STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425311	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Post Acute	550 East Gate Drive Aiken, SC 29803

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 facility policy review, the facility failed to ensure the kitchen's floor and equipment including two ovens, the shelves on two metal rolling carts, three stove top spill pans, three metal racks, one reach in freezer, five food preparation pans, and large manual can opener and its base attachment were kept clean. These failures had the potential to create an environment for food-borne illnesses which could affect 102 residents who consumed food prepared from the facility's kitchen. Review of the facility's policy titled, Sanitation revised on 04/2006 indicated, Policy Statement-The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1. All kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish . 2. All utensils, counters, shelves, and equipment shall be kept clean .1. Observation during the initial kitchen inspection on 09/09/25 from 9:15 AM to 9:55 AM, with the Registered Dietitian (RD) present, revealed the floor behind the kitchen's ovens was unclean with accumulated food and debris. The RD confirmed the area behind the kitchen's ovens was unclean.2. Observation during the initial kitchen inspection on 09/09/25 from 9:15 AM to 9:55 AM, with the RD present, revealed the following unclean food preparation and service equipment that was stored and ready for use: the interior cooking compartments of the kitchen's two ovens were unclean with an accumulation of dried and burned food spills and debris; the stove top's three spill pans were unclean with a heavy accumulation of dried and burned food and debris; the interior bottom of one of the kitchen's reach in freezers was unclean with a brownish colored ice; the shelves on two metal rolling carts which had insulated tops and bottoms stored on them were unclean with dried food substance and loose debris; the shelves on a metal rolling cart which had sheet pans stored on it was unclean with dried food substances and loose debris; the kitchen's large manual can opener which was attached to a food preparation table was unclean with dried substances on its blade and on its base attachment; and five 24 cavity food preparation pans were unclean with greasy residues and/or burned on substances.During an interview on 09/09/25 at 9:55AM, the RD confirmed all of the kitchen equipment that was observed above was unclean. The RD stated it was expected that the dietary staff would keep all kitchen equipment clean as scheduled on the kitchen's cleaning schedule and as needed. The RD stated the brownish ice observed in the bottom of the reach in freezer must have come from a spill, and the only unclean observed items that were not on the kitchen's current cleaning schedule were the three stove top spill pans.

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

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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 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 record review, interview, and policy review, the facility failed to ensure one of 24 (Residents (R)1) reviewed for comprehensive care plans failed to include the care required for R1's nephrostomy tube. care plan directing measurable goals and interventions for one of a total sample of 29 residents. This failure placed the resident at risk for unmet care needs, and the inability to meet their maximum practicable level of functioning.Review of the facility's policy titled, Care Planning - Interdisciplinary Team dated March 2022 included, .the Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).Review of R1's Electronic Medical Record (EMR) in the Clinical Census found under the Clinical Census tab revealed admitted on [DATE] with diagnoses of nephrostomy tube since 2022 due to hydronephrosis (extra fluid in the kidney) and acute kidney injury with tubular necrosis (dead tissue in the kidney).Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/01/25 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment.Review of R1'sComprehensive Care Plan found in the EMR under the Care Plan tab initiated on 08/30/25 and revised 09/05/25 revealed, At risk for complications with urinary system related to having right side nephrostomy with the goal, Will have no complications or infections r/t [related to] urinary device. Interventions included, Administer medications as ordered. Encourage fluids if not contraindicated. Labs as ordered. Notify physician of results. Notify physician of signs and symptoms of UTI [urinary tract infection] such as mental status changes, foul smelling urine, color change in urine, hematuria, sedimentation, burning with urination, increased temperature. Urology/Nephrology consults/ follow-up as ordered. R1's care plan did not address what type of care was required for the nephrostomy tube.Interview on 09/09/25 at 10:30 AM, Certified Nursing Assistant (CNA)3 confirmed that R1 had a nephrostomy tube.Interview on 09/11/2025 at 10:54 AM, the MDS Coordinator (MDSC)2 agreed that the care for the nephrostomy should have been included in her care plan.