STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of facility policy, the facility did not ensure timely notification to the physician when Resident #67 displayed a change of condition from his baseline. This affected one resident (Resident #67) of three residents reviewed for change of condition. The facility census was 83. Findings include: Record review for Resident #67 revealed an admission date of 09/10/25 with diagnoses including malignant neoplasm of the colon, malignant neoplasm of the liver and intrahepatic bile duct, neoplasm related pain, and encounter for palliative care. Resident #67 was admitted to hospice for malignant neoplasm of the colon per physician order dated 09/24/25. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #67's plan of care, date revised 10/01/25, revealed Resident #67 had a diagnosis of depression. Interventions included arrange for psychiatry consult and follow up as needed, monitor/document/report as needed any risk for harm to self, suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions, or writing a note) intentionally harmed or tried to harm self, refusing to eat or drink, refusing medication or therapies, sense of hopelessness or helplessness, impaired judgement or safety awareness.Review of the progress notes revealed a behavior note dated 10/26/25 at 3:18 A.M. written by Registered Nurse (RN) #301. The note indicated a certified nursing assistant (CNA) found Resident #67 in his room with the call light cord around his neck so the RN removed the cord and notified the doctor, hospice and the resident's daughter. RN #301 made another entry at 6:43 A.M. indicating that hospice called back and would be in to see Resident #67. At 8:53 A.M. RN #301 charted in a nursing note that the CNA at 1230 alerted the nurse Resident #67 had the call light cord around his neck and at that time the RN observed him to have no signs of pain, no injury and vital signs were obtained. Review of the Resident Transfer Form, dated 10/26/25 at 12:41 P.M. revealed Resident #67 was transferred to the hospital at 10:30 A.M. due to concerns regarding demonstrated self-harm behavior. Review of the facility document Resident Acute Change in Condition , dated 10/26/25 at 3:51 P.M. revealed Resident #67 was found with call light cord wrapped around his neck by night shift staff. The problem started 10/26/25. The Hospice provider visited. Report was given to the physician on 10/26/25 at 10:00 A.M.Review of the hospital records dated 10/26/25 revealed Resident #67 was being evaluated for suicidal ideation. Resident #67 said he was not trying to hurt himself, and he thought he was trying to put an oxygen cord around his nose. He was not attempting to harm himself. Resident #67 was calm and cooperative. Resident #67 was readmitted to the facility on [DATE]. An observation on 10/28/25 at 2:24 P.M. of Resident #67 lying in bed with family at the bedside and the Hospice RN in the room revealed Resident #67 was alert, and in no distress at the time of the observation. Resident #67 presented as weak and frail.An interview on 10/28/25 at 2:30 P.M. with Hospice RN #413 revealed Hospice had a one-on-one presence with Resident #67 since he returned from the hospital, as he was having an overall decline which they felt was he was in the process of transitioning. An interview on 10/28/25 at 7:00 A.M. with Resident #67's Power of Attorney (POA) confirmed the nurse did notify them via FaceTime video call on 10/26/25 at 12:23 A.M. to show her Resident #67 had the call light cord around his neck. The POA stated the nurse was concerned Resident #67 might be trying to hurt himself. The POA stated Resident #67 was not strong enough to strangulate himself and the POA watched as Resident #67 allowed the nurse to remove the cord. Interviews on 10/28/25 from 4:45 P.M. to 4:50 P.M. with Unit Manager RN #333 and LPN #350 revealed any resident with suspected suicidal ideation or self-harm would not be left alone and a phone call to the physician would be placed immediately. LPN #350 stated all dangerous items would be removed. An interview on 10/28/25 at 8:45 A.M. with RN #301 revealed she worked the night shift and Resident #67 wrapped the call light cord around his neck. RN #301 stated at 12:30 A.M. CNA #387 alerted her Resident #67 had a call light cord around his neck. RN #301 FaceTime video called Resident #67's POA. All cords were removed from the room, and the CNAs took turns providing one-on-one observation the whole night until Hospice nurses came in the next morning because RN #301 was concerned Resident #67 may try to hurt himself. RN #301 stated she texted the physician after the incident happened, did not received a response, and did not call the physician until 9:04 A.M. RN #301 confirmed this was over eight hours after Resident #67 had been found with the call