STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675034	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Lake Nursing & Rehabilitation, LLC	901 Pennsylvania Ave Fort Worth, TX 76104

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for 2 of 17 residents (Residents #3 and Resident #13) reviewed for environment. 1.The facility failed to maintain a comfortable or private homelike environment for Residents #3 and #13. These failures placed residents at risk of decreased feelings of self-worth, increased harm and an impersonalized homelike environment. Findings included:1. Observation on 07/22/2025 at 11:37 AM revealed Resident #3 had broken blinds. The blinds were missing the end pieces of approximately 4 blinds leaving an area of approximately 6 inches by 10 inches without blinds. Observation on 07/23/2025 at 9:20 AM revealed Resident #3 had broken blinds. The blinds were still missing the end pieces of approximately 4 blinds leaving an area of approximately 6 inches by 10 inches without blinds. Observation and interview on 07/23/2025 at 1:49 PM with CNA C revealed that she had not noticed the broken blinds, and that neither resident had complained to her about the broken blinds. CNA C stated that she had reported the blinds. CNA C said that she should have reported it to the Maintenance Director and her nurse. CNA C also revealed that it was all the staff's responsibility to report maintenance issues. CNA C said that blinds were important because it helped the residents maintain their dignity as well as providing privacy in their home. Observation and interview on 07/23/2025 at 2:03 PM with Resident #3 revealed that he had noticed the broken blinds. Resident #3 stated that the broken blinds were ugly, and he wanted them replaced. Observation and interview on 07/23/2025 at 2:10 PM with RN D revealed that she had not reported the broken blinds in Resident #3's room. RN D stated that it was her responsibility to report broken blinds to the maintenance supervisor. RN D revealed that it was important because broken blinds could injure a resident. RN D stated that if the Maintenance Director did not respond to her work order, she would report it to the ADON. Observation and interview on 07/23/2025 at 1:55 PM with the Maintenance Director revealed that it was his responsibility to ensure residents' blinds were in proper working order. The Maintenance Director stated that staff could put a maintenance request in the maintenance logbook or through the app on his phone. The Maintenance Director said that proper working blinds are important because they are a dignity issue. The Maintenance Director stated he would be purchasing new blinds for the residents' room. Interview on 07/25/2025 at 10:32 AM with the Administrator revealed that the facility uses a phone app for the maintenance requests. The Administrator stated that it was everyone's responsibility to report maintenance issues when they saw them. The Administrator stated that he had instructed the Maintenance Director, the previous day, to purchase blinds and replace the broken blinds in residents' rooms. The Administrator revealed the broken blinds were a privacy issue for residents. 2. Record Review of Resident #13's Quarterly MDS assessment, dated 06/05/25 reflected Resident #13 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #13's MDS also reflected diagnoses of non-Alzheimer's dementia (a range of neurodegenerative and other disorders that cause cognitive decline, distinct from Alzheimer's disease), anxiety disorder, and depression. Resident #13's MDS also reflected a BIMS score of 4 (meaning severe cognitive impairment). Resident #13's MDS also reflected Resident #13 required assistance and supervision for ADLs. Record review of Resident #13's Care Plan dated 02/20/25 revealed Resident #13 was dependent on staff for activities, cognitive stimulation, social interaction. Goal included Resident #13 will maintain involvement in cognitive stimulation, social activities as desired. Interventions included Assure that the activities Resident #13 was attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), compatible with individual needs and abilities and age appropriate. Resident #13 had adjustment issues to admission. Goal included to maintain the ability to seek social contact and stimulation. Interventions included encourage ongoing family involvement. Invite Resident #13's family to attend special events, activities, and meals. Encourage Resident #13 to participate in conversation with staff, other residents daily. Introduce Resident #13 to residents with similar background, interests, and encourage/facilitate interaction. Observation and interview on 07/22/25 at 11:53 AM with Resident #13 revealed he was in the small television room with other residents watching television. Resident #13 stated that he was doing ok, he liked to watch television, and that he felt safe to live in the facility. Resident #13 then got up and walked into another resident's room and shut the door.Interview on 07/22/25 at 1:16 PM with Resident #13's Responsible Party revealed that Resident #13 enjoyed watching television. The Responsible

