STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305080	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epsom Healthcare Center	901 Suncook Valley Highway Epsom, NH 03234

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to provide privacy of electronic medical records for 2 of 2 units observed (100 and 200 Halls) and during medication administration.Findings include:200 Hall Observation on 3/10/26 at 11:54 a.m. of Staff I (Licensed Nursing Assistant) was documenting on a laptop computer on a bench on [NAME] Wing short hall. Staff I set the computer down on a bench and walked away into a resident room. There was identifiable information observed on the computer screen. Interview on 3/10/26 at approximately 11:56 a.m. with Staff I confirmed the above. Staff I revealed that they had not closed the computer so that they did not have to log in again. Observation on 3/10/26 at 2:05 p.m. of the [NAME] Wing short hall revealed a computer on the above same bench that was open with a blank screen. When the keyboard was touched resident identifiable information could be seen. There were no staff members around this computer. 100 Hall Observation on 3/11/26 at 8:09 a.m. on the 100 hall [NAME] side there was a laptop computer open on a movable computer stand near the bench. When the keyboard was touched resident identifiable information could be seen, but then quickly went to a blank screen. There were no nursing staff nearby. Interview on 3/11/26 at 3:12 p.m. with Staff J (Staff Development) revealed that it is facility policy that staff click the walk away button to secure the electronic medical record when they walk away from the computer and are trained on this during orientation and annually. Interview on 3/12/26 at 8:07 a.m. with Staff K (Corporate Nurse) confirmed that it is facility policy that staff lock the screen when they are away from the computer to protect resident identifiable information. Staff K revealed that the facility's electronic medical record automatically locks after 15 minutes when idle. Resident #73 Observation on 3/11/26 at approximately 8:15 a.m. of the [NAME] Wing, East Hall medication cart with Staff A (Registered Nurse) revealed that while preparing medications for Resident #73, Staff A partially closed the laptop and walked away to go to the medication room, which was out of direct sight of the medication cart, with Resident #73's health information remaining on the screen. Further observation revealed that when Staff A returned to the medication cart to continue preparing (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications for Resident #73. Staff A partially closed the computer screen leaving Resident #73's health information visible on the computer screen while administering medications to Resident #73. Resident # 36 Observation on 3/11/26 at approximately 8:30 a.m. of the [NAME] Wing, East Hall medication cart with Staff A revealed that after preparing medications for Resident #36 Staff A partially closed the computer screen and left to provide medications to Resident #36 which was out of the sight line of the laptop. Interview on 3/11/26 at approximately 8:35 a.m. with Staff A confirmed the above observations. Resident #42 Observation on 3/11/26 at approximately 8:45 a.m. of the [NAME] Wing North Hall medication cart with Staff B (Licensed Practical Nurse) revealed Staff B partially closed the computer screen walked away from the laptop to give medications to Resident #42. The laptop was out of sightline of Staff B. Interview on 3/12/26 with Staff B confirmed the above observation. Review on 3/12/26 of the facility's policy titled HIPAA [Health Insurance Portability and Accountability Act] Privacy and Security Policy reviewed on 10/3/25 revealed, .This policy establishes safeguards to prevent unauthorized access, viewing, or disclosure of PHI [Protected Health Information], including requirements for screen privacy, computer security, and automatic system timeouts . To protect resident confidentiality, the following safeguards must be followed . 4. Staff must immediately minimize or close resident records when not actively in use. 5. Staff must not leave a computer unattended while resident information is displayed . Staff are also required to . Lock their screen when stepping away from the computer .