

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER The Arbors Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1884 Loop 343 West Rusk, TX 75785	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards in the facility's only kitchen reviewed for food service safety. The facility did not ensure foods in the freezer were labeled and dated when removed from their original packaging on 1/12/2025. These failures could place residents who received their meals from the kitchen at risk of foodborne illnesses. Findings included: During an observation on 1/12/2026 at 9:17 AM, the DM was present in the kitchen. The walk-in freezer had the following: *an opened box of chicken thighs with two bags of chicken thighs that were not dated or labeled on the box or on the bags of chicken, *two bags of chicken wings sitting on a shelf in the freezer that were not dated or labeled, and *a large roll of ground beef sitting on a shelf in the freezer that were not dated or labeled. During an interview on 1/12/2026 at 9:19 AM, the DM said she was responsible for making sure foods were dated and labeled when removed from their original containers or boxes in the kitchen. She said she removed the chicken and ground beef when she made space for storing bags of ice and forgot to date them. She said if food were not dated or labeled, staff would not know how long they had been in the kitchen or if they were safe to use. During an interview on 1/14/2026 at 10:36 AM, the Administrator said the kitchen staff and DM were responsible for checking food in the kitchen daily to ensure they are dated and labeled. She said if foods were not labeled/dated, then foods could be spoiled or make them sick. Record review of a facility policy titled Food Storage and Supplies undated indicated, .All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated to when opened .		

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 - Few	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 observation, interview, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the option he or she prefers for 1 of 6 residents (Resident #5) reviewed for the right to be informed. 1. The facility failed to ensure Resident #5 had a signed medication consent form for Haldol (antipsychotic medication) and lorazepam (anxiety medication) when ordered on 12/18/2025. 2. The facility did not ensure the need for and benefits of the proposed treatment with antipsychotic or neuroleptic medication was filled out on the HHSC Form 3713 Consent for Antipsychotic or Neuroleptic Medication when ordered on 12/18/2025. These failures could place residents at risk for treatment or services provided without their informed consent. Findings included: Record review of Resident #5's facility face sheet dated 1/14/2026 indicated Resident #5 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis of vascular dementia (problem with blood flow to the brain causing changes in memory, behaviors, and thinking.) Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 05 indicating severely impaired cognition and had received antipsychotic medications. Record review of Resident #5's comprehensive care plan dated 1/12/2026 indicated Resident #5 required anti-psychotic medications related to behavior management and to educate the resident, family, caregivers about risks, benefits and the side effects and the resident used anti-anxiety medications and to educate the resident, family, caregivers about risks, benefits and the side effects and/or toxic symptoms. Record review of Resident #5's order summary report revealed Resident #5 had an order on 12/18/2025 for haloperidol 2mg by mouth daily and lorazepam 0.5mg by mouth every 4 hours as needed for anxiety. Record review of Resident #5's consents for medications revealed no consent and no HHSC form 3713 was obtained prior to administering medications haloperidol or lorazepam to Resident #5. Record review of Resident #5's medication administration record for January 2026 revealed Resident #5 had received haloperidol daily as ordered but had not received lorazepam. During an observation and interview on 1/12/2026 at 9:46 am Resident #5 was sitting on the side of her bed and appeared drowsy. She said she was waking up but might lay back down and sleep a little longer. She was unaware of her medication regimen. During an interview on 1/13/2026 at 3:08 pm LVN A said that when a resident received an order for any medication in the antipsychotic, antidepressant, and anxiety classification a consent for that medication should be obtained from the resident or their responsible party before administering that medication by the charge nurse. She said form 3713 was completed for the physician to sign as well. She said that residents had the right to know the risk of their medications before taking them. During an interview on 1/13/2026 at 3:30 pm the Regional Compliance Nurse said that the facility was currently without a DON, and she was the acting DON. She said the DON and