

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER North Hills Life Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 27 E Appleby Road Fayetteville, AR 72703	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50924</p> <p>Based on observations, interviews, facility record review, it was determined that the facility failed to provide privacy during care for 1 (Resident #62) of 1 resident reviewed for privacy.</p> <p>Findings include:</p> <p>A review of the facility admission packet including the Resident Handbook, which provided the Arkansas Patient Rights Section 9, signed by the Resident #62 and Admission Director #5 on 07/20/2024, indicated, residents have the right to have privacy in treatment.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #62 with diagnoses that included bacteremia and sepsis.</p> <p>The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>During an observation and interview on 08/20/2024 at 2:28 PM, the Assistant Director of Nursing (ADON) entered Resident #62's room to perform a peripherally inserted central catheter (PICC) line dressing change. Resident #62's roommate with two family members were also in the room, all had direct line of sight to Resident #62 and the ADON during the procedure. The ADON failed to pull the room's curtain or ask Resident #62 if the resident was comfortable with spectators during the procedure. During the sterile part of the dressing change the ADON looked at the curtain divider and stated they should have pulled the curtain before performing the procedure.</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>42016</p> <p>Based on observation, record review, and interview, it was determined the facility failed to ensure physician orders were followed for 1 (Resident #62) of 1 resident observed receiving medications from 1 (Licensed Practical Nurse (LPN) #9) of 3 nurses observed during medication pass.</p> <p>Findings include:</p> <p>A review of a facility in-service titled, 7 Rights of medication Administration, dated 08/15/2024, indicated, Must Check All Before Administering Any Medication: 1. Right Resident 2. Right Medication 3. Right Dose 4. Right Route 5. Right Time 6. Right Documentation 7. Right Reason.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #62 with diagnoses that included local infection of the skin and subcutaneous tissue of the right toe.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact and had an infection of the right toe and was receiving an antibiotic by intravenous (IV) route.</p> <p>A review of Resident #62's Care Plan, revised 07/24/2024, revealed the resident had IV (intravenous) medication (an antibiotic) related to an infection of the right great toe. Interventions included administering an antibiotic per MD (medical doctor) orders, an Inservice of nursing staff on 08/15/2924 due to resident receiving the wrong medication by IV.</p> <p>A review of the Order Summary, revealed Resident #62 had an antibiotic being administered through a peripherally inserted central catheter (PICC) line (an access used for different medical purposes such as delivering fluids containing medications into a person's vein), a saline flush intravenous solution, Flush PICC line with 10cc (cubic centimeters) normal saline (NS) before and after IV medication administration, and a standing order for the SASH (saline, antibiotic, saline, heparin) protocol was to be followed with IV administration of antibiotic, 10cc / administer medication/Saline 10cc/heparin 5cc.</p> <p>A review of the Standing Orders [Named Medical Doctor]as of 08/07/2024, indicated the SASH protocol was to be used for PICC lines with medication administration. SASH protocol included 10cc NS, medication administration, 10cc NS, and 5cc Heparin.</p> <p>During an observation on 08/21/2024 at 5:08 AM, LPN #9 entered Resident #62's room to administer an antibiotic. LPN #9 attached a 10cc syringe containing Normal Saline, to the PICC line, located in the resident's right arm, and administered a portion of the saline. LPN #9 attached the antibiotic to the PICC line and infused the antibiotic using a medication pump. LPN #9 stated 8 and a half milliliters (ml) of normal saline was placed in the IV line prior to starting the antibiotic. [Milliliters and cubic centimeters are the same measurement or volume of a substance and wording is interchangeable]</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 08/21/2024 at 6:04 AM, LPN #9 returned to Resident #62's room, turned off the medication pump and removed IV medication line from PICC line, attached a 10cc syringe containing 10ml of NS flush to the PICC line and administered a portion of the fluid. LPN #9 removed the NS syringe and attached a syringe containing 5ml of Heparin lock to the PICC line and administered the heparin. LPN #9 was asked how much NS flush was used and stated 7ml and 5ml of Heparin.