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to hold routine interdisciplinary care plan meetings and include the resident in the meeting for 1 of 1 resident reviewed for care planning in a final sample of 22 residents (Resident identifier is #27).Findings include:Interview on 3/10/26 at 11:54 a.m. with Resident #27 revealed that he/she had not been invited to attend their care plan meetings. Review on 3/12/26 of Resident #27's quarterly comprehensive Minimum Data Set (MDS) assessments revealed that Resident #27 had been assessed by the facility on 8/13/25, 11/5/25 and 1/22/26. Review on 3/12/26 of Resident #27's Care Conference Report revealed that the most recent care plan meeting was held on 8/19/25 and that Resident #27 was their own decision maker. Resident #27 was not listed as attending this meeting and there was no documentation that he/she had been invited. There were no documented care plan meetings held after the 11/5/25 and 1/22/26 assessments. Interview on 3/12/26 at 9:12 a.m. with Staff L (Social Service Specialist) confirmed that Resident #27's most recent care plan meeting held was on 8/19/25 and that Resident #27 was not documented as attending/declining this meeting. Staff L revealed that the facility will hold care plan meetings after the MDS assessments and that Resident #27's care plan meetings were missed for 11/5/25 and 1/22/26 quarterly comprehensive MDS assessments. Review on 3/12/26 of the facility's policy titled Resident Participation in Care Planning revised 10/15/25 revealed, . The resident and his or her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan . 9. The social services director of designee is responsible for notifying the resident/representative and for maintaining records of such notices .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow professional standards for 2 of 3 residents reviewed for nutrition, 1 of 1 resident reviewed for choices, and 1 of 6 residents reviewed for unnecessary medications in a final sample of 22 residents. (Resident identifiers are #5, #8, #24, and #65.)Findings include:Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . Resident #8 Review on 3/11/26 of Resident #8's progress note dated 2/26/26 revealed that the nurse practitioner would like to decrease Resident #8's Eliquis (a blood thinner) from 5 milligrams (mg) twice daily to 5 mg once daily. This note was written by Staff D (Licensed Practical Nurse (LPN)). Review on 3/11/26 of Resident #8's February 2026 Medication Administration Record (MAR) revealed a physician's order for Eliquis (blood thinner) 5 mg (milligram) twice daily for the treatment of a cerebrovascular accident (CVA). Further review revealed that on 2/26/26, Resident #8 received the morning dose of Eliquis 5 mg, after which the medication was discontinued without a new physician's order to restart Eliquis. Review on 3/11/26 of Resident #8's March 2026 MAR revealed that there was no order for Eliquis from 3/1/26 to 3/11/26. Review on 3/11/26 of Resident #8's physician progress note dated 3/6/26 revealed . Chronic atrial fibrillation . continue Eliquis Review on 3/11/26 of Resident #8's Nurse Practitioner note dated 3/11/26 revealed .Chronic atrial fibrillation . Continue . Eliquis . This was written by Staff E (Advanced Practical Registered Nurse). Interview on 3/11/26 at 1:19 p.m. with Staff E revealed that Resident #8 should be on Eliquis 5 mg daily and confirmed that this was not in Resident #8's physician's orders. Interview on 3/11/26 at 1:24 p.m. with Staff D confirmed that they had received a verbal order from Staff E on 2/26/26 to change Resident #8's Eliquis dosage from 5 mg twice daily to 5 mg once daily. Staff D further confirmed that instead of updating the order, the Eliquis was discontinued. Review on 3/11/26 of Resident #8's Anticoagulant Care Plan revealed an intervention to administer medication as ordered. Review on 3/11/26 of the facility's policy titled Physician's Orders and revised on 10/3/25 revealed, . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verbal orders must be recorded immediately in the resident's chart by the person receiving the order . Resident #24 Review on 3/11/26 of Resident #24's outside Cardiology visit progress note dated 2/26/26 revealed the provider recommended to consider starting Pyridostigmine at 30 mg twice daily for autonomic hypotension with medication induced hypertension. Review on 3/11/26 of Resident #24's March 2026 MAR revealed a physician's order for Pyridostigmine Bromide tablet 30 mg twice daily for orthostatic hypertension with a start date of 2/27/26. Review also revealed that the Pyridostigmine Bromide 30 mg order did not have parameters to hold the medication. Further review revealed the Pyridostigmine Bromide 30 mg was not administered for the following dates and reasons: On 3/5/26, due to condition (no documentation of what the condition was to not administer the medication); On 3/9/26, due to condition with a comment that indicated 217/97; On 3/10/26, due to condition with a comment that indicated elevated blood pressure; and On 3/11/26, due to condition with a comment that indicated blood pressure of 189/82. Interview on 3/12/26 at 1:48 p.m. with Staff D confirmed that the Pyridostigmine Bromide 30 mg medication was not administered as ordered and that there was no parameters that indicated to hold the medication. Staff D also revealed that there was no documentation the provider had been notified that the Pyridostigmine medication was not administered on the above