light cord around his neck. RN #301 stated the note on 10/26/25 at 3:18 A.M was a late note summarizing the events that occurred around 12:30 A.M. An interview on 10/29/25 at 9:35 A.M. with CNA #387 revealed CNA #379 first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure timely incontinence care was provided for four residents (Resident #34, #40, #43 and #84) of four residents reviewed for incontinence care. The facility census was 83.Findings include: 1. Record review for Resident #43 revealed an admission date of 09/21/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction and dementia. Review of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 was rarely or never understood. Resident #43 was always incontinent of bowel and bladder, had impairment to one side of the upper and lower extremities, used a wheelchair for mobility, was dependent for toileting hygiene, chair/bed to chair transfers, and wheelchair mobility. Review of the care plan initiated 07/16/22 and revised 08/25/25 for Resident #43 revealed Resident #43 was incontinent of bowel and bladder. Interventions included to check for incontinence every two hours and as needed. Observation on 10/27/25 at 9:30 A.M. revealed Resident #43 was sitting in a chair in the lounge area across from the nurse's station. Resident #43 looked at the surveyor when spoken to but did not verbally respond. Further observations on 10/27/25 at 9:58 A.M., 11:30 P.M., and 1:20 P.M. revealed Resident #43 was still in the same area, in the same position sitting in her chair in the lounge across from the nurses' station. Observation on 10/27/25 at 2:45 P.M. revealed Certified Nursing Assistant (CNA) #359 removed Resident #43 from the lounge and placed her in her room. CNA #354 gathered towels and washcloths and joined Resident #43 and CNA #359 in the resident room. CNA #354 confirmed she was Resident #43's primary CNA. CNA #354 revealed that her 12-hour shift began at 7:00 A.M. and revealed the night shift (third shift) got Resident #43 up at around 5:00 A.M. every day and placed her in her chair in the lounge across from the nurses' station. CNA #354 confirmed Resident #43 was not moved from the lounge across from the nurses' station since she was placed there around 5:00 A.M. and stated, This is the first time today she will be checked and changed, there is just not enough staff. Observation revealed CNA #359 and #354 assisted Resident #43 to bed. Resident #43's clothes were soiled with food and dried spills of liquid. CNA #354 confirmed Resident #43 had an odor of urine, and the brief was heavily saturated in urine. CNA #354 again confirmed Resident #43 had not had incontinence care provided for a duration of 5:00 A.M. to 2:45 P.M. 2. Record review for Resident #34 revealed an admission date of 10/12/23. Diagnoses included visual loss of both eyes, acquired absence of the left leg below the knee and acquired absence of the right leg above the knee. Review of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was always incontinent of bowel and bladder, required substantial/maximal assistance with bed mobility, was dependent for chair/bed to chair transfers, and for toileting hygiene. Review of the care plan for Resident #34 revealed Resident #34 had an activity of daily living (ADL) self-care performance deficit related to impaired balance and need for assistance for personal care. Interventions included the resident required assistance by staff for toileting. Interview on 10/28/25 at 10:10 A.M. with Resident #34 revealed sometimes she just got soaked with urine. When she called for assistance with incontinence care, staff would say they would be right back but then they don't come back for long periods of time if at all. Resident #34 revealed she was last changed at 6:20 A.M., and she stated she recalled the time because she looked at the clock, and it was before the 7:00 A.M. shift started. Resident #34 revealed that she had not been checked or changed since then and she needed changed. Interview on 10/28/25 at 11:00 A.M. with CNA #354 revealed she was running behind and confirmed she had just finished checking and changing Resident #34 for the first time on her shift. CNA #354 confirmed her shift started at 7:00 A.M. and revealed there was just not enough help. CNA #354 revealed Resident #34's brief was saturated and the pad under her was also wet with urine. Observation revealed CNA #354 applied new linen on Resident #34's bed and revealed she worked 12-hour shifts and at times residents were only checked and changed two times a shift. 