</p> <p>During an interview on 8/21/2024 at 7:54 AM, LPN #9 was asked how much NS is ordered to flush the PICC line prior to administering Resident #62's antibiotic. LPN #9 stated 10ml and only 8 and a half was used. LPN #9 was asked how much NS is ordered to flush the PICC line after administering the antibiotic. LPN #9 stated 10ml and 7ml was used. LPN #9 stated 10ml should have been used both times because that is what the doctor ordered, and physicians orders should be followed because the NS is used to flush all the medication from the line to ensure the resident receives all the medication.</p> <p>During an interview on 08/22/2024 at 12:46 PM, the Director of Nursing (DON) stated staff should follow physician orders for flushing a resident's PICC line because it is in the best interest of the patient. If it is not done it could cause a decline in the resident's health.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50924</p> <p>Based on observations, interviews, facility document review, and facility policy review, the facility failed to write the open date on medications for 4 (Resident #5, #32, #33, and #35) and maintained pharmacy packaging of a medication card for 1(Resident #5) of 2 medication carts observed for medication labeling and storage standards. The facility also failed to maintain possession of medication cart/room keys with authorized personnel for all residents in the facility.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Medication Labeling and Storage, revised in February of 2023, indicated medications should remain stored in the packaging it was received from the pharmacy, multi-dose medication should be dated with the date it was opened, and only authorized personnel should have access to keys.</p> <p>During an observation and interview on 08/21/2024 at 2:27 PM, Licensed Practical Nurse (LPN) #2 was asked to retrieve medication for labeling review from the 200-hall medication cart. On inspection of Resident #32's Anoro Ellipita 62.5-25mcg (microgram) inhaler, Resident #33's Symbicort inhaler, and Resident #35's bottle of liquid morphine there were no open dates written on those 3 items. LPN #2 stated all 3 medications had doses utilized from them and were currently in use. Resident #5's Citalopram 20mg (milligram) tab medication card was observed to no longer have intact pharmacy packaging for slots number 29 and 30 instead tape across the back of those slot was holding a pill in each slot. LPN #2 stated someone must have put them back in. During inspection of the medications a person in black scrubs told LPN #2 they needed in the medication room to check the refrigerator and LPN #2 gave the person the set of keys she had used to open the medication cart. The person in black scrubs was seen walking to the medication room, unlocking the door with the keys, and going in alone. The person returned in a couple of minutes and returned the keys to LPN #2.</p> <p>During an interview on 08/21/2024 at 2:55 PM, the Director of Nursing (DON) stated the facility utilized the 28-day rule with opened multi use medications and agreed without the open date written on the medication there would be no way to determine the proper time to throw the medication out. When asked about the pharmacy packaging of two slots on the citalopram medication card being opened and then the pill taped back in the Nurse Consultant #6 stated we have always done that.</p> <p>During a follow-up interview on 08/21/2024 at 3:49 PM, LPN #2 stated the person the key was given to was someone with lab. LPN #2 did not know the person's name, title, or who they worked for. When asked why the facility keys including the key for the medication carts and medication storeroom were handed over to the unidentified lab personnel, the response was it was the LPN #2's practice.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a follow-up interview on 08/21/2024 at 4:08 PM, the Director of Nursing (DON) stated the person in black scrubs was a phlebotomist from their contracted lab company. The DON stated they come in for lab draws and retrieve any specimens from the specimen refrigerator in the medication room, but should not be given the keys to let themselves in. The DON stated LPN #2 should have retrieved the specimens and brought them to the lab personnel and agreed giving the keys to unauthorized personnel was a security issue.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50924</p> <p>Based on observations, interviews, and facility policy review, it was determined that the facility failed to date and maintain cold food temperature for pudding prepared in the facility's kitchen intended to be served to facility residents.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Food Receiving and Storage, revised in October 2017, indicated all food items and snacks kept on the nursing units must be kept below 41 Fahrenheit and labeled with the use by date.