ADON should be running an order listing report each morning to review each order and ensure consents were obtained for any medications requiring one. She said that system would be readdressed to ensure residents or their responsible person were informed prior to medications being given to protect the residents right to consent. During an interview on 1/14/2026 at 12:40 pm the Administrator said that any medication that required consent, the nurse obtaining the order should be discussing that medication with the resident or responsible person and obtaining that consent prior to administration of the medication. She said by not getting a consent goes against their rights and expected consents be obtained each time. Record review of an undated facility policy titled Resident Rights indicated, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. 5. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternatives or treatment options and to choose the alternative or option he or she prefers. Record review of a facility policy dated 2/12/25 titled Psychotropic Medication revealed, .Resident's Right to be Informed; Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative will be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The resident's medical record will include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred. A written consent form may serve as evidence of a resident's consent to psychotropic medication, but other types of documentation are also acceptable .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who use psychotropic drugs received appropriate monitoring for 2 of 6 residents reviewed for unnecessary medications. (Residents #5 and #48)1. The facility did not have appropriate monitoring for psychotropic medications for Resident #5's Haldol (antipsychotic) and lorazepam (antianxiety) from 12/24/2025 to 1/11/2026.2. The facility did not have appropriate monitoring of psychotropic medications for Resident #48's Zoloft and venlafaxine (antidepressants), Quetiapine (antipsychotic), clonazepam (antianxiety) from 12/29/2025 to 1/11/2026. These failures could place residents at risk for unintended, harmful events attributed to the use of medications without the appropriate monitoring or indication for use.Findings included:1. Record review of Resident #5's facility face sheet dated 1/14/2026 indicated Resident #5 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis of vascular dementia (problem with blood flow to the brain causing changes in memory, behaviors, and thinking.)Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 05 indicated severely impaired cognition and had received antipsychotic medications.Record review of Resident #5's comprehensive care plan dated 1/12/2026 indicated Resident #5 required anti-psychotic medications related to behavior management and used anti-anxiety medications and to monitor, record, and report to physician as needed side effects and adverse reactions of psychoactiveMedications.Record review of resident #5's order summary report revealed Resident #5 had an order on 12/18/2025 for haloperidol 2mg by mouth daily and lorazepam 0.5mg by mouth every 4 hours as needed for anxiety. Record review of Resident #5's nurse weekly summary report log revealed Resident #5 had not received a weekly assessment to monitor side effects of psychotropic medications. An assessment was completed on 12/24/205 and not again until 1/11/2026. 2. Record review of Resident #48's facility face sheet dated 1/14/2026 indicated Resident #48 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis Alzheimer's.Record review of Resident #48's quarterly MDS assessment dated [DATE] indicated Resident #48 had a BIMS of 00 indicated severely impaired cognition and had received antipsychotic, antianxiety and antidepressant medications.Record review of Resident #48's comprehensive care plan dated 11/17/2025 indicated Resident #48 required antidepressant, antianxiety and antipsychotic medications and to monitor, record and report side effects to the physician.Record review of Resident #48's order summary report revealed resident #48 had an order for Quetiapine Fumarate 100 milligram tablet by mouth two times a day dated 8/07/2024, Quetiapine Fumarate 50 milligram tablet by mouth one time a day dated 4/29/2025, venlafaxine 100 milligram tablet by mouth one time a day dated 4/26/2025, Zoloft 50 milligram tablet by mouth one time a day every other day dated 7/12/2025, clonazepam 1 milligram tablet by mouth two times a day dated 8/16/2025. Record review of Resident #48's medication administration record revealed Resident #48 had received quetiapine, venlafaxine, Zoloft, and clonazepam medications and there was no monitoring documented for medication side effects. Record review of Resident #48's nurse weekly summary report log revealed Resident #48 had not received a weekly assessment for monitoring side effects to psychotropic medications. An assessment was completed on 12/29/2025 and not again until 