STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Brackenville LLC	100 St. Claire Drive Hockessin, DE 19707

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to thoroughly investigate allegations of abuse for four residents (Resident (R) 59, R88, R97, and R106) out of nine residents reviewed for abuse in a total sample of 40. This failure placed residents at risk of further abuse and a diminished quality of life.Findings include:1. Review of the admission Record, located in the Profile tab of the electronic medical record (EMR), revealed that R59 was admitted to the facility on [DATE] with diagnoses that included hemiplegia/hemiparesis (paralysis on one side of the body) following a cerebral infarct (stroke) and major depressive disorder.Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/14/26, revealed R59 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R59 was cognitive intact.Review of the facility's investigation related to a 08/16/25 report of verbal abuse revealed R59 had slid to the floor when Certified Nurse Aide (CNA) 5 was assisting R59 back to bed. CNA5 called for assistance, and several CNAs came to assist. R59 asked for the Hoyer lift to get up, and CNA2 said he could get himself up. According to the report, R59 became angry and started cursing and told CNA2 to leave his room. CNA2 then told R59 that it wasn't his room; they then began bickering with each other. CNA2 did not leave R59's room until she was told to leave by the Licensed Practical Nurse (LPN) present. The investigation, provided by the facility, did not contain any resident interviews outside of R59.During an interview on 03/04/26 at 3:30 PM, R59 reported that he did not get along with CNA2, and he didn't think many people did. During an interview on 03/05/26 at 10:35 AM, the Director of Nursing (DON) was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by CNA2 and what their response was. The DON stated, I don't remember if I interviewed other residents, but if not in the folder, no. I will double check. No other interviews were located.2. Review of the admission Record, located in the Profile tab of the EMR, revealed R88 was admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis, hypertension, and peripheral vascular disease.Review of the quarterly MDS, located in the MDS tab of the EMR with an ARD of 02/03/26, revealed R88 had a BIMS score of 14 out of 15, which indicated R88 was cognitively intact.Review of the facility's investigation of a report of verbal abuse on 02/04/26 revealed that R88's roommate was relocated to another room due to the roommate becoming aggressive with R88. On the day the roommate was moved, the roommate's daughter came to R88's room and cursed R88 out. R88 reported the incident to her son, and he reported it to the social worker. The file contained no interviews with other residents outside of R88.During an interview on 03/04/26 at 10:30 AM, R88 reported that she had never been so scared in her life. The lady was so angry, called me a F-ing bitch and said I was going to hell.During an interview on 03/05/26 at 10:35 AM, the DON was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by this family member. The DON stated, No. I didn't think it was necessary because this family member always sits at her mother's bedside, and her anger was directed at [R88]. In hindsight I probably should have. 3. Review of R97's admission Record, dated 03/05/26 and found in the EMR under the Profile tab, revealed R97 was admitted to the facility on [DATE]. The resident's diagnoses included (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	type 2 diabetes and epilepsy.Review of R97's quarterly MDS with an ARD of 02/06/25, found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R97's Progress Notes, dated 06/18/25 and found in the EMR under the Notes tab, revealed Resident's daughter reported that her mother told her that a male CNA wearing a red shirt was too rough with her and that he was upset with her for having to change her linens.Review of the facility's investigation related to the 06/18/25 report of potential staff to resident abuse revealed an incomplete investigation. Review of the investigation revealed R97 had been interviewed as part of the investigation; however, no additional interviewable residents residing in the same area of the facility and/or with potential knowledge of the incident were interviewed. 4. Review of R106's admission Record, dated 03/05/26 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and heart disease. The resident was discharged from the facility on 08/03/25.Review of R106's quarterly MDS with an ARD of 05/09/25, found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R106's comprehensive record revealed nothing in the progress notes or anywhere else in the record to indicate an allegation of potential abuse.Review of the facility's investigation documentation related to a 07/26/25 allegation of potential abuse by R106 revealed the resident reported a staff member entered her room and told the resident she was a poor excuse for a human being and refused to assist her with changing her brief. The investigation documentation revealed an incomplete investigation into the allegation of abuse. There were no additional residents or staff members