STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115695	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union County Nursing Home	164 Nursing Home Circle Blairsville, GA 30512

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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 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. 46579 Based on observations, family and staff interviews, record review, and review of the facility policy titled, Mouth Care, the facility failed to provide denture care for two of 42 sampled residents (R) (R26 and R78). The deficient practice had the potential to cause mouth pain and discomfort, that could lead to decreased oral intake of nutrition and hydration for R26 and R78. Findings include: Review of the facility policy titled Mouth Care with a revision date of February 2018 revealed that the Purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the residents' mouth, and to prevent oral infections. 1. Review of the Electronic Medical Record (EMR) for R26 revealed that she was admitted to the facility with diagnoses that included but were not limited to a fracture of shaft of humerus and superior rim of left pubis. Review of the Admission Minimum Data Set (MDS) with a completion date of 5/10/2024 revealed that R26 had a Basic Interview of Mental Status (BIMS) score of five, which indicated she was severely cognitively impaired. Review of Section GG: Functional Abilities revealed that she had impairment on one side for both upper and lower extremities and required substantial/maximal assistance with grooming. Review of the Kardex (plan of care for ADLs (activities of daily living) revealed that the assistance that she needed with oral care was not addressed. Observation and interview on 6/25/2024 at 11:45 am revealed R26 was sitting up in her bed with a hospital gown on, visiting with a family member. The family member stated that she had no complaints with R26's care except for oral/denture care that she was not receiving. She stated that she and another family member come in often, as much as possible. She stated that she feels like R26 was not receiving oral care daily. She stated that staff kept leaving R26's dentures in her mouth and have not been taking them out to clean teeth or provide mouth care. She stated that at one point she came in and R26 was complaining of mouth pain. She stated that she and another family member now clean her teeth because they want to make sure R26's mouth does not hurt and that she will continue to eat some of her meals. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/26/2024 at 12:50 pm, revealed R26 was sitting up in her wheelchair, dressed in her clothes. There was a sign noted next to the sink in the bedroom that read, Mom needs help with her dentures daily, to prevent mouth sores. Review of the Functional Abilities 31- day look back for June 2024 revealed that staff had charted for thirteen days that oral care was not attempted. For two of the days, nothing at all was charted, two days it was charted that she needed partial assistance, one day that she needed substantial assistance, seven days that she needed set up assistance only, seven days that she was totally dependent with oral care, and two days that she was independent with oral care. There was only one day out of twenty-five that had oral care completed twice on the same day. 2. Review of the EMR for R78 revealed that she was admitted to the facility with a diagnosis but not limited to Alzheimer's disease. Review of the Quarterly MDS with a completion date of 4/23/2024 revealed that R78's BIMS score was not completed related to the resident is rarely/never understood. Section GG-Functional abilities revealed that she had impairment on one side of upper extremity and that she required total assistance with oral care. Review of the Kardex (plan of care for activities of daily living-ADLs) revealed that R78 was to brush teeth and wash face daily. Observation on 6/26/2024 at 4:01 pm revealed R78 laying in her bed with eyes closed. Observation on 6/27/2024 at 8:00 am revealed R78 sitting up in her bed with her meal sitting in front of her. Interview on 6/26/2024 at 3:32 pm with R78's family member revealed that he came to the facility every day to visit R26. He stated that her face does not get washed daily, and that oral care occurs maybe once a week. Review of the Functional Abilities 31-day lookback for R78 revealed that staff charted nothing for five days, was not attempted for five days, partial assistance on one day, and total assistance on 15 days. Interviews on 6/27/2024 at 3:29 pm with Certified Nursing Assistant (CNA) HH and CNA II revealed that when they were shown the Functional Abilities charted for R26 and R78, they stated that if they were to look at the charting and the days had a 9 charted, then they would think that it meant that it was not attempted. They then stated that if they did not see anything charted, just blanks, that it would mean that it was not done or not charted. They both said that denture care should be completed in the morning and at night. Interview on 6/27/2024 at 3:45 pm with Licensed Practical Nurse/Unit Manager (LPN/UM) JJ, she stated that if she looked at the functional abilities charting for oral care and there were blank boxes and a 9 charted, then she would have to assume that it was not completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/27/2024 at 3:50 pm with CNA EE, she stated that oral care should be completed first thing in the morning. She stated that there are many times that she had come in to work her shift and dentures would still be in the resident's mouth from the night before. She then stated that if she were to look at the charting on the functional abilities for a resident and saw 9's and blanks, she would think that it was not done or not charted. Interview on 6/27/2024 at 3:55 pm with CNA FF, she stated that oral care should be completed when the resident wakes up and just before they go to bed. She then stated that if she looked at the chart for oral care and it says nothing but blanks and 9's, then she would think that it was not done. Interview on 6/27/2024 at 4:04 pm with the Director of Nursing (DON), she stated that oral care should be completed daily and as needed. She then stated that if oral care was not charted or there were 9's charted, that it must just be an oversite. She stated that oral care should always be offered or attempted.

