he needed to wear them any longer. He was not sure if his heels were supposed to be elevated at any time. Interview with Business Officer Manager (BOM) #550 at the time of the observation confirmed Resident #50 was not wearing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything on his feet, and his feet were lying on top of a pillow. She confirmed there was no evidence of any kind of boots in Resident #50's room.Review of the undated facility policy titled Skin Care and Wound Management Overview revealed the facility would develop a care plan with individualized interventions to address risk for skin integrity, review the appropriate treatments, communication those interventions to the team, monitor and document the progress of identified interventions and communicate any changes to the caregiving team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure that Resident #7's therapy recommendation for built^up utensils at all meals was properly assessed, that a corresponding physician's order was obtained, and that the intervention was incorporated into the care plan. This affected one resident (#7) of one resident reviewed for assistive devices and had the potential to affect three additional residents (#16, #20, and #48) identified by the facility as utilizing assistive devices. The facility census was 54.Findings include:Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus with diabetic polyneuropathy and atherosclerotic heart disease of native coronary artery without angina pectoris.Review of the therapist's order dated 04/21/25 revealed Resident #7 was to have black built-up utensils for all meals.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact and required set up assistance for eating. The MDS did not identify the need for any adaptive equipment or assistive devices for eating.Review of Resident #7 care plan dated 02/16/26 revealed no indication of adaptive utensils for meals.Review of Resident #7's physician orders revealed no physician orders for adaptive utensils for meals.Interview with Resident #7 on 03/16/26 at 11:17 A.M. revealed he does not always get his adaptive utensils for meals and must ask for them.Interview with Certified Nursing Assistant (CNA) #538 on 03/17/26 at 12:08 P.M. revealed Resident #7 used adaptive utensils for all meals.Observation on 03/17/26 at 12:46 P.M. revealed Resident #7 had adaptive utensils on his lunch tray. CNA #572 confirmed Resident #7 had adaptive utensils on his lunch tray.Interview with Occupational Therapist #567 on 03/17/26 at 2:29 P.M. revealed there was a physician order dated April 2025 related to adaptive equipment for eating; however, no occupational therapy evaluation had been completed to assess the resident's need for, or appropriate use of, adaptive utensils.Review of policy named Assistive Eating Devices undated revealed the facility is to provide a resident assessment be completed by Occupational Therapy or Speech Therapy to determine the need for assistive devices, obtain appropriate equipment, educate staff, and ensure proper use is reflected in the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365991	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Healthcare Center	8055 Addison Road SE Masury, OH 44438

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of facility policies, the facility failed to provide wound care to Resident #16 in a manner to prevent infection. This affected one resident (#16) of two residents observed for wound care. The facility census was 54.Findings include:Review of the medical record for Resident #16 revealed an admission date of 09/03/25 and a readmission date of 01/23/26. Diagnoses included acute respiratory failure with hypoxia, pressure ulcer of the sacral region Stage IV (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed; often includes undermining and tunneling), and type two diabetes mellitus.Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had severe cognitive impairment. Resident #16 required extensive assistance for all activities of daily living.Review of the physician's order dated 03/12/26 revealed an order to clean the coccyx wound with normal saline solution, lightly pack with quarter strength Dakin's (antiseptic) moist gauze, and cover with superabsorbent dressing every shift and as needed. There was another order for Resident #16 to have enhanced barrier precautions (EBP) every shift for preventative measures.Review of the care plan dated 03/16/26 revealed Resident #16 was currently on intravenous (IV) therapy related to a wound infection. Interventions included administering medications as ordered and providing EBP when providing direct care to Resident #16.Observation of wound care on 03/18/26 at 8:00 A.M. with Registered Nurse (RN) #577 revealed she brought the whole treatment cart into Resident #16's room. She began opening packaging of wound care supplies and placing it wrapper side down on the top of the treatment cart and the bedside table. RN #577 was not observed cleaning or placing a barrier on either surface. RN #577 removed the dressing from Resident #16, removed her gloves and used hand sanitizer and began irrigating Resident #16's wound with normal saline. Resident #16's coccyx wound was very deep with coccyx bone exposed. RN #577 then applied Vaseline gauze over Resident #16's exposed coccyx bone and packed the wound with Dakin's-soaked gauze. She then applied barrier cream to the wound edges and dry dressing. RN #577 then repositioned Resident #16 and cleaned the area and removed the cart from the room. Interview on 03/18/26 at 8:25 A.M. with RN #577 confirmed Resident #16 was to be on EBP. She confirmed that Resident #16 had a deep wound and she irrigated it with normal saline and packed the wound with Dakin's-soaked gauze. RN #577 confirmed she was only wearing glasses and not a mask during the wound care because she was told that a mask was not required with wounds unless there was a splash risk. RN #577 confirmed with the size and the type of treatment for Resident #16's wound there was a splash risk. RN #577 confirmed that Resident #16's wound did pose a splash risk due to the size and treatment. RN #577 confirmed she cleaned the top of the treatment cart before she started caring for residents this morning and confirmed she did not clean the top of Resident #16's bedside table and placed an item on it with the bottom of the wrapper on the surface. Review of the undated facility policy standard precautions and transmission-based precautions revealed staff must wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Review of the undated facility policy uncomplicated dressing change revealed staff must prepare a clean, hard surface work area using disinfectant wipes. If used scissors or other reusable equipment must be wiped with a disinfectant wipe.