STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675502	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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 - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interviews, and record review the facility failed to provide a safe, functional, and comfortable environment for residents for 1 of 5 residents (Resident #4) reviewed for environment. Resident #4's footrest on the electric bed was in an elevated position and reported to Maintenance on 03/29/2025. Resident #4's bed was not repaired until 04/03/2025. This deficient practice could place residents at risk of being uncomfortable and at risk of injury from equipment that was not functioning properly. The findings were: Record review of Resident #4's undated face sheet revealed Resident #4 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (a buildup of fat in the artery walls), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic venous hypertension with ulcer of left lower leg (high blood pressure in the legs), chronic kidney disease (gradual loss of kidney function), and hemiplegia (unable to move one side of the body). Record review of Resident #4's quarterly MDS assessment, dated 02/03/2025, revealed a BIMS score of 13, indicating no cognitive impairment. Section E - Behavioral Symptoms revealed Resident #4 displayed physical, verbal, and other behavioral symptoms toward others daily during the assessment period and was resistive to care 4-6 days. Section GG- Functional Abilities revealed Resident #4 was dependent on staff for all ADL's, transfers, bed mobility, and bathing. Section H- Bladder and Bowel revealed Resident #4 was incontinent of bowel and bladder function. Section M- Skin Conditions revealed Resident #4 had a venous ulcer present. Record review of Resident #4's comprehensive care plan revealed a care plan, date initiated 11/13/2024, that read [Resident #4] has impaired physical functioning r/t SPECIFY: (left side hemiplegia, weakness, impaired mobility and transfers. The care plan interventions revealed Resident #4 was dependent on staff for bed mobility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility document titled, Work Order #550, created on 03/29/2025 at 3:24 a.m. by CNA B revealed, [Resident #4] bed not working footrest not going down. The document revealed the work order was assigned to the Maintenance Director and revealed an updated status, set to completed on 04/04/2025 at 9:13 a.m. Record review of a facility document titled, Work Order #553, created on 04/01/2025 at 1:30 p.m. by the ADON revealed, remote to bed is not working. The room number listed was [Resident #4 room number]. The document revealed the work order was assigned to the Maintenance Director and revealed an updated status, set to completed on 04/04/2025 at 9:13 a.m. During an observation, on 04/02/2025 at 10:35 a.m., Resident #4 was observed lying in bed with the foot of the bed slightly elevated underneath Resident #4's lower legs and feet. During an interview with CNA B, on 04/03/2025 at 1:44 p.m., CNA B stated she had been trained to enter maintenance work orders into the electronic [company name] work order system. CNA B stated Resident #4 had complained about the foot of his bed being elevated and the bed remote not working last week while CNA B was working the night shift. CNA B stated she entered the concern into the maintenance electronic system and CNA B stated the bed was still broken last night and she was not sure why the bed had not been fixed yet. During an interview with Resident #4, on 04/03/2025 at 2:15 p.m., Resident #4 stated his bed was fixed on the morning on 04/03/2025. Resident #4 stated he was not hurt but the elevated footrest and stated it was just uncomfortable at times. Resident #4's foot of bed was observed in a flat position with no elevation. During an interview with CNA F, on 04/03/2025 at 2:20 p.m., CNA F stated Resident #4 had not complained about his bed being uncomfortable and had not mentioned his remote or bed not functioning properly to CNA F. During an interview with MA D, on 04/03/2025 at 2:23 p.m., MA D stated Resident #4 had not reported a concern with his bed not functioning properly and MA D stated she would have reported it to the Maintenance Director and entered it into the [company name] work order system. During an interview with the ADON, on 04/04/2025 at 11:29 a.m., the ADON stated she placed a work order in the maintenance system for Resident #4 on 04/01/2025 due to Resident #4 stating his bed remote was not working. The ADON stated she did not notice the foot of the bed being elevated and stated Resident #4 was agitated and just said it was not working. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Maintenance Director, on 04/04/2025 at 11:45 a.m., the Maintenance Director stated all staff were trained to enter maintenance work orders for malfunctioning or broken equipment into the [company name] electronic work order system. The Maintenance Director stated once the work order was entered into the system, the Maintenance Director would receive a message on his work phone and on his computer notifying him of the maintenance request. The Maintenance Director stated Resident #4 was transferred from a hospice provided bed to the current bed on 03/27/2025 and the Maintenance Director stated he inspected the bed at that time and the remote and foot of the bed was operating correctly. The Maintenance Director stated the ADON notified him of Resident #4's bed not working properly on 04/01/2025 and stated he repaired the bed on 04/03/2025 around 1:15 p.m. The Maintenance Director stated the expectation was resident equipment would be fixed the same day as the work order was entered. The Maintenance Director looked through his phone during the interview and stated the first time he was notified of Resident #4's bed not working was 03/29/2025. The Maintenance Director stated the repair log revealed the work order was completed on 04/04/2025 at 9:13 a.m. because that was when he updated the work order. The Maintenance Director stated it was important to repair essential resident equipment so there are no further issues and so the patient is comfortable and does not have any pain or harm. During an interview with the facility Administrator, on 04/04/2025 at 12:58 p.m., the Administrator stated all staff members had access to [company name] maintenance work order system and once a maintenance request was entered, the Maintenance Director was responsible for prioritizing the importance of the request and updating the system when the work order had been completed. The Administrator stated the facility expectation was resident equipment would be repaired as soon as possible, I would say the same day. The Administrator stated a resident could be harmed or caused discomfort if malfunctioning resident equipment was not fixed timely. Record review of a facility policy titled, Maintenance Inspection (2005 The Compliance Store, LLC.), revealed 3. all opportunities will be corrected immediately by maintenance personnel.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48753 Based on observations, interviews, 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. Meat products were stored above other food items in the facility kitchen freezer. These deficient practices could place 34 residents who ate food from the kitchen at risk for foodborne illness. The findings were: During an observation of the facility kitchen, on 04/03/2025 at 9:45 a.m., the freezer was observed to have the following items, slabbed bacon 18/2 count box, 2-2 lb bags of diced turkey, 2-3 lb honey hams, 10 lb box of chicken, 50 portion box of beef fritters, 10 lb box of chicken sausage, stored above a box of 300 count bread rolls, a box of cookie dough, package of sweet potato fries, and a box of individual size pizzas. During an interview with the Dietary Manager, on 04/03/2025 at 10:00 a.m., the Dietary Manager stated she was responsible for storing the food in the freezer and ensuring the food was stored safely. The Dietary Manager stated meat should be stored below other food items to prevent the meat from dripping onto the other food items and stated, if the freezer breaks and starts to thaw, we would have blood all over the place and on the food it is not supposed to be on. The Dietary Manager stated she had provided education to her staff about storage, but stated she was the person who stored the food in the freezer incorrectly. The Dietary Manager stated she had a hard time lifting some of the boxes and felt like the freezer was too small. During an interview with the Dietician, on 04/03/2025 at 10:33 a.m., the Dietician stated she had not provided training to the staff specifically regarding food storage in the freezer but stated, there is an order for it and normally meat is stored on the bottom. The Dietician said it was important to store meat at the bottom because if it happens to thaw, you don't want the meat to drip and get onto the other food. The Dietician stated the Dietary Manager was responsible for ensuring the food was stored correctly. During an interview with the Administrator, on 04/04/2025 at 12:58 p.m., the Administrator stated meat should be stored at the lowest level of the freezer to prevent dripping on other products and it should be in a drip pan. The Administrator stated the facility had a policy and procedure for food storage and dietary staff received training on food storage on 04/03/2025. The Administrator stated improper food storage could cause the food to become contaminated and make the residents sick. Record review of a facility in-service titled Safe Storage of Foods, on 04/03/2025 at 11:30 a.m., presented by the Administrator had 3 employee names on the sign in list including the Dietary Manager. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility policy titled Food Receiving and Storage revealed the policy statement Foods shall be received and stored in a manner that complies with safe food handling practices. Listed under the section, Policy Interpretation and Implementation, read .13. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables, and other ready-to-eat food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #4) reviewed for accuracy of medical records. Resident #4 had a physician's order and care plan for hospice services on his medical record after he was discharged from hospice services. This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. The findings were: Record review of Resident #4's undated face sheet revealed Resident #4 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (a buildup of fat in the artery walls), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic venous hypertension with ulcer of left lower leg (high blood pressure in the legs), chronic kidney disease (gradual loss of kidney function), and hemiplegia (unable to move one side of the body). Record review of Resident #4's quarterly MDS assessment, dated 02/03/2025, revealed a BIMS score of 13, indicating no cognitive impairment. Section E - Behavioral Symptoms revealed Resident #4 displayed physical, verbal, and other behavioral symptoms toward others daily during the assessment period and was resistive to care 4-6 days. Section GG- Functional Abilities revealed Resident #4 was dependent on staff for all ADL's, transfers, bed mobility, and bathing. Section H- Bladder and Bowel revealed Resident #4 was incontinent of bowel and bladder function. Section M- Skin Conditions revealed Resident #4 had a venous ulcer present. Record review of Resident #4's physician order summary, on 04/02/2025 at 12:20 p.m., revealed Resident #4 had an order that read, Call hospice 24/7 for falls, wounds, change in condition, dated 10/21/2024. Resident #4 had an order that read, Hospice MD to sign death certificate, Hospice RN to pronounce Hospice to contact PD, ME, FH at TDD, dated 10/21/2024. Resident #4 had an additional order that read, Resident was admitted to [Hospice company name] with a dx of atherosclerotic heart disease, dated 12/04/2024. Record review of Resident #4's comprehensive care plan revealed , Needs hospice care from [hospice company name] due to terminal diagnosis of Atherosclerotic heart disease, date initiated 10/18/2024 and revised 12/04/2024. Record review of a [Hospice Company Name] Document titled, Notice of Medicare Non-Coverage, listed Resident #4's name and read, The effective date of coverage of your current services will end: 03/25/2025. The document said, patient refused to sign on the signature of patient or representative line and was dated 03/21/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Hospice visit note report by Hospice RN K, dated 03/21/2025, revealed RN K met with Resident #4 to discuss discharge planning from hospice and revealed, patient was not open to discussing any type of education. Patient asked me to leave his room. Record review of a facility document titled, SNF/NF to Hospital Transfer Form, dated 03/24/2025, revealed Resident #4 was transferred to the hospital due to a DVT (blood clot) in his left leg. Record review of a form titled, Texas Medicaid Hospice Program Individual Election/Cancellation/Update, Listed the form type as cancelled and dated 03/24/2025. During an interview with LVN A, on 04/02/2025 at 12:00 p.m., LVN A stated Resident #4 was on [Hospice company name] services and LVN A would obtain any new orders for care from the hospice company. During an interview with the DON, on 04/02/2025 at 12:11 p.m., the DON stated Resident #4 was discharged from hospice services for not following their plan of care. The DON stated [hospice company name] discharged Resident #4 last week from their services and Resident #4 had been on multiple hospice services in the past and would fire them. The DON stated in this insistence, [hospice company name] gave Resident #4 a 5-day discharge notice for refusing care and treatment and not following the plan of care. The DON stated Resident #4's clinical record, including the physician orders and care plan should have been updated to reflect Resident #4 was no longer on hospice services at the time he was discharged from services. The DON stated the Charge Nurses were responsible for updating the orders and the MDS Coordinator was responsible for updating the care plan. The DON stated the inaccuracy of a resident's medical record could cause the facility to give the wrong medications, treatments, or care. During an interview with Resident #4, on 04/03/2025 at 9:10 a.m., Resident #4 stated he was no longer on hospice because they kicked me out because I was calling other hospices and because I was calling 911 too much. When the state surveyor attempted to ask more questions, Resident #4 told the state surveyor to get out of the room and stop asking questions. During an interview with LVN E, on 04/03/2025 at 10:42 a.m., LVN E stated Resident #4 was no longer on hospice services and stated Resident #4 had made the comment to LVN E that he no longer wanted to be on hospice services. LVN E stated the facility staff provide basically the same care that hospice provides but stated it was important for the physician order and care plan in the clinical record to be accurate because he is no longer receiving the hospice services and we would need to get orders elsewhere for him. During an interview with CNA C, on 04/03/2025 at 12:39 p.m., CNA C stated Resident #4 was no longer on hospice services because Resident #4 was refusing all care and treatment from hospice and the facility staff were responsible for providing care. During an interview with CNA F, on 04/03/2025 at 1:00 p.m., CNA F stated Resident #4 