3. Record review for Resident #40 revealed an admission date of 04/12/24. Diagnoses included unspecified hemiplegia affecting left non-dominant side and spinal stenosis of the cervical region. Review of the Modification of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 was always incontinent of bowel and bladder, required substantial/maximal assistants for bed mobility, was dependent for toileting hygiene and chair/bed to chair transfer. Review of the care plan initiated 04/14/24 and revised 08/18/25 revealed Resident #40 had a self-care deficit related to legally blind, limited mobility, and impaired cognition. Interventions included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of the facility assessment, the facility did not ensure staffing levels were sufficient to provide nursing and related services to maintain the highest practicable well-being of the residents. This affected four current Residents (#26, #34, #40, and #43) and one former resident (#84) of five residents reviewed for sufficient staffing and had potential to affect an additional 79 residents residing in the facility. The facility census was 83.Findings include: 1. Review of the medical record for Resident #26 revealed an admission date of 11/28/18 with medical diagnoses including cerebral infarction, hemiplegia affecting left side, aphasia (difficulty speaking), type two diabetes mellitus, vascular dementia and adjustment disorder.Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #26's cognition was moderately intact. Resident #26 was dependent on staff for toilet hygiene and did not attempt to transfer to the toilet. Resident #26 was always incontinent with bowel and bladder.Review of Resident #26's care plan, date initiated 10/19/19, revealed Resident #26 was incontinent of bowel and bladder with incontinence related to limited mobility. Interventions included check and change every two hours and as required for incontinence. Wash, rinse and dry perineum, and change clothing as needed after incontinent episodes.An observation on 10/29/25 at 2:44 P.M. revealed the call light was lit up/activated on the outside of Resident #26's door and could be seen lit up outside the door in the hallway. No staff were observed in the room with Resident #26 while the call light was activated until at 3:00 P.M. a female caretaker was observed to enter Resident #26's room, turned off the call light and stated to Resident #26 someone would be in soon. Observation at 3:00 P.M. of Resident #26 in her room revealed a smell of urine was in the room and Resident #26 stated she had been waiting a while to have her diaper changed. She stated she was sitting in a wet diaper and wanted to be changed. Observation at 3:12 P.M. revealed Certified Nursing Assistant (CNA) #340 entered Resident #26's room with linens to assist Resident #26 and verified this was the first chance they had to change Resident #26 since the call light was activated at 2:44 P.M.An interview on 10/29/25 at 3:12 P.M. with CNA #340 revealed the staffing levels made it difficult to get all the resident care done timely because so many residents needed to be fed and changed and were dependent on staff for care.2. Record review for Resident #34 revealed an admission date of 10/12/23. Diagnoses included visual loss of both eyes, acquired absence of the left leg below the knee and acquired absence of the right leg above the knee. Review of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was always incontinent of bowel and bladder, required substantial/maximal assistance with bed mobility, was dependent for chair/bed to chair transfers, and for toileting hygiene. Review of the care plan for Resident #34 revealed Resident #34 had an activity of daily living (ADL) self-care performance deficit related to impaired balance and need for assistance for personal care. Interventions included the resident required assistance by staff for toileting. An interview on 10/28/25 at 10:10 A.M. with Resident #34 revealed sometimes she just got oaked with urine. When she called for assistance with incontinence care, staff would say they would be right back but then they don't come back for long periods of time if at all. Resident #34 revealed she was last changed at 6:20 A.M., and she stated she recalled the time because she looked at the clock, and it was before the 7:00 A.M. shift started. Resident #34 revealed that she had not been checked or changed since then and she needed changed. An interview on 10/28/25 at 11:00 A.M. with CNA #354 revealed she was running behind and confirmed she had just finished checking and changing Resident #34 for the first time on her shift. CNA #354 confirmed her shift started at 7:00 A.M. and revealed there was just not enough help. CNA #354 revealed Resident #34's brief was saturated and the pad under her was also wet with urine. Observation revealed CNA #354 applied new linen on Resident #34's bed and revealed she worked 12-hour shifts and at times residents were only checked and changed two times a shift. 3. Record review for Resident #40 revealed an admission date of 04/12/24. Diagnoses included unspecified hemiplegia affecting left non-dominant side and spinal stenosis of the cervical region. Review of the Modification of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 was always incontinent of bowel and bladder, required substantial/maximal assistants for bed mobility, was dependent for toileting hygiene and chair/bed to chair transfer. Review of the care plan initiated 04/14/24 and revised 08/18/25 revealed Resident #40 had a self-care deficit related to legally blind, limited mobility, and impaired cognition. Interventions included Resident #40 was dependent for toilet use. An interview on 10/27/25 at 10:16 A.M. with CNA #309

