STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195362	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zachary Manor Nursing and Rehabilitation Center	6161 Main Street Zachary, LA 70791

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 (#37 and #71) out of 28 residents in the final sample. The facility failed to ensure Resident #37 and #71 were coded accurately on the Entry Minimum Data Set (MDS) assessment. Resident #37 Review of Resident #37's Clinical Record revealed she was admitted to the facility on [DATE] with diagnosis which included Schizoaffective Disorder, Bipolar Type, Dementia Psychotic Disturbance, Catatonic Disorder Depressive Disorders, and Mental Disorder. Review of Resident #37's Entry MDS with an ARD of 04/17/2025 revealed the following, in part: Section A1500 Preadmission Screen and Resident Review (PASRR), Is the resident currently considered by the state level II PASRR process to have a serious mental illness and or intellectual disability or a related condition was coded as no. Review of Resident #37's Behavioral Health State Form 142 with a date of 03/18/2025 revealed Resident #37 was approved for admission by Level II authority for a temporary period effective 03/18/2025 through 03/17/2026. An interview was conducted on 02/11/2026 at 2:50 p.m. with S3CCC. After reviewing Resident #37's Behavioral Health State Form 142 with a date of 03/18/2025, S3CCC confirmed Resident #37 was approved for admission by Level II authority for a temporary period effective 03/18/2025 through 03/17/2026. S3CCC further confirmed Resident #37's Entry MDS dated [DATE] Section A1500 was coded incorrectly. An interview was conducted on 02/11/2026 at 3:05 p.m. with S2DON. S2DON confirmed Resident #37 was approved for admission by Level II authority for a temporary period effective 03/18/2025 through 03/17/2026. S2DON further confirmed Resident #37's Entry MDS dated [DATE] Section A1500 was coded incorrectly. Resident #71 Review of Resident #71's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #71's Entry MDS with an Assessment Reference Date (ARD) of 01/30/2026 revealed Section A1805 Entered From: 08. Intermediate Care Facility. Review of Resident #71's Clinical Record revealed she entered from a Long Term Acute Care hospital on [DATE]. (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
	195362	A. Building B. Wing	02/11/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 02/11/2026 at 10:45 a.m. with S3CCC. She reviewed the aforementioned findings and confirmed Resident #71 entered from a Long Term Acute Care hospital on [DATE] and the entry MDS was coded incorrectly. An interview was conducted on 02/11/2026 at 10:47 a.m. with S2DON. She reviewed the aforementioned findings and confirmed Resident #71 entered from a Long Term Acute Care hospital on [DATE] and the entry MDS was coded incorrectly.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure a resident's call light was within reach for 1 (#76) of 29 residents reviewed during the initial pool.Findings: Review of the facility's policy titled, Call Light Systems, undated, revealed the following, in part:Policy: To respond to resident's request and needs. Essential Points: Unless indicated in the care plan, each resident, when in their room or in bed, must have the call light placed within reach at all times. when out of bed, call bell is to be pulled so it is accessible from wheelchair or bedside chair. Review of Resident #76's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Unsteadiness On Feet, Parkinson's Disease, and Primary Generalized Osteoarthritis. Review of Resident #76's Entry MDS, with an ARD of 01/28/2026, indicated the resident was assessed by the facility and required substantial assistance for transfers. Review of Resident #76's current Care Plan revealed following, in part:Problem: Resident #76 is high risk for falls related to gait instability secondary to diagnosis of Parkinson's Disease and Osteoarthritis to knees. Interventions: Keep call light in reach and encourage Resident #76 to call for assist. On 02/09/2026 at 9:15 a.m., an observation was conducted of Resident #76 sitting in his wheelchair in his room. The call light was observed in the bed under the covers and out of Resident #76's reach. Resident #76 stated he needed assistance getting back in the bed but could not reach the call light. On 02/09/2026 at 9:40 a.m., an observation was conducted of Resident #76 sitting in his wheelchair in his room with his call light out of reach. An interview was conducted with S9PT at this time. S9PT confirmed Resident #76 could not reach his call light and required assistance to transfer to the bed. S9PT further confirmed Resident #76's call light should always be within reach and it was not. On 02/11/2026 at 3:01 p.m., an interview was conducted with S2DON. She confirmed the call light should be within reach at all times.

