STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Rehabilitation and Care Center	903 Borgognoni Drive Lake Village, AR 71653

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: Based on record review, observations, interviews and facility policy review, it was determined that the facility failed to ensure that the resident environment remained free of avoidable accidents and hazards for one (Resident #11) of two residents reviewed. The findings include: Review of an admission Record, indicated the facility admitted Resident #11 on 01/31/2023 with diagnosis that included heart disease, osteoarthritis [break down of cartilage in the joints of bones causes pain, stiffness and reduced mobility], anxiety, muscle weakness, difficulty walking, unsteady on feet, abnormalities of gait and mobility, lack of coordination, reduced mobility, schizophrenia [brain disorder that affects how a person think, feels and acts], dementia [memory loss, poor reasoning and personality changes], auditory hallucinations [hearing sounds or voices that are not real], post-traumatic stress disorder (PTSD) and fracture of the femur. Review of a signification change MDS with an ARD of 07/02/2025, revealed Resident #11 had a BIMS score of 13 which indicated the resident was cognitively intact. The MDS also indicated Resident #11, during that time, displayed no physical or verbal behavior symptoms, utilized a walker, had no impairment to arms or legs, and all mobility functions were independent. The MDS did indicate PTSD disorder and a major injury. Review of a Care Plan initiated on 03/01/2023, revealed the resident liked to be left alone while in room and Resident #11 would place objects in front of the door while sleeping for security. Resident #11 had ADL changes due to a total left hip replacement, revised on 06/18/2025. Resident #11 was Care Planned for an actual fall with major injury to left hip on 06/08/2025. Resident #11 had behavior problems related to diagnosis such as PTSD, anxiety and hallucinations. Care Plan interventions included explaining procedures prior to starting and approaching the resident in a soft and calm manner. Review of Hospital Records dated 06/08/2025 at 9:20 PM, indicated Resident #11's disposition as Femoral neck fracture. The Computed Tomography (CT) scan report indicated the impression as a comminuted displaced and angulated fracture of the neck of the left femur [a fracture in which the bone breaks into three or more pieces, tilts at an angle and moves from its normal anatomical alignment]. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/04/2026 at 3:40 PM, with Registered Nurse (RN) #10, the RN indicated that she was not familiar with the residents on the 400 Hall, that the hall was not where RN #10 normally worked and she was unaware of Resident #11's diagnosis of PTSD. RN #10 indicated for guidance on how to care for a resident, you would review the Care Plan. RN #10 indicated she entered Resident #11's room on 06/08/2025 to administer medication and Resident #11 jumped up, slammed the cup from RN #10's hand. RN #10 reported Resident #11 grabbed a cane or stick and ran after RN #10. RN #10 indicated running from the room and grabbing a laundry cart and placing the cart in between RN #10 and Resident #11. RN #10 stated Resident #11 grabbed the laundry cart, lost their balance, and fell into the door frame then onto the floor. RN #10 denied receiving any training in the facility on how to handle the situation. RN #10 admitted placing the laundry cart between Resident #11 and RN #10 for both the resident and nurses' safety. During an interview on 03/05/2026 at 8:11 PM, LPN #1 indicated that she did not see the incident regarding Resident #11 on 06/08/2025 but heard CNA #11 state, Oh my God, did you see that? She just pushed him. LPN #7 indicated she looked down the hall from the 100 Hall toward the 400 hall and saw RN #10 standing in the hall and saw the laundry cart. LPN #7 did not see Resident #11. LPN #7 stated all in-services, such as abuse, how to care for a resident with dementia and behaviors, were recently completed February of 2026 During an interview on 03/06/2026 at 7:52 AM, CNA#11 indicated on 06/08/2025 she walked towards the 400 Hall that Resident #11 and RN #10 were on. CNA #11 reported both Resident #11 and RN #10 had their hands on the laundry cart. CNA#11 stated Resident #11 pushed the cart and RN #10 pushed the cart back on Resident #11 and Resident #11 fell back on the floor. CNA# 11 indicated being trained on how to respond in these situations. CNA #11 stated, I would try to get away or back away if possible. During an interview on 03/06/2026 at 8:11 AM, CNA #8 reported she had Resident #11 as a patient the night of the incident on 06/08/2025. CNA #8 denied that Resident #11 displayed any behaviors that night on 06/08/2025. CNA #8 reported walking onto the hall. CNA #8 saw Resident #11 and RN #10 pushing the laundry cart back and