STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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 - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, facility policy review, and manufacturer guidelines review, the facility failed to ensure the medication administration error rate was less than 5 percent (%). The facility had 3 medication errors out of 27 opportunities, affecting 3 Residents, (R)44, R66, and R5, of 5 residents reviewed during the medication administration task, resulting in a medication error rate of 11.11%.Review of the facility's undated policy titled, Medication Handling and Administration Procedure, revealed, 1. Review E-MAR [Electronic Medication Administration Record]/MAR [Medication Administration Record]. 2. Check the E-Medication Administration Record (EMAR)/MAR for the medication due to be given. 3. Review the medication labels within the medication drawer for the appropriate medication. Verify the resident and medication information, as to the name of drug, strength, dose, route, and time of administration within the E-MAR/MAR. 4. Remove medication from the packaging over the medication cup so that the medication falls into the cup. 5. Should a dose be offered and subsequently refused or not given for any reason, discard the medication and document this on the E-MAR/MAR. 6. After the drug has been given and swallowing is observed, document administration on the E-MAR/MAR. Review of the facility's undated policy titled, Injections, Subcutaneous, revealed, 14. Expel air from syringe by priming with at least 2units [sic] of insulin to remove air. An Instructions for use Novolog (insulin aspart) injection, for subcutaneous or intravenous use 3 mL [milliliter] FlexPen prefilled pen, instruction manual, revised in 03/2023, revealed, Before each injection small amounts of air may be collected in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units [instructions refer to diagram]. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge [instructions refer to diagram]. G. Keep the needle pointing upwards, press the push-button all the way in [instructions refer to diagram]. The dose selector returns to 0. A drop of insulin should appear at the needle tip. The manufacturer instructions continued, Check and make sure that the dose selector is set at 0. H. Turn the dose selector to the number of units you need to inject. 1.Review of R44's Resident Face Sheet revealed the facility admitted R44 on 12/13/22. According to the Resident Face Sheet, the resident had a past medical history that included diagnosis of type 2 diabetes mellitus. Review of R44's Physician Order Report, dated from 12/14/25 to 01/14/26, contained an order, dated 09/17/24, for metformin tablet 500 milligrams (mg); amount: 1,000 mg, by mouth twice a day for type 2 diabetes mellitus. During an observation of medication administration on 01/14/26 at 8:08 AM, Registered Nurse (RN) 3 prepared R44's medications, to include two tablets of metformin 1,000 mg. RN 3 handed R44 the cup of medications. While the resident was still holding the cup of medications, the surveyor requested RN 3 to review the medications. RN 3 took the cup of medications from R44 and exited the room. RN #3ˆreviewed R44'sˆelectronic medication administration record,ˆphysician order, and the resident's metformin medication card.ˆRNˆ3 statedˆR44's physician orderˆfor metformin was to administer 1,000ˆmgˆand sheˆhad preparedˆtwoˆ1,000 mg tablets. During an interview on 01/14/26 at 8:18 AM, RN 3 stated she was confused by R44's metformin order because the order was to administer 500 mg tablets for a total of 1,000 mg, so she removed 2 tablets, not aware that she pulled two 1,000 mg tablets of the medication. 2. Review of R66's Resident Face (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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 - Some	Sheet revealed the facility admitted R66 on 08/16/24. According to the Resident Face Sheet, the resident had a past medical history that included diagnosis of constipation. Review of R66's Physician Order Report, dated from 12/14/25 to 01/14/26, contained an order, dated 09/16/25, for sennosides-docusate sodium 8.6 mg-50 mg, one tablet by mouth twice a day for constipation.During an observation of medication administration on 01/14/2026 at 9:01 AM, RN 1 performed hand hygiene and prepared R66's medications to include one tablet of 8.6 mg sennoside. RN 1 gathered the resident's medications, entered the resident's room, and administered the medications to the resident. During an interview on 01/14/26 at 9:19 AM, RN 1 reviewed the medications she removed from the cart for administration to R66 and confirmed that she administered sennosides 8.6 mg instead of sennosides-docusate sodium 8.6 mg-50 mg. RN 1 observed R66's physician orders and confirmed that she administered the incorrect medication to R66. Review of R5's Resident Face Sheet revealed the facility admitted R5 on 02/03/23. According to the Resident Face Sheet, the resident had a past medical history that included diagnosis of type 1 diabetes mellitus. Review of R5's Physician Order Report, dated from 12/15/25 to 01/15/26, contained an order, dated 11/23/25, for Novolog FlexPen (insulin aspart), amount 3 units subcutaneously, three times a day with breakfast, lunch, and dinner, for type 1 diabetes mellitus. During an observation of medication administration on 01/14/26 at 12:27 PM, Licensed