1/11/2026. During an interview on 1/13/2026 at 3:08 pm LVN A said that when a resident received an order for any medication in the antipsychotic, antidepressant, antianxiety classifications the nurse documents on a weekly summary of those medications that they were monitored for any side effects. She said the nurse in charge must initiate the weekly summary assessment and there were times that assessment did not get completed. She said that high risk medications like antipsychotics, antidepressants and antianxiety should be monitored to prevent any adverse effects to those medications. During an interview on 1/13/2026 at 3:30 pm the Regional Compliance Nurse (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that once a resident received an order for a high risk medication like an antipsychotic, antianxiety, and antidepressants then the nurse should monitor for any side effects weekly on the weekly nursing summary. She said that the DON and ADON should be monitoring those summaries at least monthly to ensure they were completed. She said medications not being monitored for side effects could result in a negative outcome for the residents. During an interview on 1/14/2026 at 12:40 pm the Administrator said that medications that are high risk like antipsychotics, antidepressants, and antianxiety should be monitored to ensure they were not acting as a chemical restraint, or the resident was not having any side effects or adverse reactions. She said the nurse should be monitoring those medications no less than weekly using the nurse weekly summary and expected each resident to be monitored appropriately to prevent any negative outcomes to the resident. Record review of a facility policy dated 2/12/25 titled Psychotropic Medications indicated, .The facility will ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Monitoring and Adverse Consequences Medication management is based in the care process and includes recognition or identification of the problem/need, assessment, diagnosis/cause identification, management/treatment, monitoring, and revising interventions as well as documenting medication management steps. Monitoring and accurate documentation of the resident's response to any psychotropic medication treatment (such as, lab results, vital signs, progress notes, behavior flow sheets, medication administration records and the consultant pharmacist's drug regimen review) is essential to evaluate the ongoing effectiveness, benefits as well as risks of non-pharmacological approaches and psychotropic medications. Licensed Nurses- should continually monitor for medication adverse effects and behaviors and report to the physician or their designee as needed. The Weekly Summary in Point Click Care will also cue the nurse to document and report any behaviors or medication adverse effects to the physician or their designee. Any adverse effect or behavior will trigger an alert in PCC for nursing administration review		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate MDS was completed for 1 of 6 residents reviewed for accuracy of assessments. (Resident #5) The facility failed to accurately document Resident #5's hospice services and antiplatelet therapy on her Quarterly MDS assessment on 1/05/2026. Resident #5 had an order on 12/18/2025 to admit to hospice services. This failure could place residents at risk of not receiving needed care and services. Findings included: Record review of Resident #5's facility face sheet dated 1/14/2026 indicated Resident #5 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis of vascular dementia (problem with blood flow to the brain causing changes in memory, behaviors, and thinking.) Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 05 indicated severely impaired cognition. The assessment did not include Resident #5's hospice services and her antiplatelet was miscoded as an anticoagulant. Record review of Resident #5's comprehensive care plan dated 9/23/2025 indicated Resident #5 required antiplatelet medication and did not include her hospice care. Record review of Resident #5's order summary report dated 01/13/2026 revealed Resident #5 had an order on 12/18/2025 to admit to hospice services and for Plavix 75mg po daily (an antiplatelet medication). During an interview on 1/13/2026 at 2:30 pm the MDS Coordinator said she was responsible for entering the MDS assessments as well as reviewing and revising the care plan with each assessment along with the IDT collaboration. She said that when a resident was on hospice the MDS and care plan should reflect hospice care and medications should be properly coded. She said she was sure how she missed adding hospice care and miscoded Resident#5 Plavix on the quarterly MDS assessment. She said inaccurate MDS assessments could result in delays in resident care. During an interview on 1/13/2026 at 3:30 pm the Regional Compliance Nurse said that the MDS Coordinator was responsible for accurately importing MDS assessments and the revision of the