Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115683	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Center for Nursing and Rehab at Ellijay	1362 South Main Street Ellijay, GA 30540

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policy titled Administration of Insulin, the facility failed to ensure professional standards were followed when preparing and administering insulin for one of 17 residents (R) (R142) receiving insulin from a pen device. The deficient practice had the potential to result in the resident receiving an incomplete insulin dose, which could lead to ineffective blood glucose control, and adverse clinical outcomes.Findings include:Review of the facility's policy titled Administration of Insulin, updated 03/04/2026, revealed the Policy section documented: 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. j. Injecting the insulin: iv. Fully depress the plunger until the dosing numbers count back to zero. v. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin.Review of the electronic medical record (EMR) revealed, R142 was admitted to the facility on [DATE], with diagnoses including, but not limited to, type 2 diabetes mellitus.Review of physician orders dated 12/12/2025, documented an order for NovoLog Injection Solution 100 units/mL(units per milliliter) (insulin aspart) to be administered subcutaneously with meals per sliding scale as follows: 141-180 = 10 units; 181-220 = 14 units; 221-260 = 18 units; 261-300 = 22 units; 301-350 = 26 units; 351-400 = 30 units. Notify the nurse practitioner if blood glucose is below 60 or above 400.Observation of a medication pass on 03/04/2026 at 7:39 AM revealed, Licensed Practical Nurse (LPN) BB, checked the blood sugar and prepared to administer insulin for R142. The blood glucose reading was 195 mg/dL (milligrams per deciliter), and LPN BB stated she needed to administer 14 units of insulin. She obtained the NovoLog insulin pen and attached the pen needle. She dialed the ordered sliding scale dose of 14 units by turning the dose selector. However, LPN BB did not prime the insulin pen prior to administering the insulin. She administered the insulin in the resident's right arm by fully depressing the plunger and immediately removed the needle from the skin.In an interview following the procedure, LPN BB stated she was not aware that the insulin pen should be wasted prior to administration or that the needle should remain in the skin for several seconds after injection. She stated that she removes the pen immediately after hearing the click.In an interview conducted on 03/05/2026 at 11:26 AM, the Director of Nursing (DON) stated she expects nurses to follow the facility's policy on insulin pen administration and to hold the insulin pen firmly against the skin for five to 10 seconds after pressing the injection button to ensure the full dose is delivered. She stated that removing the insulin pen immediately may result in an incomplete dose because some insulin may leak out.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure that oxygen (O2) therapy was administered according to physician's orders for one of 17 residents (R) (R69) receiving oxygen. The deficient practice had the potential to place R69 at risk for respiratory complications, adverse clinical outcomes, and diminished quality of life.Findings include:Review of the facility's undated policy titled Oxygen Administration, last reviewed 1/2025, under Policy section documented: 1. Oxygen is administered under orders of a physician. 2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists.Review of the electronic medical record (EMR) revealed R69 was admitted to the facility on [DATE], with diagnoses including but not limited to pneumonia, pleural effusion, acute respiratory failure, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).Review of the admission Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment. Review of Section O: (Special Treatments, Procedures, and Programs) documented that R69 was on oxygen therapy. Review of the care plan dated 01/12/2026 for R69 revealed a focus on the resident's diagnosis of chronic obstructive pulmonary disease (COPD), with a goal that the resident will remain free of signs and symptoms of respiratory infection. Interventions included, but were not limited to, administering oxygen as ordered.Review of the physician orders dated 03/03/2026, for R69 revealed an active order related to oxygen, including administering O2 at 2LPM (Liters per minute) via nasal cannula.Review of the physician progress notes dated 03/02/2026 