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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. 46579 Based on observations, staff interviews, and review of the facility policy titled, Storage of Medication, the facility failed to properly maintain, and store three of six medication cart as evidenced by missing end of shift controlled medication count signatures. Findings include: Review of the facility policy titled Storage of Medication revised April 2007 revealed under Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Observation on 6/27/2024 at 9:45 am of three of six medication carts revealed each cart had a controlled substance book which had the current months End of Shift Controlled Drug Count sheet in each book. The Pink A Hall sheet was missing five signatures, the pink B Hall sheet was missing 10 signatures, and the blue C Hall was missing three signatures on their sheets. Interview on 6/27/2024 at 9:52 am with RN NN revealed that the Medication Room Pink B Hall had no issues and the medication cart - Pink B Hall cart had no storage issues. The interview revealed that the nurse who was coming on and the nurse who was going off shift was responsible to count their cart at the end/beginning of each shift. She stated if the nurse worked a partial shift, the medication cart was counted at the beginning and end of the partial shift as well and documented in the eight-hour shift column. She confirmed and verified there were multiple missing signatures from the Narcotic Shift Count Sheet. Observation and interview on 6/27/2024 at 9:58 am of the medication cart - Pink A Hall with Licensed Practical Nurse (LPN) LL revealed the Narcotic Count Sheet had five spaces not signed by the oncoming /off going nurse. She stated the document should be signed by both nurses at the start of each shift (on coming/off going nurse). She stated when nurses do not work a 12- hour shift due to a call out, they come in to fill in for four to eight hours that the nurse who called out would sign in the column indicated for partial shifts. She stated the Unit Manager removed the count sheet at the end of each month, but she was not sure what happened to them after they were removed from the narcotic book. Observation and interview on 6/27/2024 at 10:30 am of the medication cart on the Blue B and C Hall with LPN KK revealed that the count sheet was signed by the nurse as the count was completed at the beginning and end of each nurse's shift. She stated if the nurse was not working a full 12-hour shift, they have a column for partial shift staff to sign and validate the narcotic count was completed. She confirmed and verified that there were some days on the count sheet that did not have a nurse signature for end/beginning of shift counts. She confirmed the sheets were removed by the unit manager at the end of each month. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/27/2024 at 10:59 am with the Director of Nurses (DON) revealed that she confirmed and verified the narcotic sheets for three carts were missing nurse's signatures. She verified and confirmed the End of Shift Controlled Drug Count sheet for the Pink B cart was missing 10 signatures, the Pink A cart was missing five signatures, and the Blue cart was missing three signatures. She stated the purpose of the narcotic count and signing the narcotic sheets was to validate the count of the controlled substances on each cart is correct. She stated if the count was not documented this could result in the count not being correct or staff not knowing the count was correct at the end/beginning of their shift. She stated she did not know why this had occurred except that it was an oversight of the nurse who was working on the indicated shifts without signatures. She stated they removed the narcotic sheet at the end of each month and reviewed them. She revealed that if there were any days missing signatures, she would find the nurse responsible for that shift and then she would provide education to the nurse.