STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove San Antonio, TX 78222

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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
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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 0583 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, interview and record review the facility failed to ensure personal privacy for 1 of 8 residents (Resident #5) observed for foley catheters in that: Resident #5 was observed in bed with her foley bag attached to the side of the bed without a privacy cover, exposing her foley bag contents to the open bedroom door. This deficient practice could affect residents who have foley catheter bags and could result in loss of dignity and low self-esteem. The findings were: Record review of Resident #5's undated face sheet revealed Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type 2 (high blood sugar levels), cerebral infarction (stroke) and hydronephrosis with renal and ureteral calculous obstruction (swelling of one or both kidneys causing a blockage or obstruction). Record review of Resident #5's MDS assessment, dated 08/12/2025, reflected Resident #5 had a BIMS score of 04, indicating severe cognitive impairment. Section GG- Functional Abilities revealed Resident #5 was dependent on staff for bed mobility, transfers, hygiene, toileting hygiene and bathing. Section H - Bladder and Bowel revealed Resident #5 had an indwelling catheter and was incontinent of bowel and bladder. Record review of Resident #5's comprehensive care plan revealed a care plan, dated 09/11/2025, that read, [Resident] has indwelling foley catheter. Record review of Resident #5's October 2025 administration orders revealed an order, Ensure foley bag is in privacy bag while in bed or wheelchair every shift for foley care. During an observation, 10/01/2025 at 1:17 p.m., Resident #5 was observed lying in bed with a foley catheter bag attached to the side of the bed, facing the open door. The foley catheter bag did not have a privacy cover and the content of the bag was exposed. During an interview with Resident #5, 10/01/2025 at 1:18 p.m., Resident #5 stated staff would often place the foley catheter bag on the opposite side of the bed for privacy and Resident #5 stated she was not bothered if people can see her bag. During an interview with LVN D, 10/02/2025 at 10:07 a.m., LVN D stated she was assigned to Resident #5 on 10/01/2025 and LVN D stated she observed Resident #5 without a foley privacy bag before lunch time. LVN D stated she looked for a privacy bag and could not locate one, so she notified the interim DON. LVN D stated the nurses were responsible for ensuring privacy bags were covering foley catheter bags and stated she had received training on privacy covers. LVN D stated it was important for privacy covers to be in place for the residents' privacy. During an interview with the Administrator, 10/03/2025 at 1:36 p.m., the Administrator stated all foley catheter bags should have a privacy cover and some of the foley catheter bags have a shaded side so the bag can be turned to expose the shaded side for privacy. The Administrator stated nursing staff and anyone that identified a resident without a foley bag privacy cover would notify the charge nurse or nursing management and said facility staff had received training on privacy covers. The Administrator stated that privacy covers were important to provide dignity and respect for the rights of each resident. The Administrator stated the facility did not have a policy on privacy covers for foley bags and stated the facility follows the resident rights policy. Record review of a facility document titled, Resident Rights, the document revealed, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect the residents' right to be free from neglect for 1 of 8 residents (Resident #1) reviewed for neglect in that: 1. Resident #1 was not provided wound care daily to the left ankle or skin assessments by facility nursing staff from 08/28/2025 - 09/24/2025. Resident #1 was admitted to the hospital on [DATE] for osteomyelitis and had to have a left BKA. 2. Resident #1 went for approximately one month without adequate treatment for wounds which led to infection and right BKA. 3. The facility failed to ensure Resident #1 was provided with wound care to a surgical wound on the resident's right leg. 4. The ADON failed to ensure wound care treatment orders were added to Resident #1's EMR. An Immediate Jeopardy (IJ) was identified on 10/04/2025. The IJ template was provided to the facility on [DATE] at 12:35 p.m. While the IJ was removed on 10/06/2025 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not IJ, due to the need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for neglect, worsening of existing wounds or the development of new pressure ulcers. The findings were: Record review of Resident #1's, undated, face sheet revealed Resident #1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of unspecified part of unspecified bronchus of lung (cancer of the lung or respiratory airway), quadriplegia (paralysis