STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide written bed hold notifications to residents and/or responsible parties for eight Residents (#2, #7, #9, #10, #11, #27, #59, & #87) of nine residents reviewed for hospitalizations. Findings include:Resident #87 (R87) was transferred to the hospital Emergency Department (ED) on 3/13/25. There was no documentation in the Electronic Medical Record (EMR) indicating the resident/responsible party were provided a bed hold notice. Resident #10 (R10) Review of a “Transfer Notice,” dated 6/4/2025 from R10's EMR, revealed the R10 was transferred to the emergency department on 6/4/2025 due to lethargy and decreased alertness. Further review of R10's EMR revealed the Resident was hospitalized following the transfer with return to the facility on 6/9/2025. In review of the EMR, it was noted there was no documentation or signed document indicating the Resident or the Resident's representative was provided with the facility bed hold policy at the time of transfer or thereafter. Resident #11 (R11) Review of a “Transfer Notice,” dated 6/20/2025 and gleaned from R11's EMR, revealed the Resident was transferred to the emergency department on 5/19/2025 for evaluation and treatment of osteomyelitis. Further review of R11's EMR revealed the Resident was hospitalized following the transfer with return to the facility on 5/29/2025. In review of the EMR, it was noted there was no documentation or signed document indicating R11 or R11's representative was provided with the facility bed hold policy at the time of transfer or thereafter. During an interview on 8/21/2025 at 10:38 AM, the Nursing Home Administrator (NHA) reported the facility was not currently supplying information to residents or resident's representatives about bed holds when transferred out to the hospital. The NHA stated he was unsure where the communication breakdown was among staff responsible for providing the information on bed holds but he was now aware and had begun to educate staff of the need to supply the information at the time of transfer or as soon as possible following transfer. Resident #7 (R27) was sent to the ED 8/17/25. There was no documentation in the EMR indicating the resident or responsible party were provided required written bed hold information. Resident #27 (R27) was sent to the ED 5/4/25. There was no documentation in the EMR indicating the resident or responsible party were provided required written bed hold information. During an interview on 8/20/2025 at 2:15 PM, The Nursing Home Administrator (NHA) stated he did (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not see (in the EMR) that facility bed hold policy was explained (to the resident or responsible parties). Resident #59 (R59) was sent to the ED on 6/22/25 and 7/25/25. The EMR did not contain documentation of the resident or responsible party being provided written bed hold information. Resident #9 (R9) was transferred to the ED 4/7/25, 5/24/25, and 8/1/25. No required written information regarding bed holds to the resident or responsible party were located in the EMR for any of the transfers. Resident #2 (R2) was sent to the ED 4/16/25. There was no documentation in the EMR indicating the resident or responsible party was provided required written bed hold information. The Administrator (NHA) was interviewed on 8/20/25 at 2:00 PM. The NHA said the facility did not issue written bed hold information to residents/responsible parties when residents were transferred to the ED because it depended on their payor source. The NHA said bed hold information was not issued for residents who had Medicaid. On 8/20/25 at 2:47 PM, the NHA confirmed there was no written bed hold information for residents who were transferred to the ED regardless of payor source. The NHA said the policy for written notification of bed holds was reviewed with the business office manager and admissions person who would be responsible for completing written notification of bed holds for all future transfers. The policy “Bed Hold Prior to Transfer” dated as reviewed/revised on 4/22/25 read, in part: “… It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave…the written information given to the resident and/or resident representative will include the following: a. The duration of the state bed-hold, if any, during which the resident is permitted to return and resume residence in the nursing facility b. The reserve bed payment policy in the state plan, if any c. The facility policies regarding bed-holds periods to include permitting residents to return to the next available bed. D. Conditions upon which the resident would return to the facility…6. The facility will provide this written information to all facility residents, regardless of their payment source…”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure safe storage of medications and labeling for three of three medication carts reviewed for medication storage. Findings include: On [DATE] at 9:30 AM, the A-hall medication cart was observed for medication storage and was found to have five insulin pens without an expiration date. One insulin pen had an opened date of [DATE] and would have been expired on [DATE] and remained in the active medication supply. On [DATE] at 9:40 AM, an