forth. CNA #8 reported she saw the laundry cart being pushed back in the direction of the resident, towards Resident #11's door. CNA #8 reported Resident #11 stated RN #10 pushed Resident #11. During a previous interview on 03/05/2026 at 7:58 PM, CNA #8 stated an abuse, dementia, and neglect in-service was completed in February of 2026. During an interview on 03/06/2026 at 8:41 AM, CNA #12 stated she observed the incident on 06/08/2025 between RN #10 and Resident #11. CNA #12 reported she was seated in a chair on the 400-hall talking to a different resident and observed RN #10 coming out of Resident #11's room fast and reported Resident #11 was also coming out of the room after RN #10 fast. CNA #12 reported that RN #10 grabbed the laundry cart and pulled it between RN #10 and Resident #11. CNA #12 reported she got up to check on Resident #11 because, when RN #10 pushed the laundry cart back towards Resident #11 it was a hard shove and Resident #11 ended up on the floor. During an interview on 03/06/2026 at 10:45 AM, the Administrator indicated all in-services were completed by the Administrator, the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). The Administrator indicated in-services were completed annually, routinely and as needed. The Administrator indicated RN #10 was terminated after the incident involving Resident #11. The Administrator stated training was received and interventions were taught to staff concerning behaviors, dementia, and abuse on 06/08/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Resident #11 Reportable document indicated an in-service was completed on 06/08/2025 conducted by the administrator and the ADON regarding Trauma-Informed care/Managing difficult Behaviors and abuse. This in-service defined neglect as The failure of facility, employees or service providers to provide goods/services to a resident necessary to avoid physical harm, pain mental anguish and emotional stress. A power point slide in the in-service on Nursing Home resident Abuse Neglect and Theft indicated you are to back off, get your supervisor, ask to be reassigned, or ask for quiet time if a resident has pushed your last button. The facility re-educated all staff on following the incident on 06/08/2025, on Trauma-Informed care/Managing difficult Behaviors and abuse. Per an in-service initiated on 06/08/2025, all staff behaviors, dementia, and abuse. In addition, RN#10 was terminated after the incident involving Resident #11. These actions were performed before the survey team entered the facility, verified by document review and staff interview resulting in this finding being cited at past non-compliance.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Number of residents sampled: Number of residents cited: Based on observation, record review, interview and facility guidance review, the facility failed to ensure the medication error rate was less than five percent during the medication administration observation of two (Residents #51 and #58) of four residents who received medications from two Licensed Practical Nurses (LPNs). This surveyor observed 25 opportunities for medication administration and two of the 25 medications were not administered in accordance with the physician's orders, resulting in a medication error rate of eight percent. The findings include: Review of a Medication Administration guidance, not dated, from an in-service given on 02/17/2026, conducted by the Director of Nursing (DON) revealed, included in the six rights of medication was the right dosage and to check the label three times, comparing the label with the order and if the medication was a tablet or caplet, to pour the correct number in the cap and then into the medication cup. Resident #51: On 03/05/2026 at 8:33 AM, after preparing medications for Resident #51, this surveyor observed LPN #1 put on gloves. LPN #1 counted the pills in the cup and stated she had 10 and a half pills in her cup. At 8:36 AM the nurse administered the medications to the resident with a cup of water. Review of a Physician Order for Resident # 51 revealed a 20 milligram (mg) diuretic medication with instructions to give three tablets by mouth twice a day with a start date of 02/11/2026. The medication card LPN #1 removed the diuretic pills from during the 8:33 AM medication pass indicated to give four 20 mg tablets in the day and three 20 mg tablets in the evening, and she removed the last four 20mg pills from the card during the observed medication pass. Review of an electronic Medication Administration Record (eMAR) for Resident #51 revealed to give three tablets of the 20 mg diuretic medication two times a day. The eMAR revealed that the diuretic medication was last administered on 03/05/2026 at 8:00 AM and LPN #1's last name was in the box with a check mark. The eMAR also revealed LPN #1 administered the 8:00 AM diuretic medication to Resident #51 on 03/01/2026 and 03/04/2026. On 03/05/2026 at 8:18 