STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility investigation review and policy review, the facility failed to ensure a resident was not left in the shower alone, resulting in a fall with fracture. This affected one (Resident #2) of four residents reviewed for falls. The facility census was 49. Actual harm occurred on 04/04/26 when Resident #2, who required supervision and touching assistance with showering and bathing, was assisted into the bathroom to shower. Certified Resident Care Assistant (CRCA) exited the shower room leaving Resident #2 to shower herself. Resident #2 suffered a fall which resulted in a comminuted, intra-articular distal radius fracture on the right arm. Findings Include:Record review revealed Resident #2 was admitted on [DATE] with diagnoses includingType II Diabetes Mellitus with hyperglycemia, overactive bladder, pain, cognitivecommunication deficit, muscle weakness (generalized), difficulty in walking and Colles'fracture of right radius. Review of Resident #2's care plan, dated 10/14/24, revealed Resident #2 had impairment infunctional status related to impaired mobility, unsteady gait, impaired posture, generalizedweakness and dyspnea upon exertion. An intervention (dated 10/14/24) included in thecare plan was to provide assistance as needed with self-care and mobility functional tasks.Resident #2 was at risk for falling related to impaired mobility, generalized weakness,impaired posture, incontinence, dyspnea upon exertion, hypertension, Diabetes Mellitusand polypharmacy. An intervention (dated 10/14/24) included in the care plan indicatedstaff to assist Resident with transfers as needed and a new intervention dated 04/06/26 forstaff to assist resident with showers. Review of the profile care guide dated 10/01/24 documented Resident #2 needed theassistance of one person for transfers and the use of a platform walker.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealedResident #2 was alert and oriented and required supervision and touching assistance withtub/shower transfers, showering and bathing. Review of the facility investigation report, dated 04/04/26 at 9:15 P.M., revealed Resident #2was found on the floor in her bathroom. Resident #2 stated she was turning to put clothesdown in a dry place and fell. The root cause analysis documented that the resident did nothave staff assisting with getting ready or performing the shower as the aide did not staywith resident to assist with shower and the aide was outside the building when the falloccurred.Review of the witness statement dated 04/04/26 authored by CRCA #168 revealed she wascalled back to the unit, and resident was laying on the bathroom floor. Review of the witness statement dated 04/04/26 authored by Licensed Practical Nurse(LPN) #123 revealed the Resident #2's spouse stated, she left my wife in the bathroom andleft and did not come in to help. Review of the X-ray of right wrist dated 04/05/26 revealed a comminuted, intra-articulardistal radius fracture.During an interview on 05/27/26 at 3:00 P.M., Resident #2 stated prior to the fall she bathedherself, although it might not have been safe. She stated she was reaching for somethingand lost her balance.During an interview on 05/28/226 at 10:55 A.M., Therapy Director #190 stated Resident #2was independent and her assist level varied. Therapy kept her on a maintenance programto keep her moving. Resident #2 had a slow decline. She does not pay attention, whichaffects her safety awareness. Therapy Director #190 confirmed Resident #2 should havebeen supervised while bathing.Review of the facility policy titled Fall Management (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
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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 0689 Level of Harm - Actual harm Residents Affected - Few	Program Guidelines dated 11/19/25,instructed to maintain a hazard free environment, mitigate fall risk factors and implementpreventative measures. Should the resident experience a fall the attending nurse shallcomplete an occurrence note. This includes an investigation of the circumstancessurrounding the fall to determine the cause of the episode, a reassessment to identifypossible contributing factors, interventions to reduce risk of repeat episode and a review bythe Interdisciplinary team (IDT) to evaluate thoroughness of the investigation andappropriateness of the interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview and review of facility policy, the facility failed to ensure medications were dated when opened and expired medications were disposed of timely. This affected three residents (Resident #48, #51 and #71) of three residents reviewed for medication storage. Facility census was 49.Findings include:1. Review of the medical record for Resident # 48 revealed an admission date of 05/08/26 with diagnoses including encounter for surgical aftercare following surgery on the digestive system status post (s/p) colostomy, sepsis, chronic obstructive pulmonary disease (COPD) and asthma.Review of the physician's orders for Resident # 48 revealed an order dated 05/08/26 for Ipratropium Bromide/Albuterol Sulfate 0.5mg/3mg per milliliter (ml) twice a day for COPD. Review of the Medication Administration Record (MAR) for Resident # 48 dated May 2026 revealed the resident received Ipratropium Bromide/Albuterol Sulfate twice daily from 05/08/26 to 05/27/26.Observation and interview on 05/27/26 at 4:56 P.M. with RN # 140 of the medication cart on 100 hall revealed one box of Ipratropium