was no longer on hospice services and CNA F stated Resident #4 refused care from hospice and facility staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Hospice Director of Clinical Services, on 04/04/2025 at 9:30 a.m., the Director stated Resident #4 was issued a 5-day discharge notice on 3/21/2025 with an effective date of 03/25/2025. The Director stated Resident #4 was admitted to the hospital on 03/24/2025, so Resident #4's hospice coverage was terminated on 03/24/2025 due to hospice not being able to follow Resident #4 in the hospital. During an interview with the MDS Coordinator, on 04/04/2025 at 10:52 a.m., the MDS Coordinator stated a resident's care plan should be updated at the time the resident experienced a change in medication, orders, behaviors, or diet. The MDS Coordinator stated she was only at the facility 2 days a week and was updated on resident changes in their plan of care through reviewing the 24-hour report and running an order listing report. The MDS Coordinator stated all nurse managers had access to update a resident care plan when the MDS Coordinator was not in the facility. The MDS coordinator stated Resident #4's clinical record should have been updated on the date he was discharged from hospice by updating the care plan and physician orders to reflect that Resident #4 was no longer receiving hospice services. During an interview with the facility Administrator, on 04/04/2025 at 12:58 p.m., the Administrator stated care plans and physician orders should be updated as the resident needs changed and stated all nursing staff was responsible for updating the clinical record. The Administrator stated the accuracy of the clinical record was important so we can make sure we are meeting the needs of the resident and so we know everything we need to know about them and stated an inaccurate clinical record could mean that a resident would not have their needs met or doctor's orders followed correctly. Record review of a facility policy titled, Maintenance of Electronic Clinical Records (Copyright 2024 The Compliance Store, LLC.), revealed under the section, Policy Explanation and compliance Guidelines, 1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the residents' information.

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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** 48753 Based on observations, interviews, 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 diseases and infections for 1 of 5 residents (Resident #4) reviewed for infection control. Resident #4 had an order for enhanced barrier precautions related to a wound and did not have a sign on his door identifying a need for enhanced barrier precautions for Resident #4. This deficient practice could affect residents on enhanced barrier precautions and place them at risk for infection. The findings were: Record review of Resident #4's undated face sheet revealed Resident #4 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (a buildup of fat in the artery walls), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic venous hypertension with ulcer of left lower leg (high blood pressure in the legs), chronic kidney disease (gradual loss of kidney function), and hemiplegia (unable to move one side of the body). Record review of Resident #4's quarterly MDS assessment, dated 02/03/2025, revealed a BIMS score of 13, indicating no cognitive impairment. Section E - Behavioral Symptoms revealed Resident #4 displayed physical, verbal, and other behavioral symptoms toward others daily during the assessment period and was resistive to care 4-6 days. Section GG- Functional Abilities revealed Resident #4 was dependent on staff for all ADL's, transfers, bed mobility, and bathing. Section H- Bladder and Bowel revealed Resident #4 was incontinent of bowel and bladder function. Section M- Skin Conditions revealed Resident #4 had a venous ulcer present. Record review of Resident #4's physician order summary, 04/02/2025 at 12:20 p.m., revealed Resident #4 had an order that read, enhanced barrier precautions every shift: left calf venous stasis and chronic venous ulcer to left heel with a start date of 01/16/2025. Record review of Resident #4's comprehensive care plan revealed , [Resident #4] is on enhanced barrier precautions r/t chronic wound, date initiated 11/14/2024 and revised 01/11/2025. The care plan interventions included, [NAME] gown and gloves during high contact personal care activities. During an observation, on 04/02/2025 at 9:00 a.m., Resident #4 was observed in a room without an orange enhanced barrier precaution sign on the door indicating staff were to wear PPE when providing direct care to Resident #4. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 04/03/2025 at 2:26 p.m., Resident #4's room did not have an enhanced barrier precaution sign on the room door. During an interview with Resident #4, on 04/02/2025 at 10:35 a.m., Resident #4 stated he had wounds on his left leg. When the state surveyor attempted to ask if staff wore PPE when providing care, Resident #4 stated he was not sure, became agitated, and told the state surveyor to stop asking so many questions. During an interview with LVN A, on 04/02/2025 at 12:00 p.m., LVN A stated Resident #4 was on enhanced barrier precautions and staff wore gloves and gowns when providing treatments or care. LVN A stated residents on enhanced barrier precautions had signs on their door indicating they were on enhanced barrier precautions. During an interview with CNA C, on 04/03/2025 at 12:39 p.m., CNA C stated residents on enhanced barrier precautions had a sign on the outside of their door. CNA C stated the DON was responsible for placing the sign on the door and stated Resident #4 had a sign on his door and was on enhanced barrier precautions. CNA C stated it was important for residents on enhanced barrier precautions to have a sign indicating enhanced barrier precautions so staff know what the precautions are when we go change him and because of his wound, so it does not get infected. During an interview with CNA F, on 04/03/2025 at 1:00 p.m., CNA F stated residents on enhanced barrier precautions had an orange sign on their door that was placed on the door by the DON. CNA F stated Resident #4 had a sign on his door and stated when a resident had an orange sign on their door, CNA F would put on a gown, gloves, and a mask when providing care. CNA F stated it was important for residents on enhanced barrier precautions to have a sign identifying the need for precautions, so we know who is on it so we can help prevent them from getting infections. During an interview with CNA B, on 04/03/2025 at 1:44 p.m., CNA B said the residents on enhanced barrier precautions were identified by having a sign on their door that indicated the resident was on enhanced barrier precautions. CNA B stated Resident #4 was on enhanced barrier precautions and CNA B said she thought Resident #4 had a sign on his door. CNA B stated it was important to have the enhanced barrier precaution sign on the door so everyone that goes into that room knows what to do. CNA B stated staff should wear gloves and a gown when providing care to any resident on enhanced barrier precautions. During an interview with the DON, on 04/4/2025 at 12:30 p.m., the DON stated residents on enhanced barrier precautions were identified with a sign on the door that read enhanced barrier precautions and listed what equipment was needed to provide care. The DON stated any resident with a wound, foley catheter, feeding tube, or antibiotics should be on enhanced barrier precautions and stated there was not a designated person responsible for placing the sign on a resident door. The DON stated she was planning to add it to the manager room rounds so managers can validate the signs were on the residents' doors when making rounds daily. The DON stated Resident #4 was on enhanced barrier precautions due to his wound and the enhanced barrier precaution sign was placed on his door on the morning of 04/04/2025. The DON said the importance of having the enhanced barrier sign on the door of residents who required enhanced barrier precautions was for their protection, we don't want to bring anything like infections to the resident due to their open areas. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility Administrator, on 04/04/2025 at 12:58 p.m., the Administrator stated residents on enhanced barrier precautions were identified by having a sign placed on their door indicating the resident was on enhanced barrier precautions and listed PPE equipment required to provide care. The Administrator said residents with foley catheters, feed tubes, wounds, or any openings on their body were required to be on enhanced barrier precautions. The Administrator stated the DON or the ADON was responsible for placing the enhanced barrier precaution sign on the residents' doors. The Administrator stated Resident #4 was on enhance barrier precautions and a sign was placed on his door last night. The Administrator said the importance of identifying residents on enhanced barrier precautions was so the resident can be protected for infection and making sure we have a barrier of PPE between ourselves and the residents, so we don't transfer anything to them. During an observation, on 04/04/2025 at 9:01 a.m., Resident #4 had an orange sign outside of Resident #4's room door that had a stop sign on it and said, Enhanced Barrier Precautions and indicated providers and staff should wear gloves and a gown when providing high contact direct care activities like dressing, bathing, transferring, changing linens, providing hygiene or toileting/brief changes. The sign also included a gown and gloves must be worn for device care or use for central lines, urinary catheters, feeding tubes, tracheostomy, and any wound care with a skin opening that required a dressing. Record review of a facility in-service titled, Enhanced Barrier Precautions, dated 03/28/2025, revealed the in-service was presented by the Administrator and the DON and had 17 employee signatures. Record review of a facility policy titled, Enhanced Barrier Precautions 2001 MED-PASS, Inc., revealed a policy statement that read, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employees targeted gown and glove use during high contact resident care activities. The section, Policy Interpretation and Implementation, read, . 11. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required.