PM, LPN #7 was at the medication cart, this surveyor asked her to remove Resident #51's diuretic medication card for the morning dose. She stated those would be in the morning section of the medication cart and she removed all the medication cards from the cart and retrieved the diuretic card. The diuretic medication card indicated the tablet was an 80 mg tablet with instructions to give one tablet by mouth two times a day. The card was filled on 02/01/2026. She placed the cards back in the medication cart in the designated area for the morning medication pass. Durning an interview on 03/06/2026 at 9:49 PM, LPN #6 stated she passed the morning medications on the hall Resident #51 resided. She was asked to retrieve the resident's diuretic medication card, and she stated she had removed the last three pills on the medication card and placed the card in the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shred box. This surveyor asked LPN #6 to retrieve the medication card from the shred bin for surveyor's review. LPN #6 retrieved a diuretic card for the resident which revealed the tablet was 20 mg with instructions to give four tablets in the day and three tablets in the evening. LPN #6 stated the diuretic medication card retrieved from the shred bin was not the card she removed the diuretic medication from. LPN #6 stated prior to administering medications, the medication card should be compared to the MAR, vital signs should be checked if needed and resident's pain level should be checked if they need pain medication. She stated if she gave the wrong dose of medication to a resident, she checked the resident's vital signs, notified her superior, whom she did not specify, reported the error to the doctor, completed an incident report and charted the error. She stated nurses received a three-day training on medication administration when hired, with another nurse or the Assistant Director of Nursing (ADON). She stated if a resident received the wrong medication, their blood pressure may be different, and depending on the amount of medication given, the resident could experience cramps or spasms. She stated the process for receiving medications from the pharmacy was to check the medication papers from the pharmacy with the medication and if the nurses see something wrong, call the pharmacy to let them know. She stated nurses would send the medication back with the pharmacy representative if that person was still in the building. If the pharmacy rep had left the building, the nurse would hold the medication by putting the medication (med) in the med room or locked the medication in the medication cart and send the medication back on the next pharmacy delivery. During a telephone interview on 03/06/2026 at 11:00 AM, LPN #1 acknowledged that she gave four 20mg diuretic pills to Resident #51 during the med pass on 03/05/2026. When asked for her process in administering meds safely, she stated prior to giving medications to a resident, she looked at the MAR as she was getting the meds out of the med cart. She stated she looked at the name to ensure she had the right patient and the right dose. She stated she would call the nurse practitioner if she gave the wrong dose of medication to a resident. She stated she would check the resident also. She stated she did not recall what the eMAR showed for Resident #51's diuretic medication. She stated she was pretty sure the label on the bubble pack indicated to give four pills in the day and three pills in the evening. She stated for as long as she could recall, she had been giving Resident #51 four diuretic pills in the morning when she worked, and she had been employed at the facility almost 3 months and usually passed medications on the hall Resident #51 resided. During a telephone interview on 03/07/2026 at 2:49 PM, the Pharmacist from a medication provider for the facility verified their pharmacy filled a prescription for Resident #51 on 02/02/2026 for a diuretic medication with 210 pills and sent those pills to the facility. He stated two cards were sent with one card having four pills in each bubble and the other card having three pills in each bubble. He stated the instructions on the card indicated four tablets by mouth every day and three tablets at bedtime. He also verified the pharmacy filled a prescription for a diuretic medication on 03/03/2026 of 180 pills with two cards, each card having three pills in each bubble to total 90 pills per card and the medication was sent to the facility. Resident #58: During a medication observation and concurrent interview on 03/05/2026 at 8:05 PM, LPN #2 stated Resident #58 was ordered to receive an anticoagulant, the medication was not available but had been ordered. She stated she reordered the medication last night, 03/04/2026, after she administered the last pill. Resident #58 did not receive the scheduled dose during the observation. Review of a Physician's Order for Resident #58 revealed