STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676343	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Waco	9101 Panther Way Waco, TX 76712

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 observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents (Resident #14) reviewed for care plans. The facility failed to include that Resident #14 was on droplet precautions in her comprehensive care plan. The facility failed to provide interventions for the care plan problem of Resident #14 having a UTI. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met.Findings included: Record review of Resident #14's face sheet dated 02/05/26 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14 had a diagnoses of Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), osteoporosis (a common silent bone disease occurring when bone density decreases, causing bones to become weak, brittle, and highly prone to fractures, particularly in the hip, spine, and wrist), influenza (the flu) (is a highly contagious viral infection of the respiratory system, causing fever, cough, fatigue, sore throat, and muscle aches, typically lasting 7 to 14 days), and urinary tract infection (UTI) (is an infection caused by bacteria-most commonly Escherichia coli-that enters and multiplies within any part of the urinary system, including the kidneys, ureters, bladder, and urethra). Record review of Resident #14's Quarterly MDS assessment dated [DATE], reflected that Resident #14 had a BIMS score of 00 which reflected the resident was severely cognitively impaired. Resident #14's Quarterly MDS assessment reflected that the resident required supervision or touching assistance with eating, was dependent on staff for toileting, and required substantial/maximum assistance with showering and personal hygiene. Resident #14's Quarterly MDS reflected that the resident was always incontinent of bowel and bladder. Record review of Resident #14's Physician's Orders, dated 02/05/26, reflected the resident had an order initiated on 01/30/26 for: Resident is on antibiotic therapy for (UTI/FLU). every shift for 10 days. Physicians Orders dated 01/30/26 reflected Resident #14 was taking levofloxacin Oral Tablet 750 MG(Levofloxacin) with an end date of 02/06/26. Physician orders dated 01/30/26 reflected Resident #14 was on Droplet isolation - gown, gloves, mask or respirator where applicable, and eye protection. Document if resident is compliant and if resident is in a single room. Disposable equipment preferred but if unavoidable, clean and disinfect such equipment immediately after use. Record review of care plan dated 01/31/26 reflected Resident #14 had not been care planned for being placed on droplet precautions. Resident #14's care plan dated 01/31/26 reflected Resident #14 has Influenza A with a goal of resident will be free from s/sx of dehydration as evidenced by good skin turgor with interventions that included Encourage good fluid intake and offer residents favorite beverages. Give antipyretics and analgesics as ordered for fever and pain. Monitor/document side (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: 676343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effects and effectiveness. Monitor/document/report PRN for signs of dehydration: poor skin turgor, dry mucous membranes, slowed capillary refill, increased heart rate (Tachycardia), cool dry skin, sunken eyeballs, decreased urinary output, difficulty breathing (Dyspnea), hypotension. Resident #14's care plan dated 02/04/26 reflected Resident #14 has a Urinary Tract Infection with a goal of resident's urinary tract infection will resolve without complications by the review date. Resident #14's UTI care plan reflected no interventions. In an observation on 02/04/26 at 12:40 PM, Resident #14's door had signage on the door for droplet precautions with a cart of PPE placed outside of Resident #14's room beside the door. In an observation on 02/04/26 at 12:42 PM, Resident #14 was sitting up in her wheel chair in her room with her call light in reach. Resident #14 appeared pleasantly confused. Resident #14 was awake and alert but not responsive to surveyors questions. Resident was dressed appropriately for the weather and appeared clean and groomed. Resident showed no signs of pain or distress. In an interview on 02/06/26 at 12:22 PM, the MDS nurse stated she was responsible for the care plans. She stated she had been trained on completing care plans correctly. She stated it was a group effort and all of the IDT (herself, DON, Social Worker, and Wound Care Nurse) team did their part. She stated she or the ADON or DON would put in a care plan about droplet precautions if a resident was on those precautions. She stated she was not aware that Resident #14 did not have a care plan for droplet precautions. She stated she thought she had care planned Resident #14 for the droplet precautions because resident had the FLU. She stated droplet precautions was absolutely something that should be care planned. She stated she was not aware that Resident #14's care plan did not include interventions for resident's UTI, but