of a person's limbs), kidney disease (damage to kidney function), viral hepatitis c (a liver disease), cirrhosis of liver (scarring and damage to the liver) and encephalopathy (condition that caused brain dysfunction). Record review of Resident #1's quarterly MDS assessment, dated 08/19/2025, revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment. Section GG - Functional Abilities revealed Resident #1 had impairment on one side of his upper and lower extremity, used a wheelchair for mobility, required moderate assistance with bed mobility and was dependent on staff for transfers and personal hygiene. Section M - Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers, had one or more unhealed pressure ulcers, had 1 Stage III pressure ulcer and 2 unstageable pressure ulcers. Record review of Resident #1's undated comprehensive care plan revealed a care plan, the resident has a pressure ulcer or potential for pressure ulcer development: 1. Unstageable left lateral, (outer) ankle, dated 08/05/2025 and revised 08/11/2025. The goal of the care plan was for Resident #1's pressure ulcer to show signs of healing and remain free from infection with a target date of 11/07/2025. Interventions revealed staff would administer treatments as ordered, monitor the effectiveness and replace loose or missing dressings PRN. The interventions also included for staff to assess/record/monitor wound healing at least weekly and measure length, width, and depth, document the status of the wound perimeter and wound bed and healing process. Staff were to report declines to the MD. 2. Unstageable right heel, dated 08/05/2025 and revised 08/11/2025. The goal of the care plan was for Resident #1's pressure ulcer to show signs of healing and remain free from infection with a target date of 11/07/2025. Interventions revealed staff would administer treatments as ordered, monitor the effectiveness and replace loose or missing dressings PRN. The interventions also included for staff to assess/record/monitor wound healing at least weekly and measure length, width, and depth, document the status of the wound perimeter and wound bed and healing process. Staff were to report declines to the MD. Record review of Resident #1's September WAR/TAR orders revealed orders, keep dressing clean, dry intact. Do not remove, do not get wet. Cover to shower, every shift for surgical wound and monitor right leg stump for signs and symptoms of infection every shift for surgical wound, with a start date of 08/19/2025. The WAR/TAR administration record for these orders was not initialed as completed on 09/07/2025 at 11 p.m. and 09/13/2025 on 3 p.m.- 11 p.m. Further review revealed there were no wound treatment orders for the left ankle. Record review of Resident #1's EMR revealed Resident #1 had a readmission initial skin assessment, dated 08/19/2025, that had yes checked for surgical incision. The assessment did not identify any other wounds and was not signed. Resident #1 had no additional weekly skin assessments or weekly pressure ulcer assessments through the end of August and during the month of September until 09/25/2025, after Resident #1 was admitted to the hospital on [DATE]. Further review revealed Resident #1 had no weekly skin assessments or weekly pressure ulcer assessments during the month of September until 09/25/2025, after Resident #1 was admitted to the hospital on [DATE]. Record review of wound care physician assessment, dated 08/26/2025, revealed Resident #1 had a Stage IV pressure wound (a wound that has full thickness skin and tissue loss with exposed muscle, tendon

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with surgical wounds received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, for 1 of 8 residents (Resident 1) reviewed for surgical wounds in that: Resident #1 did not have weekly skin assessments during the month of September 2025, did not receive care to the right surgical wound as ordered by the physician and was admitted to the hospital on [DATE] with an infection to Resident #1's right below the knee amputation. An Immediate Jeopardy (IJ) was identified on 10/04/2025. The IJ template was provided to the facility on [DATE] at 12:35 p. m. While the IJ was removed on 10/06/2025 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not IJ, due to the need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for worsening of existing surgical wounds or development of new pressure ulcers. The findings were: Record review of Resident #1's, undated, face sheet revealed Resident #1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of unspecified part of unspecified bronchus of lung (cancer of the lung or respiratory airway), quadriplegia (paralysis of a person's limbs), kidney disease (damage to kidney function), viral hepatitis c (a liver disease), cirrhosis of liver (scarring and damage to the liver) and encephalopathy (condition that caused brain dysfunction). Record review of Resident #1's quarterly MDS assessment, dated 08/19/2025, revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment. Section GG - Functional Abilities revealed Resident #1 had impairment on one side