STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045343	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nursing and Rehabilitation Center at Good Shepherd	3001 Aldersgate Road Little Rock, AR 72205

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. Based on observation, record review, interview, and facility policy review the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during medication administration through a Percutaneous Endoscopic Gastrostomy (PEG) tube for one (Resident #3) sampled resident based on one of one observation. Specifically, nursing staff did not wear a gown for Personal Protection Equipment (PPE) during medication pass. The findings include: A review of Resident #3's Medical Diagnosis revealed the resident had diagnoses which included stroke, dysphagia, and heart attack. A review of Resident #3's quarterly Minimum Data Set with an Assessment Reference Date of 11/20/2025, revealed a Brief Interview for Mental Status score of 00, which indicated the resident had severe cognitive impairment. Resident #3's MDS also indicated the resident had a feeding tube. A review of Resident #3's Care Plan, revised 07/01/2024, revealed the resident was on EBP related to a PEG tube, gown and glove during high contact resident care including feeding tubes. A review of Resident #3's Order Summary indicated on 09/02/2025, 10 milligrams of medication for reflux was ordered every six hours through the resident's PEG tube. Resident #3's Order Summary also revealed on 10/20/2025, 30 cubic centimeters (cc) of an oral laxative solution to reduce issues caused by muscle wasting was ordered via PEG tube. During an observation on 01/14/2026 at 11:28 AM, Licensed Practical Nurse (LPN) #1 was observed mixing water with medication for reflux and a laxative for Resident #3. LPN #1 walked past an EBP sign and PPE hanging on the inside of Resident #3's inside doorway. LPN #1 turned off the resident's feeding pump with gloves in place, but without a gown. LPN #1 unhooked Resident #3's feeding tube and flushed it with 30cc of water, after auscultating placement. LPN #1 revealed staff flush PEG tubes with 30cc of water before and after administering medications. Medication solution was observed being poured into the feeding tube, then LPN #1 flushed Resident #3's tube with 30cc of water after administering medications. The feeding tube was reconnected and the pump turned on. During an interview in Resident #3's room on 01/14/2026 at 11:53 AM, LPN #1 said he was not aware of any special precautions for Resident #3. LPN #1 reviewed the resident's electronic record and said, I do not see anything on the orders. LPN #1 indicated the procedure used when giving medications or water through a PEG tube was to just make sure it is not clogged or kinked. LPN #1 then said infection control concerns were to just make sure the equipment is clean and to replace the syringe and tubing in 24 hours. LPN #1 was observed washing hands prior to putting on gloves but was not observed wearing additional PPE. EBP signage and PPE were noted inside Resident #3's doorway, (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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Resident #3's name was in orange, indicating EBP, outside the doorway. During an interview on 01/14/2026 at 1:18 PM, Certified Nursing Assistant (CNA) #2 revealed staff could tell when a resident was on EBP because their name outside the door is in orange, PPE and EBP signage is hanging up inside the resident's doorway. CNA #2 revealed EBP's were an infection control measure. During an interview on 01/14/2026 at 1:22 PM, LPN #3 said EBP's are for residents with an open wound, foley catheter, or feeding tubes and staff were expected to follow EBP's, because it would be easy to introduce an infection to residents. LPN #3 indicated handwashing, gowning up, and wearing gloves was expected during direct patient care, to prevent the spread of infection and in-services were held monthly. LPN #3 confirmed that residents on EBP's names were in orange, and signage with PPE hung inside the resident's doorway. During an interview on 01/14/2026 at 2:50 PM, the Director of Nursing (DON) said, staff should follow EBP, and put on a gown and gloves when administering medications through a feeding tube. The DON revealed the last in-service on EBP was within the last few weeks [11/14/2025] and stated it was important to gown and glove when giving medications through a PEG tube to protect the resident more than anything. The DON was then asked to provide EBP and general infection control policies, and in-services. During an interview on 01/15/2026 at 11:06 AM, the Administrator revealed that nursing staff were expected to follow EBP, and she was already told by LPN #1 that LPN #1 did not put on a gown during the medication pass and this medication pass had helped identify some areas where the facility could provide some additional teaching on EBP's for infection control. Administrator revealed not following EBP increased the risk for infection. A review of a facility in-service titled Enhanced Barrier Precautions, dated 11/14/2025, revealed providers and staff were expected to wear gown and gloves during high contact resident care including feeding tubes. LPN #1 could not be found on the EBP signature roster. A review of a facility policy titled EBP in Nursing Homes, dated 03/20/2024, revealed Multi Drug Resistant Organisms (MDROs) were common in long-term care and residents were at increased risk for colonization and developing MDROs. EBP's were controlled interventions designed to reduce MDRO transmission through the use of gown and gloves during high contact resident care including wounds, central lines, urinary catheters, tracheostomies and feeding tubes.