interviewed related to the allegation, R106 was not physically and psychosocially assessed related to the allegation in a timely manner, and there was no facility review of the employee record of the staff member accused of being potentially abusive toward R106 as part of the investigationDuring an interview with the Administrator and DON on 03/05/26 at 12:19 PM, both confirmed the investigation into R106's allegation of potential abuse had not been thoroughly investigated (to include a thorough assessment of the resident, additional resident and staff interviews related to the allegation, and a facility review of the accused staff member's employee file). Both stated their expectation was that any allegation of potential abuse should be thoroughly investigated according to facility policy. Review of the facility's policy titled, Abuse, Neglect and Exploitation, reviewed/revised 11/24 revealed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, record review, review of facility policies, and review of the manufacturer's manual, the facility failed to ensure pressure relieving air mattresses were correctly set according to the manufacturer's guidelines and residents' weights for three of five residents (Residents (R) 5, R48, and R85) reviewed for pressure ulcers out of a total sample of 40 residents. This failure placed residents at risk for skin breakdown, delayed wound healing, pain, infection, and potentially avoidable complications.1. Review of R5's Face Sheet, located in the electronic medical records (EMR) under the Profile tab, revealed an admission date of 10/17/25 with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease.Review of R5's revised 01/15/26 Care Plan, located in the EMR under the Care Plan tab, revealed [R5] has a pressure ulcer to her sacrum and left buttock. Interventions included following the manufacturer's recommendation for proper function of the air mattress. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/26, located in the MDS tab in the EMR, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R5 had moderate cognitive impairment. Further review revealed that R5 was admitted with one stage three pressure ulcer and one stage four pressure ulcer.Review of R5's weight, located under the Weight/Vitals tab in the EMR, revealed on 03/03/25 that R5 weighed 115.8 pounds (lbs).Observation on 03/03/26 at 3:46 PM, R5's Proactive Air Mattress weight dial, which could be dialed to weights between 80 and 350 pounds, was set at 80 lbs.Observation on 03/03/26 at 3:55 PM with Certified Nurse Aide (CNA) 4 confirmed R5's pressure relieving mattress was set at 80 lbs.Observation on 03/04/26 at 11:40 AM with the Maintenance Director (MD) 2 confirmed the air mattress was set at 80 lbs. Observation and interview conducted on 03/04/26 at 11:47 AM with Registered Nurse (RN) 1 indicated that nurses checked the air mattresses every shift and ensured the settings were adjusted according to the manufacture's recommendations and the resident's weight to maintain proper inflation and support the healing process. During this same time, RN1 confirmed that R5's air mattress was set at 80 lbs. When updated that R5's current weight was 115 lbs, RN1 stated, The weight is set too low. 2. Review of R48's Face Sheet, located in the EMR under the Profile tab, revealed an admission date of 09/29/24 with the following diagnoses: unspecified cord compression, spinal stenosis, hypertension, and type 2 diabetes. Review of R48's Care Plan, located in the EMR under the Care Plan tab, revision date of 10/13/24, revealed R48 is at risk for skin breakdown related to ambulatory dysfunction and decreased activity, bowel incontinence . The care plan further indicated under interventions that R48 will have a therapeutic mattress. Review of R48's quarterly MDS with an ARD of 10/01/26, located in the EMR under the MDS tab, revealed R48's BIMS score was 14 out of 15, which indicated he was cognitively intact.Interview and observation on 03/02/26 at 2:16 PM revealed R48's air mattress was set at 240 lbs. R48 stated that his current weight was 193 lbs. R48 continued to share that he had been dealing with pressure ulcers and currently had a pressure ulcer on his coccyx. During an interview on 03/04/26 at 1:25 PM, R48 was in his room and stated that a facility staff member was in his room several minutes ago and readjusted his weight setting on the air mattress.Review of a Nutritional Services note, dated 03/05/26 and located in the EMR under the Progress Notes tab, indicated R48 weighed 213 lbs.3. Review of R85's Face Sheet, located in the EMR under the Profile tab, showed an admission date of 08/08/24 with diagnoses including dementia, type 2 diabetes, and adult failure to thrive.Review of R85's MDS with an ARD of 01/15/26, located in the EMR under the MDS tab, revealed he was at high risk for developing pressure ulcers. Review of R85's weight, located under the Weight/Vitals tab in the EMR, revealed on 01/12/26 R85 weight was 99.4 lbs.Interview on 03/04/26 at 11:40 AM with MD2 revealed he did not have the manufacturer's guide for the air mattresses and goes to the products website for guidance. Observation and interview conducted on 03/04/26 at 11:47 AM with RN1 indicated that nurses checked the air mattresses every shift