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38154 Based on staff interviews, record review, and review of the facility policies titled, Antipsychotic Drug Use and PRN Medication, the facility failed to make recommendations to include stop dates for psychoactive medications lorazepam, used to treat anxiety, and trazodone, used to treat insomnia, which were prescribed as needed (PRN) for two of five sampled residents (R18 and R64). The deficiency had the potential to adversely affect the severity of the diagnoses for which they were prescribed. Findings include: Review of the undated facility policy titled, Antipsychotic Drug Use revealed under Policy Interpretation and Implementation: The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. Review of the facility policy titled PRN Medication, revised 11/7/2022, revealed the Policy was The pharmacist is responsible for assuring appropriate and safe prescribing procedures are followed. The frequency with which PRN or as needed medications may be administered must be monitored to avoid interactions with other medications and to avoid exceeding maximum recommended dosing. The Procedure section stated: I. All physician medication orders which indicate a frequency for administration of PRN or as needed must state how often and for what indications the medication(s) may be administered. Exceptions to this include medications for which only one indication is approved. 1. Review of the Electronic Medical Record (EMR) for R18 revealed she was admitted to the facility with diagnoses to include spondylosis without myelopathy or radiculopathy, delusional disorder, and vascular dementia. Review of the Quarterly Minimum Data Set assessment for R18, dated 4/8/2024 revealed, Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment; Section D (Mood) revealed, a Mood score of zero, indicating no depression.; Section E (Behavior) revealed, she displayed verbal behaviors towards others and other behaviors not directed towards others; Section N (Medications) revealed, she received antipsychotic, antidepressant, and diuretic medications during the seven-day assessment period. Review of the care plan for R18 revealed a focus concern for insomnia diagnosis and risk for having trouble sleeping. Interventions included medicate as/if ordered and notify [physician] if medication is ineffective. Review of R18's Medication Administration Record (MAR) for June 2024 included an order for trazodone 100 milligrams (mg) tablet by mouth, dated 12/28/2023, to be given as needed (PRN) at bedtime for insomnia. Continued review of the MAR revealed it was given once in June 2024, not given in May 2024, and given once in April 2024. There was no stop date indicated. Review of the monthly Record of Medication Regimen and Chart Review from June 2023 through June 2024 revealed no recommendations related to the duration of the PRN medication, trazodone. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49673 2. Review of the clinical record revealed R64 was admitted to the facility on [DATE] with diagnoses including, but not limited to, major depressive disorder and mild pain. Review of R64's most recent Minimum Data Set (MDS), dated [DATE], revealed Section N (Medications) documented the resident received an antianxiety for seven of seven days. Review of the Physician Orders dated 12/8/2023 revealed an order for lorazepam (a medication used to treat anxiety) 0.5 milligrams (MG) tablet by mouth as needed every eight hours for agitation. Review of R64's December 2023 through June 2024 Medication Record revealed lorazepam 0.5 milligrams (MG) tablet by mouth as needed every eight hours for agitation with start date of 12/11/2023 and no stop date. In a telephone interview with the Consultant Pharmacist on 6/27/2024 at 6:00 pm, revealed when asked if he knew that Centers for Medicare and Medicaid (CMS) required some psychoactive medication physician orders required a stop date if ordered as needed (PRN), he stated he was aware of the regulation. He confirmed that trazodone, used to treat depression, and lorazepam, used to treat anxiety, were among those medications which required a stop date if ordered PRN. He stated when the pharmacy received a PRN order for trazodone or lorazepam, the pharmacist should contact the physician for an amended order. He confirmed the PRN physician orders for R18, and R64 should have included a stop date which he believed the pharmacy recommended but was unable to locate the documentation. He stated the pharmacy makes an effort to communicate with the provider, but he would still fulfill the order as written. In an