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations and interviews, the facility failed to ensure residents who were dependent on staff for Activities of Daily Living (ADL) assistance received services for one of four residents (Resident (R) R63) reviewed for fingernail care and bathing in a total sample of 24 residents. This failure placed residents at risk for diminished self-worth, self-esteem, feelings of embarrassment, and/or medical issueReview of the facility's policy titled Fingernails/Toenails, Care of dated 2002 documented, .Nail care includes daily cleaning and regular cleaning. Proper nail care can aid in the prevention of skin problems around the nail bed.Review of R63's Face Sheet located in the electronic medical record (EMR) under the Admissions tab documented R63 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease (COPD), depression, and adult failure to thrive.Review of R63's Care Plan located in the EMR under the Care Plan tab dated 04/10/25 revealed the resident was at risk for Activities of Daily Living (ADL)/mobility decline and requires assistance related to fracture, weakness, will have ADL and mobility needs met. Interventions included that staff would assist with bathing and hygiene as needed.Review of R63's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 07/13/25 revealed the resident had a Brief Interview of Mental Status (BIMS) score of seven out of 15 indicating severe cognitive impairment, had no behaviors and/or rejection of care, and required maximal staff assistance for personal hygiene that included nail care.Review of the Shower Schedule provided by Licensed Practical Nurse (LPN) 3 assigned to R63 on 09/11/25 revealed R63 was to receive a shower on Tuesday and Friday during the 7AM to 7 PM shift.Observations conducted on 09/09/2025 at 12:02 PM, on 09/10/25 at 9:21 AM, and on 09/11/25 at 12:50 PM revealed R63 had dark brown material under all his fingernails and needed nail care.During an interview on 09/10/25 at 4:18 PM, Certified Nursing Assistant (CNA) 2 stated that R63 was confused, and the staff had to clean his nails. She stated R63 receives two showers per week, and the staff clean his fingernails during the shower. During an interview on 09/11/25 at 12:54 PM, LPN3 stated that R63 was confused, compliant with fingernail care, and the staff provided his nail care during his showers and as needed. He confirmed R63's fingernails were dirty, had dark material under his nails, and they needed to be cleaned.During an interview on 09/11/25 at 1:54 PM, the Director of Nursing (DON) stated that staff were to provide fingernail care during showers, which were provided to the residents twice per week and as needed (prn). She said R63 did not have a history of refusing personal care and/or nail care. The DON said the CNAs were to assess a resident's fingernails every shift and provide nail care as needed.

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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 observation, interview, record review, and policy review, the facility failed to ensure two of three residents (Resident (R)15 and R63) reviewed for respiratory care in a sample of 24 residents received oxygen as ordered by the physician and R15s oxygen unit was clean and sanitary. This failed practice has the potential to cause respiratory issues and /or infections for residents.Review of the facility's policy titled Oxygen Administration dated October 2001 documented, .Verify that there is a physician's order for this procedure.Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.1. Review of R63's Face Sheet located in the electronic medical record (EMR) under the Admissions tab documented R63 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure and chronic obstructive pulmonary disease (COPD).Review of R63's Physician Orders located in the EMR under the Orders tab dated 06/03/25 revealed an order for Oxygen at 2 lpm [liters per minute] continuous via nasal cannula for COPD. There was no order for R63's oxygen filter to be cleaned.Review of R63's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 07/13/25 revealed a Brief Interview of Mental Status (BIMS) score of seven out of 15 indicating severe cognitive impairment and the resident used oxygen.Review of R63's Medication Administration Record (MAR) located in the EMR under the Orders tab, dated 09/01/25 to 09/11/25 revealed R63 received oxygen at 2 lpm.Observations conducted on 09/09/2025 at 12:04 PM and on 09/10/25 at 9:20 AM revealed R63's oxygen rate was at 3.5 lpm. There was a film of gray dust on the outside of the oxygen machine and there was visible dust on the filter, which when removed had a moderate amount of gray dust.During an interview on 09/10/25 at 3:46 PM, Licensed Practical Nurse (LPN) 3 said he was assigned to R63's unit on 09/10/25 between 7:00 AM and 7:00 PM. LPN3 said R63's oxygen rate was ordered at 2 lpm. He said although he checked the oxygen rate on residents' receiving oxygen each shift, he had not yet checked R63's oxygen rate He said the night nurse changed the oxygen tubing every Sunday and was to