STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185013	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Cornerstone Group, LLC	55 East North Street Madisonville, KY 42431

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and facility policy review, the facility failed ensure residents had the right to be informed of, and participate in their treatment by failing to inform residents and/or their representatives in advance of the risks and benefits of psychotropic medication use prior to administration, which affected 5 (Residents 2, 20, 4, 6, and 5) of 5 residents reviewed for unnecessary medications.The findings include: Review of a facility policy titled, Antipsychotic Medication Use, revised in March 2015, indicated, Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy revealed that it did not address discussing the risks and benefits of antipsychotic use with residents or their representative prior to administration. 1. An admission Record indicated the facility admitted Resident #2 on 11/22/2019. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder, vascular dementia with psychotic disturbance, and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #2 received antipsychotic medication during the seven-day lookback period.Resident #2's Care Plan Report included a focus area revised on 12/16/2025, that indicated the resident was at risk for adverse effects related to psychotropic medication use for dementia with psychosis. Interventions initiated 05/12/2025 directed staff to administer medications as ordered and to educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of prescribed psychoactive medication. Resident #2's Order Summary Report, with active orders as of 01/07/2026, contained an order dated 11/25/2025 for risperidone (an antipsychotic) oral tablet, 0.25 milligrams (mg) by mouth at bedtime for dementia with psychosis. Resident #2's January 2026 Medication Administration Record [MAR] revealed that staff documented that Resident #2 was receiving risperidone according to their order. Resident #2's record revealed no evidence of the resident or their representative being educated on the risk or benefits of the use of antipsychotic medication, and no evidence of consent from the resident or representatives on its use. 2. An admission Record indicated the facility admitted Resident #20 on 01/02/2026. According to the admission Record, the resident had a medical history that included a diagnosis of major depressive disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #20 received antidepressant medication during the seven-day lookback period.Resident #20's Care Plan Report included a focus area revised on 12/16/2025, that indicated the resident received antidepressant medication related to anxiety disorder, agoraphobia with panic disorder, and depression. Interventions revised on 12/16/2025 directed staff to administer antidepressant medications as ordered by the physician and to monitor side effects. Resident #20's Order Summary Report, with active orders as of 01/07/2026, contained an order dated 01/02/2026 for mirtazapine (an antidepressant) oral tablet, 7.5 milligrams (mg) by mouth for appetite/depression. Resident #20's (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2026 Medication Administration Record [MAR] revealed that staff documented that Resident #20 was receiving mirtazapine according to their orders. Resident #20's record revealed no evidence of the resident or their representative being educated on the risk or benefits of the use of antidepressant medication, and no evidence of consent from the resident or representatives on its use. 3. An admission Record indicated the facility originally admitted Resident #6 on 02/16/2024 and readmitted the resident on 12/12/2025. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder and anxiety disorder. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #6 received antidepressant medication during the seven-day lookback period. Resident #6's Care Plan Report included a focus area revised on 12/12/2025, that indicated the resident received antidepressant medication related to depression and anxiety. Interventions initiated 11/05/2025 directed staff to educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of prescribed antidepressant drugs. Resident #6's Order Summary Report, with active orders as of 01/07/2026, contained an order dated 12/12/2025, for mirtazapine (an antidepressant) oral tablet, 15 milligrams (mg) by mouth at bedtime for depression/appetite. Resident #6's January 2026 Medication Administration Report [MAR] revealed that staff documented that Resident #6 was receiving mirtazapine according to their order. Resident #6's record revealed no evidence of the resident or their representative being educated on the risk or benefits of the use of antipsychotic medication, and no evidence of consent from the resident or representatives on its use. 4. An admission Record indicated the facility admitted Resident #4 on 08/11/2023. According to the admission Record, the resident had a medical history that included diagnoses of vascular dementia with behavioral disturbance and agitation, anxiety disorder, and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/14/2025, revealed Resident #4 had had severe impairment in cognitive skills for daily decision-making and had short-term and long-term member problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated that the resident received antipsychotic, antianxiety, and