of his upper and lower extremity, used a wheelchair for mobility, required moderate assistance with bed mobility and was dependent on staff for transfers and personal hygiene. Section M - Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers, had one or more unhealed pressure ulcers, had 1 Stage III pressure ulcer and 2 unstageable pressure ulcers. Record review of Resident #1's undated comprehensive care plan revealed a care plan, the resident has a pressure ulcer or potential for pressure ulcer development: 2. Unstageable right heel, dated 08/05/2025 and revised 08/11/2025. The goal of the care plan was for Resident #1's pressure ulcer to show signs of healing and remain free from infection with a target date of 11/07/2025. Interventions revealed staff would administer treatments as ordered, monitor the effectiveness and replace loose or missing dressings PRN. The interventions also included for staff to assess/record/monitor wound healing at least weekly and measure length, width, and depth, document the status of the wound perimeter and wound bed and healing process. Staff were to report declines to the MD. Record review of Resident #1's September 2025 WAR/TAR revealed orders, start date 08/19/2025, keep dressing clean, dry intact. Do not remove, do not get wet. Cover to shower, every shift for surgical wound and monitor right leg stump for signs and symptoms of infection every shift for surgical wound. The WAR/TAR administration record for these orders was not initialed as completed on 09/07/2025 at 11 p.m. and 09/13/2025 on 3 p.m.- 11 p.m. Record review of Resident #1's EMR revealed Resident #1 had no weekly skin assessments or weekly pressure ulcer assessments during the month of September until 09/25/2025, after Resident #1 was admitted to the hospital on [DATE]. Record review of wound care physician assessment, dated 08/26/2025, revealed Resident #1 had an (unstageable (due to necrosis) of the right heel (signing off-area has been amputated). The etiology revealed pressure and stage was unstageable necrosis. Record review of Resident #1's Nurse Practitioner (NP) progress notes, dated 09/09/2025, revealed, surgical dressing orders reinforced; stump dressing remains clean/dry/intact without drainage. Record review of an outpatient clinic wound assessment progress note, dated 09/15/2025, revealed, Resident #1 had a right BKA and the wound bed sutures were in place and no drainage noted. Record review of Resident#1's emergency department hospital notes, dated 09/24/2025 revealed, Chief Complaint: patient presents from a nursing home with low blood pressure and possible wound infections. History of Present Illness (HPI): The patient was transported from a nursing home to a podiatry appointment where they were noted to have low blood pressure and significant ulcers. The ulcers include a deep ulcer on the left lateral malleolus open wound, as well as a recent BKA on the right, both appearing infected. The patient is found to be lethargic and poorly responsive, indicating altered mentation (occurs when illnesses, disorders and injuries affect brain function). Onset of symptoms is acute, with ulcers likely developing over time due to underlying conditions. Exam revealed, sutures in place from R BKA, central area with small area

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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 - Some	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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, for 1 of 8 residents (Resident 1) reviewed for pressure ulcers in that: Resident #1 had a Stage IV pressure ulcer on his left ankle and did not have wound treatment orders in the month of September 2025. Resident #1 was admitted to the hospital on [DATE] with osteomyelitis and had a left below the knee amputation on 09/25/2025. An Immediate Jeopardy (IJ) was identified on 10/03/2025. The IJ template was provided to the facility on [DATE] at 4:53 p.m. While the IJ was removed on 10/06/2025 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not IJ, due to the need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for worsening of existing wounds or development of new pressure ulcers. The findings were: Record review of Resident #1's, undated, face sheet revealed Resident #1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of unspecified part of unspecified bronchus of lung (cancer of the lung or respiratory airway), quadriplegia (paralysis of a person's limbs), kidney disease (damage to kidney function), viral hepatitis c (a liver disease), cirrhosis of liver (scarring and damage to the liver) and encephalopathy (condition that caused brain dysfunction). Record review of Resident #1's quarterly MDS assessment, dated 08/19/2025, revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment. Section GG - Functional Abilities revealed Resident #1 had impairment on one side of his upper and lower extremity, used a wheelchair for mobility, required moderate assistance with bed mobility and was dependent on staff for transfers and personal hygiene. Section M - Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers, had one or