Bromide/Albuterol Sulfate 0.5mg/3mg per milliliter (ml) for Resident #48, there was a yellow sticker attached to the foil packaging to enter an open date and discard after 14 days. There was no open date on the package. RN #140 verified no open date on the medication.2. Review of the medical record for Resident # 51 revealed an admission date of 10/23/23 with diagnoses including Type II Diabetes Mellitus with diabetic chronic kidney disease, hypertension and hypertensive chronic kidney disease with stage I through stage IV chronic kidney disease.Review of the physician's orders for Resident # 51 revealed an order dated 05/12/26 and discontinued on 05/17/26 for insulin Lispro 100 unit/mL per sliding scale once daily.Observation and interview on 05/27/26 at 4:40 P.M. with Registered Nurse (RN) #128 during review of the medication cart for long 200 hall revealed, one vial of insulin Lispro with an open date of 04/11/26 and a yellow sticker that read expires after 28 days of opening. During concurrent interview with RN #128 it was verified the insulin Lispro was expired.3. Review of the medical record for Resident # 71 revealed an admission date of 05/15/26 with diagnoses including COPD and Diabetes Mellitus. Review of the physician's orders for Resident # 71 revealed an order dated 05/15/26 for Levalbuterol aerosol solution 1.25 milligrams (mg) every four hours as needed and an order dated 05/19/26 through 05/21/26 for Levalbuterol aerosol solution 1.25 milligrams (mg) three times a day for wheezing. Observation and interview on 05/27/26 at 4:40 P.M. with Registered Nurse (RN) #128 during review of the medication cart for long 200 hall, revealed one box of Levalbuterol aerosol solution 1.25 milligrams (mg) with no open date, there was a yellow sticker attached to the foil packaging to enter an open date and discard date after seven days , however the yellow sticker was blank. During concurrent interview with RN #128 it was verified the the medication was not labeled with the open date. Review of facility policy titled, Medication Storage, reviewed 11/01/22, revealed outdated or otherwise unusable medications must be immediately pulled from the active inventory and segregated to an area to prevent unintentional use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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 medical record review, staff interview, physician interview, and facility policy review, the facility failed to complete laboratory orders to ensure residents were able to attend medical appointments. This affected one (Resident #1) of four residents reviewed for condition change. Also, the facility failed to provide timely comfort care during a change in condition. This affected one (Resident #52) of four residents reviewed for a change of condition. The census was 49. Findings Include: 1.Resident #1 was admitted to the facility on [DATE]. Her diagnoses were osteomyelitis, sepsis, cellulitis of right/left lower limb, fibromyalgia, acute kidney failure, bacteremia, rheumatoid arthritis, nonrheumatic aortic valve stenosis, hypothyroidism, hyperlipidemia, atrial fibrillation, and hypertension. Review of her minimum data set (MDS) assessment, dated [DATE], revealed she was cognitively intact.Review of Resident #1's After Visit Summary (AVS), dated [DATE], revealed she had a nephrology consultation appointment scheduled for [DATE]. The AVS stated to please have testing done one week before your appointment. This allows the the results to be available for the provider to review with you at your appointment. Review of Resident #1's physician orders, dated [DATE] to [DATE], revealed no laboratory orders entered or completed related to the nephrology consultation appointment on [DATE]. Review of Resident #1's laboratory test results, dated [DATE] to [DATE], revealed no laboratory results completed that were related to her nephrology consults on [DATE]. Review of Resident #1's personal electronic medical records (EMR) access information, dated [DATE], revealed her nephrology appointment on that day had been cancelled. Notes in the record documented the appointment was cancelled by the resident. Review of Resident #1's progress notes, dated [DATE] to [DATE], revealed no progress notes related to laboratory testing ordered, completed, or information about the nephrology appointment being completed or reason it needed to be cancelled. Review of Resident #1's physician orders, dated [DATE], revealed new laboratory testing was to be completed on [DATE], which was one week prior to her rescheduled nephrology consultation appointment on [DATE]. Interview with Resident #1's representative on [DATE] at 1:28 P.M. confirmed that Resident #1's nephrology appointment was cancelled prior to her attending the appointment. She confirmed that she was upset because Resident #1 really needed this appointment. Interview with Resident #1 on [DATE] at 1:55 P.M. and 2:50 P.M. confirmed she did not attend her needed nephrology appointment on [DATE]. She stated she did not cancel the appointment; she was told by staff the morning of her appointment that it needed to be cancelled because they did not get the needed testing done prior to the appointment. Interview with Director of Nursing (DON) on [DATE] at 2:40 P.M., 3:04 P.M., and [DATE] at 8:40 A.M. and 10:46 A.M. confirmed Resident #1's nephrology appointment was not completed on [DATE] as scheduled. Initially, she stated Resident #1 cancelled the appointment and she did not know the reason why. the DON later confirmed there was an order