

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: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	
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 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 observation, interview and record review, the facility failed to ensure an accurate MDS assessment was completed for 2 of 22 residents reviewed for MDS accuracy. (Resident #12 and Resident #60) The facility failed to accurately code Resident #12's falls within the last 30 days on the admission MDS assessment. The facility failed to ensure Resident #60's Annual MDS assessment accurately reflected her positive PASRR status for mental illness. This failure could place residents at risk of not receiving needed care and services. Findings included: 1. Record review of an undated face sheet revealed Resident #12 was an 83- year-old- female, admitted on [DATE] with the diagnoses CHF (congestive heart failure- is a long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and gastritis (a general term for a group of conditions with one thing, inflammation of the lining of the stomach, in common). Record review of an admission MDS assessment, dated 11/28/2025, for Resident #12 revealed a BIMS of 15, which indicated no cognitive impairment. The MDS also revealed Resident #12 required supervision level assistance with bed mobility, eating, transfer, and toileting. The MDS revealed Resident #12 had no history of falls prior to admission and no falls since admission. Record review of a nurse note, dated 11/26/2025 written by LVN G, revealed, At nurse's station heard patient yell out, I need help. Found resident in a sitting position in front of wheelchair. Resident #12 stated she dozed off while leaning on bedside table with brakes on and wheelchair unlocked. Educated patient to keep wheelchair brakes locked when not rolling around. No injury noted. Record review of Resident #12's incident/accident report, dated 11/26/2025 completed by the DON, revealed no added instruction/intervention post fall. During an interview on 01/13/2026 at 3:15 p.m., MDS Coordinator D revealed Resident #12 should have been coded for falls while a resident on the admission MDS, dated [DATE]. She stated because the fall occurred prior to the assessment it should have been coded on the MDS and care planned. She stated it was not coded because of an oversight. MDS Coordinator D stated it was important to accurately code the MDS, so the care plan was developed based on the information on the MDS will be accurate for accurate care for each resident. During an interview on 01/13/2026 at 3:30 p.m., the Regional MDS Nurse stated it was the responsibility of the MDS nurse to ensure accurate MDSs were produced and transmitted to CMS. The (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional MDS Nurse stated the DON or Regional Nurse signed the MDS for completion and the MDS nurses signed it for accuracy. During an interview on 01/14/2026 at 2:00 p.m., the Administrator stated it was the responsibility of the MDS nurse to produce accurate MDSs and care plans. The Administrator stated accuracy was important for revenue as well to ensure the facility was reporting the correct information to CMS on the quality measures. During a record review of the facility's undated Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status. 2. Record review of the face sheet dated 01/14/2026 reflected Resident #60 was a [AGE] year-old female who re-admitted to the facility on [DATE] with a diagnosis of bipolar disorder, severe with psychotic features (mental health condition that causes extreme mood swings). Record review of the PASRR Evaluation (level II assessment), completed on 11/26/2024, reflected Resident #60 did meet the PASRR definition of mental illness, which indicated she was PASRR positive. Record review of the annual MDS assessment, dated 07/24/2025, reflected in the box labeled Section A1500, Resident #60 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, which indicated she was PASRR negative. Record review of the comprehensive care plan, initiated on 09/25/2025, reflected Resident #60 was PASRR positive for mental illness. During an observation and interview on 01/12/2026 at 8:46 a.m., Resident #60 was lying in her bed. She said that she did have diagnosis of mental illness and was receiving psychiatric services in the facility. Resident #60 stated she met with PASRR every year but did not want services. During an interview on 01/14/2026 at 1:52 p.m., MDS Coordinator E stated she was responsible for completing Resident #60's annual MDS