STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER: Majestic Care of West Allen		STREET ADDRESS, CITY, STATE, ZIP CODE: 6050 S Cr 800 E 92 Fort Wayne, IN 46814	

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to ensure a bed hold policy was provided to a responsible party for 4 of 4 residents reviewed (Resident 29, Resident 9, Resident 2, and Resident 85).Findings include: 1) Resident 29's record was reviewed on 04/13/2026 10:38 AM. Diagnoses included dementia with behavioral disturbance, psychotic disorder, and autistic disorder. A current quarterly Minimum Data Set (MDS) assessment, dated 3/30/2026, indicated Resident 29 had a Brief Interview for Mental Status score of 0 (severe cognitive impairment). The MDS indicated Resident 29 had a difficulty focusing attention or difficulty keeping track of what was said. Progress notes, dated 2/10/2026 at 12:30 PM, indicated the physician was notified of x-ray results and provided orders for Resident 29 to go to the hospital. The notes indicated the guardian was notified but made no mention of a bed hold policy. There was no documentation the bed hold policy had been provided to the responsible party. A document, titled Notice of Transfer or Discharge, dated 2/10/2026, provided by the Director of Nursing (DON) on 4/14/2026 at 12:31 PM, indicated a copy of the bed hold policy was sent with Resident 29. 2) Resident 9's record was reviewed on 04/12/2026 1:04 PM. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and hypercapnia. Resident 9's current, quarterly, Minimum Data Set (MDS) assessment, dated 2/11/26, indicated Resident 9 had a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). A progress note, dated 2/15/2026 at 12:16 PM, indicated Resident 9 was not acting like himself, and was dropping items. The progress note indicated Resident 9's oxygen saturation at the time was 87%. A progress note, dated 2/15/2026 at 2:39 PM, indicated Resident 9's condition had worsened and he was being sent to the hospital by ambulance. Family notification did not include documentation of discussion of the bed hold policy. In an interview, on 04/14/2026 at 12:37 PM, the Social Services Director (SSD) indicated when a resident was experiencing a serious medical condition, the bed hold policy should be provided to the resident's family or guardian. A document, titled Notice of Transfer or Discharge, dated 2/15/2026, indicated a copy of the bed hold (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	policy was sent with Resident 9 when he went to the hospital. 3) Resident 2's record was reviewed on 04/15/2026 10:49 AM. Diagnoses included altered mental status and cerebral infarction. A current quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, indicated Resident 2 had a Brief Interview for Mental Status score of 10 (moderate cognitive impairment). The MDS indicated Resident 2 had difficulty recalling the current month and short-term memory impairment. Progress notes, dated 3/1/2026 at 06:50 AM, indicated Resident 2 had an altered mental status, fever, and weakness. The physician was notified of Resident 2's changes in condition. The notes indicated Resident 2 was their own responsible party and no other notification was completed. Progress notes, dated 3/1/2026 at 08:42 AM, indicated Resident 2 had improved, but was below baseline mental status. Progress notes, dated 3/1/2026 at 2:26 PM, indicated Resident 2 was transferred to the hospital by EMS for fever, abdominal pain and distention. The note indicated that Resident 2 was their own responsible party, and Power of Attorney or family notification of transfer was not completed. Transfer documentation did not include the bed hold policy. A document, titled Notice of Transfer or Discharge, dated 3/1/2026 and untimed, indicated a copy of the bed hold policy was signed by Resident 2. A document, titled Indiana Durable (Financial) Power of Attorney, dated 2/3/2026 indicated Resident 2 designated an agent to act in consent or refusal of health care as referenced in 30-5-5-17 of the Indiana Code. 4.) Resident 85's record was reviewed on 4/15/26 at 9:59 AM. Diagnoses included dementia and osteomyelitis. A Notice of Transfer of Discharge, dated 3/9/26, indicated a copy of the bed hold policy was sent with Resident 85. A Transfer Form, dated 3/9/26 at 8:20 AM, indicated a copy of the transfer form and bed hold policy were sent with the resident. The form indicated Resident 85 required a proxy for decision making. A current policy, dated 1/2/2024, provided by the DON, on 4/14/2026 at 12:31 PM, indicated at the time of transfer to a hospital, the facility should provide a written notice which specifies the duration of the bed-hold policy and addressed information explaining the return of the resident to the next available bed. The policy indicated the facility should keep a signed and dated copy of the bed hold notice information given to the resident or resident representative in the resident file.