STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105008	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biscayne Health and Rehabilitation Center	12505 NE 16th Ave North Miami, FL 33161

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review the facility failed to provide pharmaceutical services to ensure the accurate administration and documenting of medications for 4 of 5 sampled residents reviewed for controlled medications (Resident #43, Resident # 51, Resident # 83 and Resident #35) and failed to ensure a discontinued controlled medication was removed from the med cart for 1 of 5 residents reviewed for controlled medications (Resident #51). The findings included: Review of the facility's policy titled, Administering Medications with a reviewed date of January 2024 included in part the following: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 22. As required or indicated for a medication, the individual administering the medication records in the resident's medial record: a. The date and time the medication was administered b. The dosage c. The route of administration Review of the facility's policy titled, Storage of Medications with a revised date of January 2024 included in part the following: 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the facility's policy titled, Preparation and General Guidelines- Controlled Substances: with a date of August 2019 included in part the following: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures: A. The Director of Nursing and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications E. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record). 2) Amount administered (Accountability Record). 3) Remaining quantity (Accountability Record). 4) Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). 1 Record review for Resident #51 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission to the facility on [DATE]. The diagnoses included in part the following: Type 2 Diabetes mellitus Without Complications and Anxiety Disorder. Review of the Minimum Data Set (MDS) for Resident #51 dated 08/15/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #51 revealed an order dated 07/23/24 for Alprazolam Tablet 0.25 MG give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 Days and was discontinued on 08/06/24. Review of the Medication Monitoring/Control Record for Alprazolam 0.25 mg Resident #51 from 08/26/24 to 10/09/24 documented the following: On 08/26/24 a dose of Alprazolam was documented as removed from the med cart On 10/09/24 a dose of Alprazolam was documented as removed from the med cart Review of the Medication Administration Record (MAR) for Resident #51 from 08/26/24 to 10/09/24 documented the following: There was no documentation of the medication Alprazolam 0.25 mg being administered. 2) Record review for Resident #43 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission to the facility on [DATE]. The diagnoses included in part the following: Chronic Obstructive Pulmonary Disease, Anxiety Disorder, and Dementia. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS for Resident # 43 dated 10/10/24 documented in Section C for cognitive status indicated BIMS (Brief Interview for Mental Status) could not be conducted due to the resident is rare/never understood. Review of the Physician's Orders for Resident #43 revealed an order dated 09/02/24 for Clonazepam Oral Tablet 0.5 MG give 1 tablet by mouth two times a day related to Anxiety Disorder. Review of the Medication Monitoring/Control Record for Clonazepam 0.5 mg Resident #43 from 10/18/24 to 10/30/24 documented the following: On 10/18/24 the 5:00 PM dose had no documentation On 10/25/24 the 5:00 PM dose had no documentation On 10/27/24 the 5:00 PM dose was documented as removed from the med cart Review of the Medication Administration Record (MAR) for Resident #43 from 10/18/24 to 10/30/24 documented the following: On 10/18/24 the 5:00 PM dose of Clonazepam 0.5 mg was administered On 10/25/24 the 5:00 PM dose of Clonazepam 0.5 mg was administered On 10/27/24 the 5:00 PM dose of Clonazepam 0.5 mg was left blank 3 Record review for Resident #83 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cervical Disk Disorder with Myopathy High Cervical Region and Spinal Stenosis Lumbar Region without Neurogenic Claudication. Review of the MDS for Resident #83 dated 10/11/24 documented in Section C with a BIMS score of 14 indicating a cognitive response. Review of the Physician's Orders for Resident #83 revealed an order dated 07/24/24 for Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) give 1 tablet by mouth every 8 hours as needed for pain. Review of the Medication Monitoring/Control Record for Oxycodone/Apap (Percocet) 5-325 mg Resident #83 from 08/13/24 to 10/30/24 documented the following: On 08/03/24 at 9:30 PM documented the medication was removed from the med cart On 08/04/24 at 9:00 PM documented the medication was removed from the med cart On 08/11/24 at 10:30 PM documented the medication was removed from the med cart On 08/17/24 at 10:15 PM documented the medication was removed from the med cart On 08/25/24 at 10:00 PM documented the medication was removed from the med cart (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/08/24 at 10:00 (did not indicate AM or PM) documented the medication was removed from the med cart On 09/22/24 at 10:00 (did not indicate AM or PM) documented the medication was removed from the med cart Review of the Medication Administration Record (MAR) for Resident #83 from 08/13/24 to 10/30/24 documented the following: On 08/03/24 