at 1:24 PM documented, On this admission, chest imaging demonstrated right lower lobe pneumonia with bilateral parapneumonic effusions .His course was complicated by acute hypoxic respiratory failure requiring 2 L oxygen.Observation on 03/03/2025 at 10:37 AM revealed R69 oxygen concentrator was set on 3.5 LPM being delivered via nasal cannula.Observation on 03/03/2025 at 2:53 PM revealed R69 oxygen concentrator was set on 3.5 LPM being delivered via nasal cannula.Observation on 03/04/2025 at 9:45 AM revealed R69 oxygen concentrator was set on 3.5 LPM being delivered via nasal cannula. Interview with R69's assigned nurse, Licensed Practical Nurse (LPN) DD, revealed that only nursing staff are allowed to set and adjust oxygen, as the facility does not have respiratory therapists. When asked to check the oxygen flow rate, LPN DD confirmed it was set at 3.5 LPM. She then reviewed the physician's order and confirmed the oxygen should be set at 2 LPM. She stated she did not know who had adjusted the oxygen.In an interview with the Director of Nursing (DON) on 03/04/2026 at 3:00 PM, she stated that oxygen is considered a medication and must be administered according to the physician's order. The DON confirmed that nurses are responsible for ensuring that physician orders and care plans are followed. She added that sometimes residents adjust the oxygen flow rate themselves, and when that occurs, staff provide education and update the care plan as needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, staff interviews, and review of the facility's policy titled Medication Administration, the facility failed to ensure a medication error rate of less than five percent. Two medication errors were identified out of 31 opportunities observed, resulting in a medication error rate of 6.45 percent. This deficient practice had the potential to place resident (R) (R123) at risk for medical complications and a diminished quality of life.Findings include:Review of the facility's policy titled Medication Administration, updated 5/2022, revealed the Policy section documented: Ensure that the six rights of medication administration are followed: .c. Right dosage. e. Right time. 12. Compare the medication source (bubble pack, vial, etc.) with the EMAR to verify resident name, medication name, form, dose, route, and time.Licensed Practical Nurse (LPN) DD was observed administering 9:00 AM medications to Resident (R)123 on 03/04/2025 at 9:50 AM. She removed the medications from the source and placed them into a medication cup (aspirin, Orgovyx, tamsulosin HCl (hydrochloride), and Tylenol; metoprolol was held due to blood pressure parameters); along with a 6:00 AM dose of Protonix from the blister pack. When asked why she was administering the 6:00 AM medication, which had already been documented in the electronic medical record (EMR) as administered, she stated she did not realize it had already been given and assumed it was due because it appeared as an AM medication on the blister pack card. LPN DD further explained that she could not administer calcium carbonate 600 mg (milligrams) because the correct dosage was not available and only calcium carbonate 500 mg was on hand. LPN DD stated she was unable to locate the bottle with the correct dosage and would need to obtain the appropriate strength of calcium carbonate from the medication room.At 4:00 PM on the same date, 03/04/2026, the surveyor rechecked the medication administration record (MAR) and noted that calcium carbonate was still not documented as administered, and there was no documentation in the progress notes or elsewhere indicating that the pharmacy had been contacted or the physician notified. In a follow-up interview with LPN DD at that time, she stated she had forgotten to address it.In an interview conducted on 03/04/2026 at 4:10 PM, the Director of Nursing (DON) stated she expects nurses to administer medications as ordered by the physician. She stated the facility maintains a stock of various over-the-counter medications in the medication rooms. If the correct dosage is not available on hand, the provider should be contacted for further instructions. If prescribed medication is not available, the facility has an emergency kit (E-kit) containing multiple medications, which nurses are expected to check and follow up immediately. If the required medication is not available in the E-kit, nursing staff are expected to notify the nurse practitioner (NP) and discuss whether the medication can be substituted or if a stat delivery should be requested from the pharmacy.