mentioned dates and reasons. Interview on 3/12/26 at 2:08 p.m. with Staff E revealed that they were not aware that Resident #24 did not get the Pyridostigmine medication on the above mentioned dates. Resident #5 Review on 3/12/26 of the facility's policy titled, Weight Policy and Procedure, revised date 1/6/25, revealed .Weight should be recorded in the computer under vitals by the dietician, LNA's [Licensed Nursing Assistant] and nursing. If there is a weight gain or loss of 3 pounds or more nursing/dietician are to be notified. A reweight is to be obtained for accuracy . Review on 3/11/26 of Resident #5's Weights Vital Reports revealed the that nn 2/26/26, Resident #5 weight was 135.4 pounds (lbs.) and on 3/5/26, Resident #5 weight was 148 lbs.,which is a 12.6 lbs. weight gain in 7 days. Further review revealed that a re-weigh was not done to check the accuracy of the weight. Interview on 3/12/26 with Staff C (Dietician) revealed that confirmed the above and was not notified of the weight gain. Resident #65 Review on 3/11/26 of Resident #65's weight record revealed that on 2/25/26, Resident #65 weight (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 123.8 lbs. and on 3/8/26, Resident #65 weight was 108 lbs., which is 15.8 lbs. weight loss in 11 days. Further review of the weight record revealed no other weights were recorded after 3/8/26. Review on 3/11/26 of Resident #65's progress notes revealed no documentation verifying the accuracy of the above weight loss. Interview on 3/12/26 at approximately 10:20 a.m. with Staff D confirmed the above findings. Interview on 3/12/26 at approximately 10:20 a.m. with Staff E revealed that there were no documentation that Resident #65 was reweighed to verify the above weight loss. Staff E also revealed that Resident #65 should have been reweighed immediately to verify the weight loss and that he/she was aware of the above weight loss on 3/8/26. Interview on 3/12/26 at approximately 10:27 a.m. with Staff C revealed that he/she was unaware of the above weight loss on 3/8/26. Interview on 3/12/26 at approximately 12:27 p.m. with Staff D revealed that they obtained Resident #65's weight, and the current weight was 104 lbs. Interview on 3/12/26 at approximately 12:27 p.m. with Staff F (Medical Director) revealed that he/she was unaware of Resident #65's weight loss on 3/8/26. Staff F also revealed that there might have been a discrepancy of obtaining Resident #65's weight on 2/25/26 rather than a weight loss. Review on 3/12/26 of Resident #65's medical record revealed that Resident #65 was admitted to the facility with a diagnosis of severe protein-calorie malnutrition. Further review revealed Resident #65's nutritional care plan interventions in place prior to 3/8/26 were therapeutic diet, honor preferences, encourage intake of diet, offer snacks between meals, Megace medication (appetite stimulant), and house supplements twice a day. Further review also revealed a dietary assessment by Staff C completed on 3/1/26.

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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. Based on interview and record review, the facility failed to provide routine medications to meet the needs of 1 of 1 resident reviewed for choices. (Resident identifier is #24). Findings include:Review on 3/11/25 of Resident #24's outside Cardiology visit progress note dated 2/26/26 revealed the provider recommended to consider starting Pyridostigmine at 30 milligrams (mg) twice daily for autonomic hypotension with medication induced hypertension. Review on 3/11/26 of Resident #24's March 2026 Medication Administration Records revealed a physician's order for Pyridostigmine Bromide tablet 30 mg twice daily for orthostatic hypertension with a start date of 2/27/26. Further review revealed that the Pyridostigmine Bromide 30 mg was not administered on the following dates as the medication was not available: 2/27/26, and 2/28/26, 3/2/26, 3/3/26, 3/6/26, and 3/7/26. There was no documentation indicating that the provider was notified on 2/27/26 or 2/28/26 that Pyridostigmine Bromide 30 mg was unavailable.Review on 3/12/26 of the facility's pharmacy delivery form revealed that the above medication for Resident #24 was delivered on 2/28/26 at 10:44 p.m.Interview on 3/12/26 at 1:48 p.m. with Staff D (Licensed Practical Nurse) confirmed the above findings and and that the medication should have been administered on the above mentioned dates, as it was available in the facility.Interview on 3/12/26 at 2:08 p.m. with Staff E (Advanced Practical Registered Nurse) revealed that he/she was not aware that Resident #24 had missed the medication doses on the above mentioned dates, whether the medication was available or unavailable at the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act upon a provider approved recommendation that were identified by the pharmacist during the Pharmacy Medication