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify resident trauma and incorporate into the plan of care for 2 of 5 residents reviewed (Resident 57 and Resident 67).Findings include: On 4/12/26 at 1:44 PM, Resident A was observed in the smoking section. Resident A was sitting in their wheelchair waiting for a staff member to light their cigarette.In an interview, on 4/12/26 at 1:46 PM, Resident A indicated they had smoked 2 packs of cigarettes a day prior to their admission to the facility. Resident A indicated they were now restricted to 3 cigarettes a day and that was a hard adjustment.Resident A's record was reviewed on 4/16/26 at 9:25 AM. Diagnoses included seizure disorder, sleep disorders, psychoactive substance abuse, homelessness, major depressive disorder, anxiety disorder and chronic pain syndrome.Resident A's quarterly Minimum Data Set, (MDS) date 4/6/26, indicated their Brief Interview for Mental Status (BIMS) score was 12 (no cognitive deficit). The MDS indicated Resident A displayed behaviors of verbal aggression towards others and rejection of care. The MDS indicated Resident A had diagnoses of seizure disorder, depression, chronic pain syndrome, homelessness and anxiety disorder.A Social Service History Initial Review, dated 2/26/25, indicated Resident A had been homeless prior to admission to the facility, had a history of substance abuse and had been in a severe car accident.A progress note, dated 5/14/25 at 1:00 PM, indicated Resident A had a history of depression, polysubstance abuse disorder and opioid seeking behaviors. The progress note indicated Resident A had been a nurse prior to having viral encephalitis. Resident A had been in a coma for 3 months due to viral encephalitis. Resident A's first husband gained custody of their son when they divorced. Resident A had been married and divorced 4 times. Resident A had been physically abused by their second husband. Resident A had a fiance that was killed by a car while in their wheelchair. Resident A had a broken back, jaw, neck and leg in a car accident. Resident A had no family contact. Resident A had a past suicide attempt of overdosing on Valium.A progress note, dated 11/19/25 at 6:36 PM, indicated Resident A had a visit for an initial psychiatric evaluation. Resident A had been physically abused by a previous husband for 5 years. The progress note indicated Resident A had been raped by her brother when she was 8 years old.A progress note, dated 12/5/25 at 10:34 AM, indicated Resident A had been placed under direct supervision with administrative staff as a precaution related to suicidal ideation. Resident A's BIMS score was 15 (no cognitive deficit). Resident A had indicated all their actions with peers had been consensual.A progress note, dated 12/5/25 at 4:32 PM, indicated Resident A had been aware that all sexual contact required consent. Resident A was placed on 15-minute checks.A progress note, dated 12/6/25 at 1:52 PM, Resident A understood boundaries with sexual contact and relationships. 15-minute checks were discontinued.A progress note, dated 12/9/25 at 2:225 PM, indicated Resident A had not had any further issues with unwanted advances.Resident A's care plan, dated 8/27/25, indicated they desired intimate relationships with consenting male residents. The target goal was for Resident A's right to consensual intimate relationships to be respected through 5/26/26. Interventions included assessment and education related to consensual intimate relationships.Resident A's care plan, dated 4/1/25, indicated they displayed drug seeking behaviors. The target goal was for Resident A to demonstrate effective coping skills and seek staff support through 5/26/26. Interventions included identification and reduction of behavioral triggers. The care plan did not indicate any identified triggers.Resident A's care plan, dated 8/6/25, indicated they pretended to have seizures to gain attention or medication. The target goal was for Resident A to demonstrate effective coping skills through 5/26/26. Interventions included identification and reduction of behavioral triggers. The care plan did not indicate any identified triggers. Resident A's care plan, dated 3/26/26, indicated they had a behavior of making false allegations. The target goal was for Resident A to seek staff support when feeling frustrated or provoked through 5/26/26. Interventions included identification and reduction of behavioral triggers. The care plan did not (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicate any identified triggers.Resident A's care plan, dated 2/25/25, indicated they had a behavior of verbal aggression when they were unable to smoke. The target goal was for Resident A to comply with the facility smoking policy through 5/26/26. Interventions included education related to the smoking policy and supervision while smoking. The care plan did not indicate any identified triggers.Resident A's care plan did not indicate they had a history of physical trauma, a history of sexual trauma, a history of homelessness, a history of substance abuse, a history of medical trauma or a history of attempted suicide.In an interview, on 4/15/26 at 11:44 AM, Certified Nurse Aide (CNA) 5 indicated Resident A had displayed sexual behaviors ever since they had been admitted to the facility. CNA 5 indicated on one occasion; Resident A had voiced anger at another resident for not buying them a soda after they had engaged in sexual