resident's care plan at the time of the assessment. She said that inaccurate MDS assessments and care plans could result in delays in resident care. She said she expected all resident's MDS assessments and care plans to be completed accurately and completely. During an interview on 1/14/2026 at 12:40 pm the Administrator said that the MDS nurse was responsible for completing the MDS accurately and then the corporate MDS team reviews them monthly for accuracy. She said that there are times that mistakes just happen and when they are discovered the MDS nurse would submit a revision. She said that incorrect MDS assessments could affect resident care and expected the MDS to be completed accurately each time. She said the facility did not have a policy regarding MDS accuracy and followed the RAI manual.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop the baseline care plan within 48 hours of admission for 1 of 6 residents (Resident #5) reviewed for baseline care plans. The facility failed to ensure Resident #5's baseline care plan was completed within 48 hours of admission. This failure could affect residents by not addressing their physical, mental, and psychosocial needs for each resident to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings include: Record review of Resident #5's facility face sheet dated 1/14/2026 indicated Resident #5 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis of vascular dementia (problem with blood flow to the brain causing changes in memory, behaviors, and thinking.) Record review of Resident #5's admission MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 07 indicating severely impaired cognition, had behaviors, and required assistance with ADL's. Record review of Resident #5's care plan revealed no baseline care plan was completed within 48 hours of admission and a care plan was not initiated until 15 days after admission on [DATE]. During an interview on 1/13/2026 at 3:08 pm LVN A said that when a resident was admitted the charge nurse that admitted the resident was responsible for completing the assessments and orders and then activating the initial care plan. She said that care plan should be initiated within 24 hours so nurse aides and nurses would know the care needs of that resident. She said if a resident was to not get a care plan within the first 48 hours at the facility the resident could have a delay in care or injuries. During an interview on 1/13/2026 at 3:30 pm the Regional Compliance Nurse said nursing that admitted the resident should be completing the baseline care plan with 48 hours of admission. She said then the DON or ADON should review admissions in the morning meeting reviewing the baseline care plan for accuracy and completion to ensure each resident received the care they needed. She said she expected the baseline care plan be completed within 48 hours of admission to prevent any care delays or injuries to the residents. During an interview on 1/14/2026 at 12:40 pm the Administrator said the baseline care plan should be started by the admitted nurse and then the IDT should be reviewing and completing them within the 48-hour timeframe. She said if a resident did not receive a baseline care plan on admission it could affect resident care and expected all residents to have a baseline care plan per the guidelines. Record review of an undated facility policy titled Baseline Care Plans indicated, . This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will; be developed within 48 hours of a resident's admission .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to make sure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 6 residents (Resident #5) reviewed for care plans. The facility failed to ensure Resident #5's comprehensive care plan was reviewed and revised when she was admitted to hospice services on 12/18/2025. This failure could place residents at risk of not receiving the care and services to meet their needs. Findings included: Record review of Resident #5's facility face sheet dated 1/14/2026 indicated Resident #5 was an [AGE] year-old female that was admitted to the facility on [DATE] with the diagnosis of vascular dementia (problem with blood flow to the brain causing changes in memory, behaviors, and thinking.) Record review of Resident #5's significant change MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 04 indicating severely impaired cognition and was receiving hospice care. Record review of Resident #5's comprehensive care plan indicated it was last reviewed on 11/26/2025 and was not reviewed and revised with her significant change MDS assessment on 12/22/2025 to include her hospice services. Record review of Resident #5's order summary report dated 01/13/2026 revealed Resident #5 had an order on 12/18/2025 to admit to hospice services. During an interview on 1/13/2026 at 2:30 pm the MDS Coordinator said she was responsible for entering the MDS assessments as well as reviewing and revising the care plan with each