interview on 6/27/2024 at 6:08 pm, Pharmacist OO revealed R64's lorazepam was prescribed for agitation. Pharmacist OO confirmed on 5/21/2024, they sent a change of order but were unable to find it. Pharmacist OO confirmed lorazepam required a stop date. Pharmacist OO revealed he didn't have proof of sending the communication to the facility. In an interview on 6/27/2024 at 6:53 pm, the Director of Nursing (DON) revealed the pharmacist reviewed resident's medications monthly and makes recommendations to the provider. She confirmed she was aware there were no stop dates or recommendations for PRN trazodone for R18 or PRN lorazepam for R64. She stated, going forward, she would alert the physician to PRN medications that require stop dates.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49138 Based on observation, staff interviews, and review of the facility-provided document titled Texture Modification Inservice, the facility failed to ensure a puree recipe was followed to conserve the nutrient value of puree country-fried steak for six of six residents receiving a pureed diet. This deficient practice had the potential to cause residents receiving a pureed diet to have a decreased nutritional intake and a potential for weight loss. Findings include: Review of the undated facility-provided document titled Texture Modification Inservice revealed the section titled Guidelines for Texture Modification: Pureed Foods included Never free pour large amounts of liquids or thickeners into purees as it can impact the nutritional value and quality of the food item. Observation on 6/26/2024 at 10:45 am of the Dietary Manager in Training (DMIT) BB preparing pureed foods revealed she did not have or follow a recipe as she prepared the pureed country-fried steaks. DMIT BB prepared the pureed country-fried steak with broth and several cups of water. In an interview during the observation, she stated that she had been working at the facility for three days. DMIT BB stated she did not receive orientation but did receive on-the-job training. DMIT BB stated that the facility policy allows them to modify as needed when preparing pureed food. An interview on 6/26/2024 at 10:50 am with the Registered Dietitian (RD) revealed that he has been working at the facility for three years. The RD stated there was a recipe for pureed food, but it was not provided. An interview on 6/26/2024 at 11:45 am with the Dietary Manager (DM) revealed that water should not be used in preparing pureed food. The DM stated the use of water in preparing pureed food takes away from the nutritional value of the food. An interview on 6/26/2024 at 11:55 am with the District Manager confirmed that pureed food should not be prepared with water. He stated that he would be providing an in-service to staff today. An interview on 6/27/2024 at 3:43 pm with the Administrator revealed that kitchen staff should not use water when preparing pureed food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49138 Based on observation, staff interviews, and review of the facility's policy titled Receiving, the facility failed to appropriately label and date food items stored in the kitchen's walk-in freezer. The deficient practice(s) had the potential to place 96 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. The facility census was 101. Findings include: A review of the facility's policy titled Receiving revealed the Policy Statement of Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. The Procedures section documented 5. All food items will be appropriately labeled and dated either by manufacturer packaging or staff notation. An observation of the walk-in freezer in the kitchen with the Registered Dietitian (RD) and Dietary Manager (DM) on 6/25/2024 at 9:15 am revealed two open boxes of cookie dough with about 60 cookies in one box and 80 cookies in the other box. The RD confirmed the two boxes of cookie dough were opened and not labeled with an opened or discard date. In an interview on 6/26/2024 at 11:55 am, the District Manager confirmed all open foods should be labeled with a date before being placed in the freezer. He stated that he would be providing an in-service to staff today. In an interview on 6/27/2024 at 3:43 pm, the Administrator stated all open food items should be labeled with a date when opened.