acts with the other resident.In an interview, on 4/15/26 at 3:20 PM, the Administrator indicated they had been made aware of Resident A's alleged unwanted advances by another resident's son in December of 2025. The Administrator indicated the situation had been resolved.2. On 4/12/26 at 1:52 PM, Resident 67 was observed sitting in their wheelchair in the smoking area.During an interview, on 4/12/26 at 1:52, Resident 67 was verbally aggressive to another resident who had joined the conversation. Resident 67 indicated they had transferred from another facility last year. Resident 67 indicated they were thankful for the opportunity to smoke.Resident 67's record was reviewed on 4/13/26 at 9:34 AM. Diagnoses included dementia, seizure disorder, traumatic brain injury, (TBI) borderline personality disorder, tobacco use, anxiety, intermittent explosive disorder and other specified behavioral and emotional disorders with onset usually in childhood and adolescence (adhd).Resident 67's quarterly MDS dated [DATE], indicated their BIMS score was 15 (no cognitive deficit). The MDS indicated the resident had not displayed any behaviors.A Social History and Assessment, dated 7/30/25 at 2:28 PM, indicated Resident 67 acquired a TBI after they were hit by a semi-truck while riding his bicycle when he was 18. The resident was in a coma for 11 months. The resident lived in a state hospital for 13 years, then transferred to a group home setting.A progress note, dated 8/25/25 at 4:53 AM, indicated Resident 67 displayed inappropriate sexual behavior towards staff. Resident 67 had been touching themselves intimately during personal care and refused to stop when redirection was attempted.A progress note, dated 9/5/25, indicated Resident 67 was in a coma for 11 months following a crash between their bicycle and a semi-truck when they were 18. The progress note indicated Resident 67 was diagnosed with TBI and intermittent explosive disorder. Resident 67 allegedly shot their father when they were 26 due to their father swearing at them. Resident 67 resided at a state hospital for 13 years.A Preadmission Screening and Resident Review (PASRR), dated 11/22/22, indicated Resident 67 had diagnoses of TBI, intermittent explosive disorder and borderline personality disorder. Resident 67's PASRR indicated they were triggered by hearing the name of the current United States President.Resident 67's care plan, dated 7/31/25, indicated the resident had explosive disorder and a history of altercations with other residents. The target goal was for the resident to seek staff support and demonstrate effective coping skills through 5/4/26. Interventions included identification and reduction of triggers. The care plan did not indicate any specific triggers.Resident 67's care plan, dated 7/31/25, indicated the resident was at risk for decreased psychosocial well being due to anxiety, TBI, depression, borderline personality disorder and seizure disorder. The target goal was for the resident to verbalize feelings and adjust to the facility through 5/4/26. Interventions did not include identification of resident specific behavioral triggers.Resident 67's care plan, dated 7/31/25, indicated the resident had a history of refusal to bathe or shower. The target goal was for the resident to verbalize feelings and adjust to the facility through 5/4/26. Interventions did not include identification of resident specific behavioral triggers.Resident 67's care plan did not indicate they had a history of traumatic events such as being hit by a truck or shooting their father.Resident 67's care plan did not indicate they had displayed inappropriate sexual behavior.In an interview, on 4/15/26 at 9:20 AM, the Administrator indicated all residents should be screened for trauma upon admission.In an interview, on 4/15/26 at 1:15 PM, the Administrator indicated Resident 67's inappropriate sexual (continued on next page)

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	155322	A. Building B. Wing	04/16/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior towards a staff member was reported by another resident. Resident 67's inappropriate sexual behavior was never verified by staff. The Administrator indicated Resident 67 had not been involved in any physical altercations with other residents since they have been at the facility. The Administrator indicated they were unaware of Resident 67's specific behavioral triggers.In an interview, on 4/16/26 at 1:35 PM, the Social Service Director (SSD) indicated each resident was screened for trauma upon admission and quarterly. The SSD indicated trauma responses and posttraumatic stress disorder (PTSD) should be added to each resident's care plan. The SSD indicated life threatening medical events, abuse, and homelessness could be traumatic events.A current facility policy, dated 11/18/25, indicated trauma was an event or circumstance that was perceived as physically or emotionally harmful or life-threatening. The policy indicated the facility would ensure resident specific behavioral health plans of care.This citation is related to Intake 2976724410 IAC (Indiana Administrative Code) 16.2-3.1-