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse for 1 of 6 residents (Resident #33) reviewed for abuse. The facility failed to ensure residents were free resident-to-resident abuse when Resident #33 entered Resident #21's room, and Resident #21 pushed Resident #33 down. Resident #33 sustained abrasions on his nose and right knee. The failure placed residents at risk for abuse. Findings included:Record review of Resident #33's Quarterly MDS, dated [DATE], reflected Resident #33 was a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), non-Alzheimer's dementia (encompasses a variety of progressive neurological disorders that cause cognitive decline, but are distinct from Alzheimer's disease), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). The MDS reflected resident had severe cognitive impairment with a BIMS score of 3, and he was independent with transfers and mobility. The MDS further reflected Resident #33 did not have any behaviors.Record review of Resident #33's Care Plan, dated 07/24/25, reflected: Focus: Resident #33. wandered into another resident's room and was pushed causing him to fall back, abrasion to bridge of nose and right knee on 06/24/25 . Goal: Resident #33 will be free of falls through the review date. Interventions: When resident is wandering redirect as needed to prevent as much as possible him infringing on the rights of others.Further review of Resident #33's Care Plans reflected there were no documented care plans specifically addressing the resident's wandering behavior nor were there person-centered interventions care planned to address the resident's wandering behaviors. Record review of Resident #33's Progress Notes by LVN A, dated 06/24/25 at 8:30 PM, reflected, Resident was found in [Resident #21's room] sitting on the floor holding on his face, nose skin abrasion noted, swelling and pain = 5/10, PRN Tylenol 100mg was given, ice was applied to nose for swelling and was helpful abrasion noted on right knee, [Resident #21] was standing in front of him and denied any confrontation but later [Resident #21] claimed that Resident #33 fell down while being chased out [Resident #21's room], assessment done, neuros done and are in range, facial series called in as ordered by Doctor. Record review of Resident #33's facial series results, dated 06/25/25 at 1:50 AM, reflected, Findings: The visual skull and facial bones demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues. The nasal bone is not visualized due to overpenetration. Conclusion: 1. No obvious or acutely displaced fracture. 2. A CT is recommended for better sensitivity if symptoms persist or worsen. Record review of Resident #33's psychiatric assessment, dated 06/30/25, reflected, CN reports an incident between the resident and another male resident. CN reported the resident was hit on the face by another male resident. Pt is seen sitting in bed with his wife. Pt could not explain to the provider what happened but reported another resident hit him on the face. Some minor bruised noted on patient's face. Pt denies any pain or reoccurring thought trauma.The provider encouraged the nurse to ensure residents are separated from each other to prevent any reoccurrence of altercations. Record review of Resident #21's Quarterly MDS, dated [DATE], reflected Resident #21 was a [AGE] year-old male who was originally admitted on [DATE] and re-admitted on [DATE]. The resident's diagnoses included: cerebral infarction (a condition where blood flow to the brain is blocked, causing brain tissue damage due to lack of oxygen and nutrients), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and antisocial personality disorder (a mental health disorder characterized by disorganized for other people). The MDS reflected the resident was cognitively intact, had no behaviors, had upper extremity impairment on one side, and he was independent with transfers and mobility.Record review of Resident #21's Care Plan Report, initiated on 03/01/23 and revised 01/04/24, reflected Resident #21 had impaired cognitive function/dementia or impaired thought processes. Record review of Resident #21's Care Plan Report, initiated on 08/02/23, reflected Resident #21 was an elopement risk related to his elopement risk evaluation score being high at 15.Record review of Resident #21's Care Plan Report, initiated on 11/12/23, reflected Resident #21 was a high risk for elopement, and he was admitted to the secure unit due to his