assessment along with the IDT collaboration. She said that when a resident was on hospice the MDS and care plan should reflect hospice care. She said she was not sure how she missed adding hospice services to Resident #5's comprehensive care plan. She said if a care plan was not reviewed and updated with changes it could affect resident care. During an interview on 1/13/2026 at 3:30 pm the Regional Compliance Nurse said that the MDS Coordinator was responsible for the revision of the resident's care plan at the time of the assessment. She said that inaccurate care plans could result in delays in resident care. She said she expected all resident's care plans to be completed accurately and completely. During an interview on 1/14/2026 at 12:40 pm the Administrator said that comprehensive care plans should be reviewed and revised with significant changes, quarterly, annually and as needed with resident care changes. She said the MDS nurse and IDT should be reviewing the care plan and making sure all the care need areas were addressed. She said not having an accurate care plan could affect resident care needs and expected each resident's comprehensive care to be reviewed, revised and accurate. Record review of undated facility policy titled Comprehensive Care Planning indicated, .The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions .		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent infections and to restore continence to the extent possible for 1 of 5 (Resident #62) residents observed for incontinent care. CNA B did not provide proper incontinent care for Resident #62 and wiped from the anal area toward the urethral area (back to front) on 1/13/2026. This failure could place residents at risk for bacterial infections from improper incontinent care. Findings include: Record review of an admission Record for Resident #62 dated 1/13/2026 indicated she was admitted to the facility on [DATE] and readmitted on [DATE] and was [AGE] years old with diagnoses of epilepsy (a chronic brain disorders that causes the wrong signals and seizures), gastrostomy status (an artificial opening in the stomach for feeding), Type 1 diabetes (a disorder where the pancreas produces little to no insulin for the body), and major depression disorder (persistent sadness or loss of interest). Record review of a Significant Change MDS Assessment for Resident #62 dated 12/11/2025 indicated she had moderate impairment in thinking with a BIMS score of 10. She required substantial/maximal assistance with toileting hygiene. She was frequently incontinent with urine/bowel. Record review of a care plan for Resident #62 dated 9/30/2025 indicated she had bowel and bladder incontinence. Interventions included provide pericare after each incontinent episode. During an observation on 1/13/2026 at 2:40 PM, CNA B and CNA C were at the room of Resident #62 to provide incontinent care. Both staff donned (put on) a gown in the hallway and entered the room to provide care and washed their hands in the bathroom and then they donned gloves. CNA B opened the brief of Resident #62 and pulled it down between her thighs and removed a wipe from the bag and wiped across her lower abdomen and placed it in the trash. CNA B removed another wipe and wiped down her right thigh and placed it in the trash. CNA B removed a wipe and wiped down her left thigh and placed it in the trash. CNA B removed a wipe and wiped down middle of her vagina from front to back and placed the wipe in the trash. CNA B removed his gloves and placed them in the trash; CNA B sanitized his hand and donned gloves. Resident #62 was rolled onto her left side and assisted by CNA C. CNA B removed the brief and his gloves and placed them in the trash. CNA B sanitized his hands and donned gloves. CNA B removed wipes and wiped Resident #62's buttocks from her rectum to her urethra (back to front) and removed his gloves and placed them in the trash along with the wipes. CNA B donned gloves and placed a brief underneath her buttocks. The brief was secured, and the resident was positioned on her back. CNA B applied barrier cream to her vaginal area and removed his gloves and placed them in the trash and he sanitized his hands. CNA B donned gloves and the resident was repositioned in bed. Both CNA B and CNA C doffed (took off) their gowns in the bathroom and placed them in the trash. Both sanitized their hands and removed the trash and linens from the room. CNA B lowered the bed and elevated the head of bed. During an interview on 1/13/2026 at 3:04 PM, CNA B said she had been employed at the facility for a year. He said he was always assigned to the same hall and worked on hall 100 with Resident #62. He said he should have wiped from front to back when he provided incontinent care to Resident #62. He said he was taught to wipe from front to back and if he did not it could lead to a UTI. During an interview on 1/13/2026 at 3:14 PM, CNA C said she had been employed at the facility since 9/9/25. She said during