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure and investigation and interventions for suicidal ideation for 1 of 1 resident reviewed (Resident 6).Findings include:Resident 6's record was reviewed on 04/12/2026 12:21 PM. Diagnoses included schizophrenia, cerebral edema, hemiparesis and hemiplegia following cerebral infarction affecting right, dominant side.A current admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 6 had a Brief Interview for Mental Status (BIMS) score of 12 (mild cognitive impairment).A progress note, dated 3/11/2026, indicated Resident 6 told the Social Services Director (SSD) he was feeling down and wanted to kill himself. The note indicated the SSD offered assistance, activities, and initiated 15-minute checks. The note indicated the care plan was updated. The note did not mention asking if Resident 6 had a plan to kill himself. No additional notes pertaining to suicidal ideation or follow-up were available for review.A review of Resident 6's current care plan, initiated 2/26/2026, did not address depression or suicidal ideation.Progress notes, dated 3/11/2026 to 4/13/2026, did not include any documentation of physician notification of suicidal ideation.A care plan conference summary, dated 3/17/26, did not include any documentation of interventions provided for suicidal ideation.In an interview, on 04/13/2026 3:00 PM, The Social Services Director (SSD), indicated upon hearing a resident verbalize suicidal ideation, she would report the occurrence to the nurse, suggest 15 minute checks and request a team meeting to decide if the resident should be sent out to the hospital. The SSD indicated she would ask the resident why they wanted to kill themselves. The SSD indicated she did not normally ask if the resident verbalizing suicidal ideation if they had a plan. The SSD indicated Resident 6 had admission paperwork mentioning suicidal ideation, related to his depression due to a stroke. The SSD indicated Resident 6 vocalized suicidal ideation during a care plan meeting with his father on 3/17/2026. The SSD indicated she offered emotional support, and his father took him out of the facility for a leave of absence after the meeting. She indicated Resident 6's mood had improved when he returned. The SSD indicated she did not recall any other occurrence. After reviewing her documentation for 3/11/2026, the SSD indicated since it was the first occasion of a verbalization, she recommended nursing initiate 15-minute checks and reported the occurrence to the Director of Nursing. The SSD indicated no further visits or follow up was needed and was not done.In an interview, on 04/13/2026 3:09 PM, the Director of Nursing (DON) indicated upon notification of a suicidal verbalization, staff should assess the resident, notify the SSD, ask the resident if they had a plan, and remove anything from the immediate area that could be used for self-harm. The DON indicated the psychiatric nurse practitioner should be notified immediately, and the occurrence should be documented. The DON indicated she recalled an occurrence of Resident 6 verbalizing suicidal ideation. Resident 6's father spoke with Resident 6, and Resident 6 told his father he wanted to live and was upset when he made the statement. The DON indicated Resident 6's father took him out of the facility for a leave of absence that day and 15-minute checks were not initiated. The DON indicated a progress note should have detailed staff interventions, the outcome, and family and physician notification. The DON indicated the care plan should have been updated.In an interview, on 4/14/2026 at 10:25 AM, the Administrator indicated upon a statement indicating suicidal ideation, staff should ask if the resident had a plan to determine the severity of the situation and provide interventions accordingly. The Administrator indicated interventions should be documented, the physician and family should be notified, and the care plan should be updated. The Administrator indicated Resident 6 should have had a care plan addressing his depression with suicidal ideation.A current policy, titled Suicidal Thoughts and Ideation, dated 11/1/2024, provided by the Administrator on 4/14/2026 at 11:02 PM, indicated the DON, SSD, and physician should be immediately notified of (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any suicidal verbalization by a resident. The policy indicated the DON or SSD should immediately interview the resident, asking if there was a plan, assessing the resident's mood and means for self-harm. The policy indicated the resident's mood and behavior, and all actions taken should be thoroughly documented in the medical record.410 IAC (Indiana Administrative Code) 16.2-3.1-43(a)(1)