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NAME OF PROVIDER OR SUPPLIER Parkside Center for Nursing and Rehab at Ellijay		STREET ADDRESS, CITY, STATE, ZIP CODE 1362 South Main Street Ellijay, GA 30540	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure that one of six residents (R) (R140) reviewed for medication administration was free from significant medication errors. Specifically, the facility failed to ensure medications were administered to the correct resident, resulting in R140 receiving medications intended for another resident. This deficient practice had the potential to place the resident at risk for adverse drug reactions, medication side effects, and adverse clinical outcomes.Findings include:Review of the facility's policy titled Medication Administration, updated 5/2022, documented Policy Explanation and Compliance Guidelines: .3. Identify resident by photo in the MAR (Medication Administration Record).10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dose; d. Right route; e. Right time; f. Right documentation.12. Compare the medication source (bubble pack, vial, etc.) with the EMAR to verify the resident's name, medication name, form, dose, route, and time.An investigation was initiated following a self-reported incident to the state alleging that on 12/10/2025, during the 9:00 PM medication pass, R140 was administered her roommate R6's oral medications and injectable insulins.A review of the electronic medical record (EMR) for the affected resident (R140) revealed diagnoses that included, but were not limited to, rheumatoid arthritis, hypertension, heart failure, atrial fibrillation, pulmonary hypertension, asthma, peripheral vascular disease, lymphedema, morbid obesity, generalized weakness, and cognitive communication deficit.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section B (Hearing, Speech, Vision) that R140 has adequate hearing, does not wear hearing aids, makes herself understood, and is able to understand others. Review of Section C (Cognition) revealed a Basica Interview for Mental Status (BIMS) score of 13, indicating little to no cognitive impairment. Review of Section N (High-Risk Medications) revealed R140 was receiving anticoagulants, antibiotics, and diuretics. Section N for R140 documented no reference to receiving insulin, antipsychotics, antidepressants, opioids, or hypnotics.Review of the medications ordered for R140 active as of 03/05/2026, revealed the resident was prescribed multiple medications including acetaminophen, albuterol inhaler, amlodipine, apixaban, atorvastatin, azelastine nasal spray, calcitriol, cetirizine, cholecalciferol (vitamin D), ciprofloxacin, dexamethasone, dextrose-sodium chloride IV (intravenous) solution, ertapenem IV, fexofenadine, fluticasone nasal spray, fluticasone-salmeterol inhaler, furosemide, gabapentin, guaifenesin/dextromethorphan (Geri-Tussin DM), hydralazine, hydroxychloroquine, ipratropium-albuterol inhalation solution, lidocaine patch, loratadine, losartan, magnesium oxide, magnesium hydroxide (milk of magnesia), melatonin, menthol topical gel (Biofreeze), methenamine hippurate, methocarbamol, montelukast, multivitamin with lutein, ondansetron, permethrin topical cream, prednisone, sodium chloride IV solution, sotalol, triamcinolone cream, tuberculin PPD, and vitamin C with zinc.Review of the Medication Administration Record (MAR) dated 12/2025 for R140's roommate R6 revealed the following bedtime medications, which were mistakenly administered to R140: Tresiba FlexTouch insulin 8 units subcutaneously; Humalog insulin per sliding scale (4 units administered); melatonin 3 mg (milligrams) two tablets; sertraline HCl (hydrochloride) 50 mg; ferrous sulfate 325 mg; gabapentin 300 mg; hydroxyzine HCl 25 mg; metoprolol succinate ER (extended release) 25 mg, one-half tablet; oxybutynin chloride 2.5 mg; and ranolazine ER 500 mg.Further review of the EMR and the facility's internal investigation report revealed that Registered Nurse (RN) FF was identified as the nurse involved in the incident. The nurse recognized the error immediately, and the incident was promptly reported to the resident's physician and family. As a result of the medication error, the provider issued orders including administration of IV fluids to help flush the medications from the resident's system and close monitoring of vital signs, blood glucose levels, and lung sounds, all of which were completed.The physician evaluated the resident the next day. Following the event, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's blood glucose levels remained stable with no documented episodes of hypoglycemia. R140 was closely monitored.In an interview conducted on 03/04/2026 at 3:00 PM, the Administrator confirmed that the facility conducted an internal investigation regarding the incident and provided documentation indicating that a thorough investigation had been completed and that staff had been reeducated.In an interview with RN FF, the nurse involved in the incident on 03/04/2026 at 2:45 PM, she stated that she realized the error immediately and notified the physician and the resident's family. She reported that the resident was closely monitored following the incident. RN FF further stated that she and other nursing staff received re-education on safe medication administration practices. She also stated that laptops are now available for use when assisting other nurses with medication administration.In an interview with the Director of Nursing (DON) on 03/04/2026 at 3:00 PM, she stated that nursing staff are expected to follow the rights of safe medication administration and to properly identify residents by both name and the photograph in the EMR system. She stated that medications are expected to be documented at the time of administration. The DON further stated that if a medication error occurs, staff are expected to report it immediately and complete an incident report, which is then investigated by the facility.