</p> <p>During an observation on 08/20/2024 at 6:33 AM, a clear plastic container holding 20-25 vanilla and chocolate puddings in small plastic tubs with pop-on lids, was seen sitting at the central nurses' station. The container contained no ice and had no water to show where any ice had melted. The individual pudding tubs were not dated.</p> <p>During a concurrent observation and interview on 08/20/2024 at 6:59 AM, the pudding tubs were still sitting in the same location at the nurses' station. When touched they were room temperature. Licensed Practical Nurse (LPN) #3 stated they had been retrieved from the kitchen not long ago for use during medication pass and those not used were put in the refrigerator for resident snacks. LPN #3 stated they never come from the kitchen with a date and when LPN #3 put one on her medication cart the current date was written. Observation of the medication cart showed one vanilla and one chocolate pudding tub with some gone. The date of 08/20/2024 was written on the lid. LPN #3 was asked to take the container sitting at the nurses' station to the Dietary Manager (DM) #4 for information.</p> <p>During a concurrent observation and interview on 08/20/2024 at 7:07 AM, DM #4 stated the pudding tubs were prepared in the kitchen and placed in a storage container in the kitchen refrigerator. The storage container was dated with a sign with the date they were made, but not the individual tubs. DM #4 stated the pudding tubs were good for 7 days but was unaware LPN #3 was dating tubs with the current date. DM #4 stated the pudding tubs had been out too long to be at the correct temperature and would throw them away.</p> <p>During an interview on 08/20/2024 at 10:37, the DON stated the pudding cups should have been on ice but was unaware of the dating process the LPN #3 was using.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42016</p> <p>50924</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure staff performed hand hygiene during meal assistance; failed to utilize Enhanced Barrier Precautions (EBP), to maintain sterile and aseptic technique during a dressing removal and failed to maintain aseptic technique for IV tubing, specifically no cap was in place on the tubing to maintain a barrier from contamination for 1 (Resident #62) of 1 resident reviewed for dressing change.</p> <p>Findings include:</p> <p>1. A review of a facility in-service titled, 400 Hall Certified Nursing Assistant (CNA) Meal Service, dated 08/16/2024, indicated, 1. Keep staff hands from crossing over cups/bowls (inf control).</p> <p>A review of Resident #26's Care Plan, revised on 05/28/2024, revealed the resident had an activity of daily living (ADL) related to muscle loss and had a potential for fluid deficit related to confusion. Interventions included providing care and assistance as needed and encouraging resident to drink fluids.</p> <p>During an observation on 08/19/2024 at 1:20 PM, CNA #7 was sitting on a stool on the right side of Resident #26. CNA #7 grasped the rim of Resident #26's cup of water, by placing their index finger inside the cup and their thumb on the outside of the rim of the cup, pulled the cup toward the resident, then picked up the cup by placing their hand over the opening and their fingers around the top rim, and handed the cup to the resident, who drank from the cup. CNA #7 rested their hands on their lap, palms down. No hand hygiene was done during this observation.</p> <p>A review of Resident #68's Care Plan, revised on 05/07/2024, revealed the resident had an ADL self-care deficit related to generalized weakness and was dependent on staff to eat. Interventions included encouraging Resident #68 to participate to the extent possible.</p> <p>During an observation on 08/19/2024 at 1:26 PM, CNA #7 was sitting to left of Resident #68, lifted their hands above the table, from their lap and picked up a fork and placed chocolate pudding in Resident #68's mouth, returned the fork to the plate and picked up a biscuit and broke off piece with their hands and gave it to Resident #68 who took a bite. CNA #7 put their hands back in their lap, palms down. CNA #7 lifted hands from their lap, grasped the rim of a cup containing iced tea, by placing their hand over the opening of the cup with their fingers touching the rim, and assisted resident to drink from the cup. No hand hygiene was performed during this observation.</p> <p>A review of Resident #51's Care Plan, revised 03/13/2024, revealed the resident had a communication problem, had limited physical mobility, had the potential for a nutritional problem, had dehydration, had an ADL deficit and required assistance eating. Interventions included anticipating and meeting needs, encouraging resident to drink, setting up resident's meal, encouraging resident to eat, and encouraging resident to participate to the extent possible,</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/19/2024 at 1:22 PM, CNA #8 was sitting to the right of Resident #51, grasped the resident's cup of water with the palm of their hand over the opening and their thumb, middle, ring and small finger grasping the rim of the cup and a straw was being held in place between their index finger the knuckle of their middle finger. Resident #51 drank from the straw. No hand sanitation was performed during this observation.