the care provided to Resident #62; CNA B should have wiped Resident #62's rectal area from front to back. She said she thought he knew what to do and did not say anything. She said if staff did not wipe the correct way with female residents, then they could be at risk for infection. During an interview on 1/14/2026 at 10:10 AM, the ADON said she has been employed at the facility for 3 weeks. She said if staff provided incontinent care to a female resident, they should wipe from front to back and if they did not there could be a risk for UTI's. During an interview on 1/14/2026 at 10:23 AM, the Regional Consultant who was the acting DON said when (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Arbors Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1884 Loop 343 West Rusk, TX 75785	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent care was provided to a female, she expected the staff to follow policy, and they should clean from front to back. She said if they did not, there could be a risk of introducing bacteria or infections into the urinary tract. During an interview on 1/14/2026 at 10:36 AM, the Administrator said when care was provided to a female resident, staff should clean from front to back and if they did not there was a risk for residents to get UTI's or E. coli (infection caused by fecal material). She said she planned on all nurse aides to receive more training. Record review of a facility policy titled Perineal Care Female (with or without catheter) undated indicated, .Purpose: to clean the female perineum without contaminating the urethral area with germs from the rectal area. J. Cleaning the rectal and buttocks area, b. gently wash the rectal area and buttocks, wiping away from the base of the labia, working from the anus outward .		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident, who was fed by enteral means, received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 2 residents (Resident #62) reviewed for enteral feeding. The facility failed to ensure Resident #62's head of bed was maintained at 30 degrees elevated while receiving continuous feeding. The failure could place residents at risk of aspiration (when food or liquid goes into the lungs or airway). Findings included: Record review of an admission Record for Resident #62 dated 1/13/2026 indicated she was admitted to the facility on [DATE] and readmitted on [DATE] and was [AGE] years old with a diagnosis of gastrostomy status (an artificial opening in the stomach for feeding). Record review of a Significant Change MDS Assessment for Resident #62 dated 12/11/2025 indicated she had moderate impairment in thinking with a BIMS score of 10. She had a feeding tube while a resident. Record review of a care plan for Resident #62 dated 12/8/2025 indicated she required tube feeding. Interventions included to keep the head of bed elevated during and thirty minutes after tube feed. Record review of active physician orders for Resident #62 dated 1/13/2026 indicated she had an order for enteral feed every shift head of bed up at least 30 degrees during administration of enteral formula or water that started on 12/7/2025. During an observation on 1/13/2026 at 2:40 PM, CNA B and CNA C were at the room of Resident #62 to provide incontinent care. Both staff donned (put on) a gown in the hallway and entered the room to provide care and washed their hands in the bathroom and then they donned gloves. Resident #62 had a g-tube that was running and still connected with diabetisource AC at 53 ml/hr. Resident #62's head was lowered. CNA B opened the brief of Resident #62 and pulled it down between her thighs and removed a wipe from the bag and wiped across her lower abdomen and placed it in the trash. CNA B removed another wipe and wiped down her right thigh and placed it in the trash. CNA B removed a wipe and wiped down her left thigh and placed it in the trash. CNA B removed a wipe and wiped down middle of her vagina from front to back and placed the wipe in the trash. CNA B removed his gloves and placed them in the trash; CNA B sanitized his hand and donned gloves. Resident #62 was rolled onto her left side and assisted by CNA C. CNA B removed the brief and his gloves and placed them in the trash. CNA B sanitized his hands and donned gloves. CNA B removed wipes and wiped Resident #62's buttocks from her rectum to her urethra (back to front) and removed his gloves and placed them in the trash along with the wipes. CNA B donned gloves and placed a brief underneath her buttocks. The brief was secured, and the resident was positioned on her back. CNA B applied barrier cream to her vaginal area and removed his gloves and placed them in the trash and he sanitized his hands. CNA B donned gloves and the resident was repositioned in bed. Both CNA B and CNA C doffed (took off) their gowns in the bathroom and placed them in the trash. Both sanitized their hands and removed the trash and linens from the room. CNA B lowered the bed and elevated