

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide written notice, including the reason for the change, prior to changing the resident's room for 3 of 5 residents reviewed for choices, of a total sample of 42 residents, (#2, #6, and #79). Findings: 1. Review of the medical record revealed resident #2, a [AGE] year-old female was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included chronic pain syndrome, muscle spasm, right side lumbago (low back pain) with sciatica (pain along sciatic nerve), and generalized anxiety disorder. The most recent Comprehensive Significant Change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/15/26 indicated resident #2 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated she was cognitively intact. The Care Plan Report noted on 1/16/25, resident #2 had alteration in mood/psychosocial well-being related to anxiety with an intervention to provide a calm environment. On 2/10/26 at 11:57 AM, resident #2 said she did not like being in a room with her current roommate and stated, it's terrible. Review of resident #2's Electronic Health Record (EHR) showed room changes were made on 11/01/25 and 1/03/26. Resident #2's progress notes did not include any information about informing the resident/representative about the two room changes. On 2/12/26 at 11:19 AM, the Social Services Director said the facility's practice was obtaining resident/representative consent prior to room changes. She checked resident #2's medical record and said she was unable to find any notes or documentation about the resident's consultation or consent for two room changes. She said she was not involved in resident #2's room changes and she was recently made aware of an electronic form available to document proper protocols and consent. She checked the medical record and found a progress note that showed the resident had recently requested a transfer to another facility and conveyed it was possible she wanted to transfer because she was unhappy with her room assignment. 2. Review of resident #79's medical record revealed he was admitted to the facility on [DATE] with diagnoses including pericardial effusion (fluid around the heart), chronic obstructive pulmonary disease, and congestive heart failure. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS admission assessment with ARD of 1/15/26 revealed resident #79 had a BIMS score of 15 out of 15 which indicated he was cognitively intact. The MDS assessment indicated it was very important to him to have his family or a close friend involved in discussions about his care. Review of residents #79's medical record revealed no documentation that written notice, including the reason for the change, was provided to the resident or his representative regarding a room change. Review of a Plan of Care Note dated 2/03/26 revealed the interdisciplinary team (IDT) met for a Care Plan Review Meeting on that date, which was attended by resident #79 and his sister. The note indicated the resident's plan of care was reviewed and discussed during the meeting, including ongoing discharge plans. On 2/09/26 at 12:15 PM, resident #79 stated he was told earlier that day he was being moved to another room, but he was not told the reason. He indicated he would like to remain in his current room. He indicated his sister was his Power of Attorney (POA) and stated he did not receive written notification of the change. On 2/12/26 at 9:58 AM, during a telephone interview, resident #79's POA stated she learned about the room change when resident #79 called her while she was on her way to the facility. She stated no one from the facility notified her of the change prior to it occurring. On 2/11/26 at 3:02 PM, Certified Nursing Assistant L stated the Unit Manager (UM) informed staff about the room changes, but he did not know who informed the residents. 3. Review of resident #6's medical record revealed she was admitted to the facility on [DATE] with diagnoses including acute embolism and thrombosis of the left calf muscular vein, difficulty walking, muscle weakness, and major depressive disorder. Review of the MDS admission assessment with ARD of 12/16/25 revealed resident #6 had a BIMS score of 12 out of 15 which indicated she had moderate cognitive impairment. A subsequent BIMS evaluation completed on 1/08/26 revealed a score of 15 out of 15, indicating intact cognition. Review of residents #6's medical record revealed no documentation that written notice, including the reason for the change, was provided to the resident or her representative prior to the room change. On 2/09/26 at 3:50 PM, resident #6 stated she was informed of the move while she was outside in the courtyard and when she returned inside, her belongings had already been moved. She indicated she did not understand why she was moved and was told the room was needed for two male admissions. She stated she was upset about the situation. On 2/11/26 at 5:28 PM, the Social Services Director stated residents did not sign documentation for room changes, and discussions should be documented in the medical record. On 2/12/26 at 11:22 AM, the Administrator stated it had not been the practice of the facility to provide residents with a form to sign for room changes and there was no formal written notification process. He stated room changes were typically handled verbally. On 2/12/26 at 1:34 PM, the Transitional Care UM stated she could not identify who informed resident #6 of the room change. (continued on next page)		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled Room Changes, issued on 4/01/22, read, The resident has a right to receive written notice, including reason for the change, before the resident's room or roommate in the facility is changed. The policy further stated when a resident is being moved at the request of facility staff, the resident and/or resident representative must receive an explanation in writing of why the move is required.