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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. 46579 Based on observations, staff interviews, record review, and review of facility policies titled Hand Hygiene, Perineal Care, and Administering IV Medications, the facility failed to use proper hand hygiene during perineal and catheter care for one resident (R) (R75), failed to properly close the door to a transmission-based precautions (TBP) room for one resident (R257), and to properly disinfect a needleless connector on a percutaneous intravenous central catheter (PICC) line after flushing and before connecting the intravenous antibiotic for one resident (R258). The deficient practices had the potential to place the residents at risk for serious infections. The sample size was 42 residents. Findings include: Review of the undated facility policy titled Hand Hygiene under Policy revealed, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under Policy Explanation and Compliance Guidelines revealed, Additional considerations: (a) The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility policy titled Perineal Care revised February 2018 under Purpose revealed, The purpose of the procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Under Steps in the Procedure revealed, 10. Remove gloves and discard them into designated containers. 11. Wash and dry your hands thoroughly. Review of the facility policy titled Administering IV Medications revised December 2012 under Purpose revealed, The purpose of this procedure is to provide guidelines for the aseptic administration of a medication bolus directly into the venous system through a vascular access device. Under Steps in the Procedure revealed, To Administer medication directly through an IV catheter: 1. Disinfect catheter port with alcohol pad or antiseptic caps; 2. Attach saline-filled syringe and flush the catheter; 3. Disinfect catheter connection device again; 4. Attach medication - filled syringe and administer medications according to prescribed rate. 1. Review of the Electronic Medical Record (EMR) for R75, revealed that he was admitted to the facility with diagnoses that included but were not limited to bladder-neck obstruction. Review of the physician orders for R75 revealed an order for staff to provide catheter care every shift that instructed staff to hold catheter near meatus and wipe tube downward, away from meatus opening and to rinse using the same technique. Review of the care plan for R75 revealed that resident required an indwelling catheter related to bladder-neck obstruction. Due to that requirement, he has an increased risk for urinary tract infection (UTI) related to having an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment for R75, dated 4/8/2024, revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of three, indicating severe cognitive impairment. Section D (Behaviors), documented hallucinations and delusions. Section H (Bladder and Bowel) urinary catheter present and frequently incontinent of bowel. Observation on 6/25/2024 at 9:45 am. revealed, R75 asleep in his room on Enhanced Barrier Precautions related to having a urinary catheter. An observation of catheter care and perineal care was conducted on 6/27/2024 at 10:31 am for R75 with Certified Nursing Assistant (CNA) VV and the Registered Nurse (RN) Educator who both entered the room and provided privacy after donning personal protective equipment (PPE). They uncovered the resident and then recovered him with a sheet to expose just the perineal area and the catheter. The CNA provided perineal care, using a fresh wipe for each stroke of the penis. She then held the base of the catheter and then provided catheter care and used a fresh wipe for each swipe of the catheter and went from tip downwards towards the bag. The resident was then repositioned on to his side with the assistance of the RN Educator and then perineal care was provided, due to the resident having had a bowel movement (BM). R75 was cleaned from front to back until all feces were removed. The dirty brief and dirty wipes were removed, and the RN Educator went outside the room. The RN Educator returned with clean gloves however she did not perform hand hygiene before leaving the room. The RN Educator and CNA VV donned fresh gloves and resumed and completed the catheter care. CNA VV then applied barrier cream and a new brief to the resident. CNA VV removed her gloves, and then went to the door, to get more gloves however, she did not perform hand hygiene before leaving the room. CNA VV returned with a fresh pair of gloves, emptied the catheter bag and cleaned the drainage system with an alcohol wipe, after closing it. The trash and dirty linen were collected, and PPE was doffed. The Nurse Educator and CNA VV then performed hand hygiene upon leaving the resident's room. An interview on 6/27/2024 at 10:50 am with CNA VV confirmed hand hygiene was to be performed before entering a room, after finishing with resident when exiting, and