STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235245	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brittany Manor	3615 East Ashman Street Midland, MI 48642

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #: 2808141, 2749047, and 2977070Based on interview and record review, the facility failed to 1.) ensure comprehensive nursing assessments were completed and 2.) identify and notify the provider of a change in condition for 2 residents (Resident #7 and #8) out of 3 residents reviewed for quality of care resulting in a delay in treatment, the worsening of symptoms, and hospitalization.Findings:Resident #7 (R7)Review of an admission Record revealed R7 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure and chronic obstructive pulmonary disease. Further review of the record revealed R7 did not receive hospice services.During an interview on 04/13/2026 at 10:37 AM, Responsible Party (RP) J reported that at 5:00 AM on 3/22/2026 a facility nurse informed her R7's oxygen level had dropped down into the 80's and R7 was diaphoretic (sweaty) and was given supplemental oxygen. Wen RP J called to check on R7 an hour and a half later, the nurse indicated R7 had not been reassessed, and no additional orders were requested because R7 was a DNR and on Hospice. RP J had to clarify with the nurse that DNR did NOT mean do not treat and that R7 was NOT on Hospice but Palliative Care which are not the same thing. (Palliative care is specialized medical care focusing on relieving symptoms while incorporating curative treatments. Hospice care focuses on comfort and quality of life while ceasing curative treatments). RP J reported that it wasn't until she reached the Director of Nursing (DON) to report the nurse's dismissal of R7's change in condition was R7 ordered bloodwork, a urinalysis, an EKG (electrocardiogram, used to assess the heart's electrical function and rhythm), and a chest x-ray. The chest x-ray was obtained and results reported to the facility several hours later which showed R7 had a pleural effusion (fluid buildup in the lungs). R7's provider ordered a diuretic (Lasix) to be given IM (intramuscularly) and undergo outpatient thoracentesis (removal of fluid or air in the plural spaces around the lung, to improve breathing and identify the root cause of the buildup) without ever physically evaluating R7. During an interview on 04/14/2026 at 12:20 PM, Nursing Home Administrator (NHA) reported that when a DNR form was completed there was no specification for the type of treatment to be administered (antibiotic therapy, hospitalization, surgical interventions, etc). NHA reported that the facility treats the resident and/or informs the family and allows them to make the decision for treatment/hospitalization at the time of a change in condition.Review of R7's Palliative Care Progress Note dated 4/8/26 revealed, Her (R7's) care goals have been discussed a lot with her and her daughter, who is her legal guardian. They want aggressive treatment for conditions that can be reversed and hospitalizations if needed .Review of R7's Care Plan initiated on 11/5/24 revealed, (R7) is at risk for complications r/t (related to) diagnosis of Congestive Heart Failure .Observe & report to MD (medical doctor) PRN (as needed) any s/sx (signs or symptoms) of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea (shortness of breath when lying down), weakness and/or fatigue, increased heart rate (Tachycardia), lethargy or disorientation .Obtain weight as ordered .Review of R7's Heart Failure Clinic (HFC) handwritten consultation report dated 3/4/26 revealed, Heart failure follow up. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Euvolemic (balanced/normal) on exam. No cardiac complaints. Labs stable. No changes needed from a cardiac standpoint. The HFC printed report revealed, .weight relatively stable between 164-166 pounds. Dry weight approximately 164-166 lbs (pounds). R7's weight on 3/4/26 was 163 pounds.Review of R7's Order Summary dated 8/22/25 revealed, Weigh every morning , if there is a weight gain of > (greater than) 2 lbs in one day or >5 lbs in one week , call HFC clinic.or fax weight log to HFC.Review of R7's Weight Summary (pounds) revealed:3/16/2026 163.13/17/2026 162.8No weight 3/183/19/2026 172.43/20/2026 171.03/21/2026 169.83/22/2026 170.03/23/2026 171.2(8.1 pounds in 1 week)Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Daily weights are an important indicator of fluid status. Each kilogram (2.2 lb) of weight gained or lost overnight is equal to 1 L of fluid retained or lost.Weigh patients with heart failure daily. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1059). Elsevier Health Sciences. Kindle Edition.Review of R7's Electronic Medical Record (EMR) revealed no documentation that the facility provider or the HFC were notified of R7's weight gain per the provider order.Review of R7's Order Summary dated 11/2/26 revealed, oxygen at 2 liters per minutes for pulse OX below 90% every day and night shift for pulse ox less than 90%.Review of R7's Oxygen Saturation Summary revealed:3/16/2026 06:35 AM 85.0% Room Air3/19/2026 06:16 AM 74.0% Room Air3/22/2026 12:00 AM (SBAR) 84.0% Room Air3/22/2026 04:42 AM 94.0% @ 3 L/MinReview of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Vital Signs Acceptable Ranges for Adults. Pulse oximetry (SpO2) Normal: SpO2 ˆ95% . Pulse 60 to 100.beats/min, strong and regular.Review of R7's EMR revealed no documentation that the facility provider was notified of the abnormal low oxygen saturation level on 3/16/26 or 3/19/26Review of R7's Nurses Note dated 3/22/2026 at 04:47 AM revealed, Patient desaturation this shift down to 84% on room air. Put on oxygen at 3 lpm (liters per minute). SPO2 94% on 3 lpm of oxygen. Vitals as follows: BP (blood pressure) 159/83, (temperature) 98.2, Pulse 116. Patient is DNR and is on palliative care .Notifying Hospice for further instruction for cared (sic). (R7's order was to apply oxygen at 2 lpm if needed.)Review of R7's SBAR Change in Condition revealed, Other change in condition: Drop in oxygen saturation to 84% on room air. Elevated pulse of 116. Elevated RR (respiratory rate) 22 Temp 98.2, BP 159/83. Applied oxygen at 3 liter per minute SPO2 up to 94%. Patient is calmy (clammy) at this time. Per patient's statement she feels okay.Respiratory Evaluation: Not clinically applicable to the change in condition being reported. 5. Cardiovascular Evaluation: Not clinically applicable to the change in condition being reported .Primary Care Clinician Notified: Yes Date: 03/22/2026 Time: 12:00 AM .Notified (name omitted) Palliative Care at this time . Name of Family/Health Care Agent Notified: (RP J) Date: 03/22/2026 Time: 5:00 AM. Confirming a cardiac and respiratory assessment were not completed and the facility provider was not notified at the time of R7's change of condition.Review of R7's Nurses Note dated 3/22/2026 at 05:10 AM revealed, Notified (name omitted) on call (facility) Provider for direction .Awaiting call back from (name omitted) Palliative Care at this time. Change in Condition completed. Concern: Wounds with Vital with possible sepsis indicators.Review of R7's Nurses Note dated 3/22/2026 at 05:25 AM revealed, Per (name omitted) Palliative continue to monitor patient for pain and await orders from on-call provider.Review of R7's Nurses Note dated 3/22/2026 at 10:33 AM revealed, The writer was contacted by DON to process CBC (complete blood count), CMP (comprehensive metabolic panel), Urine analysis and C&S (culture and sensitivity) if indicated. RN (registered nurse) drew blood work and did in and out to collect urine sample, both will be delivered to (name omitted) ER (emergency room).During an interview on 4/14/26 at 11:45 AM, the DON reported R7's laboratory and diagnostic tests were generated from the facility's Sepsis Protocol and were not ordered by the facility provider. The Sepsis Protocol included a BMP (basic metabolic panel), blood culture, CBC, lactate level, UA and culture, and chest xray. An ECG was not part of the order set.Review of R7's Nurses Note dated 3/22/2026 at 2:16 PM revealed Lab results are faxed to (medical doctor) for review. Results are reviewed by (medical doctor), no new orders are given. DON is aware and will update resident's daughter (RP J) and at 2:24 PM, Chest xray results are faxed to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(medical doctor) for review.Review of R7's Provider Communication dated 3/22/26 (no time) revealed a fax with laboratory/diagnostic results (resulted on 3/22/26 at 1:00 PM) and the following handwritten note, Please review as per daughter's request.Review of R7's Provider Communication dated 3/22/26 (unknown time) revealed a fax with laboratory/diagnostic results and the following handwritten note by the provider revealed, Reviewed (labs), no new orders. Is there a special concern from her? Indicating the facility provider had not been made aware of R7's respiratory symptoms/change in condition or need for laboratory/diagnostic testing.Review