more unhealed pressure ulcers, had 1 Stage III pressure ulcer and 2 unstageable pressure ulcers. Record review of Resident #1's undated comprehensive care plan revealed a care plan, the resident has a pressure ulcer or potential for pressure ulcer development: 1. Unstageable left lateral, (outer) ankle, dated 08/05/2025 and revised 08/11/2025. The goal of the care plan was for Resident #1's pressure ulcer to show signs of healing and remain free from infection with a target date of 11/07/2025. Interventions revealed staff would administer treatments as ordered, monitor the effectiveness and replace loose or missing dressings PRN. The interventions also included for staff to assess/record/monitor wound healing at least weekly and measure length, width, and depth, document the status of the wound perimeter and wound bed and healing process. Staff were to report declines to the MD. Record review of Resident #1's September 2025 WAR/TAR revealed no wound care treatment orders for the left ankle. Record review of Resident #1's EMR revealed Resident #1 had no weekly skin assessments or weekly pressure ulcer assessments during the month of September until 09/25/2025, after Resident #1 was admitted to the hospital on [DATE]. Record review of wound care physician assessment, dated 08/26/2025, revealed Resident #1 had a Stage IV pressure wound (a wound that has full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the ulcer) of the left, lateral ankle and measured 3.5cm x 2.5 cm x 0.1 cm with a surface area of 8.75cm. The dressing treatment plan revealed, Leptospermum honey apply once daily and as needed: if saturated, soiled or dislodged. For 9 days; Alginate calcium apply once daily and as needed: if saturated, soiled or dislodged, for 9 days. Secondary Dressing - gauze island w/bdr apply once daily and as needed: if saturated, soiled or dislodged. For 9 days. The goal of the treatment was healing evidenced by a 75% decrease in nonviable tissue within the wound bed in comparison to the previous wound care visit. Record review of wound care physician assessment, dated 09/02/2025, revealed Resident #1 had a Stage IV pressure wound of the left, lateral ankle and measured 3 cm x 2.5 cm x 0.5 cm with a surface area of 7.50 cm. The dressing treatment plan revealed, Leptospermum honey apply once daily and as needed: if saturated, soiled or dislodged. For 30 days; Alginate calcium apply once daily and as needed: if saturated, soiled or dislodged, for 30 days. Secondary Dressing - gauze island w/bdr apply once daily and as needed: if saturated, soiled or dislodged. For 30 days. The goal of the treatment was healing evidenced by a 14.3% decrease in surface are a within the wound bed in comparison to the previous wound care visit.Record review of wound care physician assessment, dated 09/09/2025, revealed Resident #1 had a Stage IV pressure wound of the left, lateral ankle and measured 3.5 cm x 2.5 cm x 0.5 cm with a surface area of 8.75 cm. The dressing treatment plan revealed, Leptospermum honey apply

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post the daily nursing staffing formation that included the facility name, the current date, the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, certified nurse aides and resident census in a prominent place readily accessible to residents, staff, and visitors for 61 residents in that: The facility failed to post the daily staff posting information on 10/01/2025 and 10/02/2025. This failure could place residents and visitors at risk of not being able to review the facility's daily staffing hours. The findings included: During an observation, 10/01/2025 at 8:28 a.m., a daily staffing poster was observed on top of the receptionist desk in a plastic display holder that was titled, Daily report of nursing staff directly responsible for resident care and was dated 09/10/2025. During an observation, 10/02/2025 at 12:02 p.m., the daily staffing poster display was observed to be empty with no staffing poster observed. During an observation, 10/02/2025 at 4:00 p.m., the daily staffing poster display was observed to be empty with no staffing poster observed. Record review of a facility staff schedule, dated 10/01/2025, revealed the facility had 5 licensed nurses, 2 MAs and 11 CNAs scheduled throughout the day. Record review of a facility staff schedule, dated 10/02/2025, revealed the facility had 5 licensed nurses, 2 MAs and 10 CNAs scheduled throughout the day. During an interview with the Administrator, 10/03/2025 at 1:36 p.m., the Administrator stated the ADON was responsible for updating the daily staffing posters daily and the ADON had received a directive to complete the daily staffing form and post it daily at the reception desk. The Administrator said it was important to post the daily staffing posters because it gives families and visitors the ability to know how many staff are present for the patients and gives us a visual number of staff available and it is part of our regulatory requirements. The Administrator stated the facility did not have a policy on posting staffing information daily but followed the regulatory guidelines.