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and maintained in a safe and sanitary manner to prevent the potential for foodborne illness in the main kitchen and 1 of 2 nourishment rooms. Findings: During the initial tour of the facility kitchen on 2/09/26 at 10:11 AM, the following concerns were observed: *Multiple lids were stored on a rolling storage rack with visible food debris and residue present on the shelving surfaces and rack bars. The rack was soiled, with dried food particles noted on the horizontal supports. *The kitchen ceiling above the dishwashing area revealed multiple ceiling tiles with visible dark spots, stains, and discoloration. *Multiple baking pans contained dried food residue. Photographic evidence was obtained. The Certified Dietary Manager (CDM) validated the above findings and did not provide an explanation for why the items were in this condition. On 2/10/26 at 9:52 AM, the Regional Dietary Consultant stated the kitchen and baking pans were cleaned the previous night. Observation of approximately 20 baking pan trays revealed continued staining and residue. He acknowledged the baking pans needed to be replaced. 2. On 2/11/26 at 4:46 PM, a tour of the nourishment room in the Residential Care Unit (RCU) was conducted with Certified Nursing Assistant (CNA) I. The following concerns were observed: *A sandwich wrapped in aluminum foil was observed in the refrigerator door and was not labeled with a resident name, room number, or date. *A bag of lemon sugar cookies was observed in the refrigerator door with no name, room number, or date indicated. *A Styrofoam cup containing ice was observed in the refrigerator door and was not labeled with a resident name, room number, or date. CNA I discarded the cup and stated it was likely from a resident who liked to save cups of ice. *A Styrofoam cup containing liquid was stored inside the top rack of the refrigerator. The cup was labeled with a staff member's name and the letters CNA. CNA I stated the staff member worked the 7:00 AM to 3:00 PM shift and was not present at that time. She indicated staff were instructed to store food and beverages in the staff break room refrigerator and not in the nourishment room refrigerator. CNA I discarded the cup at that time CNA I stated resident food items were required to include the resident's name or room number and the date received. She indicated items were kept for up to three days and discarded after that time. On 2/11/26 at 4:59 PM, the RCU Unit Manager (UM) confirmed the nourishment room refrigerator was designated for resident food items only. She indicated resident items must include a name or room number and the date, and items were discarded after 72 hours. The UM acknowledged the unlabeled items should be discarded because their ownership and date could not be verified. On 2/12/26 at 11:34 AM, the Administrator stated staff beverages should not be stored in the nourishment room refrigerator and resident food items must be labeled with a name or room number and date. Review of the facility's policy and procedure titled Food Brought in From the Outside, issued on 4/01/22, revealed the facility intended to provide safe and sanitary storage and handling of all food and beverages brought into the facility. The policy stated nursing staff were to label containers with the food item name and date received.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, and interview, the facility failed to maintain the refuse storage area in a sanitary condition to prevent the development of odors and the attraction of pests for 2 of 2 dumpsters observed in the exterior kitchen refuse area. Findings: During the initial tour of the facility kitchen on 2/09/26 at 10:31 AM, observation of the exterior refuse area revealed two large waste dumpsters with lids not tightly closed. Plastic trash was protruding from the top of the dumpsters, preventing full lid closure. The surrounding ground surface contained scattered refuse debris, including four plastic gloves. Photographic evidence was obtained. The Certified Dietary Manager and the Maintenance Director acknowledged the findings at the time of the tour. On 2/11/26 at 3:40 PM, the Maintenance Director stated kitchen, housekeeping and maintenance staff disposed of trash in the dumpsters and were responsible for ensuring garbage was contained, debris was not left on the ground, and lids were kept closed, to prevent vermin. He stated he did not know where the discarded gloves originated. He further stated he was not present on weekends, and garbage was not collected on Sundays.