assessment. She stated if Resident #60's annual MDS assessment was not marked positive for PASRR then it was marked incorrectly. She stated she reviewed each section of the MDS assessment and must have overlooked that question. MDS Coordinator E stated it was important to ensure Resident #60's annual MDS assessment accurately reflected her positive PASRR status, so the facility had accurate records and information needed to care for the resident. During an interview on 01/14/2026 at 2:18 p.m., the Interim Administrator stated she expected the MDS assessments to accurately reflect the resident's status. She stated the MDS Coordinators were responsible for accurately coding the MDS assessments and the DON was responsible for monitoring to ensure MDS assessments were completed accurately. The Interim Administrator stated it was important to ensure the MDS assessment accurately reflected the resident's status for continuity of care. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the RAI Manual, dated October 2025, reflected A1500: PASRR . code 1, yes: if PASRR Level II screening determined that the resident had a serious mental illness.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment prior to admission for 1 of 5 residents (Residents #60) reviewed for PASRR care and services. The facility failed to ensure Resident #60 had a PASRR evaluation (Level II) completed prior to re-admission from an in-patient psychiatric facility. This failure could place residents at risk of not receiving care and services to meet their needs. The findings included: Record review of the face sheet, dated 01/14/2026, reflected Resident #60 was a [AGE] year-old female who re-admitted to the facility on [DATE] with a diagnosis of bipolar disorder, severe with psychotic features (mental health condition that causes extreme mood swings). Record review of the PASRR Level 1 Screening, dated 11/22/2024, reflected Resident #60 was at a psychiatric hospital and had evidence of mental illness. Record review of the PASRR Evaluation (level II assessment), completed on 11/26/2024, reflected Resident #60 did meet the PASRR definition of mental illness, which indicated she was PASRR positive. It was completed after re-admitting to the nursing facility from a psychiatric hospital. Record review of the comprehensive care plan, dated 09/25/2025, reflected Resident #60 was PASRR positive for mental illness. During an observation and interview on 01/12/2026 at 8:46 a.m., Resident #60 was lying in her bed. She said she had a diagnosis of mental illness and was receiving psychiatric services in the facility. Resident #60 stated she met with PASRR every year but did not want services. During an interview on 01/14/2026 at 1:42 p.m., MDS Coordinator D stated she and the other two MDS Coordinators were responsible for PASRR services. MDS Coordinator D stated Resident #60 re-admitted to the facility from an in-patient psychiatric hospital around November of 2024. MDS Coordinator D stated the in-patient psychiatric hospital was located in another state and the facility had a hard time obtaining the PASRR records at times. MDS Coordinator D stated there have been times when residents were admitted to the facility from a psychiatric hospital with only the PASRR Level 1 Screening completed. She stated she did not have access to see if a PASRR evaluation was completed from another state. She said she was aware a PASRR Evaluation (Level II) should have been completed prior to admission or re-admission from a psychiatric facility. She said it was important to ensure the PASRR Evaluation was completed prior to admitting to the facility to ensure the facility was able to meet the needs of each resident and ensure a nursing facility was the best place for them. During an interview on 01/14/2026 at 2:18 p.m., the Interim Administrator stated she expected the PASRR Level I Screening to have been completed prior to admission. She said Resident #60's PASRR Evaluation (Level II) should have been completed prior to re-admitting to the facility since she was admitted from a psychiatric facility. She stated the MDS nurses were responsible for monitoring to ensure the PASRR requirements were completed at the appropriate timeframes. She stated it was important for continuity of care. Record review of the PASRR policy, undated, reflected If resident is coming from the community or a psychiatric hospital, PE must be completed PRIOR to admission (Do not admit until the PE is showing in Simple [software program used by the facility]) MDS must certify PE prior to admission.		