Practical Nurse (LPN) 4 removed R5's insulin aspart insulin pen, a needle, and an alcohol pad from the medication cart. LPN 4 applied a needle to the tip of the insulin aspart pen and dialed the selector to 3 units. LPN 4 did not prime the insulin pen needle with 2 units of insulin prior to dialing the 3-unit dose. LPN 4 performed hand hygiene, donned clean gloves, cleansed R5's right lower abdomen with alcohol, and administered the insulin. During an interview on 01/14/26 at 12:39 PM, LPN 4 stated that she normally primed the insulin needle with 2 units of insulin prior to selecting the dose and administering it to the resident. LPN 4 stated that she forgot to prime the insulin pen needle prior to administering the insulin to R5. During an interview on 01/16/26 at 12:33 PM, the Director of Nursing (DON) stated nursing staff were to read the resident's medication order, verify the order on the medication card, and make sure the medication matched with the physician's order. The DON stated nursing staff should verify the right resident, right route, right time, right medication, right dose, and right date when administering medications to residents. The DON stated if that process were not followed, it could result in a medication error. The DON said she expected nursing staff to prime the needle of the insulin pen with 2 units of insulin before selecting the dose and observe the insulin come out of the needle before administering it to the resident. During an interview on 01/16/26 at 12:42 PM, the Administrator stated that she expected nursing staff to follow the DON's expectations related to medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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 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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure nail care was provided for 2 (Resident #7 and Resident #73) of 4 sampled residents reviewed for activities of daily living (ADLs). Review of the facility's undated policy titled ADL Policy indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, promote as much independent functionality as possible. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. The policy continued, 2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.1.Review of R7's Resident Face Sheet revealed the facility admitted R7 on 07/01/23. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of Parkinson's, type 2 diabetes mellitus, and neurocognitive disorder. Review of R7's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/25, revealed R7 had moderate impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated the resident was dependent on staff with all ADLs, including personal hygiene. Review of R7's Individual Service Plan included a problem statement dated 05/27/25 that indicated the resident required total assistance with ADL care. Interventions directed staff to provide and record assistance routinely and to notify a nurse of any decline noted, every shift. The Individual Service Plan also included a problem statement that indicated the resident had a decline in functional ability related to the diagnosis of Parkinson's disease. Interventions directed staff to assist the resident with activities of daily living as needed. During an observation on 01/12/26 at 9:33 AM, R7 was observed in their bed. The resident's fingernails on both hands were long. During an observation on 01/13/26 at 9:00 AM, R7 was observed in their bed. The resident's fingernails on both hands remained long and curved inward toward the resident's palms. During an observation on 01/14/26 at 10:20 AM, R7's fingernails on both hands remained long and were curved inward toward the resident's palms. During an observation on 01/14/26 at 2:00 PM, R7's fingernails on both hands remained long. During an interview on 01/14/26 at 2:08 PM, Registered Nurse (RN) #1 stated that when a resident received their baths/showers, that included trimming their fingernails. During an interview on 01/14/26 at 2:16 PM, Certified Nursing Assistant (CNA) #2 stated that trimming a resident's fingernails was part of daily ADL care provided to the resident. CNA #2 stated if the resident were diabetic then the nurses were responsible for trimming the resident's nails. CNA #2 stated she had not offered to trim Resident #7's fingernails, but she should have, because the resident was dependent on staff to assist them with their ADL care. During a concurrent interview and observation on 01/14/26 at 2:22 PM, CNA #2 confirmed R7's fingernails were too long and there was potential for the resident's fingernails to cause injury and infection if they continued to grow towards the palm of the resident's hands. During a concurrent observation and interview of R7's fingernails on 01/14/26 at 2:30 PM, RN #1 stated R7's fingernails had not been trimmed in a long time, and the fingernails were curved inward towards the resident's palms. RN #1 stated R7 was a diabetic, and a nurse should have trimmed their fingernails as part of their daily ADL care. During a concurrent observation and interview on 01/14/26 at 2:55 PM, the Administrator (ADM) observed R7's fingernails and stated that the resident's fingernails needed to be trimmed. The ADM said R7's fingernails were very long and if the resident's fingernails were not maintained/trimmed, there was potential for their fingernails to become embedded into the palms of their hands.2. A Resident Face