clean the oxygen machines and filters. LPN3 confirmed thatR63's oxygen rate was incorrectly set at 3.5 lpm, the machine needed to be cleaned, the filterhad visible lint on the outside and inside of the filter and appeared not to have been recently cleaned.During an interview on 09/11/25 at 5:27 PM, LPN5 said he was the 7 PM to 7 AM nursing supervisor. He said residents receiving oxygen required a physician order that included, the rate and method of administration and change oxygen tubing and clean oxygen filter weekly (Sunday on R63's unit). He also confirmed he could not locate documentation that the oxygen filter had been cleaned.2. Review of R15's Face Sheet located in the EMR under the Admissions tab documented R15 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and COPD.Review of R15's Physician Orders located in the EMR under the Orders tab, dated 08/02/25 revealed an order for, Oxygen at 2 lpm continuous via nasal cannula and clean oxygen machine filter every Sunday.Review of R15's quarterly MDS located in the resident's EMR under the MDS tab, with an ARD of 06/18/25 revealed R15 had a BIMS score of 15 out of 15, which indicated intact cognition and the resident used oxygen.Review of R15's MAR located in the EMR under the Orders tab dated 09/01/25 to 09/11/25 revealed R15 received oxygen at 2 lpm and the oxygen filter was cleaned every Sunday.Observations conducted on 09/09/2025 at 12:34 PM and on 09/10/25 at 9:41 AM revealed R15's oxygen rate was at 4 lpm.During an interview on 09/10/25 at 3:40 PM, LPN3 said he was assigned to R15 on 09/10/25 between 7:00 AM and 7:00 PM. LPN3 said R15 had a physician order for oxygen at 2 lpm. He said he had not yet checked R15's oxygen rate during his shift. He said R15 was not able to change her oxygen rate. LPN3 said R15's oxygen rate was incorrectly set at 4 lpm and not per the physician's order.During an interview on 09/11/25 at 11:20 AM, the Director of Nurses (DON) said the nurses were to check a resident's oxygen rate every shift. She stated the nurses were to ensure residents received oxygen per the physician's orders and notify the physician if a resident's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen rate needed to be adjusted. The DON said the nurses changed the oxygen tubing and cleaned the filters on Sunday nights and all nurses were to ensure the oxygen machines and filters were clean.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 have medications available for administration for one (Resident (R) 57) of seven sampled residents whose drug regime was reviewed in a total sample of 24 residents. The facility failed to have R57's Clonazepam medication (Generic name- Klonopin which is an antianxiety medicine) available to administer as prescribed for two days, which caused the resident to not feel well and have increased anxiety.Review of R57's admission Record revealed R57 was admitted to the facility on [DATE] and had diagnoses of which included bipolar disorder, anxiety disorder, and major depressive disorder.Review of R57's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/25, located in the EMR under the MDS tab, indicated R57 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, which indicated the resident was cognitively intact. The MDS also indicated R57 had an active diagnosis of anxiety disorder and received an antianxiety medication.Review of R57's current care plan most recently reviewed by staff on 08/20/25 and located in the EMR under the Care Plan tab contained the following Focus which was initiated on 12/29/23: Medication- Anti-Anxiety: Resident requires anti-anxiety medication related to anxiety disorder as evidenced by Verbalizations of feelings of nervousness/anxiety. The goal indicated, Medication use will result in the maintenance of the resident's functional status. The care plan approach included, Administer anti-anxiety medication as ordered by the physician.Review of R57's current Physician Orders located under the Orders tab in the EMR revealed an order for Clonazepam 1 milligram tablet to be given by mouth twice a day for anxiety.Review of R57's monthly September 2025 Medication Administration Records (MAR) provided by the facility, revealed R57 had an order to receive a one milligram tablet of Clonazepam twice a day at 9:00 AM and 8:00 PM for anxiety. Further review of R57's September 2025 MAR revealed she did not receive her prescribed Clonazepam twice a day as order on 09/02/25 and on 09/03/25. On 09/02/25 and 09/03/25, Licensed Practical Nurse (LPN) 2 noted on the MAR that R57 did not receive her 9:00 AM dose of Clonazepam because the medication was not available.Review of R57's Progress Notes located under the Prog [Progress] Note tab of the EMR, revealed the following entries:A Nurse Practitioner Note written on 08/28/25 at 09:38 AM, specified, Clonazepam order refilled at this time.A Behavior Note dated 09/03/25 at 11:14 AM, written by LPN 2, specified, Resident upset due to medication not delivered by pharmacy and threatening to call EMS [emergency medical services] if medication is not here this evening. Resident also c/o [complain of] chest pain since last night due