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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 interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 2 of 5 residents reviewed for new admissions (Resident #103 and #105). The facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was provided to the resident and/or their representative for Resident #103 and Resident #105. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of an undated face sheet revealed Resident #103 was an [AGE] year-old- male, admitted on [DATE] with the diagnoses of Stage III sacral pressure ulcer (a deep, crater-like wound on the tailbone (sacrum) showing full-thickness skin loss, where subcutaneous fat is visible, but muscle, tendon, or bone are not yet exposed, often featuring rolled edges, tunneling, or dead tissue (slough/eschar) and posing serious infection risks), atrial fibrillation (a common type of irregular heartbeat (arrhythmia) where the heart's upper chambers quiver chaotically instead of beating effectively, leading to a rapid, erratic pulse that can feel like fluttering, pounding, or skipped beats, causing symptoms like dizziness, fatigue, shortness of breath, and increasing stroke risk, mycoplasma pneumonia (a common, contagious bacterial lung infection). Record review of Resident #103's EHR on 01/13/2026 revealed no completed MDS assessments, no comprehensive care plan, and no baseline care plans created for Resident #103. During an interview on 01/13/2026 at 10:15 a.m., Resident #103 stated he did not remember the baseline care plan meeting and had no copy of the baseline care plan. He stated he needed to have a baseline care plan meeting because he had questions about why he was in isolation, why he had to do therapy in his room, and what kind of sore he had on his bottom. 2. Record review of an undated face sheet revealed Resident #105 was a [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of diabetes mellitus (condition affecting blood glucose levels), urinary tract infection (a common bacterial infection affecting any part of the urinary system (kidneys, bladder, ureters, urethra), usually occurring when bacteria enter through the urethra, multiply, and cause inflammation, leading to symptoms like painful, frequent urination, cloudy urine, and pelvic pain), and dysphagia (difficulty swallowing, where food or liquids struggle to move from the mouth to the stomach, causing choking, coughing, pain, or a feeling of food getting stuck). Record review of Resident #105's EHR on 01/13/2026 revealed no completed MDS assessments, no comprehensive care plan, and no baseline care plans created for Resident #105. During an interview on 01/13/2026 at 11:30 a.m., Resident #105 stated he had concerns about his discharge he would like to discuss with the discharge planner. He stated his concerns were about what his discharge goals were. He stated he was unsure of what medications he was discharged from the hospital on versus what medications he was receiving at the facility and no one explained it to him. He stated not knowing was making him anxious. During an interview on 01/13/2026 at 2:00 p.m., the MDS Coordinator B stated the baseline care plan was completed by the floor nurse, the social worker, department head nurses, and therapy. The baseline care plan meeting was conducted by the social worker. She stated she was aware the resident was to receive a copy of the baseline care plan. During an interview on 01/14/2026 at 11:00 a.m., the DON said base line care plans were used in place of a comprehensive care plan until one can be developed to direct resident care according to their goals and choices. The DON said the baseline care plan needed to be completed with each department and discussed with the resident and resident representative. The DON said it was her responsibility to inform the IDT of the facility policy on base line care plans and was unsure why the baseline care plans were not completed for Resident #103 and Resident #105. During an interview on 01/14/2026 at 1:45 p.m., the Administrator said the baseline care plans were an interdisciplinary form (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was discussed with the residents on admit. The Administrator said it was the DON's responsibility to ensure the MDS nurse and IDT team completed the baseline care plan and provided a copy to the resident and family. Review of an undated facility policy titled Base Line Care Plan revealed .Completion and implementation of the baseline care plan within 48 hours of a resident's admission {was} intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and ensure the resident and representative, if applicable, are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the residents' practicable physical, mental, and psychosocial well-being for 2 (Resident#17 and Resident #31) of 18 residents reviewed for care plans. The facility failed to implement a person-centered care plan for a laceration, received in the facility prior to the initiation of the comprehensive care plan on 01/05/2026, requiring sutures with interventions for Resident #17, to meet medical, nursing, mental and psychosocial needs. The facility did not ensure that Resident #31's care plan had specific triggers for a trauma related problem. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: Record review of an undated face sheet revealed Resident #17 was an [AGE] year-old female admitted on [DATE] with the diagnoses of fracture of the left acetabulum (a break in the left hip socket (acetabulum) that typically occurs from high-impact trauma, like car accidents, or falls in older individuals with weakened bones, causing severe hip/groin pain, difficulty walking, and potentially numbness), pulmonary edema (a condition where excess fluid builds up in the lungs' air sacs, making it hard to breathe), and atrial fibrillation (a common type of irregular heartbeat (arrhythmia) where the heart's upper chambers quiver chaotically instead of beating effectively, leading to a rapid, erratic pulse that can feel like fluttering, pounding, or skipped beats, causing symptoms like dizziness, fatigue, shortness of breath, and increasing stroke risk). Record review of an admission MDS assessment, dated 12/29/2025, revealed Resident #17 had a BIMS of 13, which indicated cognitively intact. She required substantial assistance (helper provided over half the help) with ADLs. The MDS revealed the resident had two stage I pressure ulcers, (two) stage II pressure ulcers, and application of ointments and medications other than feet. Record review of Resident #17's care plan indicated two stage I pressure ulcers to bilateral heels and 2 stage III pressure ulcers (one to coccyx and one to left trochanter). No other skin issues were care planned. Record review of Resident #17's nurses notes, dated 12/29/2025 written by LVN M, revealed: 3:09 p.m., CNA came to the desk and asked me to come look at resident's leg, entered resident room where resident was lying in bed with legs bent. Laceration to left lower extremity approximately 3-4 inches in length noted. Applied pressure dressing, assessed for pain, no complaints of pain at this time. Notified DON and MD and received orders to send out for evaluation and treatment. 5:56 p.m., Resident returned from ER with 9 sutures to left lower extremity due to laceration, with orders to remove in 10 days. Resident has no complaint of pain at this time. During an interview on 01/13/2026 at 1:00 p.m., MDS Coordinator E stated the treatment for the laceration on Resident #17's was on the admission MDS assessment. She stated the laceration should have been care planned with interventions. She stated the treatment nurse normally care planned all of the skin issues. She stated she was unsure how the laceration was missed on the care plan. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2026 at 1:30 p.m., the Treatment Nurse stated she care planned all major skin issues for the residents. She stated Resident #17 had a laceration caused during an incident while a resident at the facility and it should have been care planned with interventions for prevention and interventions for healing. She stated care plans were used to guide staff on individual resident needs. During an interview on 01/13/2026 at 2:00 p.m., the DON stated it was important for all residents to have a care plan. She stated the care plan provided an individualized guide to resident care. She stated that without the care plan everyone received generalized care. The DON stated Resident #17's laceration needed to be care planned so everyone was aware of the treatment. Record review of an undated facility policy titled, Comprehensive Care Planning ,revealed, 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.services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life. Record review of Resident #31's face sheet, dated 08/01/13, indicated Resident #31 was a [AGE] year-old female, re-admitted on [DATE] with diagnoses of anxiety disorder (mental health conditions marked by intense, persistent, and excessive worry or fear about everyday situations, leading to significant distress and impairment in daily life, often accompanied by physical symptoms like rapid heart rate, trembling, and shortness of breath, and typically treated effectively with therapy and medication), bi-polar disorder (mental illness causing extreme shifts in mood, energy, and activity, from manic highs to depressive lows), and polyneuropathy (damage to multiple peripheral nerves, causing symptoms like numbness, tingling, weakness, and burning pain, often starting in the feet and hands and progressing upwards, due to causes like diabetes, autoimmune diseases, infections, toxins, or genetics). Record review of Resident #31's quarterly MDS, dated [DATE], indicated Resident #31 usually understood others and made herself understood. Resident #31 had a BIMS score of 06, which indicated her cognition was severely impaired. Record review of Resident #31's trauma assessment, dated 12/12/24, indicated she had a history of trauma related to the death of a roommate. Record review of Resident #31's comprehensive care plan, dated 01/12/26, revealed the facility did not ensure Resident #31's care plan had specific triggers for a trauma related problem initiated on 12/12/24. The care plan indicated Resident #31 had a history of Trauma and to Create an emotionally and physically safe environment Respond with empathy and respect. The care plan did not address what Resident #31's trauma was from or her triggers. During an interview on 1/13/26 at 2:25 p.m., Resident #31 did not respond to the surveyor's questions regarding her trauma. During an interview on 1/14/26 at 9:57 a.m., LVN H said if a resident was assessed with trauma, she could identify that specific resident's triggers for their trauma by looking at their care plan. She said (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she did not know what the triggers were for Resident #31's trauma or what her trauma was. During an interview on 01/14/26 at 1:48 p.m., the Director of Nurses said that residents could be placed at risk for further trauma if their specific triggers were not addressed in their care plan. She said she believed that the residents care plan should address their trauma if they truly have a traumatic event in their lifetime. During an interview on 01/14/26 at 1:58 p.m., the Administrator said that a resident's trauma should be fully described in their care plan so that a staff who was researching a resident's trauma knew what their triggers were. She said that residents could be placed at risk if a trauma is not well documented by potentially triggering their specific trauma. Record review of a facility policy, dated 11/24/22, titled, Care Planning revealed that the purpose of the policy was, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA guidelines. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed bases. A culturally competent and trauma-informed comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication storage rooms. (Storage room [ROOM NUMBER])The facility failed to ensure Resident #95's expired Gabapentin was removed from Storage room [ROOM NUMBER].These failures could place residents at risk for not receiving the therapeutic benefit of medications or adverse reactions to medications and inaccurate drug administration.Findings included:Record review of a face sheet, dated 1/14/2026, indicated Resident #95 was a [AGE] year-old male admitted [DATE] with diagnosis of Alzheimer's (a progressive neurodegenerative disorder that primarily affects memory, thinking and behavior), chronic pulmonary edema (occurs when fluid accumulate in the lung's air sacs over an extended period of time), chronic pain syndrome (a complex condition characterized by persistent pain lasting longer than three months), and Parkinson's disease with dyskinesia (degeneration of nerve cells in the brain that produce dopamine, leading to symptoms such as slow movement, tremors, rigidity and balance problems).Record review of a quarterly MDS, dated [DATE], indicated Resident #95 made self-understood and was understood by others. Resident #95 had a BIMS of 5 indicating severe cognitive deficits. The MDS indicated Resident #95 had a feeding tube and was on a mechanically altered diet.Record review of Medication Administration Record, dated 1/1/2026-1/31/2026, indicated Resident #95 was prescribed Gabapentin 100 mg one capsule via G-Tube (a gastrostomy tube is a surgically placed device used to give direct access to stomach for supplemental feeding, hydration or medicine) three times daily for pain.Record review of Care plan, dated 11/1/2023, indicated Resident #95 required tube feeding bolus (a single, concentrated dose of medication or fluid given over a short period) as needed per Physician orders. Interventions included check placement and gastric contents/residual volume per facility protocol and record.During an observation on 1/13/2026 at 10:39 a.m., Storage room [ROOM NUMBER] on 300 hall revealed medication overflow. Observed overflow container of medications for Resident #95 with four blister packets of Gabapentin 100 mg capsules (an anticonvulsant medication used primarily for nerve pain and to manage certain types of seizures) expired. The following blister packets were identified:Gabapentin 100 mg one capsule via G-tube three times daily for pain expiration date: 12/18/2025.Gabapentin 100 mg one capsule via G-tube three times daily for pain expiration date: 12/18/2025.Gabapentin 100 mg one capsule via G-tube three times daily for pain. expiration date: 11/14/2025Gabapentin 100 mg one capsule via G-tube three times daily for pain expiration date: 11/14/2025. During an interview on 1/13/2026 at 10:40 a.m., ADON L said the nurse receiving the medications were responsible for removing expired medications from the overstock. ADON L said if the medication were administered, it may not be as effective. ADON L said the nurses rotated the medication when there was excess and should remove the expired medication. ADON L said it was everyone's responsibility. ADON L said a resident may not have their pain relieved if the medication was not as effective.During an interview on 1/14/2026 at 2:06 p.m., CMA J said the nurses check the medication storage room for expired medications. She said the nurse would be responsible for ensuring the medications were expired. CMA J said she had access to the medication storage room. CMA J said the resident could have a reaction or the medication may not be as effective.During an interview on 1/14/2026 at 2:06 p.m., LVN H said the nurses were responsible for ensuring the medication storage did not have any expired medications. She said when a medication was expired, the nurses would place the medication in a box located in the medication storage room for the ADON to pick up and take to the DON for medication destruction when the Pharmacist visited the facility. LVN H said the properties of the medication could change with expired medications and would not be (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as effective.During an interview on 1/14/2026 at 2:40 p.m., ADON C said the nurses were responsible for removing expired medications. She said expired medications should not be administered to a resident. She said she did not know what would happen if a resident were administered expired medications. ADON C said she did not think they were bad, but the