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	195362	A. Building B. Wing	02/11/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect each residents' right to be free from verbal abuse for 1 (#33) of 29 residents reviewed for abuse in the initial pool. The facility failed to protect Resident #33 from verbal abuse by Resident #11.Findings: Review of facility's policy titled Abuse-Neglect Prevention Manual with a revision date of 04/03/2025 revealed the following:II. Policy: It is the policy of the facility that each resident will be free from abuse.Each resident residing in this facility has the right to be free from verbal abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents.Definitions:Verbal abuse is defined as the use of oral, written, or gestured communication, or sounds to residents within hearing distance, regardless of their age, ability to comprehend, or disability. Resident #33 Review of Resident #33's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Dementia, Mood Disturbance, and Anxiety. Review of Resident #33's Admit MDS with an ARD of 01/28/2026 revealed she had a BIMS of 8, which indicated she was moderately cognitively impaired. Resident #11Review of Resident 11's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Schizophrenia, Generalized Anxiety Disorder, and Other Genetic Related Intellectual Disability. Review of Resident #11's Admit MDS with an ARD of 11/11/2025 revealed she had a BIMS of 9, which indicated she was moderately cognitively impaired. Review of Resident #11's most recent Care Plan revealed the following:Problem: Resident #11 has a behavior problem related to Schizophrenia12/26/2025-Resident #11 yelled, screamed, cursed at staff and threw her meal tray across the room. Resident #11 became aggressive with Resident #33. Interventions: 12/26/2025 Staff intervened immediately and separated Resident #11 and Resident #33. Resident #11 remained separated from others and was transferred for further evaluation and treatment. Review of the facility's incident report dated 12/26/2026 at 12:30 p.m. revealed the following:Name: Resident: #11Description: S7ADON called to Resident #11's room due to Resident #11 yelling, screaming, cursing staff and threw her meal tray across the room at the CNA. Staff removed resident's roommate from the room to allow her time to calm down. Resident #11 continued to yell, scream and curse. Resident #11 exited out of her door and cursed Resident #33. Resident #33 utilized her wheelchair for mobility and Resident #11 stood over Resident #33. Resident #11 then became aggressive, combative and hit Resident #33. S8LPN immediately separated the residents and assessed Resident #33. Resident #11 currently experiencing symptoms related to mental history. MD notified and Resident #11 sent out for further evaluation and treatment. An interview was not conducted with Resident #11 due to the resident remained at an inpatient behavior health facility. On 02/09/2026 at 3:20 p.m., an interview was conducted with Resident #33. Resident #33 could not recall the residents name or when the incident occurred but stated there was an incident where another resident was yelling and cursing. She stated she went to the doorway of another resident. She stated the resident yelled and swung her arms and hit her. She stated she was not scared of the resident, the resident was removed from the facility and she had not seen the resident since the incident occurred. On 02/09/2026 at 9:00 a.m., an interview was conducted with S8LPN. She stated Resident #11 was very active and had behaviors which included throwing things, screaming and yelling profanity. She stated on 12/26/2025 at 12:30 p.m., Resident #33 rolled to Resident #11's doorway to ask Resident #11 if she was ok. Resident #11 exited her room and stood over Resident #33's wheelchair yelling. She stated Resident #33 stated Resident #11 hit her in the lips. She stated she could not see if Resident #11 hit Resident #33 but Resident #11 stood over Resident #33's wheelchair and screamed and cursed at her. She stated she immediately separated Resident #11 and Resident #33. She stated she brought Resident #33 back to her room and assessed her. She stated Resident #33 did not have any visible markings on her face. She stated she did report the incident to S7ADON. (continued on next page)