for testing to be completed prior to her [DATE] and there was no evidence it was ever ordered or completed. The DON also confirmed there was no evidence the provider was contacted to clarify what orders needed to be completed prior to her [DATE] appointment. Interview with Nephrology Office Staff #300 on [DATE] at 11:16 A.M. confirmed Resident #1's nephrology consultation appointment that was scheduled for [DATE], was cancelled on [DATE] at 9:00 A.M. She confirmed their documentation has the reason for the cancellation as patient cancelled, but she also confirmed they will document that as the reason for cancelling, if the facility calls and cancels on behalf of the resident. She confirmed she has no other documentation or information to support the reason for the cancellation, other than it was cancelled the morning the appointment was supposed to occur. 2. Resident #52 was admitted to the facility on [DATE]. Her diagnoses were encephalopathy, chronic respiratory failure with hypoxia, urinary tract infection, atherosclerotic heart disease, non-rheumatic aortic valve insufficiency, pulmonary hypertension, interstitial pulmonary disease, edema, altered mental status, personal history of urinary tract infections, osteoarthritis, spinal stenosis, pyuria, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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	hypo-osmolality and hyponatremia, nausea with vomiting, insomnia, depression, acute on chronic diastolic congestive heart failure, acute kidney failure, chronic pain syndrome, pleural effusion, obstructive sleep apnea, Type II Diabetes, fibromyalgia, hyperlipidemia, venous insufficiency, irritable bowel syndrome, and chronic obstructive pulmonary disease. Review of her MDS assessment, dated [DATE], revealed she had a severe cognitive impairment.Review of Resident #52's physician orders, dated [DATE] to [DATE], revealed she was prescribed Gabapentin (used for nerve pain) 200 milligrams (mg) twice daily for pain and Acetaminophen (analgesic) 650 mg every eight hours for pain. Review of Resident #52's progress notes, dated [DATE], revealed a new order from the provider to discontinue Gabapentin 200 mg twice daily scheduled and replace it with Percocet (Oxycodone-Acetaminophen) (opioid) 5-325 mg four times a day as needed. Review of Resident #52's progress notes, dated [DATE] to [DATE], revealed the following documentation about changes in condition and no notification to the provider about these changes: [DATE] at 12:31 A.M., Resident #52 was having difficulty sleeping, stated she doesn't want to be alone, telling staff Don't go, and staff providing one on one supervision; [DATE] at 1:03 A.M., Resident #52 was climbing out of bed and yelling when staff is out of the room; [DATE] at 4:21 A.M., Resident #52 was inconsolable at this time, resident noted to be crying and would scream out when staff left the room, was crying and noted to be tired and hurting; [DATE] at 5:42 P.M.; resident had a pain level of four to five with dull pain noted, non-verbal displays of pain were noted as well with resident complaining of pain; [DATE] at 10:20 P.M., noted Resident #52 had been restless, anxious, calling out for people who are not there and who are deceased ; and [DATE] at 2:43 A.M., Oxycodone-Acetaminophen 5-325 mg was administered for pain level seven out of ten, but Resident #52 spit some out, pain all over, resident was whining, crying, calling out, seeing and talking to people not in the room. Review of Resident #52's progress notes, dated [DATE], revealed at 8:36 A.M., the provider was finally notified of the changes and laboratory tests were ordered. At 12:27 P.M., the laboratory tests returned and based on the results (nothing of note was found to cause the changes in condition), the provider ordered that Percocet was to be discontinued and for the facility to discuss changing Resident #52's code status and hospice options with the family. Review of Resident #52's progress notes, dated [DATE], revealed the following: at 1:05 P.M., Resident #52 continued to cry and yell out for people, and at 5:46 P.M., Resident #52 continues with restlessness and tremors. Review of Resident #52's Medication Administration Records (MAR), dated [DATE] to [DATE], revealed she accepted and swallowed all other scheduled medication until [DATE]; her Percocet on [DATE] at 2:43 A.M. was the only medication documented as not being swallowed when offered/administered. Review of Resident #52's progress notes, dated [DATE], revealed the family decided not to move forward with hospice care at the facility due to financial reasons, so the facility sent Resident #52 to the emergency room for the following documented reasons: resident was unable to swallow, family's refusal for hospice services, and resident's continued decline. Review of Resident #52's Emergency Department provider notes, dated [DATE], revealed the family reported that she was in terrible pain, they can not get her to eat or drink anything, and wants her under hospice care. The report from the facility was, they are having difficulties doing anything due to the family not wanting to pay for anything. Resident #52 was given 50 micrograms (mcg) of Fentanyl (opioid) prior to arrival to the emergency room by EMS. While in the emergency room, she was administered Hydromorphone (opioid) injection 0.5 mg and Midazolam HCl (benzodiazepine) injection 0.5 mg. Her differential diagnosis in the emergency room was: evaluation for hospice, intractable pain, decline in mental status, and failure to