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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** Based on observations, staff interviews, and review of the facility's policies titled Enhanced Barrier Precautions and Cleaning and Disinfection of Resident-Care Equipment, the facility failed to consistently implement enhanced barrier precautions (EBP) and sanitize shared medical equipment (blood pressure machine and glucometer) between resident uses in four of 13 medication administration observations. This deficient practice had the potential to expose residents to harmful pathogens, increasing the risk of cross contamination, and spread of infections.Findings include:Review of the facility policy titled Cleaning and Disinfection of Resident-Care Equipment, reviewed 01/06/2026, documented in the Policy section: 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include:.b. Each user is responsible for routine cleaning and disinfection of multi-resident items [NAME] each use, particularly before use for another resident.d. Multiple-resident use equipment shall be cleaned and disinfected after each use.Review of the facility policy titled Enhanced Barrier Precautions, reviewed 10/06/2025, documented in the Policy section: 2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds .and/or indwelling medical devices .even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: .b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy.On 03/04/2026 at 7:26 AM, a medication pass observation was conducted with Licensed Practical Nurse (LPN) BB. LPN BB was about to enter the room for resident (R) (R122), to check his blood pressure, but stopped at the door and began reading the enhanced barrier precautions (EBP) signage posted on the door. After reviewing the signage, she donned a gown and stated she was required to do so every time she entered the room. When the surveyor asked what the signage meant to her, she stated she was not sure but said, The resident has some kind of condition. Something is going on-I'm not sure what-but the sign tells me to gown up and put gloves on. LPN BB then looked at the surveyor and added, If you want to come in with me, you have to gown up too, even if you are just watching.LPN BB brought a blood pressure machine into the room and obtained the resident's blood pressure. Upon leaving the room, she did not sanitize the blood pressure machine. When asked about her use of personal protective equipment (PPE) upon entering the room compared to not cleaning the equipment after use, LPN BB stated she did not think it was necessary because she was not sure what condition the resident had and believed the roommate, not the resident she was providing care to, likely had the condition. LPN BB confirmed she should have cleaned the blood pressure machine.On 03/04/2026 at 7:39 am, LPN BB stated she needed to check R142's blood sugar. She performed hand hygiene, prepared the necessary supplies, entered the room, and placed the supplies, including the glucometer, on the resident's bed. She checked the resident's blood sugar and then exited the room to obtain insulin. Upon exiting the room, she placed the glucometer back on the medication cart without sanitizing it.LPN BB continued her medication pass, and at 7:59 AM she went into R6's room to check the resident's blood sugar. She brought the necessary supplies, including the same unclean glucometer, into the room and placed them on the resident's bed. After completing the check, she exited the room and again placed the glucometer on the medication cart without sanitizing it. When the surveyor asked why she continued to use the glucometer for different residents without cleaning it and whether shared equipment should be sanitized between uses, LPN BB acknowledged that she should have cleaned the device before placing it back on the cart.On 03/04/2026 at 8:35 AM, Registered Nurse (RN) CC was observed during a medication pass to R12 who received nutrition and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications via tube feeding. RN CC prepared medications by crushing them and brought the medications to the resident's room. Enhanced Barrier Precautions (EBP) signage was posted on the door; however, although the nurse performed hand hygiene, she did not wear personal protective equipment (PPE) while administering medications via the percutaneous endoscopic gastrostomy (PEG) tube.After the medication administration was completed and RN CC exited the room, the surveyor asked the nurse about the EBP signage posted on the door. RN CC stated she was not sure why the signage was present. She stated the resident's roommate had recently had the flu but believed the condition was no longer present and was unsure why the signage remained posted.The surveyor asked whether PPE should have been used prior to administering medications via the PEG tube, given the presence of an external device and the potential for splashing during medication administration. RN CC stated she was not sure. The surveyor then asked about the EBP order and what it meant to her when she documented it daily in the MAR. RN CC stated she was not sure.In an interview conducted on 03/05/2026 at 9:25 AM, the Infection Control (IC) Nurse stated that staff are educated and expected to sanitize shared equipment, such as glucometers and blood pressure machines, using the purple top wipes. She stated that when checking a resident's blood sugar, staff are expected to use a barrier to place supplies on and should not place supplies directly on the resident's bed. She further stated that staff receive regular education on Enhanced Barrier Precautions (EBP).In an interview conducted on 03/05/2026 at 11:26 AM, the Director of Nursing (DON) stated that she expects nursing staff to follow Enhanced Barrier Precautions (EBP) practices to reduce the transmission of infections. She stated that staff are aware of and trained on high-risk care activities that require enhanced barrier precautions. She further stated that she expects staff to sanitize shared equipment between residents' uses.