no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 08/04/24 had no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 08/11/24 no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 08/17/24 had no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 08/25/24 had no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 09/08/24 no documentation for Oxycodone/Apap (Percocet) 5-325 mg On 09/22/24 had no documentation for Oxycodone/Apap (Percocet) 5-325 mg 4. Record review for Resident #35 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Primary Generalized (Osteo)Arthritis, Chronic Pain Syndrome, and Muscle Spasm of Back. Review of the MDS for Resident #35 dated 08/22/24 documented in Section C a BIMS score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #35 revealed an order dated 06/05/24 for Oxycodone-Acetaminophen Oral Tablet 10-325 MG (Oxycodone w/ Acetaminophen) give 1 tablet by mouth every 4 hours as needed for moderate-severe pain. Review of the Medication Monitoring/Control Record for Oxycodone/Apap 5-325 mg Resident #35 from 10/27/24 to 10/30/24 documented the following: On 10/27/24 at 9:00 PM documented the medication was removed from the med cart On 10/28/24 at 12:00 PM documented the medication was removed from the med cart On 10/29/24 at 5:00 PM documented the medication was removed from the med cart On 10/29/24 at 9:00 PM documented the medication was removed from the med cart Review of the Medication Administration Record (MAR) for Oxycodone/Apap 5-325 mg Resident #35 from 10/27/24 to 10/30/24 documented the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/27/24 at 9:00 PM no documentation of the medication was administered On 10/28/24 at 12:00 PM no documentation of the medication was administered On 10/29/24 at 5:00 PM no documentation of the medication was administered On 10/29/24 at 9:00 PM no documentation of the medication was administered During an interview conducted on 10/30/24 at 12:00 PM with Staff D Licensed Practical Nurse (LPN) who stated she has worked at the facility for 3 years. When asked about controlled medications removed to be administered to a resident, she said we document the medication being removed on the Control sheet (Medication Monitoring/Control Record) and then we document on the MAR for the resident. During an interview conducted on 10/30/24 at 1:00 PM with the Director of Nursing (DON) who stated she has worked at the facility since the middle of August 2024. When asked about the controlled medications she stated the nurse will sign the medication off on the paper log Medication Monitoring/Control Record) and the e-mar (Electronic Medication Administration Record) as well. When asked if a controlled medication is discontinued what happens to the controlled medication in the med cart, she stated the medication is removed from the cart by the nurse who took the order for the med to be discontinued. When asked if they audit the controlled medications on the med carts, she said they are audited every few days but do not keep any record of the audits being performed. When asked who is responsible for the audits, she said the DON (herself) is responsible and either she does the audits, or the pharmacists does. When asked if a discontinued medication was left in the med cart would be administered, she said no because there is no active order, the nurse would not be able to sign the medication off as administered in the e-mar. When asked about Resident #51 and the controlled medication Alprazolam 0.25 mg, she acknowledged she had signed the medication as removed from the cart on 10/09/24. She then acknowledged the medication was not documented as being administered on the MAR on 10/09/24. When asked why the medication was not documented as being administered, she stated sometimes the order is only for 14 days and then it is no longer on the MAR after that so she cannot document the medication as administered on the MAR. During an interview conducted on 10/30/24 at 1:50 PM with Staff F, Registered Nurse (RN) who was asked about controlled medications, she stated they document on the paper Medication Monitoring/Control Record) and on the computer (Medication Administration Record). When asked if a controlled medication is discontinued what happens to the medication, she stated they remove it from the med cart and give it to the DON to be returned to the pharmacy. When asked about the Alprazolam 0.25 mg for Resident #51 she acknowledged the medication was not documented as administered on 10/09/24 even though it was documented as being removed from the med cart on 10/09/24 on the Medication Monitoring/Control Record. The DON also acknowledged the medication Alprazolam 0.25 mg for Resident #51 was discontinued on 08/06/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to properly secure dispensed medications left at the bedside for 1 of 1 resident (Resident #39). The facility also failed to ensure that 1 of 4 medications carts was locked and inaccessible to unauthorized staff and residents. The findings included: Review of the facility's policy titled, Administering Medications, dated January 2024, included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 21. The individual administering the medication initials the resident's Medical Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. Review of the facility's policy titled, Storage of Medications, dated January 2024, included the following: Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation 9. Unlocked medication carts are not left unattended. 1)Record review for Resident #39 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Dependence on Renal Dialysis. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #39 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that she was cognitively intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders showed that Resident #39 had an order dated 10/19/24 and the following medications were scheduled to be administered at 9:00 AM on 10/28/24: Aspirin 81 mg oral tablet chewable for Deep Vein Thrombosis (DVT) prophylaxis. Ascorbic Acid 500 mg oral tablet, give 1 tablet for supplement. Folic Acid 1 mg oral tablet for supplement. Carbamazepine Extended Release (ER) 300 mg oral capsule for Status Epilepticus. Metoprolol Tartrate 50 mg oral tablet for Hypertension (HTN). Ferrous Sulfate 325 mg oral tablet, Give 1 tablet for anemia. [NAME]-Vite (B-Complex w/ C & Folic Acid) oral tablet for supplement. Review of the October Medication Administration Record (MAR) documented that all the above medications were administered on 10/28/24 at 9:00 AM as scheduled. In addition, the nurse signed for all the medications indicating that Resident #39 did not refuse any medications. Review of the Care Plan dated 10/10/24 documented that Resident #39 does not have behaviors of refusing her medications nor is Resident #39 able to self-administer her medications. Record Review of the nursing progress notes revealed no documentation noting Resident #39 refusing medications. During an observation conducted on 10/28/24 at 9:51 AM noted Resident #39 in bed with the over-bed table in front of her. Further observation revealed on the over-bed table, 2 medication cups with pills, photographic evidence obtained. At this time, an interview was conducted with Resident #39 who stated those were her medications and the nurse had placed them there. During an interview conducted on 10/30/24 at 4:18 PM with the Assistant Director of Nursing (ADON), she stated she has been the ADON at the facility for 5 months. The ADON stated Resident #39 does take her time to take her medications, and the nurse was probably called away for something else. She stated she has educated the nursing staff to dispose of the medications if the resident is not ready to take their medications. The ADON acknowledged that the medications were left there by the nurse and not brought in by the resident's family. 41837 2 On 10/31/24 from 11:43 AM to 11:53 AM an observation was made of a med cart next to room [ROOM NUMBER] left unlocked and unattended with multiple residents, visitors and staff passing by the med cart. During an interview conducted on 10/30/24 at 11:54 AM with Staff D Licensed Practical Nurse (LPN) who stated she has worked at the facility for 3 years. She acknowledged she had left the med cart unlocked and unattended and stated she did not know how that happened.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to follow fluid restriction orders for 1 of 1 resident on dialysis (Resident #16). The findings included: A chart review revealed that Resident #16 was readmitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Muscle Weakness, and Type 2 Diabetes. The Medicare 5-day Minimum Data Set, dated dated dated [DATE] showed that Resident #16 had a Brief Interview of Mental Status score of 15, which was cognitively intact. A review of the physician ' s orders showed the following: No added salt diet with 1,500 milliliters (ml) fluid restriction with 1080 ml allocated for dietary. Dietary 240 ml every Dinner meal, dietary 240 ml every Lunch, and 600 ml every Breakfast meal, which was dated 10/22/24. In an observation conducted on 10/28/24 at 11:00 AM, Resident #16 was noted in her room with 16 ounces of water in a Styrofoam cup near her bed on the side table. In an observation conducted on 10/28/24 at 12:20 PM, Resident #16 was observed eating her lunch meal with the following noted on the meal tray: 8 ounces of water and 4 ounces of juice. Closer observation showed 16 ounces of water in a Styrofoam cup near the lunch tray. This showed that 28 ounces of fluids (828 millimeters) were provided to Resident #16 and not the needed 240 ml of fluids for the lunch meal. The meal ticket showed Resident #16 was on 1500 ml fluid restriction with 8 ounces of water and no juice. In this observation, Resident #16 stated that she was on fluid restrictions but did not know how much per day or per meal and stated, I think I am allowed one cup of water. The Registered Dietitian Progress note dated 09/23/24 revealed that Resident #16 is non-compliant with the renal diet and fluid restriction. She remains resistant to education related to diet/fluid restriction compliance. The note further showed that the therapeutic diet with fluid restriction remains appropriate. The Care plan dated 09/11/24 revealed that Resident #16 was on fluid restrictions and is at risk for complications of hemodialysis and is receiving hemodialysis treatment within the house. An interview conducted on 10/30/24 at 10:20 AM with Staff E, Certified Nursing Assistants, stated that the facility ' s Dietitian would tell her which residents are on a fluid restriction. When asked if she has any residents on fluid restrictions that are assigned to her, she said yes and named Resident #16 ' s roommate but not Resident #16. When asked by this Surveyor if she was the one who gave Resident #16 the 16 ounces of the Styrofoam cup at the bedside, she said no and that it must have been the other nursing staff. An interview conducted on 10/30/24 at 2:00 PM with the Clinical Dietitian stated that the fluid restriction is listed on the diet orders in the electronic system. She further said it is also listed on the meal ticket when the trays arrive.

