

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER Brittany Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medication according to professional standards of practice for 2 residents (R89 and R94) of the 6 residents reviewed. Findings include:R89 Review of an admission Record revealed R89 originally admitted to the facility on [DATE] with pertinent diagnoses which included acute cholecystitis (inflammation of the gall bladder), muscle wasting, and urinary tract infections. Review of R89's Physician's Orders revealed an active order started 4/8/2026 for one midodrine (used to treat low blood pressure) 10 milligram (mg) tablet by mouth every 8 hours as needed for hypotension (low blood pressure) and to administer to R89 when SBP (systolic blood pressure) was less than 100. Review of R89's Blood Pressure Summary and Medication Administration Record (MAR) revealed the following blood pressures readings with no midodrine administered: 4/9/2026 at 7:29 AM -92/48 millimeters of mercury(mmHg) 4/9/2026 at 6:46 PM -95/45 mmHg 4/12/2026 at 6:22 PM -91/41 mmHg 4/13/2026 at 11:04 AM -99/54 mmHg 4/14/2026 at 6:23 PM &ndash; 97/52 mmHg 4/23/2026 at 6:13 PM &ndash; 98/51 mmHg 4/24/2026 at 6:35 PM &ndash; 98/48 mmHg 4/26/2026 at 7:16 PM &ndash; 98/48 mmHg In an interview and record review on 5/12/2026 at 12:01 PM, Unit Manager (UM) C reported that the midodrine 10 mg tablet was not administered for the eight blood pressures documented when the systolic blood pressure was less than 100 following the active date of the midodrine order of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 235245	If continuation sheet Page 1 of 13

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/8/2026. UM C reported that the midodrine order was not followed per physician's order. Review of facility policy/procedure Medication Administration revised on 10/17/2023, revealed . Medications are administered in accordance with written orders of the attending physician. Review of the medical record reflected R94 originally admitted to the facility 12/28/2022 with pertinent diagnoses that included Diabetes Mellitus and Chronic Pain Syndrome. Review of the Minimum Data Set (MDS) for R94 dated 2/24/2026 reflected a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the Resident was cognitively intact. Review of the Doctor's Orders for R94 revealed a current order for Humalog Kwikpen per sliding scale before meals following Fasting Blood sugar (FBS) scheduled for 7:00 AM. And Lantus (insulin) 15 units one time a day. Additionally, a Doctor's Order for a Lidocaine External Patch 4% to be applied to Upper Right arm topically one time a day. Lastly, a current order for Biofreeze external gel 10% as needed was initiated 2/21/2026. On 5/13/2026 at 8:02 AM at the medication cart with Registered Nurse (RN) L an observation and interview were conducted. R94 approached the medication cart in a wheelchair and requested the Lidocaine patch be applied to her right upper arm as she was in pain. RN L checked the medication cart and reported no patch was available. RN L proceeded to check the Resident's blood sugar without donning gloves or sanitizing the hands. R94 reported she had eaten breakfast in her room earlier. The test reflected a blood sugar result of 192 milligrams per deciliter which the sliding scale called for 2 units of insulin. RN L then administrated both insulins (the to scale and long-acting insulins) by exposing the Residents abdomen while in the hall with other staff and residents about. RN L did not wear gloves during the administration of insulin but held an ongoing conversation with the Resident that the insurance company would not send the lidocaine patch until the last minute. On 5/13/2026 at 11:18 AM an interview was conducted with R94 in her room. R94 reported that she did not have a Lidocaine patch applied and that RN L did not offer her other pain medication. R94 reported pain in her right upper arm at a current pain level of 8 on a 1 to 10 pain scale. On 5/13/2026 at 11:48 AM RN L reported that R94 refused the Lidocaine patch and took Biofreeze (a topical analgesic) instead. RN L reported he had put in an order for the Lidocaine patch and had spoken to the Medical Provider. RN L was asked about the checking of a fasting blood sugar level and administration of to scale insulin after a resident had eaten. RN L indicated that the assigned Hall had approximately twenty residents on insulin and that it was physically impossible to meet that Doctor ordered standard. Review of R94's Medication Administration Record (MAR) for May 2026 reflected that the Lidocaine Patch 4% had been signed out by RN L as administered. The MAR did not reflect that Biofreeze had been applied. Review of the Progress Notes for R94 did not reflect an entry on 5/13/2026 by RN L regarding a conversation with the Medial Provider of the Lidocaine patch or the complaint of pain by R94. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 adherence to standard infection control practices during medication administration for one Resident (R24) and failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). Findings:Medication Administration Review of the medical record reflected R24 originally admitted to the facility 8/27/2025 with diagnoses that included congestive heart failure. Review of the Doctor's Orders for R24 reflected the Resident received medications daily from facility staff. The policy provided by the facility titled Medication Administration last revised 10/17/2023 was reviewed. The policy reflected Procedure, 1. Follow infection control practices. A. Perform hand hygiene prior to medication preparation for each medication pass. c. Place medications into a soufflé or medication cup without touching the inside of the cup. A. If medications come into contact with the bare hands of the nurse/QA med tech, or with the cart, the medication should be disposed of per policy and new medications obtained. On 5/13/2026 at 7:40 AM an observation was conducted with Registered Nurse (RN) L during a medication administration. RN L was observed setting up medications for R24 by retrieving stock and prescriptions medications by placing them in his bare hands before placing them in a medication cup. RN L was observed opening a stock medication container of aspirin 81 milligram (mg) and pouring into a bare hand several aspirin tablets, selecting one pill, pouring the unneeded doses from the bare hand back into the stock (community used) container and placing the selected tablet into the medication cup bare-handed. This was repeated with the stock magnesium oxide 400 mg and Vitamin D3 oral capsules. Other prescribed medications that were directly deposited into the hand of RN L after being removed from the package before being placed in the medication cup included: pyridostigmine bromide 60, Lyrica capsule 100 mg, linaclotide oral capsule 72 microgram, and Lexapro oral tablet 5 mg. The medications were then administered to R24. On 5/13/2026 at 11:48 AM an interview was conducted with RN L. RN L was asked about touching resident medications with his bare hands from the container or pack and placing the medication in the cup. RN L stated that's usually what I do, is that not right? I guess I do do that. On 5/13/2026 at 12:03 PM an interview was conducted with RN Unit Manager (UM) C in his office. RN UM C was informed of the observation of the method RN L implemented for setting up oral resident medications. RN UM C indicated this method was not consistent with facility policy or standards of practice. No additional information was provided as of survey exit. Water Management On 05/11/2026 at 1:34PM, during review of the water management plan, it was discovered there was (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no documentation of a water management team meeting, water management plan risk assessment or review of policy or assessment for 2025 or 2026. On 05/11/2026 at 1:40PM, a copy of the 2025 and 2026 documents regarding the water management team meeting agenda or minutes and review of the risk assessment was requested from Maintenance Director (MD) I On 05/11/2026 at 3:25PM, observed in the bathing room on [NAME] hallway, a spa tub surrounded by stored bathing chairs and bathing beds. When asked, MD I was not sure if the spa tub was in use or not. MD I indicated the spa tub is currently not on the flushing schedule. On 05/11/2026 at 3:27PM Certified Nursing Assistant (CNA) J was asked if they knew if the spa tub was working, CNA J stated that they had worked at the facility for over a year and have never seen the tub in operation. CNA J did not know if lack of use was because the tub was broken or if residents chose not to use it. On 05/12/2026 at 8:00AM, during interview with MD I regarding the documents that were requested on 05/11/2026, MD I stated that they were unable to locate water management team meeting minutes, agenda or completed risk assessment forms for 2025. MD I stated they have been with facility for two months and the former Maintenance Director did not leave documentation of the requested items for 2025. On 05/12/2026 at 12:00 PM, Nursing Home Administrator (NHA) indicated that the water management team meeting and risk assessment had not been completed for the current year.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dignified care was provided for 1 resident (R72) of 3 residents reviewed for dignity. Findings include: Review of an admission Record revealed R72 originally admitted to the facility on [DATE] with pertinent diagnoses which included absence of right leg below knee amputation, chronic congestive heart failure, and muscle wasting and atrophy (shrinking). Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R72, with a reference date of 4/28/2026 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R72 was cognitively intact. In an interview on 5/11/26 at 11:47 AM, R72 reported that she waited for assistance to the bathroom for over an hour early this morning until a certified nursing assistant came in at 2am and had been incontinent in her bed soaking through her brief, pad and sheet requiring a total bed change. R72 stated that made her feel embarrassed. R72 reported that same occurrence happened at least weekly. Review of 72's Urinary Continence documentation dated 4/29/26 through 5/11/26 revealed that R72 had been incontinent 20 times out of 25 times continence was documented. Further documentation revealed Personal Hygiene documentation that R72 required moderate to complete assistance with personal hygiene 22 times out of 26 times assistance had been documented. In an interview on 5/12/26 at 12:30 PM, the Director of Nursing (DON) reported that Sunday the facility had three call offs for certified nursing assistants for the evening shift in which all of the 3 shifts had been covered with other staff members except for a four-hour shift from 10pm to 2am. Review of a facility/procedure Resident Dignity & Personal Privacy, revised 3/28/2024, revealed .the facility provides care for residents in a manner that respects and enhances each resident dignity. staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth.		