a diagnosis of cerebral atherosclerosis (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(hardening or narrowing of arteries in the brain), and the resident was to receive an antiplatelet medication with a start date and time of 12/20/2025 at 8:00 PM. Review of a March 2026 eMAR revealed Resident #58 was to receive an anticoagulant medication at bedtime related to cerebral atherosclerosis. The eMAR indicated the time for administration as 8:00 PM and on 03/05/2026 the number five was in the box with LPN #2's initials in the box. The chart code revealed the number five indicated hold/see progress notes. The March 2026 eMAR did not have any documentation under progress notes as to why the medication was not given. During an interview on 03/06/2026 at 12:28 PM, the ADON stated if a nurse gave the wrong dose of medication to a resident, the nurse should notify the nurse practitioner or the doctor. She stated if the provider had any recommendations or orders, the nurse would follow those orders. She stated the nurse should also check on the resident in case they had adverse reactions from the medication. The ADON stated the nurses received education/training quarterly and the facility also did skills check off for nurses. She stated LPN #1 would have done medication administration training on hire and she was asked to provide this information for review. She also stated the nurses were responsible for reordering prescribed medications and the nurses were also to follow up with the pharmacy to ensure the medication had been received once ordered. She stated if the nurses had issues receiving the medication, they would come to her. She stated any omitted doses of medication should be reported to the medical provider. She stated the turnaround time for the pharmacy to deliver medication after it was ordered was 24 hours. As of 03/06/2026 at 5:05 PM, the facility had not provided any skills check off for medication administration for LPN #1 to the survey team.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review, interviews and facility policy review, it was determined that the facility failed to have the medical care of each resident supervised by a Physician for three (Resident #3, Resident #6, Resident #20) of three residents reviewed for unnecessary medications and antibiotic stewardship. The findings include:Review of the facility's undated policy titled Antibiotic Stewardship indicated the medical director provides oversight to team functions and responsible for program outcomes, provides clinical guidance and enforcement, and provides monitoring of patients receiving selected microbials. The policy also indicated the Antibiotic Stewardship Team, core members, included at a minimum, an infection preventionist, physician and a pharmacist, along with any administrative, developmental and IT support. Review of a facility policy titled, Consultant Pharmacist Services Provider Requirements dated 01/01/2015, indicated A written or electronic response of report of findings and recommendations resulting from the activities as described is given to the attending physician, the director of nursing, medical director and other as appropriate at least monthly, The facility has a process to ensure that the findings are acted upon.Resident #3 Review of an admission Record indicated the facility admitted Resident #3 on 04/11/2025 with diagnoses that included chronic kidney disease, respiratory failure, pressure ulcer of sacral region and urinary tract infections. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/02/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. Review of a Care Plan, initiated on 11/14/2025, revealed Resident #3 had an open wound. Care Plan interventions included Enhanced Barrier Precautions (EBP). Review of a Pharmacy Medication Regimen Reviews (MMR) for Antibiotic Stewardship with antibiotic recommendations from the pharmacist for Resident #3 completed on 05/17/2025, 07/20/2025, 07/24/2025, 08/16/2025, and 10/04/2025 were signed by ADON/LPN #1 in place of the Physician's signature. Review of Progress Notes for Resident #3 indicated no verbal orders documented on 05/17/2025, 07/20/2025, 07/24/2025, 08/16/2025, and 10/04/2025. Resident #6Review of an admission Record indicated the facility admitted Resident #6 on 12/07/2021 with diagnoses that included type two diabetes, enlarged heart, bronchitis, infection of the skin and subcutaneous tissue, cough, retention of urine, and bacterial bone infection.Review of a quarterly MDS, with an ARD of 11/26/2025, revealed Resident #6 had a BIMS score of 15, which indicated the resident was cognitively intact and was independent for daily decision making. The MDS also indicated Resident #6 was dependent on self-care and mobility with substantial to maximum assistance. Lastly, the MDS indicated Resident #6 had a diagnosis of kidney disease and received hemodialysis. Review of a Care Plan, initiated on 01/17/2025, revealed