facility did not want to find out.During an interview on 1/14/2026 at 3:07 p.m., the DON said she expected the medications on the cart to not be expired. She said the facility had a lot of overflow medications. She said the important thing for her was the medication was not on the medication cart. The DON said she was not concerned with the medication in the storage room being expired. She said expired medications were stored in the medication storage room. The DON said as the nurses saw the expired medications, they pulled the medication once a month for medication destruction.During an interview on 1/14/2026 at 3:27 p.m., the ADM said she expected the medication with expirations to be removed from the medication storage room. She said it could cause issues if someone took the expired medications.Record review of the facility's policy titled Medication Destruction for Non-controlled medications revised 08/2020 indicated.Policy.Discontinued medications and medications left in the facility after a resident's discharge that do not qualify for return to the pharmacy for credit are destroyed.1. Unused and non-returnable medications should be removed from their storage area and secured until destroyed.		

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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 store all drugs and biologicals in locked compartments for 1 of 4 medication carts (Medication Cart #1) reviewed for pharmacy services. The facility failed to ensure Medication Aide Cart #1 for the 200 short hall was locked when unattended. This failure could place residents at risk of having unauthorized access to medications or lead to harm or drug diversions. Findings included: 1. During an observation on 1/13/2026 beginning at 7:25 a.m. revealed medication cart #1 for 200 short hall was unlocked and unattended with no staff within eyesight of the medication cart. The medication cart was found near a resident's room, an elevator, and main sitting area where staff and visitors congregate. There was one resident navigating the hallway in a wheelchair near the unlocked medication cart. CMA J immediately locked medication cart when she returned. At time of observation, the length of time remained unattended and unlocked could not be determined. During an interview on 1/13/2026 at 7:25 a.m., CMA J said she was going to check on a resident and forgot to lock her cart. She said she heard a noise and went to go check on the resident and left her cart unlocked. She said someone could get in her medication cart and could cause counts to be off, cause damage to the cart or an overdose could happen. She said she was responsible for ensuring her medication cart was locked. She said she was in-serviced on medication storage and locking medication carts. During an interview on 1/14/2026 at 1:57 p.m., CMA J said all staff were responsible for ensuring medication carts were locked. CMA J said medication carts were to be locked at all times. She said any residents or staff could open the cart and take something. CMA J said a person would not know what kind of reaction a medication could have on them, or the person could have an allergic reaction. During an interview on 1/14/2026 at 2:06 p.m., LVN H said everyone was responsible for ensuring medication carts were locked and should be locked at all times. LVN H said the cart should be locked when stepping into a resident's room. She said anyone could get in the medication cart and take something that was not prescribed to them. She said it could hurt them, or they could have a drug reaction or overdose. LVN H said a person with dementia could take something not prescribed to them. During an interview on 1/14/2026 at 2:40 p.m., ADON C said the nurse was supposed to keep medication carts locked when they stepped away from the cart. She said someone could get into the medication cart and take a medication that was not prescribed to them. ADON C said it could negatively impact someone who took the medication, and it could cause harm. ADON C said the nurse or staff with the keys to the cart were responsible. ADON C said nursing staff were all responsible if they observed an unlocked cart and should lock it. During an interview on 1/14/2026 at 2:53 p.m., the DON said the medication cart should be locked when no one was around it. The DON said she expected the nurses to keep the medication carts locked when not in use. She said the nurse assigned to the medication cart was responsible for the cart. The DON said if a person took medication not prescribed to them, it could cause harm or have no effect but there were all sorts of potentials. During an interview on 1/14/2026 at 3:07 p.m., the ADM said she expected the medication cart to remain locked when not in use. The ADM said the nurse was responsible for ensuring the medication carts were locked. She said someone could get into the medication cart and take something that was not prescribed to them. She said it could be detrimental. Review of the facility's policy titled Storage of Medications last revised 08-2020 reflected the following: . Policy statement. Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Procedures. 2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aids) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with (continued on next page)		

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorized access. III. Expiration Dating (Beyond-use dating) indicated .8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.		