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 5 residents (Resident #19 and Resident #59) reviewed for ADL care.The facility failed to provide Resident #19 and Resident #59 assistance with grooming and nail care. Resident #19 and Resident #59's nails were observed to be about half inch long with black debris under nails on both hands. Both resident's appearance was disheveled with their clothing and uncleaned hair. This failure could place the residents at risk for decreased feelings of self-worth and infection. 1.Record review of Resident #19's face sheet, dated 07/25/25, revealed Resident #19 was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted [DATE] and current admission date of 01/14/25.Record review of Resident #19's Quarterly MDS assessment, dated 04/14/25, revealed Resident #19 had cognition intact with a BIMS score of 9 (indicating cognitive impairment). Resident #19 required substantial/maximal assistance with shower/bathe self, and personal hygiene. Active diagnosis included Stroke, Dementia (memory loss), Heart Disease, anxiety disorder (uncontrollable feelings of fear), bipolar disorder (mood swings of emotional highs and lows), psychotic disorder (thought process leading to loss of touch with reality), Schizophrenia (having hallucinations and delusions) and lack of coordination and other abnormalities of gait and mobility. Review of Resident #19's care plan, undated, revealed Resident #19 had Self Care Deficit related to age and disease processes. Goal: Resident #19 will maintain current level of function in (.toilet use and personal hygiene). Interventions included Resident #19 required minimal to moderate assist of one staff member for bathing, transfer and had to reach areas and supervision for other areas. Resident #19 required set up and minimal assist and supervision of one staff member for personal hygiene/oral care. Observation on 07/22/2025 at 11:14 AM of Resident #19 in his room revealed he was sitting on the side of his bed. His hair was greasy and disheveled. His nails were at least half inch long with black debris underneath and around the nail bed. Resident #19 stated he was unsure of the last time staff assisted with showers, hair shampooing, or his nails cleaned. 2. Record review of Resident #59's face sheet, dated 07/25/25, revealed Resident #59 was an [AGE] year-old male originally admitted to the facility on [DATE].Record review of Resident #59's Quarterly MDS assessment, dated 05/14/25, revealed Resident #59 had cognition intact with a BIMS score of 99 (indicating Resident was not able to complete assessment). Resident #59 required partial/moderate assistance with shower/bathe self, and personal hygiene. Active diagnosis included Traumatic Brain Injury (external force that disrupts normal brain function), Dementia (memory loss), High Blood Pressure, anxiety disorder (uncontrollable feelings of fear), depression (persistent feeling of sadness) and lack of coordination and other abnormalities of gait and mobility.Review of Resident #59's care plan, undated, revealed Resident #59 had Self Care Deficit related to Dementia. Goal: Resident #59 will maintain current level of function in (. toilet use and personal hygiene). Interventions included Resident #59 required extensive assist of one staff member for bathing, and personal hygiene/oral care.Observation on 07/22/2025 at 11:57 AM with Resident #59 revealed Resident #59 had long nails at least half inch and longer on some with black debris underneath his nails. Resident #59 had on socks with holes in the toe area. Resident #59's hair was not combed and his clothing with colored stains. Interview on 07/23/25 at 2:02 PM with CNA F revealed Resident #19 was scheduled for showers on 2:00 PM - 10:00 PM shift on Monday, Wednesday, and Fridays. According to CNA F it was hard to say if he had a shower last night because he will mess with his hair, it does not look like he recently had a shower but would have one today on 07/23/25. Interview on 07/24/25 at 11:18 AM with CNA F revealed nail care, shaving and hair grooming should be completed on resident shower days. CNA F stated it did not appear that Resident #19 or Resident #59 completed a shower or any grooming on 07/23/25 . Shower sheet for Resident #19 revealed showers were done 7/22/25, 07/21/25, 07/17/25, 07/15/25, 07/14/25, 07/11/25, 07/10/25, sheet for Resident #59 revealed showers were completed on 07/22/25, 07/21/25, 07/20/25, 07/19/25, 07/18/25, 07/17/25. CNA F stated it was the responsibility of the aides to complete nail care and grooming for residents, not doing so placed residents at risk of infections, and becoming ill. Interview on 07/24/25 at 3:26 PM with LVN G revealed some residents were showered on Monday, Wednesday, and Fridays depending on which bed letter they had, (A, B or C beds). LVN G stated both Resident #19 and Resident #59 needed assistance with nail care and grooming and it should be completed on their shower days by the CNAs (Monday, Wednesday, and Fridays). LVN G stated if there was