of R7's Provider Communication dated 3/22/26 at 4:21 PM revealed a fax with laboratory/diagnostic results and the following handwritten note by the nurse, .Resident's SaO2 (low) 84% during the night. Resident is put on oxygen via nasal cannula in am. As per report from night nurse, resident was diaphoretic, During the day today resident is more lethargic & tired than her baseline. As per primary nurse, chest is clear. I am not a primary nurse of this resident today & I was requested by DON to do CBC, CMP, UA, Chest x-ray, & ECG (ECG will be done tomorrow).Review of R7's Nurses Note dated 3/22/2026 at 5:14 PM revealed, Chest xray and lab results refaxed to MD x2. Waiting for response from MD. DON is made aware.Review of R7's Provider Communication dated 3/22/26 (no time) which revealed, Lasix 40 mg (IM) twice a day for 2 days and monitor oxygen level if she drops oxygen below 90% please let me know. We may have to transfer her to the emergency room.Review of R7's Nurses Note dated 3/22/2026 at 6:16 PM revealed, Received order from (medical doctor) .Will continue to monitor oxygen level if resident drops oxygen below 90% and notify MD on call. May have to transfer resident to emergency room.Review of R7's Oxygen Saturation Summary revealed an oxygen assessment on 3/22/26 at 6:12 PM. R7's oxygen level was not assessed again until 3/23/26 at 6:35 AM.Review of R7's EMR revealed no documentation of any comprehensive or focused respiratory/cardiac assessments from the time of symptom onset until the time paramedics arrived on 3/23/26 at 10:14 AM. There was no documentation on R7's condition throughout the night and into the morning of 3/23/26 or of the date, time, or rationale for her transfer to the hospital.During an interview on 04/14/2026 at 1:10 PM, the DON confirmed there was no documentation related to R7's transfer to the hospital and her condition on 3/23/26.Review of the EMS (Emergency Medical Services) Report dated 3/23/26 revealed, The patient is an [AGE] year-old female with a medical history of congestive heart failure, chronic obstructive pulmonary disease, hypertension, and type 2 diabetes .The patient reports experiencing difficulty breathing, which began on March 22, 2026 at 1600 (4:00 PM) and has persisted for one day .ECG shows pt is in atrial fibrillation. Per her medical record this is a new onset. The patient presents with shortness of breath as the primary impression.Upon assessment, lung sounds are decreased in the left upper and lower chest areas, while no abnormalities are noted in the right upper and lower chest areas. R7 was transported to the hospital on 3/23/26 at 10:32 AM.Review of R7's emergency room Report dated 3/23/26 revealed, History of Present Illness-This is an [AGE] year-old female with a history of dementia, COPD, congestive heart failure, and new onset atrial fibrillation presenting via EMS with dyspnea for several days. She does not typically use home oxygen but has it available at her facility and is currently requiring 3 L nasal cannula. She received intramuscular Lasix yesterday. The patient is not on any anticoagulation. She is accompanied by her daughter, who is her guardian. Earlier this week, the patient was placed on supplemental oxygen at her facility due to difficulty breathing. Yesterday morning, she experienced a drop in oxygen saturation into the 80s, accompanied by clamminess and an increased heart rate. She did not report any pain but stated she did not feel well and was experiencing difficulty with respirations. After being placed on oxygen, her saturation improved to the 90s and she was reportedly resting comfortably in bed. A chest x-ray performed between 3:00 and 4:00 PM yesterday showed a moderate left pleural effusion. An EKG was not performed as the facility was awaiting an outside company. The patient is followed by clinicians at the CHF clinic, with her last visit approximately one week ago. Following the identification of the pleural effusion, intramuscular Lasix was administered and an outpatient thoracentesis was scheduled, but her daughter felt she was not in suitable condition for outpatient (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	by the provider. Treatment changes, laboratory and diagnostic testing, and oversite was conducted by the facility provider.Review of R8's Physician Communication dated 3/4/26 may we obtain an (sic) wound culture & sensitivity r/t foul odor and copious exudate to sacrum wound.Review of R8's Order Summary dated 3/4/26 revealed, Obtain culture and