to her not having clonazepam stating, Not only do I need it. I am addicted to it. I have been taking it since I was 23 and I feel like I am having withdrawals. Nurse did reach out to pharmacy to get status of medication and get it in stat. Nothing was given in report resident c/o chest pain. Will continue to monitor.A Nurse Practitioner Note written on 09/03/25 at 11:22 AM, specified, Clonazepam order refilled again per pharmacy request.During an interview on 09/09/25 at 10:45AM, R57 stated she went without her Klonopin for two or three days during the prior week. R57 stated she had a physician's order to receive Klonopin twice a day, but the facility did not have it available last week, so she did not receive it. R57 stated as a result of not receiving her Klonopin she experienced sweating and was more anxious than normal. R57 explained when the facility could not obtain her Klonopin from the pharmacy she received a dose of Ativan during the afternoon of the second day (09/03/25) which did help ease her anxiety. R57 stated the following morning (09/04/25) she received her 9:00 AM dose of Klonopin as scheduled.During an interview on 09/10/25 at 4:50 PM, LPN2 stated she worked with R57 and administered her medications during the 7:00 AM to 7:00 PM shift. LPN2 confirmed that R57 missed doses of Klonopin a week ago because the medication was not available in the facility because the pharmacy did not send it to the facility. LPN2 explained that the staff called the pharmacy about the resident's Klonopin not being available, but the medication was not received for a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	couple days. LPN2 stated she did not observe R57 experiencing any sweating or signs of withdrawal, but she may have been more anxious than normal related to missing her medication.During an interview on 09/10/25 at 5:03 PM, the Director of Nursing (DON) confirmed R57 missed a total of four doses of Klonopin on 09/02/25 and 09/03/25 because the medication was not available. The DON stated she was notified on 09/03/25 that R57's Klonopin was not available in the facility. The DON explained that she contacted the pharmacy on 09/03/25 and was informed that R57's Klonopin would not arrive at the facility until after the resident's 8:00 PM dose was scheduled. The DON stated an order was written on 09/03/25 for R57 to receive stat dose of Ativan to help ease her anxiety until her Klonopin could be administered during the morning of 09/04/25. The DON stated she spoke with R57 on 09/03/25 and did not observe the resident experiencing any signs of withdrawal from not receiving the medication.During an interview on 09/11/25 at 12:25 PM, R57's physician, who was also the facility's Medical Director, stated the resident's Klonopin should have been available for administration as ordered. The MD stated it was appropriate for the facility to obtain a stat order on 09/03/25 to administer Ativan in place of the Klonopin to reduce the resident's anxiety, because the Ativan would likely be available in the facility's emergency medication kit. The MD stated that he did not feel the resident experienced any serious consequences, but most likely experienced an increase in anxiety as a result of the missed doses of Klonopin.During an interview on 09/11/25 at 12:40 PM, the Administrator explained R57's Klonopin was reordered on 08/28/25. However, the pharmacy did not dispense the medication at this time because the refill order was submitted too early, so the resident's insurance would not reimburse the pharmacy. The resident's Klonopin was again reordered by staff on 09/03/25 after the resident had run out of the medication.During an interview on 09/11/25 at 12:50 PM, the Administrator stated the facility did not have a policy for obtaining medications from the facility's pharmacy

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, test tray observation, record review, and facility policy review, the facility failed to serve food that was palatable and hot to four of four residents (Resident (R) 4, R35, R57, and R80) reviewed for food palatability out of a total sample of 24 residents. This failure had the potential to affect 102 residents who consumed food prepared from the facility's kitchen and could result in residents skipping meals and experiencing weight loss.Review of the facility's policy titled Food and Nutrition Services dated 10/17 indicated, Policy Statement Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident . 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature .1. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/25 and located in the electronic medical record (EMR) under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact.During an interview on 09/09/25 at 12:53 PM, R4 stated the food served at the facility did not always taste good and was not always hot. R4 stated she would like the food to be seasoned and served hot at meals.2. Review of R35's quarterly MDS with an ARD of 06/13/25 and located in the EMR under the MDS tab revealed a BIMS score of 14 out of 15, which indicated the resident was cognitively intact.During an interview on 09/09/25 at 9:05 AM, R35 stated the food served at the facility did not taste good. R35 specified the breakfast food including eggs and toast were always served cold. R35 stated the meals sat in the food delivery cart on the hallway for long periods before being served. R35 explained all meals needed to be improved, not just breakfast.3. Review of R57's quarterly MDS with an ARD of 08/16/25 and located in the EMR under the MDS tab revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact.During an interview on 09/09/25 at 10:45 AM, R57 stated the food served at the facility was not consistent. R57 explained that some meals taste good and other meals do not taste good at all. R35 stated food was cold when served. R35 specified that she ate most of her meals in her roomand nursing staff did not serve meals timely on the hallway which resulted in food being served cold.4. Review of R80's admission MDS with an ARD of 07/01/25 and located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.During an interview on 09/09/25 at 12:55 PM, R80 stated the food was cold when served at meals and she was served very few good meals at the facility. R80 specified at breakfast she was served cold eggs and toast.5. In response to resident complaints about food, a test tray was requested to be sent to the facility's 200 hallway during the breakfast meal on 09/11/25. Observation revealed before the meal tray cart, which contained the test tray, left the kitchen at 8:22 AM, resident meals were observed being served on unheated plates. Observation of the kitchen's plate warmer which contained the plates staff were serving resident meals on was turned off. Food temperatures on the kitchen tray line were monitored by staff and were at acceptable levels of 135 degrees Fahrenheit (F) and above for the hot foods. The test tray and other resident meal trays were placed on an enclosed tray cart that had no heating element and were delivered to the 200 hallway at 8:23 AM. The last resident's breakfast tray was observed to be served on the 200 hallway on 09/11/25 at 8:56 AM. At this time, the food and beverages on the test tray were sampled in the presence of the facility's Registered Dietitian (RD). The RD utilized a calibrated facility thermometer to obtain temperatures of the food and beverages served on the test tray. The RD also tasted the food served on the requested test tray. Temperature checks and tasting of the food served on the test tray revealed the following:a. The grits on the test tray registered 115 degrees Fahrenheit (F) and were barely warm when tasted. The grits were observed to be served directly on the plate and had started to solidify. The RD also tasted the grits and confirmed the grits tasted barely warm and needed to be hotter.b. The pancakes on the test tray registered 117 degrees F and were barely warm when tasted. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD also tasted the pancakes and confirmed they were barely warm and needed to be hotter.During an interview on 09/11/25 at 9:05 AM, the RD stated the kitchen's plate warmer should have been turned on by staff prior to the breakfast meal service and the grits and pancakes should be hot when served to resident

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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 observations, record review, interview, and review of Centers for Disease Control (CDC) guidelines, the facility nursing staff failed to wear Personal Protective Equipment (PPE) when providing direct care for one of one (Resident (R)1) reviewed for Enhanced Barrier Precautions (EBP) in the sample of 24 residents. This could place this resident and other residents and staff at risk of infection by cross-contamination.Observation on 09/09/25 at 10:30 AM of R1 lying in bed revealed a small black bag hanging on the side of her bed. Interview with Certified Nursing Assistant (CNA)3 at this time confirmed that R1 has a nephrostomy tube.Observations on 09/09/25 at 10:30 AM, 09/10/25 at 2:00 PM, and 09/11/25 at 10:00 AM, and 3:00 PM revealed CNA3 entered R1's room to provide direct care without wearing any PPE.Review of R1's Electronic Medical Record (EMR) Clinical Census under the Clinical Census tab revealed admitted on [DATE] with diagnoses of nephrostomy tube since 2022 due to hydronephrosis (extra fluid in the kidney) and acute kidney injury with tubular necrosis (dead tissue in the kidney).Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/01/25 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which showed she had moderate cognitive impairment.Interview on 09/11/25 at 4:00 PM, the Director of Nursing (DON) revealed the Infection Preventionist (IP) was out of the facility. The DON agreed that since R1 had a nephrostomy tube and is on EBP. The DON stated that nursing staff were to wear PPE when providing direct resident care.Review of CDC guidelines, https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html indicated EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Further, under the section Implementation of EBP indicated gowns and gloves are the minimum level of PPE required for these high-contact resident care activities.