thrive. Interview with Physician #301 on [DATE] at 3:20 P.M. confirmed she felt like she was kept up to date on the changes that Resident #52 was having during her stay in the facility. She confirmed she discontinued the order for as needed Percocet because they were not certain her changes in condition were caused by pain, and she was spitting the medication out; indicating she was having trouble swallowing. She confirmed there were no other tests or assessments completed (that she was aware of) to support that Resident #1 was not able to swallow. When asked why other pain medication or psychotropic (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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	medications were offered for the changes in condition to keep her comfortable, she stated, If she (Resident #52) was spitting out her Percocet, she would not swallow another type of medication. Physician #301 confirmed she was not told whether Resident #52 was swallowing her other scheduled medications during that time; she made the decision to stop the Percocet due to her swallowing difficulties. When asked if she could have ordered injectable medications (pain or psychotropics), she stated she would not take the responsibility of ordering those; she would rather send a resident to the emergency room for those to be administered. She is not comfortable ordering medications that are not swallowed for liability reasons. Interview with Regional Director #191 on [DATE] at 3:25 P.M. revealed from the time Percocet was discontinued ([DATE]) to the time the family made a decision to decline hospice services, the facility allowed the family to spend time with the resident at bedside. He confirmed there were no other medications ordered, such as psychotropics or injectable pain medications. He confirmed the facility was waiting for the family to make a decision on hospice services ([DATE] at 12:27 P.M. to [DATE] at 10:09 A.M.), so they did not put any other orders or interventions in place other than one on one staffing and allowing the family to sit with the resident at bedside. Review of facility Notification of Change in Condition policy, dated [DATE], revealed the following were sample reasons to notify the physician immediately for a change in condition: a deterioration in health, mental, or psychosocial status un either life-threatening conditions or clinical complications, need to alter treatment significantly, or clinical complications such as development of a pressure area, onset of delirium or recurrent urinary tract infections. Documentation of notification or notification attempts should be recorded in the electronic health record. Review of facility Guidelines for Pain Observation and Management policy, dated [DATE], revealed the purpose of the policy is to ensure each resident's pain, including it's origin, location, severity, alleviating and exacerbating factors, current treatment, and response to treatment will be observed and documented according to the needs of each individual. If there is a change in pain indicators or verbalizations from resident, a pain event form will be completed to indicate changes and care plan update.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple Avenue Zanesville, OH 43701

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, medical record review, staff interview and review of facility policy, the facility failed to ensure staff donned personal protective equipment (PPE) prior to entering Resident # 66 room, who was on contact precautions. This had the potential to affect all residents on the long 200-hall. (Resident #2, #6, #7, #11, #15, #22, #23, #24, #46, #51 and #58). The facility census was 49.Findings include: Review of Resident #66 medical record revealed an admission date of 05/21/26 with diagnoses including sepsis due to Clostridioides difficile (C-diff). Review of Resident #66's physician orders revealed an order dated 05/21/26 for contact precautions. Review of the care plan dated 05/26/26 revealed resident had a need for contact isolation related to active infectious disease related to C-diff. Interventions included use principles of infection control and universal/standard precautions. Observation on 05/26/26 at 11:24 A.M. revealed Environmental Services Worker #154 entering contact isolation room for Resident #66 without donning proper PPE prior to entrance. A sign was posted outside of the room door to Resident #66's room indicated he was on contact precautions and a cart containing personal protective supplies was noted outside the resident's room door. Interview on 05/26/26 at 11:24 A.M. with the Environmental Services Worker #154 verified she did not follow the guidance for contact isolation and should have put PPE on prior to entering Resident #66's room due to contact precautions. Review of Center of Disease Control and Prevention (CDC) guidance for contact precautions, signage posted outside of Resident #66's room read Providers and Staff must also put on gloves before room entry. Put on gown before room entry. Review of facility policy titled Guidelines for Contact Precaution, reviewed 12/10/25 revealed wear a clean non-sterile, fluid resistant gown when entering the room if it is anticipated clothing will have substantial contact with the resident or environmental surface or when there is likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or item's in the resident's rooms. Post a sign at the resident's door that is appropriate according to Center for Disease Control and Prevention (CDC) guidance.