Sensitivity to sacrum wound R/T foul odor and copious amounts of drainage.Review of R8's Order Summary revealed no initiation of the Sepsis Protocol-Order Set.Review of R8's Laboratory Services revealed that the wound culture was collected on 3/5/26.On 3/6/26 at 5:06 PM a preliminary result revealed MODERATE WBCs SEEN, MANY GRAM NEGATIVE RODS, MANY GRAM POSITIVE RODS, MODERATE GRAM NEGATIVE COCCI, and Pending final culture.On 3/7/26 at 12:54 PM a preliminary result revealed MODERATE WBCs SEEN, MANY GRAM NEGATIVE RODS, MANY GRAM POSITIVE RODS, MODERATE GRAM NEGATIVE COCCI, and culture in progress.On 3/8/26 at 11:14 AM a preliminary result revealed MODERATE WBCs SEEN, MANY GRAM NEGATIVE RODS, MANY GRAM POSITIVE RODS, MODERATE GRAM NEGATIVE COCCI, and culture result MODERATE SKIN FLORA.On 3/11/26 at 11:20 AM a final result revealed MODERATE WBCs SEEN, MANY GRAM NEGATIVE RODS, MANY GRAM POSITIVE RODS, MODERATE GRAM NEGATIVE COCCI, culture result MODERATE SKIN FLORA, and FEW MIXED ANAEROBES.During an interview on 04/14/2026 at 1:10 PM, the DON reported that the facility provider did not review preliminary culture results and would review only the final result to determine the next course of action. The DON reported that the final result of R8's wound culture was resulted/printed off following R8's transfer to the hospital on 3/11/26.Review of R8's EMR revealed no documentation that the facility provider assessed R8 following the notification of the deterioration of the wound. There were no other laboratory or diagnostic studies/tests ordered to rule out systemic infection despite the documentation of the presence of infection: increased foul odor, non-healing, deteriorating, and copious exudate. There was no documentation that a risk versus benefit assessment had been completed to determine if the use of empiric antibiotics to prevent systemic infection was necessary, despite the availability of the preliminary culture results and the current use of prophylactic antibiotics for his wounds. There were no additional wound assessments completed prior to hospital transfer on 3/11/26 to identify the further deterioration of R8's wounds.Review of R8's Dietary Note dated 2/26/2026 revealed, Some decline in intake is noted since last review. Resident currently being treated for oral thrush; likely plays role in intact/wt loss.Review of R8's EMR revealed no documentation of interventions implemented to promote fluid intake following the identified concern of thrush.Review of R8's Skin Check dated 3/7/26 revealed Skin Baseline-Skin warm & dry, skin color WNL, turgor normal. Not Met . (This assessment excludes R8's known wounds/pressure injuries). Indicating a change in R8's skin baseline and potential dehydration.Review of R8's EMR revealed no documentation that a comprehensive assessment was completed or that the physician was notified of the change in R8's skin baseline.Review of R8's Nurses Notes dated 3/11/2026 revealed, Resident was transferred to the emergency department per request of daughter, who is the resident's POA (power of attorney), after presenting to the facility and expressing concern that the resident may be experiencing pain related to his wounds and requesting further evaluation. Resident is followed by wound care nurse weekly on Wednesdays, with daily and PRN wound treatments performed by nursing staff per physician orders. Vital signs obtained prior to transfer were within normal limits for the resident with no acute changes noted. Per POA request, resident was transferred to the emergency department for further evaluation.Review of R8's EMS Report dated 3/11/26 revealed the paramedics arrived to the facility at 9:07 AM.Once in the ambulance, vitals were found to be unstable. Blood pressure and O2 saturation were quite low. Monitor showed Afib controlled.Review of R8's emergency room Notes dated 3/11/26 at 9:50 AM revealed, .Patient has pending wound cultures, collected 3/5/26, which show many Gram positive and negative rods, moderate gram negative cocci, with few mixed anaerobes.Micro: Moderate skin flora, mixed anaerobes.As the source of his infection appears to be his decubitus ulcer patient was given Zosyn and vancomycin IV (intravenously) (Treatment initiated prior to the final result of the wound culture (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brittany Manor	3615 East Ashman Street Midland, MI 48642