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to promote resident rights related to the choice of the type of wheelchair used for 1 of 5 residents reviewed for choices, of a total sample of 42 residents, (#104). Findings: Review of resident #104's medical record revealed she was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, displacement of internal fixation device of vertebrae, hemiplegia and hemiparesis (partial paralysis and weakness) following cerebral infarction affecting her left non-dominant side, and difficulty in walking. Review of the Minimum Data Set (MDS) admission assessment with Assessment Reference Date of 1/27/26 revealed resident #104 had a Brief Interview for Mental Status score of 15 out of 15, indicating she was cognitively intact. The MDS assessment indicated she did not reject evaluation or care needed to achieve her goals for health and well-being. The MDS assessment noted she used a manual wheelchair and was able to independently propel at least 150 feet. Review of resident #104's comprehensive care plan dated 1/27/26 revealed she was there for a short stay and clearly expressed desire to discharge from the facility. She anticipated returning home where she lived alone. Review of a PT (Physical Therapy) Evaluation and Plan of Treatment form dated 1/21/26 revealed that prior to admission resident #104 used a large electric wheelchair primarily for mobility in the home and community; and was independent with transfers. Documentation also indicated she had a smaller foldable electric wheelchair she used for community outings. On 2/09/26 at 1:13 PM, resident #104 stated the facility did not allow her to use her own wheelchair. She shared she was required to use a facility wheelchair. She reported she had used her electric wheelchairs for approximately five years and had traveled with them. She stated the facility did not test her ability to use the wheelchair in manual mode and did not assess her ability to safely operate it. On 2/11/26 at 1:42 PM, Occupational Therapy Assistant (OTA) G stated resident #104 had expressed her desire to use her electric wheelchair in the facility. OTA G indicated electric wheelchairs were not allowed due to safety concerns. On 2/12/26 at 12:20 PM, the Director of Rehabilitation (DOR) stated resident #104 informed therapy of her preference to bring her power chair. The DOR indicated electric wheelchairs were not generally used in the facility due to safety concerns for residents and staff. The DOR stated therapy would not be working with the electric wheelchair during treatments. She further stated she was not aware of a specific motorized wheelchair policy. On 2/12/26 at 12:45 PM, Physical Therapy Assistant F stated staff were aware resident #104 wanted to use her electric wheelchair and that he was told electric wheelchairs were not allowed in the facility. On 2/12/26 at 3:16 PM, the Administrator stated the facility historically did not use motorized wheelchairs; however, near discharge, therapy may request families bring them in for assessment in preparation for return to the community. Review of the medical record revealed no documentation that therapy or nursing assessed resident #104's ability to safely use her motorized wheelchair in the facility. Review of the facility's policy and procedure titled Motorized Wheelchairs revised 4/01/22 revealed an intent to allow and assist residents who can safely and competently utilize motorized wheelchair to do so. The procedure stated therapy and/or nursing would determine the need for a motorized wheelchair based on assessment of the resident's capability and safe operation while in the facility. An addendum to this policy titled Resident Use of Motorized Wheelchairs/Scooters indicated the use of electric wheelchairs and scooters was discouraged in the facility. Review of the facility's policy and procedure titled Resident Rights, Dignity, and Visitation Rights, issued on 4/01/22, stated the facility would ensure residents could exercise their rights without interference and would observe resident's choices whenever able.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prompt resolution of grievances for 1 of 5 residents reviewed for choices, of a total sample of 42 residents, (#94). Findings: Resident #94 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease, chronic obstructive coronary disease, unspecified dementia and major depressive disorder. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed resident #94 was cognitively intact with a Brief Interview for Mental Status score of 13 out of 15, meaning he was cognitively intact. The assessment indicated he did not have any behaviors nor refused care. On 2/11/26 at 3:05 PM, resident #94 was up in his wheelchair with his wife at the bedside. He stated this was the first time he had been out of bed in a very long time. He explained the reason he had to get up was to attend the care plan meeting. Both the resident and his wife said they had voiced a lot of issues to the facility, but the concerns did not seem to be addressed. Resident #94's wife said she had even filed a grievance last month but had not heard anything back. She said she often spoke to the resident care unit (RCU) Unit Manager (UM), but felt she often talked around her issues. The wife said she did not think anything had been resolved, I do not remember signing the grievance or having a discussion that there was any resolution to my concerns. Resident #94 stated he wanted to be taken out of bed more often and had been asking for a long while, but staff often reported that he refused whenever his wife would ask. On 2/11/26 at 3:30 PM, Certified Nursing Assistant (CNA) E said she had never assisted resident #94 out of bed nor ever put