antidepressant medication during the seven-day lookback period. Resident #4's Care Plan Report included a focus area revised 07/21/2025, that indicated the resident received psychotropic medications related to anxiety/depression and dementia with behavioral disturbance. Interventions initiated 08/08/2024 directed staff to monitor for side effects such as tardive dyskinesia, extrapyramidal symptoms (EPS), frequent falls, suicidal ideation, and report to the physician as needed; consult with the pharmacy and physician to consider dosage reduction when clinically appropriate; and discuss with the physician and family regarding ongoing need for medication. Resident #4's Order Summary Report, with active orders as of 01/07/2025, included the following orders:- Citalopram hydrobromide (an antidepressant) 10 milligrams (mg) by mouth one time a day, ordered 10/06/2025.- Buspirone hydrochloride (HCl) (an antianxiety) 10 mg, two tablets by mouth three times a day, ordered 07/21/2025.- Quetiapine fumarate (an antipsychotic) 75 mg by mouth at bedtime, ordered 10/06/2025. Resident #4's January 2026 Medication Administration Record [MAR] revealed staff documented that the resident was receiving the citalopram hydrobromide, buspirone HCl, and quetiapine fumarate according to their physician orders. Resident #4's record revealed no evidence of informed consent or evidence of discussion of risks, benefits, and alternatives with the resident or their representative prior to initiation or continuation of those medications. 5. An admission Record indicated the facility admitted Resident #5 on 05/17/2019 and readmitted on [DATE]. According to the admission Record, the resident had a medical history that included a diagnosis of depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/01/2025, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident received antidepressant medication during the seven-day lookback period. Resident #5's Care Plan Report (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included a focus area revised 06/08/2025, that indicated the resident was at risk for adverse effects related to psychotropic medication use related to diagnosis of depression. Interventions initiated 05/30/2019 directed staff to observe and report side effects and adverse reactions of psychoactive medications, such as tardive dyskinesia, extrapyramidal symptoms (EPS), suicidal ideation, and behavior changes. Resident #5's Order Summary Report, with active orders as of 01/07/2026, revealed an order for escitalopram oxalate (an antidepressant) 20 milligrams (mg) by mouth one time a day for depression, ordered 10/27/2025. Resident #5's January 2026 Medication Administration Record [MAR] revealed staff documented the resident was receiving the escitalopram oxalate according to their physician orders. Resident #5's record revealed no evidence of informed consent or evidence of discussion of risks, benefits, and alternatives with the resident or their representative prior to initiation or continuation of the antidepressant. During an interview on 01/07/2026 at 10:55 AM, the Administrator/Interim Director of Nursing (DON) stated the facility did not obtain consents for psychotropic medication use; they only obtained the resident's general consent to treat while they resided in the facility. The Administrator/Interim DON further stated that most residents who received psychotropic medications were seen by psychiatric services, and she did not know if they discussed the risks versus benefits of those medications with the resident or their representative prior to use. During an interview on 01/08/2026 at 11:16 AM, the Administrator/Interim DON stated she was not aware that the risks versus benefits of psychotropic medication use needed to be discussed with residents or their representatives prior to use. She further stated that moving forward, she planned to initiate a new assessment for psychotropic medication use, found in their electronic medical record software, to obtain consent before use. On 01/08/2026 at 9:56 AM, the Administrator/Interim DON stated that she could not find a facility policy related to the use of antidepressant or antianxiety medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, review of facility policy and manufacturer instructions, the facility failed to ensure a medication error rate of less than 5 percent (%). There were six errors out of 26 opportunities, which yielded a medication error rate of 23.08%, which affected 2 (Resident 36 and Resident 15) of 8 residents observed during medication administration.The findings include: A facility policy titled, Administering Medications, revised December 2012, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The policy specified, 3. Medications must be administered in accordance with the orders, including any required time frame. Further review revealed, 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. An admission Record indicated the facility admitted Resident #36 on 04/12/2022. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, essential hypertension, and irritable bowel syndrome. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/07/2025, revealed Resident 36 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident 36's Order Summary Report, with active orders as of 01/07/2026, included the following orders:- Polyethylene glycol powder (a laxative)17 grams (gm) by mouth one time a day for constipation, dated 01/30/2025.