interview was conducted with Licensed Practical Nurse (LPN) D, who was asked how long the insulins in her cart were good to use and replied, I don't know. I would have to ask the unit manager. LPN D was asked if she was unsure how long the insulin pens were good for how would she know when to discard them and replied, I guess I better find out. On [DATE] at 2:15 PM, the E-hall medication cart was observed for medication storage and was found to have 13 insulin pens and two insulin vials without an expiration date. On [DATE] at 2:25 PM, an interview was conducted with LPN F, who was asked why none of the insulins had an expiration date on them and replied, Well because we discard all of them when it has been 28 days. LPN F was made aware that currently a nursing staff member was unaware of how long certain insulins were good to utilize and if they were pulled to work in any of the five units they would be unaware if the insulin they were administering was still good to use and replied, I guess we need to add an expiration date to all of them then. On [DATE] at 3:35 PM, an interview was conducted with the Director of Nursing (DON) who was made aware that the medication carts lacked an expiration date on all the insulins and that there was currently a nursing staff member who was unaware of how long the insulin medication was good to utilize and replied, The insulins should have an opened date and an expiration date on all of them. On [DATE] at 4:00 PM, the D-hall medication cart was observed for medication storage and was found to have one insulin pen without an expiration date. On [DATE] at 4:02 PM, an interview was conducted with LPN B who verified that there was no expiration date on the insulin pen. On [DATE] at 4:13 PM, an observation was made of the A-hall medication cart which was unlocked and unsecured. During the six minutes the A-hall medication cart was left unlocked and unattended two unidentified residents went strolling by the A-hall medication cart. On [DATE] at 4:13 PM, an interview was conducted with Certified Nurse Aide (CNA) K, who was asked if nurses were to leave the medication cart unlocked and replied, Well no. CNA K was asked where the nurse was and replied, In helping with the other aide(CNA). On [DATE] at 4:19 PM, an interview was conducted with LPN D, who was asked when she returned to the medication cart why she left the medication cart unlocked and unattended and replied, I wasn't thinking. I just went and was helping out. Review of policy titled, Medication Storage, dated [DATE], read in part, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines. 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments. Review of policy titled, Storage of Medications, dated 9/2018, read in part, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Expiration Dating (Beyond-Use Dating).3. Certain medications or package types, such as IV [intravenous] solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to supply appropriate devices to ensure resident safety while smoking for one Resident (#104) of one resident reviewed for safe smoking. Findings include:Resident #104 (R104)On 8/19/2025 at 3:08 PM, R104 was observed in the hallway on her way to the smoking area outside. The smoking times listed for the facility were every two hours on odd hours of the clock. On 8/20/2025 at 1:17 PM, three resident smokers were observed in the outdoor pavilion smoking area accompanied by Certified Nursing Aide (CNA) A and one visitor. R104 was smoking a cigarette and was not wearing a smoking apron for protection against burns. Several ashtrays were on the table with one ashtray positioned directly in front of R104. While R104 was smoking, she backed her wheelchair away from the table and was observed not using the ashtray and flicking ashes from her burning cigarette into the air. The ashes were drifting in the air and not controlled. When questioned, R104 admitted to not wearing a smoking apron and stated she usually did. CNA A stated she did not usually take the smokers out at 1:00 PM as the hall assignments had recently changed, CNA A said, I had no idea (R104 should be wearing a smoking apron.) When R104 was discussing her physical abilities, she said, My fingers are so bad I can't even snap them indicating she had trouble even holding a cigarette at times. The Electronic Medical Record (EMR) for R104 included a Minimum Data Set (MDS) assessment dated [DATE] revealing an admission date of 8/22/24 and a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severely impaired cognition. A review of a physician's order, initiated 9/25/24, stated, Resident to wear a smoking apron at smoke times. Nurse to ensure resident has apron to wear while smoking and that she is using it. The most recent Nursing Quarterly/Significant Change Evaluation -V9 completed on 5/26/25, included a smoking assessment. The summary of this evaluation read, Resident may smoke, at this time 2. Yes, with smoking aid(s), and Smoking aids needed included Smoking apron and Cigarette holder. Both were checked as needed for safety while smoking. The current care plan for R104 reviewed on 8/20/25 included a focus of: Resident chooses to smoke dated as initiated: 8/22/2024. The goal was written as, Resident will smoke safely at