the UTI should have most definitely been on there. She stated there could have been a potential spread of infection to other residents if droplet precautions were not care planned and the staff did not know to take those precautions. In an interview on 02/06/26 at 1:14 PM, MA C, stated she had worked in the facility for about 2 years. She stated she was in-serviced on following residents care plans. She stated she knew where to find the residents care plans and she followed the care plans to provide care to the residents. In an interview on 01/27/26 at 1:31 PM, CNA E stated she had worked in the facility for about 2 years. She stated she was in-serviced on following residents care plans. She stated she knew where to find the residents care plans and they were in their electronic records. She stated she followed the care plans to provide care to the residents. In an interview on 01/27/26 at 1:41 PM, LVN A stated she had worked in the facility for about 7 months. She stated she was in-serviced on following residents care plans. She stated she knew where to find the residents care plans and she followed the care plans to provide care to the residents. In an interview on 01/27/26 at 2:05 PM, LVN B stated she had worked in the facility for about 6 months. She stated she was in-serviced on following residents care plans. She stated she knew where to find the residents care plans and she followed the care plans to provide care to the residents. In an interview on 01/27/26 at 2:11 PM, the DON stated she was in-servicing staff regularly on following residents care plans. She stated all nurses knew where to find the residents care plans and the CNA's knew where to find the tasks that rolled over from the care plans which shows the transfer requirements and assistance needed. She stated the staff should follow the care plans to provide care to the residents. She stated if they were unsure or there was a change in the amount of assistance the resident needed, the staff would come to her so the resident could be evaluated by therapy and the care plan could be changed. She stated she, the MDS nurse, the ADON, and the Care Plan Nurse were responsible for completing the care plans and they all did different parts. She stated with an acute change she or the MDS would do that. She stated she also initiated the initial care plans. She stated those staff and herself have been trained on completing the care plans correctly and if they (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had questions they would come to her. She stated if a resident was on droplet precautions it should be a part of the residents care plan. She stated Resident #14 had the FLU and she was on droplet precautions. She stated she was not aware that Resident #14's care plan did not include droplet precautions. She stated she was the one that care planned Resident #14 for the FLU but she failed to care plan resident for being on droplet precautions. She stated if a resident was on droplet precautions and it was not care planned it could cause a potential spread of infection to other residents. She stated interventions should have been in place for residents UTI and she was not aware there were not interventions added until recently. She stated she put the care plan in for the UTI but must have forgotten to add the interventions. In an interview on 02/06/26 at 3:06 PM, CNA F stated she had worked in the facility for about a year. She stated she was in-serviced on following residents care plans. She stated she knew where to find the residents care plans. She stated she follows the care plans to provide care to the residents. Record review of facility policy dated 2001 and revised March 2022 titled reflected Care Plans, Comprehensive Person-Centered: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services, (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 3 of (Resident #30. Resident #62 & Resident #83) of 5 residents reviewed for pharmacy services.The facility failed to administer Resident #30's antipsychotic medication Risperidone 1mg two times a day for schizophrenia as prescribed from 02/01/2026-02/03/2026 during the standard time frame.The facility failed to administer Resident #62's antipsychotic medication Risperidone 0.5mg two times a day for schizophrenia as prescribed from 02/01/2026-02/05/2026 during the standard time frame.The facility failed to administer Resident #83's antiseizure medication Valproic Acid 15ml two times a day and Venlafaxine 75 MG 1 capsule a day for depression as prescribed from 02/01/2026-02/05/2026 during the standard time frame.This failure could place residents at risk for serious complications such as increased behaviors, seizures, and/or increased depressive episodes. The findings included: Review of Resident #30's annual MDS assessment dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: acute kidney failure, schizophrenia (a mental disorder characterized by a disruption in thought process), and moderate intellectual disabilities. He had a BIMS score of 1, indicating severe cognitive impairment. Review of Resident #30's comprehensive