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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** 49060 Based on observations, interviews, and record review, the facility failed to properly post signage for Enhanced Barrier Precautions (EBP) for a resident with a central line, failed to wear appropriate Personal Protection Equipment (PPE) during care of a central line, and failed to maintain the IV catheter tubing in a manner to prevent infection for 1 of 1 resident reviewed for central line receiving IV therapy (Resident #90). The findings included: Review of the facility's policy titled, Enhanced Barrier Precautions, dated 04/01/24, included the following: Policy: It is the policy of this facility that Enhanced Barrier Precautions (EBP), . will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. Procedures: EBP consists of the use of gowns and gloves for high-contact care activities which include but may not be limited to: Device care or use: central line . CDC recommends the use of EBP for the following residents: 1. All residents with an indwelling medical device such as a urinary catheter, central line, feeding tube, etc. regardless of colonization or infection status. Review of the facility's policy titled, Intravenous Administration of Fluids and Electrolytes, revised 2024, included the following: Purpose: The purpose of this procedure is to provide guidelines for the safe and aseptic administration of IV fluids and electrolytes for hydration. Steps in the Procedure 10. When infusion is complete: a. For intermittent therapy: (2) if tubing will be reused, replace sterile cap (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review for Resident #90 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Chronic Osteomyelitis with Draining Sinus, Right Ankle and Foot and Type 2 Diabetes Mellitus with other specified complications. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #90 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that she was cognitively intact. Review of Section N of the same MDS revealed Resident #90 was on antibiotic. Review of the Physician's Orders showed that Resident #90 had an order dated 10/28/24 for Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl), use 166 ml/HR Chronic Osteomyelitis with Draining Sinus, Right Ankle and Foot for 16 days with end date: 11/13/24 (This is a re-order, Resident #39 has been on Vancomycin since admission to facility). Maintain Enhanced Barrier Precautions every shift for Midline, every shift, Active 10/29/24 (no order for EBP found prior to 10/29/24). Review of the Care Plan dated 10/22/24 documented that Resident #90 had IV access and is receiving IV antibiotic related to Chronic Osteomyelitis. The goals were for Resident #90 to complete IV Therapy without discomfort through the next review. The interventions included: Administer IV medication as ordered: Vancomycin HCl Intravenous Solution Reconstituted 750 mg. Review of the Care Plan dated 10/22/24 documented that Resident #90 requires Enhanced Barrier Precaution related to surgical wound, and IV. The goals were: Enhanced Barrier Precaution (EBP) will be maintained through the next review date. The interventions included: Educate resident, responsible party or caregivers regarding EBP. Follow infection control guidelines as indicated. Maintain EBP as indicated during dressing, bathing/showering, transferring. providing hygiene, changing linens, changing briefs or assisting with toileting, IV site care, during wound care. Record review of the admissions note dated 10/06/24 revealed Resident #90 had a central line for Vancomycin IV in her right inner arm. During the initial tour conducted on 10/28/24 10:57 AM noted there was no EBP sign outside of Resident #90's room, photographic evidence obtained. Further observation revealed that Resident #90 was receiving IV therapy. During an observation on 10/28/24 at 3:14 PM of Resident #90's room conducted by 2 surveyors and observed the IV medication tubing wrapped around the IV pole without any sterile cap at end of IV tubing, photographic evidence obtained. While surveyors were still in the room, Staff D, Licensed Practical Nurse (LPN) came into Resident #90's room to flush the central line catheter and attach the IV medication tubing to continue medication administration. She entered the room with normal saline syringe and alcohol wipes, performed hand hygiene, and donned gloves, however she did not don a gown. Staff D cleaned the central line catheter with the alcohol wipe in a circle-like motion (not the tip of the catheter) and flushed the line, then attached the uncapped IV tubing to the central line catheter and started the medication. (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 conducted on 10/29/24 at 3:41 PM with Staff A, Certified Nursing Assistant (CNA), who stated she has worked at the facility since 2020. She stated she usually works on the 2nd floor. Staff A noted that if there is an EBP sign on the outside of the resident's room, the resident has either a tube feeding, under dialysis, or has a wound. She acknowledged that with these residents she will need to don on PPE if she is providing care. During an interview conducted on 10/29/24 at 4:13 PM with Staff B, CNA stated she has been working at the facility for [AGE] years. She acknowledged when the EBP sign is at a resident's door, she must don on PPE while providing care. During an interview conducted on 10/29/24 at 3:56 PM with Staff C, LPN, she noted working at the facility for 4 years. She stated that for residents under EBP, she will need to don on gown and gloves. During an interview conducted on 10/30/24 at 4:18 PM with the Assistant Director of Nursing (ADON), who has worked at the facility as the ADON for 5 months. She stated that she is the facility's infection Preventionist and responsible for posting signage for residents under any precaution or isolation. She acknowledged not having a sign for Resident #90 since she has a central line and donning of PPE should be done prior to care to resident with an IV port. During an interview conducted on 10/30/24 at 3:41 PM with the Director of Nursing (DON), who has worked at the facility for over 2 months. She acknowledged that the nurse should have worn a gown while providing IV care for Resident #90.