the head of bed. During an interview on 1/13/2026 at 3:04 PM, CNA B said she had been employed at the facility for a year. He said he was always assigned to the same hall and worked on hall 100 with Resident #62. He said he should have gotten the nurse to disconnect the tubing as it could be pulled while being attached and connected. He said he forgot and was nervous. During an interview on 1/13/2026 at 3:14 PM, CNA C said she had been employed at the facility since 9/9/25. She said during the care provided to Resident #62 they should have asked the nurse to disconnect the feeding because the resident could potentially aspirate. During an interview on 1/14/2026 at 10:10 AM, the ADON said she has been employed at the facility for 3 weeks. She said if staff provided care to a resident with tube feeding before they provided care the staff should inform the nurse to pause the feeding because when the head of bed (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was lowered there was a risk for aspiration. During an interview on 1/14/2026 at 10:23 AM, the Regional Consultant who was the acting DON said before incontinent care was provided to a resident with a feeding tube, the staff should get the nurse to stop the feeding as there could be a risk for a negative outcome or aspiration when the head of bed was lowered. During an interview on 1/14/2026 at 10:36 AM, the Administrator said before incontinent care was provided to a resident with a feeding tube, the staff should notify the nurse and have them turn the pump off and disconnect to prevent damage or chance of damage to the peg site and risk for aspiration. Record review of a facility policy titled Gastrostomy Tube Care undated indicated, Gastrostomy is a surgically created abdominal opening into the stomach for the purpose of administering feedings. 10. Maintain the resident in a semi to high-Fowler's position following a feeding .		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to complete a performance review of every nurse aide at least once every 12 months, for 1 of 6 (CNA B) reviewed for annual competency evaluations. The facility failed to complete a performance review of CNA B and conducted services based on the results of the review. This deficient practice could affect residents and place them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs. Findings included: Record review of a personnel file review for CNA B indicated he was hired at the facility on 11/4/2024, with no evidence of a competency evaluation in the past 12 months. His last evaluation was on 11/4/2024. Record review of a CNA proficiency audit dated 11/4/2024 for CNA B indicated he was satisfactory with skills in the facility. During an interview on 1/13/2026 at 3:04 PM, CNA B said he had been employed at the facility for a year. He said he had a competency skills check-off when he was hired at the facility a year ago but could not remember if he had one since then. During an interview on 1/14/2026 at 10:10 AM, the ADON said she had been employed at the facility for 3 weeks. She said she would be responsible for ensuring the nurse aides receive their competency evaluations for skills yearly. She said she was not aware that CNA B did not have a yearly evaluation. She said if the evaluations were not done yearly, there was a risk of a lack of patient care. During an interview on 1/14/2026 at 10:23 AM, the Regional Consultant who was acting as the DON in the facility. She said the nurse aide evaluations with skills would be the responsibility between the ADON and DON to ensure they were completed. She said the evaluations should be done on hire and annually thereafter. She said she was not aware that CNA B did not have an annual check-off. She said residents could be at risk for a negative outcome if they were not completed yearly. During an interview on 1/14/2026 at 10:36 AM, the Administrator said the DON was responsible for making sure skill checks offs were done on hire, annually, and prn. She said she was not aware CNA B did not have an annual evaluation. She said residents could be at risk of not getting properly cleaned, infections, and skin issues if staff did not have proper training. Surveyor requested a policy for competency evaluations, and none was provided prior to exit.		