Regimen Review (MRR) for 1 of 6 residents reviewed for unnecessary medications in a final sample of 22 residents. (Resident Identifier is #95).Findings include:Review on 3/12/26 of Resident #95's pharmacy review titled Consultant Pharmacist MRR (Medication Regimen Review) Recommendation to the Prescriber, dated 2/16/26, revealed a recommendation to the physician/prescriber to Suggest considering change of lisinopril to losartan. Further review revealed that Staff E (Advanced Practical Registered Nurse) agreed to the recommendation and signed the form.Review on 3/12/26 of Resident #95's physician orders revealed that there was no change in Resident #95's order for lisinopril.Interview on 3/12/26 at approximately 12:15 p.m. with Staff E confirmed that he/she agreed with the above mentioned MRR recommendation but did not update Resident #95's electronic health record to reflect the recommended change to the orders.Review on 3/12/26 of the facility's policy titled Pharmacy Consultant Policy reviewed 4/1/2025 revealed .A written or electronic report of findings and recommendations is given to the attending physician, director of nursing, medical director, and others as may be appropriate .to ensure that the findings are acted upon.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure self-administered medications were properly secured for 1 of 1 resident reviewed for choices in a final sample of 22 residents. (Resident identifier is #53.)Findings include:Observation on 3/10/26 at approximately 9:32 a.m. in Resident #53's room revealed three prescription medication boxes with pharmacy labels on the bedside table. These medications were not secured in a locked storage area. Further observation revealed that Resident #53 was in bed sleeping and these prescription medications were Breztri inhaler (corticosteroid), Albuterol Sulfate inhaler (short-acting bronchodilator), and Ipratropium Bromide nasal spray (treat allergies). Review on 3/10/26 of Resident #53's care plan for self administration of medications revealed that Resident #53's medications (i.e. inhalers and nasal sprays) may be kept in Resident #53's room. Review on 3/10/26 of Resident #53's active physician orders revealed that the above medications had orders that indicated that the above medications may be kept at bedside. Observation on 3/11/26 at approximately between 12:25 p.m. in Resident #53's room revealed that the Breztri inhaler and Ipratropium Bromide nasal spray were on the bedside table and the Albuterol Sulfate inhaler was on top of Resident #53's bedside dresser. These three medications were not secured in a lock storage area. Interview on 3/11/26 at approximately 12:27 p.m. with Staff D (Licensed Practical Nurse (LPN)) confirmed that the above mentioned medications were not locked. Interview on 3/12/26 at 8:10 a.m. with Staff H (LPN) revealed that there was a resident on the unit that had a history of wandering in other resident's room. Observation on 3/12/26 at approximately between 8:12 a.m. in Resident #53's room revealed that Resident #53 was not in the room and the Breztri inhaler and Ipratropium Bromide nasal spray were on the bedside table. Review on 3/12/26 of the facility's policy titled, Self-Administration of Medications, review date 10/2/25, revealed .Self-administered medications are stores in a safe and secure place, which is not accessible by other residents . Review on 3/12/26 of the facility's policy titled, Medication Storage, review date 10/5/25, revealed .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Drugs and biologicals used in the facility are stored in lock compartments .Only authorized to prepare and administer medications have access to lock medications .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure equipment was clean for 1 of 1 kitchen and 1 of 2 kitchenette observed. Findings include:Observation on 3/10/26 at approximately at 8:14 a.m. during the kitchen tour with Staff G (Food Service Director) revealed a fryolator with yellowˆbrown, food-like debris on the top surface. The oil inside the fryolator appeared cloudy, dark in color, and contained visible crumbs. Further observation revealed a thick layer of yellowˆbrown, greaseˆlike grime on the upper portion of the fryolator, including the basket and the top area of the tank. Interview on 3/10/26 at approximately at 8:14 a.m. with Staff G confirmed the above observation. Staff G revealed that the fryolator was last cleaned two weeks ago and gets cleaned every two weeks. Review on 3/11/26 of the fryolator cleaning log revealed the fryolator was last cleaned on 2/28/26. Review on 3/11/26 of the fryolator manufacturer's instructions revealed .DAILY PREVENTATIVE MAINTENANCE .DAILY PREVENTATIVE MAINTENANCE Performing the preventative maintenance steps below on a daily basis will keep your equipment safe and at peak performance. During the cooking process, oil/shortening may spill and splatter