Sheet indicated the facility admitted Resident #73 on 12/20/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of seizures, muscle spasm, and unspecified pain. Review of R73's annual MDS, with an ARD of 11/24/25, revealed R73 had moderate impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS indicated that the resident required substantial/maximal assistance from staff for personal hygiene. Review of R73's Individual Service Plan included a problem statement dated 12/10/24 that indicated the resident required assistance with activities of daily living (ADL) Care. Interventions directed staff to provide and record assistance routinely and to notify a nurse of any decline noted, every shift. During an observation on 01/12/26 at 9:24 AM, R73 was lying in their bed. The resident's fingernails on both hands were long and dirty. Resident #73's fingernails were uneven and with what appeared to be dried food under the resident's fingernails. During an observation on 01/13/26 at 9:56 AM, R73 was sitting in their medical recliner. The resident's fingernails on both hands remained long and dirty. During an observation on 01/14/26 at 10:30 AM, R73 was sitting in their medical recliner. The resident's fingernails on both hands remained long, extending past the end of the resident's fingertip. During an interview on 01/14/26 at 2:08 PM, RN #1 stated that when residents received their baths/showers, that included trimming their fingernails. RN #1 stated that diabetic residents were trimmed as needed by the nurses. During an interview on 01/14/26 at 2:17 PM, CNA #2 stated R73 did not refuse ADL care and was dependent on staff to trim their fingernails. CNA #2 stated R73 was non-verbal and unable to ask staff for ADL assistance, and she should have offered to trim the resident's fingernails. During a concurrent observation and interview on 01/14/26 at 2:20 PM, CNA #2 confirmed R73's fingernails were too long and needed to be trimmed. During a concurrent observation and interview on 01/14/26 at 2:35 PM, RN #1 observed R73's fingernails and stated that the resident's fingernails needed to be trimmed. During a concurrent observation and interview on 01/14/26 at 2:55 PM, the ADM stated R73 was dependent on staff for ADL care including nail care. The ADM stated R73's fingernails needed to be trimmed. During an interview on 01/15/26 at 10:32 AM, the Director of Nursing (DON) said she expected staff to trim the residents' fingernails. The DON stated that the nurses were responsible for trimming the fingernails of the diabetics. The DON stated her staff knew trimming fingernails was part of their daily ADL duties. During an interview on 01/15/26 at 11:05 AM, the ADM stated she expected the staff to offer to trim the residents' fingernails. The ADM stated the CNAs could trim non-diabetic residents' fingernails, but the nurses were responsible for trimming diabetic residents' fingernails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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 - 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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were secured in 1 of 3 medication carts when not attended by staff and failed to ensure proper disposal of medications during 2 of 5 observations during the medication administration task. Review of the facility's policy titled, Medications - Discarding and Destroying Medications, revised on 09/08/25, revealed, 9. Medications should be discarded in the sharps container by Nurses during medication pass as indicated. Review of the facility's undated policy titled, Medication Storage, revealed, a. All drugs and biologicals will be stored in locked compartments (i.e. [id est, that is], medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. The policy continued, c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. During an observation of medication administration on 01/14/26 at 8:08 AM, Registered Nurse (RN) 3 prepared medications for R44, gathered the medications, and entered the resident's room with the medications. RN 3 left the medication cart unlocked in the hallway. No other staff members were observed in the unit hallway at the time of the observation. RN 3 then exited the room with the cup of medications, at the surveyor's request, to review and discuss the medications. RN 3 reviewed R44's electronic medication administration record, physician order, and the resident's medication card for metformin. RN 3 stated R44's physician order for metformin was to administer 1,000 milligrams (mg) and she had prepared two 1,000 mg tablets. RN 3 removed the additional tablet of metformin 1,000 mg from the medication cup and disposed of it in the medication cart trash can. During a concurrent interview and observation on 01/14/26 at 8:18 AM, RN 3 stated she normally locked the medication cart whenever she walked away from the cart during medication administration and stated she forgot to lock the medication cart. RN 3 stated that if medications needed to be wasted, they would normally be disposed of in the sharps container on the medication cart. RN 3 stated that she disposed of the extra metformin 1,000 mg pill in the medication cart trash can. A cup of 10 medication pills was also observed in the medication cart trash can. RN 3 removed the cup of 10 medication pills from the medication cart trash can and stated that a resident refused their medications earlier that morning and she