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	**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 displays or was diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #33) reviewed for dementia services. The facility failed to ensure Resident #33 was provided with treatment and services to address his wandering behaviors related to his diagnosis of dementia which resulted in the resident entering Resident #21's room and being pushed by Resident #1. Upon being pushed, Resident #33's face/head bumped Resident #21's dresser, and Resident #33 sustained abrasions on his nose and right knee. This failure puts residents with dementia at increased risk of not having their dementia-related needs met. Findings included: Record review of Resident #33's Quarterly MDS, dated [DATE], reflected Resident #33 was a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), non-Alzheimer's dementia (encompasses a variety of progressive neurological disorders that cause cognitive decline, but are distinct from Alzheimer's disease), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). The MDS reflected resident had severe cognitive impairment with a BIMS score of 3, and he was independent with transfers and mobility. The MDS further reflected Resident #33 did not have any behaviors.Record review of Resident #33's Care Plan Report, dated 07/24/25, reflected: Focus: Resident #33. wandered into another resident's room and was pushed causing him to fall back, abrasion to bridge of nose and right knee on 06/24/25 .Goal: Resident #33 will be free of falls through the review date. Interventions: When resident is wandering redirect as needed to prevent as much as possible him infringing on the rights of others. Further review of Resident #33's Care Plan Reports reflected there were no documented care plans specifically addressing the resident's wandering behavior nor were there person-centered interventions care planned to address the resident's wandering behaviors. Record review of Resident #33's Progress Notes by LVN A, dated 06/24/25 at 8:30 PM, reflected, Resident was found in [Resident #21's room] sitting on the floor holding on his face, nose skin abrasion noted, swelling and pain = 5/10, PRN Tylenol 100mg was given, ice was applied to nose for swelling and was helpful abrasion noted on right knee, [Resident #21] was standing in front of him and denied any confrontation but later [Resident #21] claimed that Resident #33 fell down while being chased out [Resident #21's room], assessment done, neuros done and are in range, facial series called in as ordered by Doctor. Record review of Resident #33's facial series results, dated 06/25/25 at 1:50 AM, reflected, Findings: The visual skull and facial bones demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues. The nasal bone is not visualized due to overpenetration. Conclusion: 1. No obvious or acutely displaced fracture. 2. A CT is recommended for better sensitivity if symptoms persist or worsen. Record review of Resident #33's psychiatric assessment, dated 06/30/25, reflected, CN reports an incident between the resident and another male resident. CN reported the resident was hit on the face by another male resident. Pt is seen sitting in bed with his wife. Pt could not explain to the provider what happened but reported another resident hit him on the face. Some minor bruised noted on patient's face. Pt denies any pain or reoccurring thought trauma.The provider encouraged the nurse to ensure residents are separated from each other to prevent any reoccurrence of altercations. Record review of Resident #21's Quarterly MDS, dated [DATE], reflected Resident #21 was a [AGE] year-old male who was originally admitted on [DATE] and re-admitted on [DATE]. The resident's diagnoses included: cerebral infarction (a condition where blood flow to the brain is blocked, causing brain tissue damage due to lack of oxygen and nutrients), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and antisocial personality disorder (a mental health disorder characterized by disorganized for other people). The MDS reflected the resident was cognitively intact, had no behaviors, had upper extremity impairment on one side, and he was independent with transfers and mobility.Record review of Resident #21's Care Plan Report, initiated on 03/01/23 and revised 01/04/24, reflected Resident #21 had impaired