- Symbicort Inhalation Aerosol (a bronchodilator combination) inhaler, 160-4.5 micrograms (mcg) per actuation, two puffs inhaled orally two times a day for COPD, with orders to rinse their mouth with water after use and do not swallow, dated 01/30/2025. The manufacturer's instructions for the Symbicort inhaler, dated 12/2017, revealed, Rinse your mouth with water and spit the water out after each dose (2 puffs) of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat. During an observation on 01/09/2026 at 7:28 AM, Certified Medication Technician (CMT) 1 administered medications to Resident 36. The CMT mixed the polyethylene glycol powder with 4 to 5 ounces (oz) of water and administered the medication to the resident but did not ensure the resident consumed the entire amount, discarding approximately 2 oz. The CMT administered two puffs of the Symbicort inhaler and did not have the resident rinse and spit afterward as ordered. 2. An admission Record indicated the facility admitted Resident 15 on 10/27/2023. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, hepatic encephalopathy (a brain dysfunction due to liver disfunction), and cicatricial lagophthalmos of the left eye (an inability to fully close the eye lid). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/08/2025, revealed Resident 15 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident 15's Order Summary Report, with active orders as of 01/07/2026, included the following orders:-Breo Ellipta Inhalation Aerosol Powder (a bronchodilator combination) Breath Activated 100-25 micrograms (mcg) per actuation, one puff inhaled orally one time a day for COPD, with orders to rinse mouth with water after each use and spit, ordered 01/31/2025.-Polyethylene glycol-propylene glycol ophthalmic gel (an ophthalmic lubricant) 0.4-0.3% instill one application in the left eye two times a day for lagophthalmos, ordered 01/31/2025.- Polyethylene glycol powder (a laxative)17 grams (gm) by mouth one time a day for constipation, ordered 12/11/2025.-Lactulose oral solution 10 gm/ 15 milliliters (ml), 45 ml by mouth four times a day for hepatic encephalopathy, ordered 03/31/2025. The manufacturer's instructions for the Breo Ellipta inhaler, revised May 2023, revealed, 2.3 Administration Information included, After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis. An observation on 01/09/2026 at 7:41 AM revealed Certified Medication Technician (CMT) 1 prepared and administered (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications to Resident #15. The CMT mixed the polyethylene glycol powder with approximately 4 ounces (oz) of water and administered only approximately 2 oz of the medication. CMT 1 administered the inhaler and did not have the resident rinse and spit afterward, applied polyethylene glycol-propylene glycol ophthalmic gel to both eyes instead of only the left eye as ordered, and administered 30 milliliters of the lactulose instead of the 45 ml ordered. During an interview on 01/07/2026 at 12:32 PM, CMT 1 stated that she was supposed to have the resident rinse and spit after using inhalers and confirmed that she did not do that for Resident 36 or Resident 15 but should have in order to prevent thrush. CMT 1 stated that she put Resident 15's eye gel in both eyes and stated that she did not realize it was only ordered for the left eye. CMT #1 confirmed that she gave 30 ml of lactulose and stated that she knew the resident was supposed to get 45 ml, but she was nervous. She stated that she should have read the whole order and double checked prior to administering the medications to ensure she was giving medications according to physician orders. During an interview on 01/07/2026 at 3:25 PM, CMT 2 stated that she would have a resident rinse and spit after using inhalers in order to prevent thrush. She stated that when passing medications, she compared the label of the medication card with the MAR and checked for the five rights, right resident, medication, dose, time, and route and checked three times. During an interview on 01/07/2026 at 3:17 PM, Licensed Practical Nurse (LPN) 3 stated that after a resident was administered an inhaler, staff should have the resident rinse their mouth and spit. She stated that in order to ensure medications were administered according to physician orders, the staff should read the medication administration record (MAR), and check it three times with the five rights, right resident, medication, dose, route, and time. During an interview on 01/08/2026 at 11:33 AM, LPN 4 stated that when administering medications, the staff should follow the five rights and check it three times. She stated that polyethylene glycol powder should be mixed in 8 oz of water, and if the resident did not take the whole thing, then it should be documented. She stated the resident should rinse their mouth and spit after the use of an inhaler to prevent oral problems. During an interview on 01/08/2026 at 11:16 AM, the Administrator/Interim Director of Nursing (DON) stated that when medications were being administered, the CMT/Nurse should look at the order, look at the MAR, and check it three times for the right dosage, resident, route, medication, and time. She stated polyethylene glycol powder should be mixed in 4 to 8 oz of fluid, and if the resident did not consume the full amount of a mixed medication, staff should document and notify the physician. She stated that when a resident used an inhaler, they should rinse their mouth and spit after use to prevent coating in their mouth.