care plan dated 05/28/2022 and revised 12/19/2025 reflected he was care planned for diagnosis of anxiety. Exhibits signs and symptoms of anxiety/behaviors. A risk for side effects to medications. Interventions included Monitor for side effects to medications to include but not limited to dizziness, drowsiness, nausea, headache, fatigue, diarrhea, insomnia, and notify medical doctor of abnormal findings, provide medications as ordered. Review of Resident #30's active doctor's orders as of 2/05/2026 reflected an order for Risperidone 1mg two times a day for schizophrenia. Review of Resident #30's medication administration audit report dated 02/01/2026-02/05/2026 filtered by late administrations greater than 1 hour revealed the following: An order for Risperidone 1mg two times a day for schizophrenia was scheduled to be administered on 02/01/2026 at 9:00 a.m. but was administered at 10:20 a.m.An order for Risperidone 1mg two times a day for schizophrenia was scheduled to be administered on 02/02/2026 at 9:00 a.m. but was administered at 11:36 a.m.An order for Risperidone 1mg two times a day for schizophrenia was scheduled to be administered on 02/03/2026 at 9:00 a.m. but was administered at 10:16 a.m. In an observation on 02/05/2026 at 9:15 a.m. of Resident #30 revealed he was clean and up in his wheelchair sitting in the day area. Resident #30 was not interview able. MA D administered Resident # 30 his medications. Review of Resident #62's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: muscle weakness, schizophrenia (a mental disorder characterized by a disruption in thought process), and major depression. She had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident #62's comprehensive care plan dated 08/29/2025 reflected he was care planned for Resident has a diagnosis of schizophrenia. At risk for side effects to medications Interventions included Observe for side effects, adverse reaction from medication to include but not limited to agitation, sedation, headache, sleep disturbance, and notify medical doctor of abnormal findings, provide medications as ordered. Review of Resident #62's active doctor's orders as of 2/05/2026 reflected an order for Risperidone 0.5mg two times a day for schizophrenia. Review of Resident #62's medication administration audit report dated 02/01/2026-02/05/2026 filtered by late administrations greater than 1 hour reflected the following: An order for Risperidone 0.5mg two times a day for schizophrenia was scheduled to be administered on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avir at Waco		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 Panther Way Waco, TX 76712	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/01/2026 at 8:00 a.m. but was administered at 09:59 a.m., scheduled for 4:00 p.m. but was administered at 5:13 p.m.An order for Risperidone 0.5mg two times a day for schizophrenia was scheduled to be administered on 02/02/2026 at 8:00 a.m. but was administered at 11:41 a.m.An order for Risperidone 0.5mg two times a day for schizophrenia was scheduled to be administered on 02/03/2026 at 8:00 A.M. but was administered at 10:59 a.m., scheduled for 4:00 p.m. but was administered at 5:30 p.m.An order for Risperidone 0.5mg two times a day for schizophrenia was scheduled to be administered on 02/04/2026 at 8:00 a.m. but was administered at 9:54 a.m., scheduled for 4:00 p.m. but was administered at 5:13 p.m.An order for Risperidone 0.5mg two times a day for schizophrenia was scheduled to be administered on 02/05/2026 at 8:00 a.m. but was administered at 9:06 a.m. In an observation and interview on 02/05/2026 at 9:06 a.m. Resident #62 was clean in her bed, alert and dressed in her pajamas. She stated she was not feeling well and wished to remain in bed. MA D administered Resident #62 her medications. Review of Resident #83's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: high blood pressure, hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone), lumbago with sciatica (a condition that causes pain in the lower back and legs due to nerve compression), anxiety (feelings of worry, nervousness, or unease), and depression (persistent feelings of sadness, loss of interest). She had a BIMS score of 14, indicating intact cognition. Review of Resident #83's comprehensive care plan revealed she was care planned for being at risk of alteration in comfort, at risk for pain presence r/t sacroiliitis, lumbago with sciatica and the goals were to have pain alleviated with both pharmacological interventions and nonpharmacological interventions.She was care planned for having episodes of anxiety and at risk for fluctuation in moods and the goal was to maintain the anxiety at a tolerable level demonstrated by reduced anxiety from proper medication. The interventions included administering medications as ordered, monitor and document s/sx of adverse effects of medications given.She was care planned for potential complications r/t hypothyroidism and the interventions included to administer prescriptions as ordered by the MD. She was care planned for having hypertension and the interventions