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review the facility failed to promptly assess and treat a new skin concern for one resident (R1) of 3 residents reviewed for skin concerns. Findings include: Review of an admission Record revealed R1 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and chronic respiratory failure. In an observation and interview in R1's room on 5/11/2026 at 11:05 AM, Certified Nursing Assistant (CNA) D found a new wound on R1's right gluteal fold while performing incontinence care and reported she would notify nursing staff. Review of R1's Electronic Medical Record (EMR) on 5/12/26 revealed no assessment of his new right gluteal fold skin condition. In an interview on 5/12/2026 at 7:52 AM, Registered Nurse (RN) Wound Nurse C reported he had not been notified of R1's new wound identified the previous day and would investigate this. In an observation and interview on 5/12/2026 at 8:13 AM in R1's room, RN Wound Nurse C reported he had reviewed R1's chart and his new wound had not been assessed by nursing staff on 5/11/2026 when it was identified by the CNA. RN Wound Nurse C assessed R1's wound and initiated a treatment plan. RN Wound Nurse C reported new wound concerns should be evaluated by nursing staff at the time they are identified and a treatment plan initiated. Review of R1's Electronic Medical Record (EMR) reflected that after being notified of the of the unreported new wound, RN Wound Nurse C documented an assessment of this on a Skin Check progress note. Review of R1's Skin Check progress note, dated 5/12/2026 at 10:50 AM, revealed .New skin issue. Right gluteal fold. Moisture associated skin damage (MASD). Wound acquired in house. Review of R1's Physician's Orders, started 5/12/2026, revealed .Right gluteal fold MASD: Clean area with soap and water, pat dry, apply barrier cream to affected area. every shift for MASD. In a telephone interview on 5/12/2026, CNA D reported she told Registered Nurse (RN) B about R1's new skin concern when she found it on 5/11/2026. In an interview on 5/12/2026 at 11:50 AM, RN B reported she was not notified of R1's new skin concern on 5/11/2026. RN B reported she would have contacted the medical provider and initiated a treatment plan had she been notified. In an interview on 5/12/2026 at 11:45 AM, the Director of Nursing (DON) reported nursing staff should immediately assess new skin concerns and initiate a treatment plan. Review of facility policy/procedure Skin Management, effective 1/28/2026, revealed .Residents with wound and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The licensed nurse will initiate documentation in the electronic health record, which includes a description of the skin impairment. The CNA. will report any new skin impairment to the licensed nurse that is identified during daily care.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up with pressure ulcer wound clinic recommendations for two residents (R3 and R4) of two residents reviewed for the treatment of pressure ulcers. Findings include: R3 Review of an admission Record revealed R3 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and muscle wasting. Review of R3's Physician's Orders revealed an order, started 5/1/2026 and still active 5/13/2026, .Right heel wound: Clean wound with wound cleanser, pat dry, apply xeroform to wound bed. Review of R3's community wound clinic right heel wound treatment recommendations, dated 5/5/2026, revealed .Cleanser: Dakin 0/125% . Primary dressing: Triple Helix Collagen Dressing. Secondary dressing: Xeroform Petrolatum gauze. Further review of the electronic medical record (EMR) revealed no indication these wound clinic recommendations were reviewed or initiated by facility staff. In an observation and interview on 5/13/2026 in R3's room, right heel dressing change was observed. Registered Nurse (RN) Wound Nurse C reported the current dressing order was for xeroform, but he planned to discuss updating the treatment order due to the progress of the wound. In an interview on 5/13/2026 at 9:29 AM, RN Wound Nurse C reported he was not aware of R3's 5/5/2026 right heel wound treatment recommendations and these recommendations had not been reviewed by facility clinical staff. RN Wound Nurse C reported wound clinic recommendations should be addressed by facility staff. R4 Review of an admission Record revealed R4 admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region and muscle wasting. Review of R4's EMR revealed community wound clinic sacral ulcer wound treatment recommendation dated 5/4/2026 which recommended to apply a pad of Prisma (or equivalent collagen) to the center of the wound bed, then black foam, for her VAC (negative pressure wound therapy) dressing. Further review of the EMR revealed no indication these wound clinic recommendations were reviewed or initiated by facility staff. Review of R4's Physician's Orders