STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookridge Retirement Community	1199 Hayes Forest Drive Winston-Salem, NC 27106

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, resident, and the Physician the facility failed to change the dressing for the peripherally inserted central catheter (PICC) for intravenous antibiotic administration according to the order. This deficient practice affected 1 of 3 residents reviewed for intravenous access devices (Resident #63). The findings included: Resident #63's hospital Discharge summary dated [DATE] documented she had a PICC line placed on 7/14/25 into her right antecubital space (front of the elbow) and a clear dressing was placed. The resident was receiving antibiotics for endocarditis (infection of the heart tissue) and sepsis (infection of the blood) through the PICC line. Resident #63 was receiving Ceftriaxone (antibiotic) 2 grams every 12 hours intravenously to continue at the facility. There was no mention of the PICC line dressing change in the hospital discharge summary. Resident #63 was admitted to the facility on [DATE] with diagnoses including septicemia (infection of the blood) and endocarditis. Resident #63's admission nursing note dated 7/16/25 documented she was admitted from the hospital with a PICC line in the right arm. The resident was alert and oriented and able to make her needs known. The care plan for Resident #63 dated 7/16/25 included she was at risk for infection related to peripheral intravenous access. The intervention included monitoring the catheter site for any signs or symptoms of infection. Resident #63's PICC line dressing change order was initiated on 7/21/25 by Nurse #1. The order specified that the PICC line dressing change was to be changed each week on Sunday using aseptic technique. A review of Resident #63's July 2025 Medication Administration Record documented Nurse #1 signed her initials for the PICC line dressing change completion on 7/27/25. On 7/31/25 at 3:00 pm an interview was conducted with Nurse #1. Nurse #1 stated she input the PICC line management order on 7/21/25 for Resident #63 to have the dressing on the PICC line changed once a week on Sunday. The resident was admitted on [DATE] from the hospital with the PICC line in place and a clear dressing dated 7/14/25. Nurse #1 stated she signed for completion of the dressing change on Sunday 7/27/25 in error. The shift was very busy on 7/27/25 and the electronic medical record had been updated which caused problems and error. After the date calendar was reviewed, Nurse #1 stated when she input the PICC line order it was Monday (7/21/25) and the day before Sunday was a missed opportunity to change the dressing within a week from 7/14/25 because the order was not started on admission. On 7/28/25 at 11:10 am an observation and interview were completed with Resident #63. The resident was able to state why she had a PICC line and her antibiotic treatment. The PICC line was observed in the right antecubital space and had an intact clear dressing that was dated 7/14/25. The resident stated the site was without pain and the observation revealed no signs and symptoms of infection. The resident stated the PICC line and dressing was placed at the hospital and the dressing had not been changed at the nursing home. On 7/29/25 at 10:45 am an observation of Resident #63's PICC line was completed with the Administrator. The PICC line had a clear dressing and was dated 7/14/25 and appeared the same as the day before. The Administrator was interviewed on 7/29/25 at 10:50 am. The Administrator stated nursing should have changed the dressing. It was dated 7/14/25 and was required to be changed every week. On 7/30/25 at 11:10 am the Physician was interviewed and informed that Resident #63's PICC line dressing was the original dressing from the hospital dated 7/14/25 when it was placed and the dressing change due on 7/27/25 at the facility was missed. The physician stated it takes a village in response.