had disposed of those medications in the medication cart trash can. RN 3 identified the 10 medications in the cup as one tablet of montelukast 10 mg, two tablets of divalproex sodium 125 mg, two tablets of metoprolol tartrate 5 mg, one tablet of donepezil 10 mg, one tablet of trazodone 100 mg, two tablets of memantine 5 mg, and one tablet of simvastatin 20 mg. RN #3 stated that the medications should have been disposed of in the sharps container. ^ During an observation of medication administration on 01/14/26 at 9:01 AM, while preparing medications, RN 1 dropped an omeprazole 20 mg tablet and missed the medication cup. RN 1 picked the tablet up and disposed of it in the medication cart trash can. During an interview on 01/14/26 at 9:19 AM, RN 1 stated that she disposed of the wasted omeprazole 20 mg in the medication cart trash can. RN 1 stated that the wasted medication should have been disposed of in the sharps container on the medication cart. During an interview on 01/16/26 at 12:37 PM, the Director of Nursing (DON) said she expected nursing staff to dispose of wasted medications in the sharps container because nobody could access the medication. The DON stated it was not acceptable for nursing staff to dispose of medications in the medication cart trash can unless it was a cream or an ointment. The DON stated that if the medication cart was out of the nurse's eyesight, she expected the medication cart to be locked. During an interview on 01/16/26 at 12:41 PM, the Administrator (ADM) stated that she expected nursing staff to follow the facility policies and procedures related to medication storage and disposal. The ADM stated she expected nursing staff to ensure medications were kept in a secure and locked location.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425309	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Ronald E McNair Nursing & Rehabilitation Center	56 Genesis Drive Lake City, SC 29560

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. Based on observation, interview, record review, and facility policy review, the facility failed to maintain infection control practices by failing to ensure the proper implementation of Enhanced Barrier Precautions (EBP) for 1 Resident (R)7 of 5 residents observed during the medication administration task. Review of the facility's undated policy titled, Enhanced Barrier Precautions, revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. The policy revealed, b. We implement enhanced barrier precautions as indicated for residents with any of the following: i. Wounds (e.g. [exempli gratia, for example], chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wound, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted central catheter] lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO [multidrug-resistant organism]. Review of R7's Resident Face Sheet revealed the facility admitted R7 on 06/25/19. According to the Resident Face Sheet, the resident had a past medical history that included diagnosis of gastrostomy status. Review of R 7's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/25, revealed R7 had moderate impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS revealed the resident received nutrition through a feeding tube during the last seven days of the assessment look-back period. R7's Individual Service Plan included a problem statement, dated 05/27/25, that indicated the resident was on EBP related to the increased risk for infection due to gastric feeding tube, chronic diagnoses that increase risk, and frequent antibiotic use related to aspiration pneumonia and urinary tract infection. Interventions directed staff to use EBP when performing high-contact resident care activities and for residents who met criteria for the use of EBP (initiated 05/27/25). During an observation of medication administration on 01/14/26 at 9:36 AM, Registered Nurse (RN) 1 removed nine medications from the medication cart, crushed the medications as needed, and placed each medication in a separate cup for administration to R7. A sign was observed on R7's door, which indicated that the resident was under EBP. The signage directed staff to wear gloves and a gown for high-contact resident care activities. RN 1 performed hand hygiene, donned clean gloves, and entered the resident's room. RN 1 did not don a gown prior to the procedure. RN 1 administered the medications to R7through the resident's gastrostomy tube. During an interview on 01/14/26 at 10:18 AM, RN 1 stated R7 was on EBP, and she should have donned a gown prior to administering the resident's medication. RN 1 stated that EBP was implemented for any residents who had an open area, such as a wound, gastrostomy tube, or urinary catheter. During an interview on 01/16/26 at 12:29 PM, the Director of Nursing (DON) stated that EBP was used as a protective measure due to the resident having an external device, such as a tracheostomy, gastrostomy tube, or urinary catheter. The DON stated that when facility staff provided care for residents on EBP, they should don the equipment that was listed on the signage posted on the resident's door. The DON stated she expected nursing staff to don the appropriate personal protective equipment when administering medications through a gastrostomy tube. During an interview on 01/16/26 at 12:43 PM, The Administrator stated that she expected nursing staff to follow the expectations of the DON regarding EBP.