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and facility policy review, the facility failed to ensure 1 of 2 sampled residents (R14) reviewed for beneficiary notifications was provided a Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) prior to the end of covered Medicare Part A services.The findings include: An undated document provided by facility staff titled, Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), indicated, A Medicare provider or health plan (Medicare Advantage plans and cost plans collectively referred to as ?plans') must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The policy continued, The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Resident 14's admission Record indicated the facility admitted the resident on 07/22/2025. According to the admission Record, the resident had a medical history that included diagnoses of dementia, depression, and diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/21/2025, revealed Resident 14 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. A list of residents discharged from a Medicare covered Part A stay with benefit days remaining during the six months prior to the survey revealed Resident 14 was discharged from a Medicare covered Part A stay on 12/05/2025 but remained in the facility. Resident 14's SNF Beneficiary Notice Scenarios for Surveyors form, completed by the facility staff, revealed the facility initiated Resident 14's discharge from Medicare Part A services when the resident's benefit days were not exhausted. During an interview on 01/07/2026 at 11:21 AM, the Administrator/Interim Director of Nursing (DON) stated the Corporate [NAME] Specialist told her that she accidentally missed the email notifying her that Resident 14's payor source was changing, so she did not issue a NOMNC or SNF ABN notifying the resident or their representative of the change. During an interview on 01/08/2026 at 10:31 AM, the Corporate [NAME] Specialist stated the facility staff notified her when a resident was discharging from Medicare several days in advance, and she then prepared the paperwork to notify the resident and their family of their billing options. The Corporate [NAME] Specialist further stated she was notified of Resident 14's payor change in a timely manner, but she did not issue a NOMNC or SNF ABN due to an oversight on her part. During an interview on 01/08/2026 at 11:16 AM, the Administrator/Interim DON stated that if a resident received skilled nursing services and was scheduled to discharge from those services, they were notified several days in advance. Per the Administrator/Interim DON, the MDS Coordinator then emailed the Corporate [NAME] Specialist of the payor changes, then issued a NOMNC or SNF ABN notifying the family and their representative of their billing options moving forward. She further stated that she expected NOMNCs and SNF ABNs to be completed prior to a resident's last day of coverage so the resident and their family could prepare for their next payor source or get started on a Medicaid application.

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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. Based on observation, interview, and record review, the facility failed to provide necessary activity of daily living (ADL) care for 1 of 1 sampled resident's (Resident 12) reviewed for ADL care. Specifically, the facility failed to offer to shave Resident 12's facial hair. The findings include: An admission Record indicated the facility originally admitted Resident 12 on 03/03/2025 and readmitted the resident on 06/03/2025. According to the admission Record, the resident had a medical history that included diagnoses of left humerus fracture, chronic obstructive pulmonary disease (COPD), asthma, diabetes mellitus, peripheral vascular disease, hypertension, gastroesophageal reflux disease (GERD), chronic pain, major depressive disorder, morbid obesity, anxiety disorder, dysphagia, and diverticulosis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/01/2025, revealed Resident 12 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated that the resident required set-up or clean-up assistance for eating, and supervision or touching assistance for showering/bathing. Resident 12's Care Plan Report included a focus area revised 12/1/2025, that indicated the resident had a self-care deficit related to general weakness and requiring assistance with ADLs. Interventions initiated 06/10/2025 directed staff to assist the resident with bathing needs daily per bath schedule and resident's preference, shampoo hair with showers, keep nails clean daily and trim weekly as needed, and explain procedures prior to beginning and provide privacy. Resident 12's December 2025 and January 2026 bath/shower indicated that staff documented that Resident 12 received showers at least twice a week; however, there was no documentation that shaving was offered or completed. On 01/05/2026 at 12:38 PM, Resident 12 was observed sitting in the dining room with long facial hair on their chin. During an interview at that time, Resident 12 stated that they disliked the length of the facial hair and stated that they received a shower that morning but did not get shaven. Resident 12 stated they did not ask to be shaved but stated that they should not have to. On 01/06/2026 at 9:40 AM, Resident 12 was observed sitting at a dining room table visiting with other residents. Resident #12 continued to have long facial hair on their chin. On 01/07/2026 