when hands are soiled. In an interview on 6/27/2024 at 11:20 am with RN Nurse Educator confirmed hand hygiene should be performed before a procedure, when you change your gloves and after the procedure. She confirmed she did perform hand hygiene at the PPE cart outside of the room before returning to the room with gloves. She confirmed CNA VV did not perform HH after changing gloves in the room. In an interview with the RN Nurse Educator on 6/27/24 at 2:45 pm, she stated she started at the facility about four months ago. She then stated that she conducts annual competencies for peri care with return demonstration as well as upon hire and as needed (PRN). She then stated that nurses are to monitor the CNAs for compliance. She ended her interview by stating that she is currently reviewing old policies and competencies and conducts CNA training classes. 2. Review of the EMR for R257 revealed that he was admitted to the facility with diagnoses that included but were not limited to pneumonitis due to the inhalation of food and vomit, and dysphagia. Review of the physician orders for R257 revealed that he was to receive vancomycin liquid (an antibiotic) from 6/19/2024 until 6/24/2024. An observation of the resident was completed on 6/25/2024 at 10:35am. The resident was in his room, and there was an Enteric Contact isolation signage on his door. The door was completely open. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115695	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union County Nursing Home	164 Nursing Home Circle Blairsville, GA 30512

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	An observation of a medication administration was conducted on 6/26/2024 at 8:25am. Licensed Practical Nurse (LPN) KK was observed preparing medication for R257. She prepared the medications and then placed medication on top of the electronic blood pressure cuff. She entered the room with the electronic blood pressure cuff and medications without donning personal protective equipment and then left the room to don PPE. Before entering the room, she donned (put on) personal protective equipment (PPE), to prepare for going into the transmission-based precaution room. The door to the room was completely open. After entering the room, she remembered that she did not have her stethoscope in the room to check for placement of the percutaneous endoscopic gastrostomy (PEG) tube. She then doffed (removed) her PPE and used hand sanitizer before leaving the room. After administering the medications and tube feeding, she doffed the PPE and then washed her hands at the sink. After leaving the room, she went back to the medication cart. At the cart she stated that she cleans the blood pressure cuff after using it with the purple topped wipes. She stated that R257 had a history of Clostridium difficile (c-diff). She stated that the door to his room needed to be closed. In an interview on 6/27/2024 at 3:35 pm with LPN/Unit Manager (UM) JJ, she confirmed R257 was on isolation precaution for a history of C-diff. 3. Review of the EMR for R258 revealed that she was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with sepsis. Review of physician orders revealed that R258 was to receive two grams of ceftriaxone intravenously (IV) once a day for a urinary tract infection until the date of the last dose to be administered on 6/27/2024. Observation on 6/27/2024 at 11:07 am of RN GG preparing to administer medications for R258 revealed, she verified the orders for the IV antibiotic and gathered her supplies. She donned PPE and then entered the room. She verified the resident, who was observed dressed and seated in her wheelchair. The peripherally inserted central catheter (PICC) line was observed with a change date of 6/25/2024, and dressing was clean, dry and intact. She removed the cap that was on the end of the connector and flushed the line with 10 milliliters (ml) normal saline (NS). She stated that she did not need to clean it because it had a cap on it. She left the syringe in place and clamped the port. She then mixed the antibiotic, primed the tubing, then programmed the pump to administer the antibiotic. She then removed the syringe and attached the primed tubing. She verified that the antibiotic was running and dripping before leaving the room. She removed the PPE and then washed hands and returned to the cart. In an interview on 6/27/2024 at 3:35 pm with LPN/UM JJ, she stated that even if a PICC line connector has a cap on it, the nurse should still disinfect the connector after removing the cap and before attaching the saline flush to flush the line, before attaching the antibiotic to administer it. In an interview on 6/27/2024 at 4:04 pm with the Director of Nurses (DON), she confirmed hand hygiene (HH) should be completed before entering the room, before donning gloves, after doffing gloves, and before leaving the resident's room. She confirmed that a PICC line connector should be disinfected with an alcohol wipe prior to attaching the flush or medication.