revealed an order, started 5/9/2026 and active 5/13/2026, to apply black foam/wound vac to wound bed, with no direction to use collagen under the black foam. In an interview on 5/12/2026 at 10:40 AM, RN Wound Nurse C reported he was not aware of R4's wound clinic treatment recommendations. RN Wound Nurse C reported he should have reviewed these recommendations when they were received by the facility and the recommended changes to the treatment plan should have been reviewed by the clinical team and medical provider. RN Wound Nurse C reported he was not sure why wound clinic recommendations were not being received by the clinical team, or why communication documentation was not being sent to the facility from the wound clinic when the resident returned from appointments. In an interview on 5/13/2026 at 9:20 AM, the DON reported she did not believe clinical staff were receiving wound clinic recommendations from medical records staff when they were faxed to the facility or they would have been followed up with. In an interview on 5/13/2026 at 11:00 AM, the DON reported wound clinic treatment recommendations should be addressed in real time and documented in the EMR. Review of facility policy/procedure Skin Management, revised 1/28/2026, revealed .Residents with wounds and/or pressure injury. are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The licensed nurse will notify the practitioner with any changes as needed.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate urinary catheter care for one resident (R4) of three residents reviewed for catheter care. Findings include: Review of an admission Record revealed R4 admitted to the facility on [DATE] with pertinent diagnoses which included chronic interstitial cystitis (bladder pain syndrome) and acute cystitis (bladder infection). Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R4, with a reference date of 3/30/2026 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R4 was cognitively intact. Review of a current incontinence Care Plan for R4, created 3/4/2025, revealed R4 was incontinent of bowel and staff were instructed to check her for incontinence and wash, rinse, and dry perineum after episodes of incontinence. Review of a current urinary catheter Care Plan for R4, created 2/26/2025, revealed R4 was at risk for urinary tract infection and instructed staff to cleanse her perineum front to back and provide catheter care per policy. In an interview on 5/11/2026 at 2:09 PM, R4 reported staff did not clean around her urinary catheter regularly. In an observation and interview on 5/12/2026 at 8:35 AM in R4's room, Certified Nursing Assistant (CNA) E performed catheter care for R4. R4 had not recently been incontinent of bowel and was complaining of burning down there. While cleaning around R4's urinary catheter, CNA E cleaned stool out of her vagina from in between her labia. Stool was visible on the washcloth as CNA E cleaned the perineum. CNA E reported the stool should not have been there and should have been cleaned the last time R4 had a bowel movement. R4 was not sure when she had her last bowel movement and reported it might have been the previous day. R4 stated, They never clean down there. R4 reported staff will leave stool when they find it on her, stating it's not much. R4 reported the burning sensation improved after CNA E cleaned her. In an interview on 5/12/2026 at 8:50 AM, Registered Nurse Unit Manager C reported stool should never be left on resident's skin. Review of facility policy/procedure Catheter Associated Urinary Tract Infection Prevention, effective 2/28/2025, revealed .Clean around the catheter insertion site daily with soap and water.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate assessments and monitoring were implemented for 1 resident with a PICC (Peripherally Inserted Central Catheter) (R45) out of 2 residents reviewed for PICC lines. Findings include: Review of an admission Record reflected R45 admitted to the facility with diagnoses that included Methicillin Resistant Staphylococcus Aureus (MRSA) infection as the cause of diseases classified elsewhere, Shiga toxin-producing Escherichia coli (E.Coli) as the cause of disease classified elsewhere, Pseudomonas (aeruginosa mallei pseudomallei) as the cause of diseases classified elsewhere, chronic osteomyelitis with draining sinus, left ankle and foot, non-pressure chronic ulcer of left ankle with muscle involvement, non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin. During an observation on 6/17/2026 at 8:36 AM, R45 was observed in her room, in bed. R45's PICC line was visible, a transparent dressing in place, dated 6/13/2026. R45's right arm did not show signs of infection or swelling. There was no drainage visible under the transparent dressing. During an interview on 6/17/2026 at 2:12 PM, Licensed Practical Nurse (LPN) A reported he was familiar with PICC line use and