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 0684 Level of Harm - Actual harm Residents Affected - Few	(Nurses) are accountable to report any significant changes in your patient's condition in a timely manner to the health care provider and to document these changes in the patient's electronic health record (EHR). Timely and truthful documentation is important to provide communication necessary among health care team members. Documentation must be accurate. In the EHR, ensure that assessments are complete and consistent with those completed previously. Ensure that you conduct your own assessment rather than copying the previous assessment in the patient's medical record to ensure accuracy of information.Notify other team members in a timely manner when changes in condition are triggered within the record. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2748888. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 8 sampled residents (R4). Findings include:A review of R3's admission Record, dated 4/14/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's admission Record revealed they had multiple diagnoses that included encephalopathy, anxiety, dementia, and repeated falls. A review of R3's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/3/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 6 which revealed R3 was severely cognitively impaired. A review of R4's admission Record, dated 4/13/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R4's admission Record revealed they had multiple diagnoses that included dementia and anxiety. A review of R4's MDS, dated [DATE], revealed a BIMS score of 7 which revealed R4 was severely cognitively impaired. A review of the Incident and Accident Investigation Form, dated 1/29/26, revealed on 1/28/26 at 7:44 PM, staff near the nurse's station heard a banging noise. When they went to investigate they saw R3 lying on the floor of his room with blood coming from his nose. They also observed R4 standing with his left fist balled up. Both residents were making threatening statements to each other when staff intervened. The Incident and Accident Investigation Form also revealed that R3 stated R4 walked up to him and struck him causing R3 to fall to the floor. R4 did not recall the incident when interviewed soon after the incident occurred. A review of R4's electronic medical record (EMR), dated 12/28/25 to 2/28/26, failed to reveal any mention that R4 had been involved in an incident with another resident (R3). During an interview on 4/14/26 at 8:00 AM, Nurse Manager (NM) D stated when there is an incident between two residents, even if it was not witnessed (e.g., a resident is found on another resident's room floor bleeding) she would document it in a progress note. She stated, That's just basic nursing. You document what happened. During an interview on 4/14/26 at 8:15 AM, Licensed Practical Nurse (LPN) E, stated when there is an incident between residents, or a suspected incident, she would make sure the residents are safe. She stated she would do skin assessments on the residents and treat any wounds, if applicable. LPN E further stated she would contact the Nursing Home Administrator (NHA) right away because it would need to be reported [to the State Survey Agency]. She also stated she would also contact the physician. LPN E finally stated she would do vitals (blood pressure, heart rate, respiratory rate) and document the incident in a progress note. During an interview on 4/14/26 at 11:20 AM, the NHA was notified that the surveyor could not locate any progress notes or other notations in R4's medical records that would indicate an incident happened between him and another resident (R3) on 1/28/26. The NHA stated she would get with nursing and see if there was anything noted. During an interview on 4/14/26 at 12:15 PM, the NHA stated she looked into the concern that R4 was missing notes in his medical records about the incident on 1/28/26. She stated they had completed a risk management form, however that was an internal document and not a part of the resident's medical record. The NHA stated there was not anything documented in R4's medical record because R3 was the one with the bloody nose and R4 was not injured. She stated they had only monitored R3's bloody nose and had not monitored R4 post-incident. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25). Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient. Patient responses and outcomes, including changes in the patient's status; and Plans of care that reflect the social and cultural framework of the patient. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).