and ensured the settings were adjusted (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	according to the manufacture's recommendations and the resident's weight to maintain proper inflation and support the healing process. During this same time, RN1 went to R85's room and confirmed the resident's air mattress was set too high at 450lbs. During an interview on 03/05/26 at 11:19 AM, the Director of Nursing (DON) confirmed air mattresses should be set as close as possible to the resident's current weight. She shared her expectations that all air mattresses are set at the appropriate weight. Staff should readjust as the resident gains or loses weight to ensure proper healing and to reduce developing new skin issues. Review of facility policy titled Use of Support Surfaces, revised 03/13/23, revealed 'Support surface' refers to specialized mattress . to manage pressure . The policy further revealed, Motor powered devices, or those requiring air, the licensed nurse will check each shift and prn [as needed] for proper functioning and /or inflation . alternatingˆpressure or active support surface is a medical mattress designed to reduce and redistribute pressure on the skin especially for people who spend extended time in bed or have limited mobility . helps prevent and treat bed sores . Under the heading How to set up and use the mattress it directed to Adjust firmness . pumps have a dial based on patient weight . Review of the Proactek, Protect Aire 2000/3000 model provided by the manufacturer at https://proactivemedical.com revealed under the Operating Instructions, Step 6 . Determine the patient's weight and set the control knob to that weight setting on the control unit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to ensure accommodation of needs for two of two residents (Resident (R) 71 and R5) in the sample of 40. Specifically, the facility failed to address necessary wheelchair repairs for R71 and did not provide R5 with access to a functioning call light. This created a potential risk for resident injury. Findings include: 1. Review of R71's electronic medical record (EMR) titled Face Sheet, located under the Profile tab, indicated an admission date of 10/25/24 with diagnoses of traumatic brain injury and quadriplegia. Review of R71's EMR titled Care Plan, located under the Care Plan tab, dated 10/28/24, indicated that R71 was at risk for skin integrity due to fragile skin. Review of R71's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/25 indicated the staff were unable to determine a Brief Interview for Mental Status (BIMS) score. R71 was dependent on all activities of daily living from staff. During an observation on 03/02/26 at 11:52 AM, R71 was seated in his room in a customized, adapted wheelchair (tilt in space). The resident's bilateral wheelchair arms were cracked. The right-side arm rest had a large peeled opened area which exposed the cushion underneath the upholstery. The left side arm rest had multiple cracks. The concave back, attached to the back of the wheelchair, provided lumbar support. The left side of the concave cushion had an open area, which exposed the cushion underneath the upholstery. During an observation on 03/04/26 at 10:30 AM, R71 was in an activity. The bilateral arm rests were still in disrepair and so was the concave back support. During an interview on 03/04/26 at 12:15 PM, the Maintenance Director (MD) 2 stated that arm rests could be easily replaced on a resident's wheelchair, but he was unsure if he could repair the concave supportive device attached to the back of the resident's wheelchair. During an interview on 03/04/2026 at 3:38 PM, the Director of Nursing (DON) stated that the process was to inform maintenance, who would then repair the resident's wheelchair. The Administrator was present during this interview and stated that R71 owned the wheelchair, or even if the wheelchair was donated, this was considered a medical device, and the facility was not responsible for the repairs of the wheelchair. MD2 stated that there were no work orders in TELS (a web-based work order system). Review of the facility's policy titled Accommodation of Needs dated 03/13/23 indicated, . The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered . 2. Review of R5's Face Sheet, located in the electronic medical records (EMR) under the Profile tab, revealed an admission date of 10/17/25 with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's quarterly MDS with an ARD date of 02/17/26, located in the MDS tab in the EMR, revealed R5 had a BIMS score of 11 out of 15, which indicated R5 had moderate cognitive impairment. Observation and interview on 03/02/26 at 4:43 PM revealed that R5 was visiting with a family friend in her room. During the observation, the call light was noted to be disconnected; the end of the cord that must be inserted into the wall for proper function was not inserted. Both the resident and the family friend confirmed the call light cord was not inserted into the wall. Interview with MD2 on 03/03/25 at 3:02 PM revealed call lights were randomly checked for function weekly. R5's call light system was repaired in 2020 and has had no other issues. Observation on 03/03/26 at 3:46 PM, R5's call light remained disconnected from the wall. Interview