maintenance. LPN A reported that the PICC line should be measured weekly with dressing changes. LPN A said that the measurement obtained during the dressing change should match the measurement recorded by the previous nurse. During an interview and observation on 6/17/2016 at 2:23 PM, agency LPN H reported she was familiar with PICC lines and believed the PICC line should be measured daily. LPN H said she had administered an IV antibiotic to R45 that day but could not report the PICC measurement. LPN H obtained a paper ruler and measured R45's PICC line and reported the length of the PICC line was 11 cm. During an interview on 6/17/2026 at 2:56 PM, the Director of Nursing reported that if a resident is admitted with or received a PICC line while living at the facility, orders for the care and maintenance of the PICC line are selected in batches from the Electronic Medical Record (EMR) program. The DON said the PICC should be measured from the insertion point to the end of the hub weekly with the dressing change. If the measurements differ, the physician should be notified, and the licensed nurse would follow orders obtained after physician notification. The DON said she would refer to hospital records or to the cardiovascular consultation/insertion report for a baseline measurement. The DON reviewed the cardiovascular consultation notes for R45's PICC line insertion on 5/14/2026 and 5/22/2026 and could not determine what the baseline measurement would be. The DON reported it would be important to include the baseline measurement in the actual order so all the nurses were working from correct information. The DON reviewed the PICC line orders for R45 and could not explain why dressing changes were ordered on a different day than the PICC line measurement. Review of a Resident At Risk note dated 5/14/2026 reflected, (R45) Continues with wound care to left foot-lateral, heel and plantar, diabetic in nature. Areas are stable. Follows with wound clinic. Recently diagnosed with non-refractory osteomyelitis (a bone infection that successfully respond to standard treatment). Will be receiving a PICC line for IV (intravenous) abx (antibiotic) treatment. Interventions in place and ongoing. Review of Progress Notes dated 5/14/2026 - 5/15/2026 reflected a PICC line was placed in R45 on 5/14/2026; the placement was verified with a chest x-ray. On 5/15/2026 the chest x-ray results were reported and confirmed appropriate placement of the PICC line, ensuring safe use of the device. Review of R45's Medication Administration Record (MAR) for the month of May 2026 reflected the following orders:- Measure PICC catheter length every day shift every 7 day(s) for IV maintenance ordered by ID (Infectious Disease) -Start Date- 5/14/2026 -D/C Date- 6/11/2026. The MAR also included an as (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brittany Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 East Ashman Street Midland, MI 48642	
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed measurement order. Neither order specified what measurement was expected or what to do if the measurement deviates from an established baseline.- Change transparent dressing to PICC every day shift every 7 day(s) for IV maintenance - Start Date- 5/15/2026. The MAR also included a corresponding as needed dressing change order. Review of a Nurses Notes dated 5/15/2026 indicated, PICC lumen 3 cm (centimeters) .Review of an eMAR (electronic Medication Administration Record)- Medication Administration Note dated 5/16/2026 at 6:40 PM, reflected Changed CVA (Central Vein Access) dressing at this time. Due 5/15/26. Kit came in this AM (morning). Writer completed task at this time. Progress Notes leading up to this dressing change did not reflect the PICC dressing was compromised, and it is unclear why the dressing needed to be changed due to the PICC was originally placed on 5/14/26, two days prior. The note did not reflect a measurement of the PICC line. Review of another eMAR progress note, dated 5/16/2026 at 7:05 PM reflected Measurements 6 cm to lumen and 6 cm to entrance total length 12 cm. This measurement conflicted with the measurement recorded in the Nurses Notes dated 5/15/2026 by 9 cm.Review of Nurses Notes from 5/17/2026 and 5/18/2026 reflect the same measurements as were obtained and documented on 5/16/2026 (12 cm).Review of a Nurses Note dated 5/21/2026 reflected, Medication held due to loss of IV access. Provider (name of provider) and cardiovascular team notified. The note does not include a measurement of the PICC line, nor does it include a physical assessment of R45's PICC site. Review of a Peripherally Inserted Central Catheter (PICC)/Midline Insertion Documentation consultation form dated 5/22/2026 reflected a specialty nurse from an outside company replaced R45's PICC line. Notes on the consultation form reflected Pt. (patient, R45) w/ (with) PICC line, not