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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 interview and record review, the facility failed to ensure accurate and complete documentation was provided for 1 of 2 residents reviewed (Resident 6).Findings include:Resident 6's record was reviewed on 04/12/2026 12:21 PM. Diagnoses included schizophrenia, cerebral edema, hemiparesis and hemiplegia following cerebral infarction affecting right, dominant side.A current admission Minimum Data Set (MDS) assessment, dated 3/6/2026, indicated Resident 6 had a Brief Interview for Mental Status (BIMS) score of 12 (mild cognitive impairment)A review of Resident 6's current care plan, initiated 2/26/2026, did not address depression or suicidal ideation.A Social Services progress note, dated 3/11/2026, 1:54 PM indicated: Visited [NAME] as it was reported that [NAME] is feeling down today and said he wants to kill himself. Had a chat, offered help, talked to Activities to encourage participations in activities or offer 1:1 activity time. [NAME] appears to agree. Advised if feels like to talk to call SSD or nurse. Resident scheduled for 15 mins checks. Care plan updated. On 4/14/2026 at 10:04 AM, the following progress notes were reviewed:A Social Services progress note, created on 4/13/2026 at 3:52 PM, with an effective date of ,3/12/2026 at 3:46 PM, labeled as a late entry indicated: Follow up meeting with resident, who stated he has no plan and does not have any suicidal ideation anymore. Resident father present and aware. Resident much calmer and present without any psychosocial distress or mood changes. Resident continues his daily routine and attends therapy. After conversation and 1:1 time with the writer resident stated that he feels much better and has no suicidal ideation or intend (sic).A Social Services progress note, created on 4/14/2026 at 7:58 AM, with an effective date of 3/13/2026 at 7:58 AM, labeled as a late entry indicated: Visited resident today, who stated he has no plan and does not have any suicidal ideation anymore. Care plan meeting is set up on 3/17/26. After conversation and 1:1 time with the writer resident stated that he feels much better and has no suicidal ideation or intend (sic). A Social Services progress note, created on 4/14/2026 at 7:59 AM, with an effective date of 3/14/2026 at 7:58 AM, labeled as a late entry indicated: Visited resident today, who stated he has no plan and does not have any suicidal ideation anymore. Care plan meeting is set up on 3/17/26. After conversation and 1:1 time with the writer resident stated that he feels much better and has no suicidal ideation or intend (sic). In an interview, on 04/13/2026 3:00 PM, The Social Services Director (SSD), indicated upon hearing a resident verbalize suicidal ideation, she would report the occurrence to the nurse, suggest 15-minute checks and request a team meeting to decide if the resident should be sent out to the hospital. The SSD indicated she would ask the resident why they wanted to kill themselves. The SSD indicated she did not normally ask if the resident verbalizing suicidal ideation if they had a plan. The SSD indicated Resident 6 had admission paperwork mentioning suicidal ideation, related to his depression due to a stroke. The SSD indicated Resident 6 vocalized suicidal ideation during a care plan meeting with his father on 3/17/2026. The SSD indicated she offered emotional support, and his father took him out of the facility for a leave of absence after the meeting. She indicated Resident 6's mood had improved when he returned. The SSD indicated she did not recall any other occurrence. After reviewing her documentation for 3/11/2026, the SSD indicated since it was the first occasion of a verbalization, she recommended nursing initiate 15-minute checks and reported the occurrence to the Director of Nursing (DON). The SSD indicated no further visits or follow up was needed.In an interview, on 04/14/2026 at 10:01 AM, the DON indicated late entries had been added to the medical record to address concern of suicidal verbalization. In an interview, on 4/14/2026 at 10:25 AM, the Administrator indicated upon a statement indicating suicidal ideation, staff should ask if the resident had a plan to determine the severity of the situation and provide interventions accordingly. The Administrator indicated interventions should be documented, the physician and family should be notified, and the care plan should be updated. The Administrator indicated Resident 6 should have had (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a care plan addressing his depression with suicidal ideation. In an interview, on 04/16/2026 at 10:00 AM, the Administrator indicated he believed the late entry documentation provided by the SSD was not intended to be inaccurate.In an interview, on 4/16/2026 at 10:04 AM, the SSD indicated she did not personally provide individual visits with Resident 6 for follow up regarding suicidal ideation.In an interview, on 4/16/2026 at 10:05 AM, the Administrator indicated the SSD's documentation was indicative of interdisciplinary team visits with Resident 6. A current policy, titled Documentation in the Medical Record, dated 1/2/2024, provided by the Administrator on 4/16/2026 at 10:14 AM, indicated staff should document all assessments, observations and services provided in the medical record. The policy indicated documentation should be completed at the time of service, but no later than the shift in which assessment, observation, or care service occurred. The policy indicated documentation should be factual and based on first-hand knowledge of the assessment, observation, or service provided.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)