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	195362	A. Building B. Wing	02/11/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She confirmed standing over someone, screaming and cursing was verbal abuse. She stated Resident #33 was upset in that moment but had not mentioned the incident again. On 02/10/2026 at 9:52 a.m., an interview was conducted with S2DON. She stated on 12/26/2025 around 12:30 p.m., S7ADON reported Resident #11 screamed, yelled and cursed at Resident #33. She stated when she arrived to Resident #11's doorway, Resident #33 had been removed. She stated the MD was notified and Resident #11 was transferred to an inpatient Behavior Health facility. She stated Resident #33 reported to her Resident #11 hit her and called her a b****. She confirmed she immediately reported the incident to S1ADM. She further confirmed screaming and cursing was verbal abuse. On 02/10/2026 at 10:11 a.m., an interview was conducted with S1ADM. She stated S2DON reported on 12/26/2025 Resident #11 was having behaviors and physically aggressive with Resident #33. She stated she immediately interviewed Resident #33. She stated Resident #33 reported she was fine and confirmed Resident #33 reported Resident #11 hit her but Resident #33 did not have any injuries. She further stated screaming and cursing was Resident #11's behaviors and not considered abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to report allegations of physical and verbal abuse to the State Survey Agency immediately, but no later than 2 hours, for 1 (#33) of 29 residents reviewed for abuse in the initial pool. Findings: Review of facility's policy titled Abuse-Neglect Prevention Manual with a revision date of 04/03/2025 revealed the following:6. Reporting and Response: it is the policy of the facility that abuse allegations are reported per Federal and State Law. Reports are to be no later than 2 hours to health standards if the incident or allegation involves abuse with or without serious bodily harm.Definitions:Verbal abuse is defined as the use of oral, written, or gestured communication, or sounds to residents within hearing distance, regardless of their age, ability to comprehend, or disability. Physical Abuse includes hitting, slapping, pinching, biting, and kicking. B. Alleged Violation: is the terminology used when a verbal allegation of resident abuse. has been made either by a resident, family member, visitor or employee. Resident #33 Review of Resident 33's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Dementia, Mood Disturbance, and Anxiety. Review of Resident #33's Annual MDS with an ARD of 01/28/2026 revealed she had a BIMS of 8, which indicated she was moderately cognitively impaired. Resident #11Review of Resident 11's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Schizophrenia, Generalized Anxiety Disorder, and Other Genetic Related Intellectual Disability. Review of Resident #11's Admit MDS with an ARD of 11/11/2025 revealed she had a BIMS of 9, which indicated she was moderately cognitively impaired. Review of the facility's incident report dated 12/26/2026 at 12:30 p.m. revealed the following:Name: Resident: #11Description: S7ADON called to Resident #11's room due to Resident #11 yelling, screaming, cursing staff and threw her meal tray across the room at the CNA. Staff removed resident's roommate from the room to allow her time to calm down. Resident #11 continued to yell, scream and curse. Resident #11 exited out of her door and cursed Resident #33. Resident #33 utilized her wheelchair for mobility and Resident #11 stood over Resident #33. Resident #11 then became aggressive, combative and hit Resident #33 on her lips. S8LPN immediately separated the residents and assessed Resident #33. Resident #11 currently experiencing symptoms related to mental history. MD notified and Resident #11 sent out for further evaluation and treatment. Review of the facility's State Agency Reported Incidents revealed none for Resident #11 or Resident #33. On 02/09/2026 at 9:00 a.m., an interview was conducted with S8LPN. She stated on 12/26/2025 at 12:30 p.m., Resident #11 exited her room and stood over Resident #33 yelling. She stated Resident #33 then stated Resident #11 hit her in the lips. She confirmed standing over someone, screaming and cursing was verbal abuse and hitting someone was physical abuse. She further confirmed she reported the incident to S7ADON. On 02/10/2026 at 9:52 a.m., an interview was conducted with S2DON. She stated on 12/26/2025 around 12:30 p.m., S7ADON reported Resident #11 screamed, yelled and cursed at Resident #33. She stated Resident #33 reported to her that Resident #11 hit her and called her a b****. She confirmed she immediately reported the incident to S1ADM. She confirmed screaming and cursing was verbal abuse and hitting someone was physical abuse. On 02/10/2026 at 10:11 a.m., an interview was conducted with S1ADM. She stated S2DON reported on 12/26/2025 Resident #11 was having behaviors and physically aggressive with Resident #33. She confirmed Resident #33 reported Resident #11 hit her but Resident #33 did not have any injuries. She stated she was responsible for reporting all allegations of abuse to the state agency. She stated a resident hitting another resident was abuse. She further stated screaming and cursing was Resident #11's behaviors and was not considered abuse. She confirmed the incident did not require reporting because Resident #33 did not have any injuries.