flushing & partially dislodged on assessment, replacement recommended. Staff nurse removed PICC line RUE (right upper extremity) - new PICC inserted, confirmed tip location w/ECG (electrocardiogram) & OK to use. Please change dressing Q (every) 7 days or PRN (as needed) if loose/moisture present. Please no BP (Blood Pressure) or tourniquets on R (right) (even by wrist) while line in indwelling.Review of R45's May 2026 MAR did not reveal orders had been discontinued after the removal of the PICC from R45's RUE and a new PICC was placed pertained to the PICC in R45's left upper extremity. Review of an eMAR - Medication Administration Note dated 6/11/2026 at 9:04 AM reflected, 8.1 cm. Prior to this documentation, there was not a recorded PICC line measurement on the record from the date the new PICC was inserted on 5/22/2016. No additional measurements were noted in the clinical record from 6/11/2026 - 6/17/2026.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Peripherally inserted central catheter (PICC) lines enter a peripheral arm vein and extend through the venous system to the superior vena cava, where they end. Other central lines enter a central vein such as the subclavian or jugular vein or are tunneled through subcutaneous tissue before entering a central vein. Central lines are more effective than peripheral catheters for administering large volumes of fluid, PN (parenteral nutrition), and medications or fluids that irritate veins. Proper care of central line insertion sites is critical for the prevention of central line-associated bloodstream infection (CLABSI) (Box 42.6) (Centers for Disease Control and Prevention [CDC], 2020; [NAME] et al., 2021; [NAME] et al., 2019). Nurses and health care providers must have specialized education regarding care of CVCs (Central Venous Catheters) and implanted infusion ports (The Joint Commission [TJC], 2021b). Nursing responsibilities for central lines include careful monitoring, flushing to keep the line patent, and site care and dressing changes to prevent CLABSIs ([NAME] et al., 2021; [NAME] and [NAME], 2019). [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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to adhere to principles of antibiotic stewardship for 1 resident with a fungal infection (R24), out of 15 residents reviewed. Findings Include: Review of an admission Record reflected R24 admitted to the facility with diagnoses that included urinary tract infection, sepsis, a body mass index (BMI) of 39.0-39.9 (severe obesity), and type 2 diabetes. R24 was their own responsible party. Review of a late entry Nurse Practitioner Note dated 5/14/2026 reflected R24 had been seen due to itching to labia . No redness, discharge or burning with urination. Review of a Nurses Notes dated 5/14/2026 at 4:07 PM reflected the Nurse Practitioner (NP) had assessed R24 that day and ordered Miconazole 2% cream (an over the counter and prescription antifungal medication used to treat vaginal yeast infections) BID (twice a day) x 2 weeks for vaginal itching. Review of R24's May 2026 Medication Administration Record (MAR) reflected the order Miconazole 7 Vaginal Cream 2% (Miconazole Nitrate Vaginal) Insert 1 dose vaginally every day and night shift for vaginal itching for 14 days - Start Date - 5/14/2026. Further review of the MAR reflected that the medication was NOT given as ordered on the following dates:-5/14/26 - medication not given as evidenced by (AEB) the number 5 (The number 5 is a chart code for Hold/See Nurse Note) on the MAR. The eMAR (electronic MAR)-Medication Administration Note reflected the medication was on order. -5/15/26 - medication not given in the evening, the MAR for this date and time is blank; -5/16/26 - medication not given all day AEB the number 5 on the MAR for both doses. The corresponding eMAR note reflected not available, awaiting pharmacy delivery, and Med not available. -5/17/26 - medication not given in the evening AEB the number 5 on the MAR. The eMAR note reflected med not available. -5/18/26 - medication not given in the morning, the MAR for this date and time is blank; -5/21/26 - medication not given in the evening AEB the number 5 on the MAR. There was NOT an eMAR progress note to explain why the medication was not given. -5/22/26 - medication not given in the evening AEB the number 5 on the MAR. The corresponding eMAR note reflected med not available. -5/25/26 - medication not given in the morning, the MAR on this date and time is blank. Further review of all available Progress Notes for the duration of the prescribed treatment for R24's vaginal itching did not indicate the physician had been notified of the medication unavailability. The Progress Notes did not reflect R24 had been assessed for ongoing vaginal itching, discomfort and/or worsening of symptoms due to multiple missed doses of medication and incomplete duration of therapy. There was