at 10:36 AM, Resident #12 was observed sitting at a dining room table playing a game with other residents. The resident had long facial hair on their chin and increased hair growth on their upper lip. On 01/07/2026 at 3:20 PM, Resident #12 was observed to continue to have long facial hair on the chin and increased growth on the upper lip. During an interview on 01/07/2026 at 3:25 PM, Certified Nursing Assistant (CNA) #5 stated all residents should be shaved every shower day, and it should always be offered. She stated she was not usually in that hall, and CNA #6 was the shower aide for the resident. During an interview on 01/08/2026 at 9:16 AM, CNA #6 stated she gave Resident #12 a shower on Monday (01/05/2026) but did not shave them because the resident did not ask and she did not think about it. She stated she should have offered. During an interview on 01/07/2026 at 3:17 PM, Licensed Practical Nurse (LPN) #3 stated that all residents should be shaved on their shower days if needed. She stated a resident should not have to ask to have it done, and it should be offered when needed. During an interview on 01/08/2026 at 11:16 AM, the Administrator/Director of Nursing (DON) stated residents should be shaved upon request and, if visible, shaving should be offered and completed during showers. She stated that it applied to all residents, and that if facial hair was seen, shaving should be offered. The Administrator/Interim DON stated the CNAs sometimes worried about offending residents, but shaving should still be offered. She stated that Resident #12 should have been shaved with the shower on Monday. On 01/08/2026 at 11:16 AM, the Administrator/Interim DON stated she was unable to locate a policy for ADLs, showers, or shaving.

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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 observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented Enhanced Barrier Precautions (EBP) and followed infection prevention and control practices for 1 (Resident 29) of 1 resident's reviewed for tube feeding. The findings include:A facility policy titled, Enhanced Barrier Precautions, updated 04/05/2024 revealed, It is the policy of this facility that Enhanced Barrier Precautions in conjunction with standard precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO, or residents with ?[sic] infection or colonization with a CDC [Centers for Disease Control and Prevention]-targeted MDRO when Contact Precautions do not otherwise apply. The policy revealed, Enhanced Barrier Precautions (EBP) 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. The policy revealed, EBP should be used for any residents who meet the definitions/criteria below, wherever they reside in the facility, which included, Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The policy revealed, High-contact Resident Care activities included, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. An admission Record indicated the facility admitted Resident 29 on 12/05/2025. According to the admission Record, the resident had a medical history that included diagnoses of traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue that covers it) with loss of consciousness, non-traumatic subarachnoid hemorrhage from anterior (towards the front) communicating artery, hypertension, vitamin B deficiency, anemia, anxiety disorder, seizures, and muscle spasms. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2025, revealed Resident 29 had severe impairment in cognitive skills for daily decision-making and had no short-term or long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident required a feeding tube and received 51% or more of their total calories and 501 cubic centimeters (cc) or more of fluid via tube feeding each day. Resident 29's Care Plan Report, revealed a focus area initiated 12/17/2025, that indicated the resident had a potential for nutritional problems related to their NPO [nothing by mouth] status and indicated that resident had a feeding tube. Interventions initiated 12/17/2025 directed staff to administer medications as ordered and provide tube feeding as ordered. An observation on 01/07/2026 at 3:10 PM revealed Licensed Practical Nurse (LPN) 3 entered Resident 29's room without putting on the proper personal protective equipment (PPE), wearing only gloves, and administered medication to the resident through the resident's feeding tube. There was no signage on the door indicating that the resident was on Enhanced Barrier Precautions, and there were no PPE supplies in the room or in the hallway outside the door. During an interview on 01/07/2026 at 3:17 PM, LPN 3 stated that the facility had two residents on EBP because of MDRO, but she did not know she was supposed to wear a gown when providing care for the feeding tube. She stated that she did not know it was required for wounds, indwelling catheters, or other conditions besides MDROs and thought it was at the discretion of the physician. During an interview on 01/07/2026 at 3:29 PM, the Administrator/Interim Director of Nursing (DON) stated that the facility only implemented EBP for MDROs based on consultant guidance. After reviewing the policy, the Administrator/Interim Administrator acknowledged that EBP should have been implemented for residents with wounds, catheters, and feeding tubes. She stated that she was not aware of this requirement until it was brought to her attention and stated that the consultant did not provide that information.