Resident #6 would pick at scabs and skin until open areas developed. Care Plan interventions included administering medications as prescribed by the Physician. Review of a Pharmacy Medication Regimen Reviews (MMR) for Antibiotic Stewardship with antibiotic recommendations from the pharmacist for Resident #6 completed on 11/02/2025, 12/25/2025, 01/09/2025, 01/24/2025, 01/24/2025 and 02/21/2026 were signed by ADON/LPN #1 in place of the Physician's signature. A different antibiotic was listed on each of the 01/24/2025 MRR's. Review of Progress Notes for Resident #6 indicated no verbal orders documented on 11/02/2025, 12/25/2025, 01/09/2025, 01/24/2025, 01/24/2025, and 02/21/2026. Resident #20Review of an admission Record indicated the facility admitted Resident #20 on 08/18/2023 with diagnoses that included lung disease, type two diabetes, and a stroke. Review of a quarterly MDS, with an ARD of 11/30/2025, revealed Resident #20 had a BIMS score of 13, which indicated the resident was cognitively intact and independent for daily decision making. The MDS also indicated Resident #20 was completely dependent on staff for self-care and mobility and Resident #20 had an active diagnosis of asthma/chronic lung disease. Review of a Care Plan, initiated on 08/18/2023, revealed Resident #20 had diabetes, chronic lung disease, and bladder incontinence. Care (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan interventions included if an infection was present to consult with the Physician regarding any changes in medication, administer medication as prescribed, and observe for any signs or symptoms related to a bladder infection. Review of a Pharmacy Medication Regimen Reviews (MMR) for Antibiotic Stewardship with antibiotic recommendations from the Pharmacist completed on 04/27/2025, 09/14/2025 and 09/14/2025 were signed by ADON/LPN #1 in place of the Physician's signature. A different antibiotic was listed on each of the 09/14/2025 MRR's. Review of Progress Notes for Resident #20 indicated no verbal orders documented on 04/27/2025, 09/14/2025 and 09/14/2025. During an interview on 03/04/2026 at 4:30 PM, the Director of Nursing (DON) stated the Assistant Director of Nursing (ADON) who was a Licensed Practical Nurse (LPN) oversees the MRR reviews monthly. The DON indicated no MRR forms were signed by the DON. The MRR forms nurses' signature would be the ADON. The DON stated a nurse should never sign in a Physician's place unless there was a verbal order to do so. The DON indicated if a nurse does sign for a Physician there should be documentation of the reason, such as a verbal order. The DON indicated the signatures on the MRR should be the pharmacist, the physician and then the nurse.During an interview on 03/05/2026 at 2:54 PM, the ADON, who was an LPN, indicated the Pharmacist came monthly and reviewed different medications. The ADON indicated once the review was complete it would trigger the Physician to sign when there were new orders or suggestions made. The ADON stated the signatures on the MRR were the Pharmacist, the Physician, and the nurse. The ADON indicated a nurse's signature would be acceptable if no new orders were made and there were just recommendations for the residents to change medication. The ADON stated the difference in the MMRs that were signed by the nurse in the Physician's place verses the MRRs that were signed by the Physician was that the physician was present those days and was assisted in logging into the computer to sign the MRRs. The ADON stated the medical director was unable to access the electronic system without the ADON's assistance. The ADON stated a phone call was made to the Physician and antibiotic stewardship orders were completed over the phone. The ADON stated a call was made and the ADON then recorded what was said and signed in the Physician's place. The ADON indicated an Advance Practical Registered Nurse (APRN) was present in the facility Monday through Friday and previously was in the facility three days weekly. During an interview on 03/05/2026 at 3:55 PM, Pharmacist #13 indicated a MRR was completed monthly and a Gradual Dose Reduction (GDR) was completed quarterly, every six months and annually. Pharmacist #13 stated, recommendations are made and the Physician must agree to them or document a reason why they disagree. Pharmacist #13 stated with a GDR, the Physician should sign for any changes to stop medication or alter the orders. The Pharmacist indicated three signatures were needed on the MRR/GDR form: the Pharmacist, the Physician and the nurse. During an interview on 03/05/2026 at 4:21 PM, the APRN indicated the role of the APRN regarding the MRR and GDR forms was to review recommendations and make changes accordingly for the residents' medications. The APRN stated reviews were done monthly and as needed. The APRN stated she checked the recommendations and the residents' medication and documented if the risks outweighed