and requires immediate attention. Furthermore, during the cooking process, particles, crumbs and crackling collect inside the cooker tank reducing product quality and decreasing oil/shortening life. If you are producing high quantities of fried food and/or frying heavily battered food, it may be necessary to perform these steps more then once a day. DAILY CLEANING At least daily, filtering the oil is required. Make sure a clean filter is use every day. Using the cleaning brush, crumb scoop, and clean out rod, remove all the loose debris .CLEANING THE COOK TANK Recommended at least once a week .CLEANING THE CABINET 1. Wipe any spilled oil/shortening, dust and lint from the cabinet exterior with a clean damp cloth and a mild food grade detergent. Be careful not to get any water or detergent in the oil/shortening. Use a nonabrasive pad for tougher stains if needed. 2. Remove detergent from all surfaces. 3. Cleaning the interior cabinet requires a clean cloth to remove any oil/shortening, dust, lint or filter powder (i.e.: Magnesol) from the interior of the cabinet WEEKLY PREVENTATIVE MAINTENANCE Performing the preventative maintenance steps above on a daily basis will keep your equipment clean and safe . Observation on 3/10/26 at approximately 8:47 a.m. with Staff G of the second floor kitchenette microwave revealed multiple dried food particles scattered across the interior surfaces, including the bottom, side walls, and top interior area of the microwave. Interview on 3/10/26 at approximately 8:47 a.m. with Staff G confirmed the above observation of the second floor kitchenette microwave. Review on 3/12/26 of the FDA 2022 Food Code revealed . Cleaning of Equipment and Utensils (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris .

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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, and record review, the facility failed to follow infection control policy regarding Enhanced Barrier Precautions (EBP) for 2 of 4 residents reviewed for EBP. (Resident identifiers are #65 and #90.)Findings include:Resident #65Observation on 3/10/2026 at approximately 10:44 a.m. in Resident #65's room revealed a EBP sign posted outside the room that indicated to wear gloves and gown (Personal Protective Equipment (PPE)) during high-contact resident care activities (e.g. dressing and transfers). Further observation revealed that Staff M (Certified Occupational Therapy Assistant) was with Resident #65 while wearing gloves and no gown for PPE. Interview on 3/10/2026 at approximately 10:55 a.m. with Staff M revealed that he/she was assisting Resident #65 with dressing. Staff M confirmed that he/she was not wearing a gown while assisting Resident #65 with dressing, which is a high-contact resident care activity.Review on 3/10/26 of Resident #65's medical record revealed a care plan and a physician order for EBP due to open wounds. Further review revealed that Resident #65 has pressure injury to the right scapula which was present on admission. Observation on 3/11/2026 at approximately 12:13 p.m. in Resident #65's room revealed an EBP sign posted outside the room. Further observation revealed Staff M assisting Resident #65 while seated in the wheelchair. Staff M was wearing gloves and no gown for PPE.Interview on 3/11/26 at approximately 12:18 p.m. with Staff revealed that he/she was assisting Resident #65 with dressing and transferring from bed to wheelchair. Staff confirmed that he/she was not wearing a gown for PPE while assisting Resident #65 with dressing and transferring.Resident #90Observation on 3/11/2026 at approximately 7:36 a.m. in Resident #90's room revealed a EBP signage posted outside of the room that indicated to wear gloves and gown during high-contact resident care activities (e.g. dressing, toileting, and changing linens). Observation revealed Staff N (Licensed Nursing Assistant) was in Resident #90s room changing the blue soak pads on Resident #90's bed wearing gloves and no gown for PPE then went in Resident #90's bathroom and appeared to be assisting Resident #90. Interview on 3/11/26 at approximately 9:48 a.m. with Staff N confirmed the above observation in Resident #90's room. Staff N revealed that he/she was assisting Resident #90 with dressing in the bathroom. Review on 3/11/2026 of Resident #90's care plan revealed that Resident #90 has a history of Extendedˆ Spectrum Betaˆ Lactamase (ESBL) and an intervention in place for EBP.Review on 3/12/26 of the facility's policy titled, Enhanced Barrier Precautions (EBP), revised date 4/2025, revealed .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing .c.transferring .e.changing linens .f. changing briefs or assisting with toileting .EBPS are indicated .for residents infected or colonized with the following: .g. ESBL .EBPs may be indicated.for residents with chronic wounds and/or indwelling medical devices regardless of MDRO colonization .