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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, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #41) reviewed for infection control. The facility failed to ensure LVN A followed enhanced barrier precautions guidelines when wound care was provided to Resident #41 on 01/13/2026. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: Record review of an admission Record for Resident #41 dated 01/13/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with a diagnosis pressure ulcer (localized injuries to the skin and underlying tissue caused by prolonged pressure) to left hip and left heel. Record review of an admission MDS assessment dated [DATE] for Resident #41 indicated he did not have any impairment in thinking with a BIMS score of 15. He required substantial assistance with activities of daily living. He had one Stage 2 pressure ulcer (a shallow wound with a pink or red base), one stage 3 pressure ulcer (a wound that may go into the skin's fatty layer) and one unstageable pressure ulcer (a wound that penetrates all three layers of skin, exposing muscles, tendons and bones). Record review of a care plan for Resident #41 revised 11/04/2025 indicated he was on enhanced barrier precautions and had pressure ulcer to left heel and left hip. During an observation on 01/13/2025 at 10:10 AM, a sign indicating Resident #41 was on EBP (enhanced barrier precautions) and a container with PPE (personal protective equipment) was located outside of his room. LVN A was organizing supplies at the door of Resident #41's room to perform wound care. LVN A washed her hands in the bathroom. She applied gloves to both hands and cleaned the over bed table of the resident with a sani-cloth bleach wipe and a tray for supplies. She placed a protective barrier on the table and removed her gloves and sanitized her hands. She applied clean gloves and placed the wound care supplies on the barrier that was on the tray. She cleaned a pair of scissors using a sani-cloth bleach wipe and placed it on the tray. She removed her gloves and placed them in the trash and washed her hands in the bathroom. She put on clean gloves, she did not put on a protective gown prior to wound care. A dressing was noted to Resident #41's left heel that was dated 01/12/2026. LVN A removed the dressing and placed it in the trash. LVN A removed her gloves and used hand sanitizer and put on clean gloves. LVN A cleaned Resident #41's left heel with normal saline and gauze and she patted the wound dry with a gauze. She applied Santyl external ointment and calcium alginate topically to the wound bed and covered it with a dressing. She removed her gloves and placed them in the trash. She removed the trash, exited the room, and washed her hands. During an interview on 01/13/2026 at 10:30 AM, LVN A said during the wound care provided to Resident #41 she should have put on a gown prior to providing wound care. She said if a resident was on enhanced barrier precautions then a gown and gloves should be put on when providing wound care. She said the gowns and gloves are to prevent transmission of bacteria from the residents room to other residents. She stated not wearing the proper PPE could increase the chance of spreading infection to other residents. During an interview on 01/14/2026 at 9:30 AM with the ADON, she said she has been working at the facility for 3 weeks. She stated staff caring for residents placed on EBP were to wear the appropriate PPE according to assistance being provided to the resident. She stated staff should utilize gowns and gloves while providing wound care. She said the risk of not utilizing PPE per policy was increased risk of infection to the resident and other residents and staff in the facility. She said she expected the staff to follow the facility policy on infection control protocols and enhanced barrier precautions. During an interview on 01/14/2026 at 9:40 AM with the Regional Compliance Nurse, she said she was filling in as the DON until a full time DON was hired. She stated staff caring for residents on EBP was expected to follow the facilities policies and protocols regarding the use of gowns and gloves when providing care for the residents. She stated staff is (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated on infection control policies and EBP upon hire and as needed. She stated the risk of not using proper PPE could be spreading infection to the resident under enhanced barrier precautions and to other residents in the facility. Her expectations are for the staff to follow all infection control and EBP policies and procedures when providing care for the residents. During an interview on 01/14/2026 at 10:00 AM with the administrator, she said staff who provide care to residents that are placed on enhanced barrier precautions are to wear PPE appropriate to the care being provided. She said staff providing wound care should wear gowns and gloves as stated in the facility policy. She stated staff is expected to wear PPE as indicated and that education on infection control policies and EBP policies are provided to all staff upon employment, annually and as needed. She said the risk of staff not following the infection control and EBP policies are increase risk of spreading infections to the residents and staff. Record review of the facility policy titled Enhanced Barrier Precautions dated 4/1/2024. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO's) that employ targeted gown and glove use during high contact resident care activities. It also indicates, EBP are indicated for residents with any of the following . wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO's.		