included to give anti-hypertensive medications as ordered. Review of Resident #83's active doctor's orders as of 2/05/2026 reflected an order for Valproic Acid 15ml two times a day for seizures. An order for Venlafaxine 75 MG 1 capsule a day for depression. Review of Resident #83's medication administration audit report dated 02/01/2026-02/05/2026 filtered by late administrations greater than 1 hour revealed the following:An order for Valproic Acid 15ml two times a day for seizures was scheduled to be administered on 02/01/2026 at 7:00 A.M. but was administered at 09:12 A.M., scheduled for 7:00 PM but was administered at 8:58 PM.An order for Valproic Acid 15ml two times a day for seizures was scheduled to be administered on 02/02/2026 at 7:00 A.M. but was administered at 09:17 A.M., scheduled for 7:00 PM but was administered at 9:50 PM.An order for Valproic Acid 15ml two times a day for seizures was scheduled to be administered on 02/03/2026 at 7:00 A.M. but was administered at 09:51, scheduled for 7:00 PM but was administered at 8:50 PM.An order for Valproic Acid 15ml two times a day for seizures was scheduled to be administered on 02/04/2026 at 7:00 A.M. but was administered at 08:46 A.M.An order for Valproic Acid 15ml two times a day for seizures was scheduled to be administered on 02/05/2026 at 7:00 A.M. but was administered at 11:31 A.M. An order for Venlafaxine 75 MG one time a day for depression was scheduled to be administered on 02/05/2025 at 9:00 A.M. but was administered at 11:31 A.M. In an interview on 02/04/2026 at 1:47 PM with Resident #83, she stated that she had a seizure this past Monday (2/02/2026), but did not require hospitalization, and that she took medication for her seizure disorder twice a day. She stated that sometimes they receive their medications after breakfast, and that she was supposed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to receive her seizure medication at 7 A.M., but that she never missed her doses. She stated that with her medication, she still occasionally had seizures, but they were controlled and did not require hospitalization. She stated that since her admittance to the facility she had not been admitted to the hospital. In an interview on 02/05/2026 at 9:50 a.m. MA D stated if she sees medications were going to be late, she would notify the nurse. The Nurse will notify the doctor to ensure it was safe to give the medication to the resident. The Medication aides were responsible for making sure residents got their medications on time. She stated on time means a 2-hour window. She said the negative effects for not giving residents medications within a time limit could include overall health such as blood pressure could lead to unregulated blood pressure. In an interview on 2/5/26 at 2:11 p.m. the DON stated all nurses and medications aides were responsible for ensuring medications were given in a timely manner. Administration does not run a late medication report daily, so they had not monitored late medications. Medications should be given within an hour before or an hour after designated time on the order. If staff were late administering medications, nurse managers need to be notified so they can assist and get them caught up if needed. She stated the medication aides were checked off on medication pass annually and as we identify any issue. Pharmacy does medication pass [NAME] with the medication aides. The potential risk for residents receiving medications later than allotted time could include pain or blood pressure could be too high. Record review of facility policy titled Administering Medications dated April 2019 reflected: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation.1. The facility failed to ensure sanitation practices (cleaning the dishwasher from buildup).2. The facility failed to ensure all items were covered and stored properly in the pantry and freezer.3. The facility failed to label and date all food items in the kitchen.This failure could place residents at risk of foodborne illness. Findings included:In an initial observation on 02/04/2026 at 9:05 AM the kitchen pantry revealed opened bags of cereal placed inside plastic labeled and dated bags that were not properly sealed to limit exposure to outside air. An opened package of cornstarch was observed in the dry pantry and the contents were exposed to the air. In an initial observation on 02/04/2026 at 9:10 AM in the facility's only kitchen revealed 2 bags of chopped yellow squash with no label or use by date in the freezer, and an opened box of frozen biscuits exposed to freezer air.In a follow up observation on 02/05/2026 at 8:48 AM in the facility's only kitchen revealed the top of the low temperature dish washing machine that was at about eye level of a 5 foot 5 inch person, was covered in food particle build up at the door that opened to insert dirty dishes, and the door that opened to remove clean dishes. In an interview on 02/04/2026 at 9:30 AM, the DM stated that normally after serving a meal the kitchen staff would individually label and date food items in the pantry or freezer. She stated that