the benefits. The APRN stated there was really no reason for a nurse to sign in a Physician's place unless the nurse was given a verbal order. If the MRR/GDR was signed for a Physician by a nurse there should be documentation where the discussion took place. During an interview on 03/06/2026 at 10:5 AM, the Administrator indicated that a nurse should not sign in a Physician's place without a verbal order. The Administrator stated if a verbal order was received then the nurse would sign the physicians' name, the nurse's name with verbal order written behind it and a note should be documented if that were the case. The Administrator stated if it was just a recommendation to change the medication and not an order then the nurse can sign the MRR/GDR. During an interview on 03/06/2026 at 12:40 PM, the APRN stated that all orders were entered into the electronic system and not written. The APRN stated if there was a verbal order given the electronic system alerted them to sign the orders. The APRN stated if a recommendation was made by a Pharmacist the APRN/Physician should review and sign it. During an interview on 03/06/2026 at 1:38 PM, the ADON (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if a written order was received it was scanned into the electronic system and entered into the electronic system under orders. This process would populate Progress Notes automatically. When a verbal order was received it was entered the same way into orders and it triggered an automatic note in the electronic system. The ADON stated the Physician would get an alert when new orders were entered and recommendations were sent to the physicians as well. The ADON denied any other places where an MRR/GDR were accessed or signed other than through the electronic system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Rehabilitation and Care Center	903 Borgognoni Drive Lake Village, AR 71653

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled: Number of residents cited: Based on observation, record review, interview and facility policy review the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented during tracheostomy (trach) care for one (Resident #1) of one resident reviewed for tracheostomy care. The findings include: On 03/06/2026 at 9:22 AM, this surveyor observed Registered Nurse (RN) # 3 provide trach care to Resident #1. RN #3 did not put on a gown before or during the trach care. Review of March 2026 Physician's Orders (PO) for Resident #1, revealed an order for EBP related to trach and gastrostomy tube with a revision date of 02/08/2026. The PO also revealed an order with a start date of 06/05/2025 to change the inner cannula every day. Review of a quarterly Minimum Data Set, with an Assessment Reference Date of 02/04/2026 for Resident #1 revealed a Staff Assessment for Mental Status score of 3, which indicated Resident #1 had severe cognitive impairment, never or rarely made decisions, and received tracheostomy care. Review of a Care Plan, with a revision date of 02/20/2026, revealed Resident #1 required EBP related to Percutaneous Endoscopic Gastrostomy (PEG) tube feedings and tracheostomy with an intervention to wear disposable gloves and gowns when providing high contact care. During an interview on 03/06/2026 at 9:40 AM, RN #3 stated Resident #1 was on regular standard precautions and not EBP. This surveyor and RN #3 stepped out of the resident's room, and she stated she was familiar with EBP, and she was not wearing a gown. When asked if a gown should have been worn for trach care RN #3 looked up at the EBP signage posted on the outside of Resident #1's door and stated, Yes ma'am. During an interview on 03/06/2026 at 12:10 PM, the Assistant Director of Nursing (ADON) stated Resident #1 was on EBP and the nurse should wear a disposable gown and gloves to perform trach care. She stated she had done EBP in-services with the staff but was not positive of the date of the last in-service. She was asked to provide a policy for EBP and any in-services on EBP to staff. Review of an in-service dated 07/02/2025 with a topic of EBP, conducted by a different Director of Nursing (DON), indicated providers must wear gloves and a gown for the following high-contact care activities: tracheostomy care was listed. RN #3's name did not appear on the in-service sign-in sheet. The DON was unavailable for interview. Review of facility policy titled Enhanced Barrier Precautions policy, with no revision date, indicated enhanced barrier precautions involved the use of gown and gloves during high-contact resident care activities for residents known to be colonized with a MDRO (Multi-drug-resistant organism) as well as those at increased risk of MDRO acquisitions (i.e. (for example) residents with wounds or indwelling medical devices. The policy indicated an order for enhanced barrier precautions will be obtained for residents with certain conditions which included a tracheostomy tube.