</p> <p>During an interview on 08/19/2024 at 1:57 PM, CNA #7 stated they should not have grabbed the cup by the rim while assisting Resident #26 or Resident #68 and should not touch resident's food with their bare hands because it could cause germs to be passed to resident. CNA #7 stated they were used to doing that for their son and Just did not think about it and should have sanitized their hands between residents and did not do so because there was not enough sanitizer in the room. The sanitizing station was located on a wall in the assisted dining area.</p> <p>During an interview on 08/19/2024 at 2:18 PM, CNA #8 stated they should have sanitized hands prior to feeding Resident #51 after their hands were in their lap and should not have touched the rim of the cup and straw prior to providing a drink to the resident because something could have dropped into cup from their hands or germs on their hands could have gotten into resident's mouth and caused problems.</p> <p>During an interview on 08/22/2024 at 12:48 PM, the Director of Nursing (DON) stated some residents have compromised immune systems and staff should perform hand hygiene while assisting residents in the dining room, so they are not passing germs from one resident to another and making everyone sick. Staff should not be picking up cups by the rims or placing their fingers inside a resident's cup and giving it to the residents. They should be holding cup by the side (demonstrated on cup on their desk). The DON further stated contaminates on their hands could be transferred to the residents and you don't put your fingers where the resident places their lips.</p> <p>2. A review of a facility policy titled, Enhanced Barrier Precautions, dated August 2022, indicated Enhanced Barrier Precautions (EBP) are used as an infection prevention and control intervention. Under EBP, gowns and gloves are used during high contact resident care like device care of a central line.</p> <p>A review of a facility policy titled, Center Venous Catheter Dressing Changes, revised April 2017, indicated central line dressings should be done every 5-7 days. Removal of the old dressing is an aseptic technique.</p> <p>A review of a facility policy titled, Guidelines for Preventing Intravenous Catheter-Related Infections, revised August 2014, indicated aseptic techniques should be observed at all times when working with intravenous (IV) equipment, IV administration set for IV medications should be discarded if found without a sterile cap at the end of the tubing.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #62 with diagnoses that included bacteremia and sepsis, and that Resident #62 was admitted with a peripherally inserted central catheter (PICC) line, a type of central venous catheter, for long term IV medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p> <p>A review of Resident #62's Admission Care Plan, dated 08/08/2024, revealed the resident had an infection of the right great toe. Interventions included EBP and IV medication administration through the right upper arm peripherally inserted central catheter, (PICC) line. Care of the PICC line included weekly dressing changes.</p> <p>During an observation on 08/20/2024 at 1:06 PM, Resident #62's cefazolin IV tubing was seen hanging on the IV pole. The end of the tubing was left but open to air without a cap. Resident #62's right upper arm PICC line dressing was dated 08/06/2024.</p> <p>During an interview on 08/20/2024 at 1:08 PM Registered Nurse (RN) #1 did not know the date on Resident #62's PICC line dressing and didn't not know the policy for how often dressings were changed. After accessing the Medication Administration Record (MAR), RN #1 stated it was due on Tuesdays. RN #1 stated no knowledge of a policy for IV tubing care.</p> <p>During a concurrent observation and interview on 08/20/2024 at 2:28 PM, the Assistant Director of Nursing (ADON) prepared setup for Resident #62's PICC line dressing without putting on a gown as required when utilizing EBP. The ADON stated the date on the PICC line dressing was 08/06/2024 and should have been changed a week ago. The ADON used gloved hands and touched Resident #62's face when applying a mask but did not remove the dirty gloves or perform hand hygiene prior to removing the old PICC line dressing. The ADON's left dirty gloved hand touched the PICC line insertion site while the right dirty gloved hand pulled the old dressing off. The ADON stated the IV medication tubing should have a cap on it to reduce infection risk from exposure and it now needed to be thrown away.</p>		