no documentation indicating R24 refused the medication administration or was not available for the medication administration. During an interview on 6/17/2026 at 2:23 PM, the Director of Nursing (DON) reviewed the clinical record for R24 and confirmed the Miconazole Vaginal Cream 2% was not given as ordered. The DON said she did not know whether the antifungal was house stock or if pharmacy would have to send it. The DON reported she did not know how a dose of the medication could have been given in the morning on 5/15/2026 if the medication was not available and could not explain the sporadic administration of the prescribed treatment for R24's vaginal yeast infection. According to the DON, once the medication became available, the order should have been modified to ensure R24 received the prescribed vaginal cream for the entire 14 days of the course of treatment, which was not done. The DON said that typically the Infection Control Nurse and/or Unit Manager would monitor antibiotic/antifungal orders.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and maintain education of pneumococcal immunizations for two Residents (R2 and R18) of five residents reviewed for their status of pneumococcal vaccinations. Findings: The policy provided by the facility titled Immunizations: Pneumococcal Vaccinations (PPV) of Residents, last revised 11/4/2024 was reviewed. The policy reflected Recognizing the major impact and mortality of the pneumococcal vaccine on residents in nursing homes and the effectiveness of vaccines. the facility has adopted the following policy statements. These adopted policy statements included, All residents of our facility should receive the pneumococcal vaccine if they are [AGE] years of age or older or younger than 65 years with underlying conditions that are associated with increased susceptibility to infection or increased risk for serious disease or its complications. And II, Administrative Procedure: Each resident's pneumococcal immunization status will be determined upon admission or soon afterwards, and will be documented in the resident's medical record. Current residents will have their immunizations status determined by reviewing available past and present medical records. And B. All residents with undocumented or unknown pneumococcal vaccination status will be offered the vaccine. And C. Informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination (This may be with the resident's authorized representative when appropriate. And D. Residents may refuse vaccination. Vaccination refusal and reasons why .should be documented by the facility. If the resident/family/legal representative chooses to exercise the right to decline the vaccination, it will be re-evaluated annually. R2 Review of the medical record reflected R2 admitted to the facility 3/21/2025 with diagnoses that included Diabetes Mellitus and Vascular Dementia. Review of the Minimum Data Set (MDS) dated [DATE] reflected that R2 was severely cognitively impaired. The electronic Medical Record (EMR) reflected R2 had in place a Power of Attorney (POA) for medical and financial decisions. Review of the EMR Immunization record for R2 did not reflect current or historical data for either the PCV20 or PVC21 (Pneumococcal) vaccines. Review of the pneumococcal Immunization notes for the PCV20 and PVC21 for R2 dated 3/21/25 (date of Resident's admission reflected, Confused - waiting on DPOA. On further review of the EMR for R2 no other documentation was identified that indicated that the pneumococcal immunizations of R2 had been revisited or reviewed with the responsible party for R2, that education had been provided, or that a signed consent for administration or declination of the vaccination had been obtained. R18 Review of the MDS dated [DATE] reflected R18 admitted to the facility 1/24/2024 and had current diagnoses that included Renal Insufficiency and Pulmonary conditions. The MDS reflected R18 was cognitively intact. Review of the electronic Medical Record (EMR) immunization documentation for R18 reflected the Resident refused the pneumococcal vaccination 2/6/2024 and that No education was provided. No other documentation was located in the EMR that R18 had since been offered (minimally annually per facility policy) a pneumococcal vaccination or that education was provided on the risks or benefits of vaccination for residents (this resident who had a) with a documented history of pulmonary conditions. On 5/12/2026 at 12:56 PM an interview was conducted with Infection Preventionist (IP) K. IP K reported she had been in the IP position for approximately three months. IP K acknowledged that the facilities' immunization program to maintain resident immunizations and education was incomplete. IP K reported she only recently obtained approval to access the state immunization data base and updating the status of new and current residents was ongoing.		