him back to bed. She heard from other staff that he often refused but recalled she once saw him out of bed for a doctor's appointment. Assigned CNA D said that today was the first time in a long time she saw resident #94 out of bed and had thought he only got out of bed for showers. On 2/11/26 at 3:54 PM, the Social Services Director (SSD) said she was also the Grievance Officer and whenever she received a grievance, based on the issue, it was often forwarded to the department responsible for a resolution. She explained that it usually takes them about two weeks to resolve. The SSD was asked to review the grievance filed on behalf of resident #94 and retrieved it from her binder. She explained it was filed on 1/21/26 by and did not appear to be resolved. She continued to explain that this would have been handled by the RCU UM and the Assistant Director of Nursing (ADON) and they would have information about it. On 2/11/26 at 4:27 PM, the RCU UM said she did not know anything about the grievance filed on behalf of resident #94 and the only reason it might have taken longer than two weeks was because they might not have been able to contact the family. The RCU UM explained that during that time, she was on vacation and the ADON was handling the grievances. On 2/11/26 at 4:47 PM, the ADON provided a copy of the grievance and stated she remembered it was resolved over the phone with resident #94's wife. A review of the actions taken for the resident wanting to be shaved was the task was included it in the CNA Kardex. Their investigation showed that resident #94 refused to get out of bed, and explained they were honoring his right to refuse. There was no mention about the resident wanting a private room nor an explanation given about the roommate having the TV too loud. A review of the grievance form did not indicate if the grievance was resolved. The form did not contain any signatures or dates for when the grievance was resolved. On 2/12/26 at 10:15 AM, the SSD said she could not answer why the grievance had not been resolved since the same issues were brought up in the Care Plan meeting yesterday. She said that nursing was still working on it. The facility's policy on grievances issued 4/01/22 indicated the facility would provide residents, resident representatives, family and visitors with methods of sharing grievances and/or concerns with the facility and the facility would make prompt efforts to resolve grievances. The procedure listed in section 4, The individual filing the grievance has the right to a reasonable expected time frame for completing the review of the grievance, being kept apprised of the progress toward a resolution and a right to obtain a written decision regarding his or her grievance.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hearing aid assistance was provided for 1 of 2 residents reviewed for Communication/Sensory, of a total sample of 42 residents, (#81). Findings: Review of the medical record revealed resident #81, a [AGE] year-old female was admitted to the facility from an acute care hospital on 6/04/23 with diagnoses that included adjustment disorder with mixed anxiety and depressed mood, dementia, recurrent major depressive disorder, retinopathy (damage to retina of the eyes), and generalized muscle weakness. Review of the most recent Comprehensive Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/30/25 documented the Preferences for Routine & Activities interview completed with the resident/family member indicated it was very important to resident #81 to listen to music she liked, keep up with the news, do things with groups of people, do favorite activities, and participate in religious services. The most recent Quarterly MDS assessment with an ARD of 12/31/25 noted during the look-back period, the resident scored 8 out of 15 on the Brief Interview for Mental Status that indicated she was moderately cognitively impaired and wore a hearing aid that provided adequate hearing ability if normally used. Review of the Care Plan Report included a care plan dated 1/13/25, for self-care deficits with dressing, grooming, dementia, generalized weakness, and cognitive deficits that noted the resident participated with cues from staff with interventions to assist the resident. The care plan noted (10/21/25) resident #81 was often observed in the hallway people watching and socializing with peers; enjoys group programs and had potential for alteration in communication; hearing was adequate with bilateral hearing aids with interventions (10/21/25). Resident #81 had a care plan focus for hearing aids to bilateral ears. Interventions included, in AM assist resident to put her hearing aids in; evening assist resident to remove hearing aids daily, and on 7/22/25 an intervention that read, hearing aids to both ears, change battery every 10 days. On 2/09/26 at 12:14 PM, resident #81 was observed sitting in a wheelchair eating lunch with her daughter in the nursing unit's common area. The resident was not wearing hearing aids and was unable to hear without speaking within a few inches of her ear. The resident's daughter explained that her mother was very hard of hearing and had been fitted for hearing aids however, even though she had complained to management that staff were not assisting with putting the hearing aids in, they never followed up and staff were still not putting them in. She said her mother enjoyed activities like