the cornstarch in the pantry was supposed to be placed inside a clear plastic bag and labeled and dated, not just folded up, and that the cereal had been used for the breakfast meal and was not properly sealed shut afterwards. She stated a negative outcome if foods were exposed, would be contamination or losing their nutritional value. In an interview on 02/06/2026 at 2:30 PM with the DON, she stated that she did not oversee the kitchen, but that the ADM did. She stated that she thought their expectation concerning labeling and dating of food products was that the kitchen dated all food items and stored all food items in order to prevent debris from getting in the food. Additionally, that they were to not give expired or contaminated foods to residents, which could cause food borne illness. In an interview on 02/06/2026 at 2:40 PM with the ADM, stated their expectations concerning labeling and dating of food items was that the kitchen staff labeled and dated food items when they were delivered by the vendor, and/or by the facility policy. He stated that if a food item was not properly sealed bugs could get in the packaging. The ADM stated if labeling and dating practices were not followed that could negatively affect residents by diminished taste, spoiled food, and diminished health status. The ADM stated their expectation concerning kitchen cleaning and general sanitation was that the kitchen followed company policies for cleaning and general sanitation. He stated that the top of the dishwasher should probably be cleaned after each meal. He stated that cross contamination could occur if clean dishes were going through a dirty machine. Review of the facility's policy titled Food Receiving and Storage dated November 2022 reflected, Foods shall be received and stored in a manner that complies with safe food handling practice. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are stored in such a way that promotes adequate air circulation around food storagecontainers. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging untilthey are ready to use.

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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 observation, interview and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for one (Resident # 68) of six residents reviewed for infection control. IP A failed to wear enhanced barrier precautions (a protective layer over clothing to prevent the spread of germs) during an observation of wound care on 2/05/2026.This failure could place residents at risk of cross contamination which could result in infections or illness. Findings included:Review of Resident #68's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: heart failure, hypertension (elevated blood pressure), Diabetes Mellitus (elevated blood sugars), and depression. He had a BIMS score of 15, indicating intact cognition.Review of Resident #68's comprehensive care plan reflected he had a chronic non-healing wound or indwelling medical device. This places them at an increased risk of transmission of MDROs. Interventions included change personal protection equipment before caring for other residents. Face protection may be needed if performing activity with risk for splash or spray. Personal protection equipment will be used for the following situations during resident care: dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, or assisting with toileting. Date Initiated: 07/07/2025In an interview on 02/04/2026 at 3:01 PM Resident #68 denied any abuse or neglect. He stated he does have wounds, and the facility nurse does care for them. He stated the wound doctor sees him weekly in the facility.In an observation on 02/05/2026 at 10:11a.m., IP A performed wound care to Resident #68s right leg. Wound care to right lower extremity, posterior: Cleanse with wound cleanser, pat dry, apply Calcium Alginate (a type of dressing to promote healing) and cover with dry dressing. Resident #68 denied any pain prior to and during care. The IPN did not use enhanced barrier precautions during wound care. Signage was posted for enhanced barrier precautions at the residents' door.In an interview on 02/05/2026 at 10:35 a.m. IP A stated she should have used enhanced barrier precautions while performing wound care. She stated it just slipped her mind. She stated she has been instructed on using EBC and educated on infection control. She said not using enhanced barrier precautions could spread infection. In an interview on 02/05/2026 at 2:11 p.m. the DON stated all nurse management ADON and DON educate staff on enhanced barrier precautions. The DON said the DON and ADON were responsible for monitoring infection control and use of enhanced barrier precautions. She stated all nurses should use enhanced barrier precautions when performing wound care. The negative effects of not using enhanced barrier precautions could be the spread of infection. Record review of facility policy titled Enhanced Barrier Precautions dated March 2024 reflected 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include wound care (any skin opening requiring a dressing).