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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 store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. A sack of flour was not stored six inches off the floor. 2. Raisin bread, sliced cheese, and tortillas were not labeled or dated. These failures could place residents at risk for food borne illness. Findings included: During an observation and interview on 1/12/26 at 8:05 a.m. it was observed during the initial tour of the kitchen that a large sack of flour was lying on the floor of the dry food storage. The Dietary Manager said she needed help lifting the bag as it was too heavy for her. She said it was recently delivered. It was observed that raisin bread stored in the dry food storage, sliced cheese on a preparation table, and tortillas stored in the dry food storage were not labeled and dated. The cheese was stored in a gallon size bag on top of a preparation table that was used recently been recently used. During an interview on 1/14/26 at 1:06 p.m. the Dietary Manager said that food should not be left to sit on the floor as the regulations state it should be stored at least six inches off the floor. She said that it could place food at risk of being contaminated by rodents or pests. She said that food should be labeled or dated. She said that not having labels or dates on food could place residents at risk of foodborne infections. During an interview on 1/14/26 at 1:48 p.m. the Director of Nurses said food should be labeled and dated to ensure old or expired food was not used by kitchen staff to feed residents. She said that feeding a resident expired or old food could place them at risk of foodborne illness. She said that food should not be left on the floor as it could expose it to pests. During an interview on 1/14/26 at 1:58 p.m. the Administrator said that flour or any food should not be left on the floor as it could contaminate the food and encourage rodents. She said that food should also be labeled and dated to prevent residents from eating expired food. She said residents could be placed at risk of illness if they eat expired food. Review of the facility policy, dated 01/01/22, Food Labeling and Dating provided by the Dietary Manager revealed the purpose of this policy was to, To establish guidelines for storing, thawing, and preparing food. Dietary employees will be trained regarding proper food storage procedures, labeling, and dating. The product name will be labeled on food items, including the original packaging, box, zip-lock bag, and storage bin. Label each package, box, can, etc., with the date of receipt. Items stored should be dated upon receipt, unless they contain a manufacturer's use-by, or a date delivered. If the vendor pick stickers have the receive date or delivery date printed on the pick sticker, this can serve as a receiving date labeling. Record review of the FDA Food Code updated in 2022 revealed that, FDA Food Code dry storage requires keeping foods cool, dry (under 60% humidity), and, in many cases, ventilated. Items must be stored at least 6 inches off the floor and away from walls to prevent contamination. Use FIFO (first-in, first-out) inventory rotation, maintain, clean, and secure areas from pests.		