socializing and stated, if she wore them, they would improve her quality of life; more people would talk to her. Review of a Plan of Care Progress Note on 1/21/26 noted resident #81's daughter participated with her in a Care Plan review meeting. It was noted that the resident enjoyed interactions with staff and other residents. The note indicated hearing services were discussed. The Grievance/Complaint Log showed on 1/21/26, a complaint was reported by resident #81's daughter concerning hearing aid placement. On 2/11/26 at 11:08 AM, resident #81 was observed near the nurse's station when she propelled herself from the activities room towards her room. Her hearing aids were not on. On 2/11/26 at 11:26 AM, Certified Nursing Assistant (CNA) A said she was aware resident #81 needed assistance to wear her hearing aids. She said she checked them the same day and there was no sound. She explained she informed the nurse the previous day and the hearing aid specialist checked them once a month. On 2/11/26 at 10:56 AM, Licensed Practical Nurse (LPN) B said she was familiar with resident #81 who was frequently included in her assignments. The nurse explained that CNAs were responsible for assisting residents to put hearing aids in, they were kept in the resident rooms, and the task was included in their documentation. The LPN stated she was unaware of any issues about resident #81's hearing aids malfunctioning. Review of the Audiologist's (hearing specialist) Chart Note on 12/09/25 indicated upon examination, the resident was not wearing her hearing aids, and her ear canals were clear. The note mentioned the nurse was reminded to assist (continued on next page)		

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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** Based on observation, interview, and record review, the facility failed to maintain complete and accurately documented clinical records for medication administration, in accordance with accepted professional standards and practices, for 1 of 7 residents observed for medication administration, of a total sample of 42 residents, (#33). Findings: Resident #33 was admitted on [DATE] with diagnoses that included cellulitis of the left lower limb, respiratory failure, peripheral vascular disease and rash. Review of the admission Minimum Data Set assessment with reference date 11/30/25 revealed resident #33's cognition was intact with a brief interview of mental status score of 15 out of 15. Review of resident #33's plan of care showed the resident had the following skin impairments: rash in right lower quadrant of the abdominal folds, scalp seborrheic dermatitis, right dorsal hand wound and stasis dermatitis on bilateral lower legs. Interventions included instruction for nurses to perform wound care treatments as ordered. Physician's orders included Urea External Cream 40% (Urea), applied to bilateral lower legs topically every day shift for stasis dermatitis for six months, Hibiclens External Solution 4% (Chlorhexidine Gluconate) applied to lower legs topically every day for stasis dermatitis and Ketoconazole External Shampoo 2% (Ketoconazole (Topical)) applied to scalp topically every day shift for seborrheic dermatitis. On 2/10/25 at between 9:00 AM and 9:30 AM, Licensed Practical Nurse (LPN) C, was observed during medication administration for resident #33. LPN C administered five oral medications. A short time later, during medication reconciliation, a review of the Medication Administration Record (MAR), revealed the resident received Hibiclens External solution, Ketoconazole External Shampoo and Urea external cream in addition to the five oral medications observed. A further review of the medication administration audit report showed LPN C administered Hibiclens External Solution at 8:57 AM, ketoconazole external shampoo at 9:16 AM, and Urea External cream at 9:16 AM. On 2/10/26 at 1:24 PM, resident #33 was sitting up in his wheelchair and said no creams or other topical medicine were applied to his legs today nor did he receive the shampoo to his scalp. The resident explained sometimes he got the creams in the afternoon but said he didn't ask for the medications when he did not get them. On 2/10/26 at 1:33 AM, LPN C explained he documented after providing treatment or after giving medication and not before. LPN C acknowledged he documented the medications were given before they were actually administered to the resident. He confirmed he should have documented after the treatment was applied not prior but could not say why he did. At that time, the Director of Nursing (DON) who was standing next to LPN C at the nurse's station, was told that resident #81's topical medications were documented as performed when they had not actually been given. The DON acknowledged the MAR was inaccurate because it showed the treatment was applied, when it was not. She stated her expectation was for nurses to document immediately after medications were administered or treatment were applied, not beforehand. The facility's policy on Medication Administration dated 4/01/22 indicated medications were administered in a timely manner and as prescribed by the physician unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. In section 12, the policy described, Should a drug be withheld, refused or given other than the scheduled time, the individual administering the medication will document this in the clinical record.		