the designated area(s) at scheduled times through the next review. Date Initiated: 08/22/2024 Target Date: 08/26/2025. Interventions included, Smoking apron - Date Initiated: 09/25/2024. During an interview on 8/20/2025 at approximately 2:00 PM, the Director of Nursing (DON) stated there had been a recent evaluation of R104s capabilities and a cigarette holder was no longer needed, and this intervention had been removed from the care plan. The DON did not present the documentation for this care plan revision, and it was not found in the EMR during the time of the survey. The DON did confirm R104 should have had a smoking apron in place for her protection while smoking. The facility policy titled Smoking Policy Smoking Campus - Residents dated as reviewed/revised on 5/31/2023 read in part: It is the policy of this facility to establish and maintain safe resident smoking practices. The Attending Physician and the Director of Nursing Services (DNS) shall have the authority to make the determination as to what restrictions, if any, will need to be placed on the resident's smoking privileges. Smoking restrictions may be imposed on residents at any time if the Attending Physician and/or Director of Nursing determine that the resident is not able to smoke safely with supervision. Smoking restrictions (such as need for smoking apron, or specific scheduled smoking times), shall. (be) for the safety and well-being of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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 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 observation, interview, and record review, the facility failed to ensure a medication error rate less than 5 percent, with 3 errors identified, out of 25 medication administration opportunities observed. This deficient practice resulted in a medication error rate of 11.54 percent, and the potential for the administration of non-therapeutic doses of medication, and preparation of medication not according to manufacturer's instructions. Findings include: Error 1 and 2. Resident #94 (R94) - During observation of preparation of oral medications for R94 on 8/20/25 at 7:50 AM, Licensed Practical Nurse (LPN) D dispensed cyanocobalamin 500 micrograms (mcg), one tablet into a medication cup prepared for R94. LPN D completed her preparation for morning medication pass for R94 which included 0700 (7:00 AM) and 0800 (8:00 AM) medications. LPN D was asked how much cyanocobalamin was dispensed and replied, One. That's what the order says. LPN D was asked to check her dose of cyanocobalamin that was stored in her medication cart and replied, It is only 500 mcg. I need to give her two I guess. LPN D was asked if that was the only dose supplied in the facility and replied, I think so. I guess I will need to change the order to reflect the correct amount to dispense. Review of R94's physician order, dated 8/7/25, revealed an order for cyanocobalamin 1000 mcg, give one tablet by mouth one time a day at 8:00 AM for B-12 deficiency. Review of R94's physician order, dated 7/18/25, revealed an order for metoclopramide 5 milligrams (mg), give one tablet by mouth before meals for gastroparesis, administer 30 minutes to an hour prior to meals at 7:00 AM, 11:00 AM, and 4:00 PM. Review of R94's medication administration time for metoclopramide, revealed that this medication was dispensed and given at 8:17 AM (17 minutes late). On 8/20/25 at 8:20 AM, an interview was conducted with LPN D, who was asked if R94 liked her metoclopramide prior to breakfast and replied, Yes. LPN D was asked what time breakfast trays came down from kitchen and replied, Around 9:00 AM. LPN D was asked if the metoclopramide was to be given at 7:00 AM then that would be too early to dispense then why she (LPN D) did not have the order time changed to 8:00 AM and replied, I am not sure, but that is a good question because all her (R94) other medications are given at 8:00 AM, and that makes more sense. Error 3. Resident #126 (R126) - During observation of preparation of a rapid-acting insulin pen for R126 on 8/20/25 at 9:00 a.m., LPN D primed the rapid-acting insulin pen by dialing the insulin pen to 2 units and proceeded to prime the pen holding it horizontal (sideways). LPN D administered the insulin in R126's left lower quadrant and held post injection for only six seconds. Review of R126's medication administration record (MAR), dated August 2025, revealed that the rapid-acting insulin was administered in R126's right upper quadrant of her abdomen. On 8/20/25 at 3:35 PM, an interview was conducted with the Director of Nursing (DON), who was made aware of the medication error rate and replied, The nurses are to refer to the manufacturer guidelines for insulin. Priming is done by holding the insulin pen upright (vertical) and post injection hold time is ten seconds. Review of the [rapid-acting insulin pen name] instructions, revealed the following, in part: .Wipe the pen tip (rubber seal) with an alcohol swab . Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times . Keep the pen straight, insert the needle into your skin. Press and hold the button to give the dose. Keep the button pressed and hold for ten seconds. Release the button and remove the needle from your skin . Review of the policy titled, Medication Administration, dated 1/17/23, read in part, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines.10. Review MAR to identify medication to be administered. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration.b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure current infection control practices were maintained for two Residents (#10 & #126) of 24 residents reviewed for infection control practices related to medication administration and reusable oxygen tubing.Findings include:Resident #10 (R10) Review of the Minimum Data Set (MDS) assessment, dated 6/17/2025, revealed R10 was admitted to the facility on [DATE] with diagnoses including heart failure, chronic respiratory failure, diabetes and dementia. Further review of the MDS assessment revealed R10 had moderate cognitive impairment, required substantial/maximal assistance with personal hygiene and was dependent on staff for transfers and mobility. Review of R10's active physician's orders revealed the following: Oxygen: Run [at] 3 L/Min [liters per minute] via NC [nasal cannula] 24 hours per day continuous. Every day and night shift. Start Date: 6/09/2025. Upon entering R10's room on 8/19/2025 at 12:50 PM, a portable oxygen concentrator was observed to be positioned on the floor next to R10's room. The concentrator was running and set to deliver 3 liters per minute of supplemental oxygen. The tubing dated 8/17 [2025] attached to the concentrator was observed to be draped over a bedside table with a portion of the tubing and an unsheathed nasal cannula resting on a handbag that was positioned atop the table. It was noted there was no protective barrier between the table with the handbag and the tubing and nasal cannula. R10 was not present at the time of the observation. On 8/20/2025 at 8:32 AM the portable oxygen was again observed to be positioned next to R10's bed. The tubing, dated 8/17 [2025], attached to the concentrator was observed to be wrapped around the upper left grab bar of the resident's bed with the unsheathed nasal cannula draped over the head of the bed and resting on the bottom portion of the bed frame, approximately six inches from the ground. R10 was not present at the time of the observation. During an interview on 8/21/2025 at 12:34 PM, the Director of Nursing (DON) reported the expectation was for oxygen tubing to be housed in a clear plastic bag when not in use and if tubing was found touching the floor or a surface deemed to be dirty, the tubing and nasal cannula should be replaced with a new set to avoid resident use of contaminated oxygen tubing. Review of the facility policy titled, “Infection Prevention and Control Program,” implemented 8/20/2020, revealed the following: “The facility has established and maintains an infections preventions and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted [NAME] standards and guidelines … Non-sterile supplies are stored and maintained as clean prior to use.” Resident #126 (R126) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

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	On 8/20/25 at 7:50 AM, an observation of R126's medication pass in the main dining room was completed with Licensed Practical Nurse (LPN) “D” who approached R126 seated with three other unidentified residents and placed R126's water, medication cup, and inhaler on the dining room table without a barrier and proceeded to administer R126's medications. LPN “D” separated the water cup with an empty cup and handed R126 her inhaler and then after R126 used the inhaler placed in back on the dining room table without a barrier. After the administration of R126's medication LPN “D” returned the inhaler to her medication cart without sanitizing the inhaler before placing it back into her medication cart. On 8/20/25 at 9:00 AM, an observation was made of LPN “D” administering R126's medications in R126's room and upon entry R126 was utilizing the bathroom. LPN “D” entered R126's bathroom and placed R126's two insulins on top of the bathroom sink vanity without a barrier. LPN “D” assisted R126 in the bathroom, to her bed, and proceeded to wash her hands. During LPN “D's” hand washing LPN “D” turning the water off with her bare hands. LPN “D” then picked up the two insulins for R126 and placed them on R126's bedside table without a barrier. LPN “D” prepped R126's abdomen and proceeded with the first insulin administration while the second insulin pen fell to R126's floor. LPN “D” pick the insulin pen off the floor and placed it back onto R126's bedside table without sanitizing the pen. LPN “D” then gave the second insulin injection to R126 and returned to her medication cart without sanitizing the pen and returned it to her medication cart. On 8/20/25 at 3:35 PM, an interview was conducted with the Director of Nursing (DON), who was asked if for infection control purposes, during medication pass, if items had to be set down that were reusable, and returned to the medication cart, needed a barrier such as a tissue or paper towel and replied, “Yes, staff should be using a barrier if setting medications like this down and returning them to the medication cart and sanitizing them. The insulin pen should have been sanitized before using it if it fell to the floor.”