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 - Some	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to maintain infection control practices while providing care to Resident #40 who required Enhanced Barrier Precautions (EBP). This affected one resident (Resident #40) of one resident observed for EBP and had the potential to affect an additional 41 residents (Resident #1, #2, #3, #6, #7, #8, #11, #15, #18, #19, #20, #21, #22, #23, #24, #26, #27, #28, #29, #31, #34, #35, #36, #39, #41, #43, #44, #46, #51, #55, #56, #59, #60, #61, #66, #75, #76, #77, #78, #81, and #83) who resided on the upper floor. The facility identified 19 residents (Resident #10, #11, #14, #17, #18, #20, #38, #39, #40, #45, #50, #53, #54, #56, #60, #66, #73, #74, and #75) as requiring EBP. The facility census was 83. Findings include:Record review for Resident #40 revealed an admission date of 04/12/24. Diagnoses included unspecified hemiplegia affecting left non-dominant side and spinal stenosis of the cervical region. Review of the Modification of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired. Resident #40 had one unstageable pressure injury presenting as a deep tissue injury. Resident #40 was always incontinent of bowel and bladder, required substantial/maximal assistance for bed mobility, was dependent for toileting hygiene and chair/bed to chair transfer. Review of the care plan initiated 04/19/24 and revised 08/18/25 revealed Resident #40 required Enhanced Barrier Precautions (EBP) to reduce transmission of multidrug-resistant organisms (MRDO's) related to wounds. Interventions included to use disposable gowns and gloves during high contact care activities, remove gowns and gloves promptly after care activities and dispose of in proper receptacle. Review of the physician order for Resident #40 revealed Resident #40 had an order dated 10/21/25 to cleanse the right shin with normal saline, pat dry and apply collagen, cover with non-border super absorbent dressing and wrap with kerlix securing with paper tape every night shift. EBP: Gloves and gown to be worn when providing: Dressing, bathing, transferring, providing hygiene care, changing linen, changing brief or assisting with toileting, devise care and wound care dated 08/04/25. Observation on 10/27/25 at 10:16 A.M. with Certified Nursing Assistant (CNA) #309 revealed Resident #40 was lying in bed. Resident #40 had a gauze wrap/dressing to the right leg. The bottom sheet near the dressing had multiple areas of dried blood. The dressing was dated 10/26/25 but had no blood on it. Observation revealed Resident #40 had a sign at the entrance of the doorway for EBP. Observation revealed the sign had fallen to the floor. Observation revealed no Personal Protective Equipment (PPE) including gloves or gowns were available inside Resident #40's room or near the entrance to the room. Observation on 10/27/25 at 10:30 A.M. revealed CNA #309 went to several resident rooms to find gloves to provide care for Resident #40. Observation with CNA #309 and #359 providing incontinence care for Resident #40 revealed during the entire incontinence care provided (incontinent of stool and urine) to Resident #40 and the changing of Resident #40's linen, neither CNA #309 nor #359 wore an isolation gown. CNA #309 and #359 confirmed they never wore an isolation gown and confirmed none were available in Resident #40's room or outside the doorway near the entrance of the room. CNA #359 revealed he did not even know Resident #40 was on EBP. Both CNA's confirmed they assisted/have worked in all areas of the facility and gowns were often not readily available. CNA #309 and #359 confirmed they could potentially provide care to any of the 41 residents residing on the upper floor during their shift. Review of the facility policy titled, Enhanced Barrier Precautions dated August 2022 revealed EBP are utilized to prevent the spread of multi-drug-resistant organisms (MRDO's) to residents. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care use and wound care. This deficiency represents noncompliance investigated under complaint number 2648929 and represents continued non-compliance from the survey dated 08/13/25.