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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)

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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 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, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 8 residents (Resident # 5, 6 and 8) reviewed for infection control in that: Resident #5 had a foley catheter and did not have a sign for Enhanced Barrier Precautions (EBP).Resident #6 had a foley catheter and was observed with her foley catheter tubing touching the floor under Resident #6's wheelchair.Resident #8 had a gastric tube and did not have a sign for Enhanced Barrier Precautions (EBP). This deficient practice could affect residents on enhanced barrier precautions and place them at risk for infection. The findings were: 11.Record review of Resident #5's undated face sheet revealed Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type 2 (high blood sugar levels), cerebral infarction (stroke) and hydronephrosis with renal and ureteral calculous obstruction (swelling of one or both kidneys causing a blockage or obstruction).Record review of Resident #5's MDS assessment, dated 08/12/2025, reflected Resident #5 had a BIMS score of 04, indicating severe cognitive impairment. Section GG- Functional Abilities revealed Resident #5 was dependent on staff for bed mobility, transfers, toileting hygiene, and bathing. Section H - Bladder and Bowel revealed Resident #5 had an indwelling catheter and was incontinent of bowel and bladderRecord review of Resident #5's comprehensive care plan revealed a care plan, dated 08/11/2025 and revised 09/11/2025, that read, [Resident] is on enhanced barrier precautions. An intervention revealed, posting at the residents room entrance indicating the resident is on enhanced barrier precautions.During an observation, 10/01/2025 at 1:17 p.m., Resident #5's room did not have any postings indicating Resident #5 was on enhanced barrier precautions. During an interview with LVN D, 10/02/2025 at 10:07 a.m., LVN D stated she was assigned to Resident #5 and stated Resident #5 was on EBP. LVN D stated residents on EBP should have had a sign outside of the door indicating the residents were on EBP and what PPE supplies were required to provide direct care. LVN D stated she had received training on EBP and stated it was important to identify residents on EBP to prevent the spread of infection.2. Record review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body), dysphagia (difficulty swallowing), cerebral infarction (stroke) and chronic kidney disease (loss of kidney function to filter waste from the blood). Record review of Resident #6's quarterly MDS assessment, dated 09/02/2025 revealed Resident #6 had short term and long-term memory deficits and Resident #6's cognitive decision making was severely impaired. Section GG - Functional Abilities revealed Resident #6 required supervision assistance with transferring from the bed to wheelchair and required maximum assistance with toileting hygiene. Section H - Bladder and Bowel revealed Resident #6 had an indwelling catheter and was incontinent of bowel and bladder.Record review of Resident #6's comprehensive care plan revealed a care plan dated 03/07/2025, catheter. The interventions revealed, check tubing for kinks and maintain the drainage bag off the floor.During an observation of Resident #6, 10/01/2025 at 1:45 p.m., Resident #6 was observed sitting at the nurse's station with a foley catheter bag underneath her wheelchair and the foley tubing was touching the floor underneath the wheelchair.During an interview with LVN C, 10/01/2025 at 2:03 p.m., LVN C stated a resident's foley catheter tubing should not touch the floor and the tubing should have been secured to prevent the spread of infection. LVN C stated all nursing staff were responsible for ensuring tubing was not loose or touching the floor and LVN C stated she had received training on infection control.3. Record review of Resident #8's undated face sheet revealed Resident #8 was a [AGE] year-old male who admitted to the facility in 07/11/2025 with diagnoses that included spastic quadriplegic cerebral palsy (a disorder that causes muscle stiffness in all four limbs), dysphagia (difficulty swallowing) and epilepsy (a disorder causing seizures).Record review of Resident #8's quarterly MDS assessment, dated 09/05/2025, revealed Resident #8 had a BIMS score of 00, indicating a severe cognitive impairment. Section GG - Functional Abilities revealed Resident #8 was dependent on staff for eating, transfers, and bed mobility. Section K - Swallowing/Nutritional Status revealed Resident #8 had a feeding tube. Record review of Resident #8's undated comprehensive care plan revealed a care plan, dated 07/11/2025 and revised 07/30/2025, [Resident] is on enhanced barrier precautions in relation to the gastric tube placement and the intervention, posting at the residents room entrance indicating the resident is on