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 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 disease and infection for 2 (Resident #76 and #96) of 3 residents reviewed for infection control during medication administration.The facility failed to ensure MA E disinfected the blood pressure cuff in between blood pressure checks for Resident #98 and Resident #76. RN D failed to wear a gown while providing care for Resident #96, who was on enhanced barrier precautions for Gastronomy tube. These failures could place residents at-risk of cross contamination which could result in infections or illness.Findings included:1.Review of Resident #76's MDS assessment dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #76 had diagnoses which included hypertension (high blood pressure) and heart failure (a serious condition but not the same as a heart attack, where blood flow to the heart is suddenly blocked). He had a BIMS score of 09 which indicated his cognition was moderately impaired. Observation on 07/23/25 at 07:29 AM revealed MA E did not disinfect the blood pressure cuff after she checked the blood pressure for Resident #98. She went directly from Resident #98's room to Resident #76's room and checked Resident #76's blood pressure without disinfecting the blood pressure cuff. Interview with MA E on 07/23/25 at 07:40 AM revealed she did not disinfect the blood pressure cuff between Residents #98 and #76. She stated she knew she should disinfect between 2 residents. She stated she had been told here in the facility she should disinfect between resident, and she forgot. She stated she was supposed to disinfect between residents to prevent cross contamination, but she had developed a habit of disinfecting after 2 residents. She stated she had done trainings on infection control two months ago. 2. Record review of Resident #96's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE] and readmission on [DATE]. The resident had severe cognitive impairment with a BIMS score of 00, and his diagnoses included gastronomy status (presence of a gastrostomy tube, an artificial opening into the stomach used for feeding) and dysphagia (swallowing difficulties), and the MDS reflected he had a feeding tube for nutrition. Record review of Resident #96's care plan dated 06/01/25 reflected: Focus: [Resident #96] has infection of the G tube site. Goal: [Resident #96] will be free from complications related to infection through the review date. Interventions: Maintain universal precautions when providing resident care. Observation on 07/23/25 08:20AM revealed RN D prepared all the medications, and she entered to Resident #96's room. RN D washed her hands, put on gloves, and performed blood pressure check. She removed her gloves, washed her hands, and put on new gloves. She administered Resident #96's medications through his gastronomy tube without wearing a gown. The gloves were the only PPE that RN D wore while administering medication through gastronomy tube. Resident #96 was observed to have a gastronomy tube with a dressing dated 07/23/25. Interview on 07/23/25 at 08:41 AM with RN D revealed she knew she was supposed to wear gloves and a gown when caring for residents on enhanced barrier precautions, but she forgot to wear a gown before entering the room. She stated she had done in-services on infection control, but she could not recall the date. Interview on 07/24/25 at 01:00 PM with the ADON revealed, her expectation was for staff to disinfect blood pressure cuffs between each Resident. She stated she noticed MA E did not disinfect the blood pressure cuff after she left Resident #98 room and she used the same cuff on Resident #76. She also stated she expected for all residents on EBP, for staff to wear a gown and gloves when having direct contact with the resident. The ADON stated the EBP were in place to protect the resident from exposure to infectious agents and disinfecting blood pressure cuff between residents was to prevent cross contamination. She stated the facility had done training on enhanced barrier precautions, and disinfection of equipment, but she was not sure whether the staff were in attendance since some were new to the facility. Interview with the DON on 07/24/25 at 03:32PM revealed, her expectation was for staff to disinfect blood pressure cuffs between each resident due to risk of cross contamination. She stated when it came to contact, staff should use gown and gloves on residents who are on enhanced barrier precautions. She stated the facility had done in-services on infection control and enhanced barrier precautions. She stated the facility's management was supposed to be doing spot check on staff for equipment disinfection and the use of enhanced barrier precautions, but she had not done one since she was new to the facility. Record review of the facility's training records for EBP, dated 05/13/25, reflected RN D, was in attendance. Record review of