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out ADLs received the necessary services to maintain good grooming and personal hygiene for 1 (#24) of 2 residents reviewed for ADL's. The facility failed to trim and clean Resident #24's fingernails.Findings: Review of the facility's undated policy, Nail Management, revealed the following, in part:Policy: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails.It includes cleansing, trimming, smoothing, and cuticle care and is usually done during the bath. Non diabetic residents may have nail care performed by Certified Nursing Assistants (CNA). Review of Resident #24's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Muscle Wasting and Atrophy of Right and Left Shoulder and Need for Assistance with Personal Care. Review of Resident #24's current Physician Orders revealed the following:Check, clean, and/or trim fingernails and toenails weekly by CNA every evening shift every Wednesday with a start date of 11/05/2025. Review of Resident #24's current Care Plan revealed the following:Problem: Self-care ADL deficit: resident will receive person-centered care.Interventions: Assist with hygiene, dressing, and grooming as needed. Fingernails cleaned and trimmed as needed. On 02/09/2026 at 9:05 a.m., an observation was made of Resident #24 with fingernails noted to be long and dirty. Fingernails observed to extend approximately 1 centimeter past the nailbeds of all 10 fingers. Fingernails noted to have a brown/red colored substance under each nail. On 02/10/2026 at 8:56 a.m., an observation was made of Resident #24. Resident #24's fingernails extended approximately 1 centimeter past the nailbeds on all 10 fingers. On 02/11/2026 at 1:08 p.m., an interview was conducted with Resident #24. Resident #24 stated his fingernails were too long. He stated staff had not cut his fingernails in a while. He stated he wanted his fingernails cut. On 02/11/2026 at 1:24 p.m., an interview was conducted with S4LPN. S4LPN stated CNAs were responsible for cleaning and trimming non-diabetic residents' nails. She confirmed Resident #24 was not diabetic. She stated nail care should have been performed during baths/showers. She stated Resident #24 did not refuse baths or nail trimming. On 02/11/2026 at 1:28 p.m., S4LPN observed and confirmed Resident #24's fingernails were long and dirty. On 02/11/2026 at 2:38 p.m., an interview was conducted with S6CNA. She stated if a resident did not have Diabetes, the CNAs were responsible for cleaning and trimming fingernails. On 02/11/2026 at 3:00 p.m., an interview was conducted with S2DON. S2DON stated CNAs were responsible for performing nail care for non-diabetic residents. She stated nail care should be performed weekly during the bath or shower. She confirmed resident's nails should be kept clean and trimmed.

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	195362	A. Building B. Wing	02/11/2026

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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. Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of infection for 1 (#68) of 5 residents reviewed on Enhanced Barrier Precautions (EBP). The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) while providing direct care for Resident #68 who was on EBP.Findings: Review of the facility's policy titled, Enhanced Barrier Precautions Policy and Procedure, dated 08/12/2024, revealed the following, in part: Definitions: Precautions involve gown and glove use during high contact resident care activities for residents.at increased risk of multi drug resistant organism acquisition (for example residents with wounds or indwelling medical devices.)High-contact resident activities include:Device care or use: feeding tubeCare and use of indwelling medical devices would mean any dressing changes, injecting or infusing medication or tube feedings with indwelling medical device. Review of Resident #68's current Physician's Orders revealed the following:Start date - 11/06/2025 - Enhanced Barrier Precautions utilized when performing high-contact resident care activities related to (feeding tube) every shift. On 02/10/2026 at 3:26 p.m., an observation was made of the Enhanced Barrier Precautions sign posted on Resident #68's door, which revealed the following, in part: Providers and staff must also:Wear gloves and a gown for the following high-contact resident care activities:Device care or use: feeding tube. On 02/10/2026 at 3:26 p.m., an observation was made of S5LPN performing PEG tube placement check, residual check, and a water flush. S5LPN did not wear a gown while performing high contact resident care. On 02/10/2026 at 3:33 p.m., an interview was conducted with S5LPN. S5LPN confirmed Resident #68 was on Enhanced Barrier Precautions, and she should have worn a gown while performing a PEG tube procedure and had not. On 02/11/2026 at 3:00 p.m., an interview was conducted with S2DON. S2DON confirmed staff should have worn a gown while performing Resident #68's PEG tube care.