and observation on 03/03/26 at 3:55 PM with Certified Nurse Aide (CNA) 4 stated that call lights are used to alert staff that residents need assistance. CNA4 went to R5's room and confirmed the call light was not plugged into the wall. CNA4 proceeded to plug in the call light, which activated the alert sound as well as the light above the door, confirming the system was working properly. Interview and observation on 03/04/25 at 11:40 AM with MD2 confirmed R5's call light was unplugged. MD2 shared that he expected all call lights to remain plugged into the electrical socket. Interview with the Director of Nursing (DON) on 03/05/26 at 11:19 AM stated the expectation that all call lights would remain plugged into the electrical socket and were never unplugged from the wall socket. Review of the facility's policy titled, Call Lights: Accessibility and Timely Response, revised 03/14/23, revealed, 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light . 9. Ensure the call system alerts staff members directly or goes to a centralized staff work area .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, and policy review, the facility failed to ensure hearing services were provided for one of one resident (Resident (R) 97 reviewed for vision and hearing services. The facility's failure to ensure the provision of timely hearing services had the potential to negatively impact R97's ability to effectively communicate. A total of 40 residents were reviewed in the sample. Findings include: Review of R97's admission Record, dated 03/05/26 and found in the electronic medical record (EMR) under the Profile tab, revealed R97 was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and epilepsy.Review of R97's Audiology Consultation Report, dated 09/04/25 and found in the EMR under the Miscellaneous tab, revealed the resident had hearing loss and indicated the resident was in need of, and agreed to, a hearing aid evaluation for an assistive hearing device.Review of R97's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/06/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R97's care plan, dated 02/06/26 and found in the EMR under the Care Plan tab, revealed no care plan to address the resident's hearing needs.Review of R97's comprehensive record revealed nothing to indicate a referral had been made for the resident to have a hearing aid evaluation.During an interview with R97 on 03/02/26 at 2:45 PM, she stated she thought hearing aids were supposed to have been ordered in October of 2025, but she still did not have them. She stated she needed the hearing aids to hear appropriately. During an interview with the Social Services Director (SSD) on 03/04/26 at 12:15 PM, she indicated if a resident were having hearing concerns, she would notify the Director of Nursing (DON), and the DON would then generate a referral to obtain the hearing aids. The SSD confirmed she was unable to locate anything in R97's record to indicate follow-up after the 09/04/25 recommendation for R97 to acquire hearing aids. During an interview with the DON on 03/05/26 at 3:00 PM, she stated it was the responsibility of the Social Services Department to generate referrals for hearing and vision services. During an interview with the Administrator on 03/05/26 at 11:11 AM, he confirmed the facility should have followed up with the 09/04/25 recommendation for R97 to be evaluated for hearing aids and stated, Obviously a resident who needs hearing aids should not go six months without them. The facility's Hearing and Vision Services Policy, most recently dated 04/05/23, revealed, It is the policy of this facility that all residents have access to hearing and vision services and receive adaptive equipment as indicated and Employee should refer any identified need for hearing or vision services/appliances to the social worker/social services designee and Once vision or hearing services have been identified, the social worker/social services designee will assist the resident by making appointments and arranging for transportation and Assistive devices to maintain hearing include, but are not limited to, hearing aids and amplifiers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and facility procedure review, the facility failed to ensure the routine provision of ordered respiratory services for one resident (Resident (R) 89) of two residents reviewed for respiratory services. The facility's failure created the potential for R89 to develop complications related to the ineffective administration of oxygen. A total of 40 residents were reviewed in the sample. Findings include:Review of R89's admission Record, dated 03/05/26 and found in the electronic medical record (EMR) under the Profile tab, revealed R97 was admitted to the facility on [DATE]. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary mycobacterial infection.Review of R89's physicians orders, found in the EMR under the Orders tab, revealed orders, with an original order date of 02/04/26, for the resident to receive oxygen three liters continuously per nasal cannula and for the resident's humidification bottle and oxygen tubing to be changed weekly on Wednesdays on the night shift. Review of R89's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/11/26 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated R89 was receiving oxygen at the time of the assessment.Review of R89's Medication and Treatment Administration Records (MARs/TARs), found in the EMR under the Orders tab and dated 02/04/26 through 03/05/26, revealed nothing had been documented to indicate the resident's humidification bottle and tubing had been changed on 02/11/26 or 02/25/26 per the physician's orders.During observations on 03/03/26 at 12:29 PM, 1:47 PM, and 3:01 PM and on 03/04/26 at 10: 08 AM, 10:57 AM and 2:39 PM, R89 was observed in bed in her room wearing her oxygen which was running at three liters per minute continuously. There was nothing on the resident's oxygen tubing to indicate the date it had been changed last. In addition, there was no humidification bottle attached to the resident's oxygen compressor.R89 was observed, along with the Interim Unit Manager, Registered Nurse (RN) 1 on 03/04/26 at 2:39 PM. RN1 confirmed there was nothing on R89's oxygen tubing to indicate when the tubing had last been changed, confirmed there was not a humidification bottle attached to the resident's oxygen concentrator as ordered, and confirmed there was nothing in the resident's record to confirm the tubing had been changed. RN1 stated oxygen being delivered at any rate above two liters per minute required humidification.During an interview with the Director of Nursing (DON) on 03/04/26 at 2:44 PM, she confirmed her expectation that all oxygen tubing/equipment was to be changed at least weekly, and this was to be documented on the MAR/TAR. The DON confirmed R89's oxygen should have been humidified.The facility's undated Changing Disposable Humidifier Bottles Procedure revealed, Change humidifier bottles weekly or as per institution infection control policy.The facility's undated Stationary Concentrators Procedure revealed, Oxygen delivery devices and humidifiers should be changed weekly.

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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. Based on record review, observations, interviews, and review of the facility policies, the facility failed to ensure staff followed enhanced barrier precautions (EBP) and standard nursing precautions while providing care for one of one resident reviewed on EBP (Resident (R) 5). Specifically, a Certified Nurse Aide (CNA) failed to follow personal protective equipment (PPE) guidelines and wear a gown and gloves while performing incontinent care. This failure had the potential to cause further infection to the resident's wounds. Findings include:Review of R5's Face Sheet, located in the electronic medical records (EMR) under the Profile tab, revealed an admission date of 10/17/25, with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease.Review of R5's Care Plan, revised 01/13/26 and located in the EMR under the Care Plan tab, revealed, [R5] requires enhanced barrier precautions related to (wound, indwelling medical device, infection or colonization with MDRO) It did not specify the reason for EBP but did document a skin opening requiring a dressing.Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/26, located in the MDS tab in the EMR, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R5 was moderately cognitively impaired. Further review revealed that R5 was admitted with one stage three pressure ulcer and one stage four pressure ulcer.Observation on 03/03/25 at 3:42 PM revealed an orange sign, Enhanced Barrier Precautions posted on the wall outside of R5's room with a B written in black. The sign read, Stop: Enhanced Barrier Precautions, everyone must wash their hands including before entering and when leaving . wear gloves and a gown for the following high contact resident care activities- changing linens, providing hygiene, changing briefs, and dressing. During this same observation, CNA3 entered the resident's room and proceeded to provide incontinent care without donning a gown or gloves. Once R5's incontinent care was completed, CNA3 exited the room and asked CNA4 to retrieve some clean linen. Interview on 03/03/26 at 3:43 PM, CNA3 confirmed that R5 was on EBP and stated, I should have put on my PPE. She further shared that EBP and Infection Control training was completed annually and as needed. During trainings staff were taught how to properly don and doff PPE along with what PPE was required based on residents' conditions. Interview on 03/03/26 at 3:55 PM with CNA4 confirmed R5 was on EBP.Interview on 03/04/26 at 11:47 AM with Registered Nurse (RN) 1 confirmed R5 was on EBP. RN1 stated all staff are trained on infection control to include how to identify residents on EBP. RN1 shared that the information about residents who are on EBP was listed on the Kardex, a sign posted at the resident's room, and in the EMR.Interview with the Director of Nursing (DON) on 03/05/26 at 11:19 AM revealed staff received infection control and EBP training upon hire, annually, and if needed during specific in-services. She stated she expected all staff to follow the infection control protocol and know how to identify residents on EBP and what PPE to use. Review of the facility's policy titled, Enhanced Barrier Precautions, revised on 02/25/25, revealed Enhanced Barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.