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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 observation, interview, 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 4 residents (Resident #106) reviewed for infection control practices. The facility failed to ensure LVN A and CNA B utilized enhanced barrier precautions while pulling Resident #106 up in bed on 01/12/2026. This failure could place residents and staff at risk for cross contamination and the spread of infection. The findings included: Record review of the face sheet, dated 01/15/2026, reflected Resident #106 was a [AGE] year-old male who re-admitted to the facility on [DATE] with diagnoses of sepsis due to E. coli (blood infection caused from bacteria), chronic kidney disease (kidneys are damaged and unable to filter blood as well as it should), and obstructive and reflux uropathy (blockage in the urinary tract that causes urine to back flow into the kidneys). Record review of the MDS assessment, dated 01/11/2026, reflected Resident #106 had clear speech, was understood by others, and was able to understand others. Resident #106 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #106 had an indwelling urinary catheter. Resident #106 received hemodialysis (machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) while a resident. Record review of the comprehensive care plan, undated, reflected Resident #106 had an indwelling urinary catheter and required enhanced barrier precautions. The interventions included: Staff members will wear a clean gown and gloves while performing high contact resident care activities. The care plan further revealed Resident #106 received dialysis treatments three times a week. Record review of the order summary report, dated 01/15/2026 reflected, Resident #106 had an order, which started on 01/08/2026, for Enhanced Barrier Precautions [interventions to prevent spread of infection in high-risk residents] related to Indwelling urinary Catheter: Staff members will wear a clean gown and gloves while performing high contact resident care activities. During an observation on 01/12/2026 at 11:16 a.m., LVN A and CNA B walked into Resident #106's room and applied clean gloves. Resident #106 was lying sideways in the bed. LVN A and CNA B pulled Resident #106 up in the bed, lifting and repositioning him by lifting him underneath the legs, near the indwelling urinary catheter. They did not wear an isolation gown. During an attempted telephone interview on 01/14/2026 at 12:47 p.m., LVN A did not answer the phone or return the call upon exit of the facility. During an interview on 01/14/2026 at 1:26 p.m., CNA B stated if a resident was on enhanced barrier precautions, they had a sign outside the door. CNA B stated residents with a indwelling urinary catheter or residents who received dialysis required enhanced barrier precautions during high-contact resident care activities, which included pulling someone up in bed. She said enhanced barrier precautions included gown and gloves. She stated she realized she had not worn a gown after they left Resident #106's room, but should have. She said she was nervous because the state surveyor was watching her, and she was rushed because she had just come out of another room. She said it was important to ensure enhanced barrier precautions were used to protect both the residents and staff and prevent infections. During an interview on 01/14/2026 at 2:10 p.m., the DON stated she expected the nursing staff to ensure that enhanced barrier precautions were being used. The DON stated residents who required an indwelling urinary catheter or residents who received dialysis required enhanced barrier precautions during high-contact resident care activities. She said enhanced barrier precautions included gloves and an isolation gown. The DON stated in-service education was provided to the facility staff on enhanced barrier precautions. She said signage to alert staff was posted on the resident's door and PPE supplies were located in the hallway. The DON stated it was important to ensure staff were using enhanced barrier precautions for high-risk residents to prevent the spread of infection and contamination of open areas or devices. During an interview on 01/14/2026 at 2:13 p.m., ADON C (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was the infection control preventionist for the facility. She said her role as the infection control preventionist included monitoring infection control practices and teaching facility staff as needed. She stated she provided in-service education that included enhanced barrier precautions and how to put on and take off PPE. She stated she also performed spot checks to random staff and questioned them about infection control practices. She stated enhanced barrier precautions included an isolation gown and gloves while performing high-contact resident care activities. She stated it was important to ensure the staff used enhanced barrier precautions for high-risk residents to prevent infections. During an interview on 01/14/2026 at 2:18 p.m., the Interim Administrator stated she expected the facility staff to use all available PPE as required or indicated. She stated the nursing staff were responsible for monitoring to ensure enhanced barrier precautions were used during high-contact care activities. She said it was important to ensure enhanced barrier precautions were used during high-contact care activities for high-risk residents to prevent cross contamination. Record review of the Standard and Enhanced Precautions policy, implemented on 04/01/2024, reflected Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities that are associated with high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (e.g., urinary catheter, vascular catheters.). EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. for residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.		