STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Meadows	2 E Tilden Brownsburg, IN 46112

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 38768 Based on observations, interviews and record reviews, the facility failed to ensure a newly admitted resident, (Resident C) had a baseline care plan in place to address his immediate medical needs for a new surgical wound upon his admission for 1 of 3 new admission records reviewed. Findings include: 1. On 4/21/25 at 9:50 a.m. Resident C's wife was observed as she left the hall and stopped a nurse to ask about her husband's leg. She indicated to the unidentified nurse that his leg was still bleeding and had gotten all over his sheets. On 4/21/25 at 10:32 a.m., Resident C was observed as he laid in bed. He had a left below the knee amputation (BKA) which was wrapped up however, he had bleed through the dressing and bandage. A folded sheet had been placed under his soiled dressing and there was a moderate amount of bright red stains on the white sheet as well. Resident C indicated, he admitted to the facility on Friday the 18th. Everything had been find at the hospital after his amputation, but shortly after he arrived to the facility, he noticed he started bleeding through the bandage. He and his wife, (who was also a resident) had talked to several staff member, but he still had not had a dressing change. On 4/23/25 at 9:15 a.m., Resident C was observed. His bandage remained dry and intact, and he indicated he had not needed it changed since the bleeding seemed to have stopped. On 4/23/25 at 8:50 a.m. Resident C's medical record was reviewed. He was a newly admitted resident for aftercare following a left BKA with a history of atherosclerosis of native arteries of extremities with gangrene, (a condition where hardened plaque buildup in the arteries of the legs and feet leads to poor blood flow and tissue death [gangrene]). and peripheral vascular disease ([PVD] a condition where blood flow to the extremities, primarily legs and feet, is restricted due to narrowed or blocked blood vessels). The record lacked a baseline care plan for his immediate medical needs related to his left BKA. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, IDT Baseline Care Plans, revised 4/2018, and indicated, baseline care plans should be added to the Care Plans upon admission to provide orders and interventions which were critical for the first 48 hours after admission. The policy indicated, It is the policy of this facility that each resident will have an interdisciplinary baseline care plan developed within 48 hours of admission the baseline care plan will be developed in collaboration with the resident, family and/or representative and direct care staff to incorporate findings based on the admission assessment, observations, interviews, and resident preferences. The baseline care plan will include resident centered goals and interventions relative to resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial needs procedure: baseline care plans will be opened in matrix and initiated within 48 hours of admission to the facility by the admitting nurse in collaboration with the interdisciplinary team the baseline care plan will include but is not limited to the following colon the residents initial goals for care instructions . the Baseline Care Plan will include, but not limited to the following . the resident's immediate health and safety needs, physician's orders

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38768 Based on observation, interview and record review, the facility failed to ensure a resident (Resident 87) received care plan revisions to implement new goals and/or approaches to address her diabetic management for 1 of 5 residents reviewed for unnecessary medications. Findings include: On 4/22/25 at 9:00 a.m., Resident 87 was observed in bed. A over-bed table with a breakfast tray was observed in front of her, but Resident 87 indicated she did not want to eat her breakfast. Resident 87 indicated she did not like the food and because of her diabetes, there were certain things she could or could not eat. On 4/23/25 at 10:16 a.m., Resident 87's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to diabetes mellitus type II (a blood sugar disorder) and kidney failure. A nursing progress note, dated 2/21/25 at 10:14 p.m., indicated, Resident 87 had refused all evening medications and refused to have her blood glucose checked. She was asked three separate times but remained adamant about her refusal. An interdisciplinary team (IDT) progress note, dated 3/4/25 at 9:20 a.m., reviewed Resident 87's recent refusals of evening medications and blood sugar checks. Her refusal was attributed to delusions of contracting an illness due to sharing a room. She was provided assurance and staff showed her infection prevention tasks. A nursing progress note, dated 4/6/25 at 9:04 p.m., indicated, Resident 87 refused insulin that shift. She stated she felt she did not need to take medication. Resident 87 continued to refuse her insulin but took her oral medication. A nursing progress note, dated 4/15/25 at 11:51 p.m., indicated, Resident 87 had received her scheduled insulin, but refused to eat her dinner and refused to eat any snacks. Her blood sugar level was taken and was 152. A nursing progress note, dated 4/19/25 at 5:18 a.m., indicated, Resident 87 refused to have her blood sugar checked and refused her scheduled insulin. She stated, she didn't need to have her blood sugar checked and she felt like she didn't need any insulin. The resident was reminded of the importance of taking her insulin and getting her blood sugars checked. She had a care plan dated 8/21/24 which indicated, she was at risk for adverse effects of hyperglycemia/hypoglycemia (high/low blood sugar) related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. This care plan, and her full care plan set, lacked revision to include her history of behaviors for refusing her medications, insulin and meal schedules for her diabetic management (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, IDT Comprehensive Care Plan Policy, revised 8/2023. The policy indicated, It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on the resident's needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being . care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MSDS assessment 3.1-35(d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 A. Based on record review and interview, the facility failed to obtain resident weights as ordered for 2 of 2 residents reviewed for weights (Resident 74 and 107). B. Based on observations, interview and record review, the facility failed to ensure a newly admitted resident, (Resident C) had physician's orders in place and treatments rendered for a new surgical wound upon his admission for 1 of 5 residents reviewed for quality of care. C. Based on record review and interview the facility failed to ensure a resident's (Resident B) physician's ordered were followed to apply and remove a transdermal medication patch for 1 of 5 residents reviewed for quality of care. Findings include: A1. On [DATE] at 11:04 a.m., a record review was completed for Resident 74. She had the following diagnoses which included but were not limited to dementia, hyperlipidemia (high cholesterol), depression, and insomnia. She had an order, dated [DATE], to obtain her weight weekly on Monday. Her weight was not obtained on [DATE], [DATE] and [DATE]. She had a care plan dated [DATE] that indicated she was at risk for unintentional weight loss related to dementia. The goal indicated she would be free from significant weight changes. A2. On [DATE] at 10:30 a.m., a record review was completed for Resident 107. He had the following diagnoses which included type 2 diabetes mellitus, congestive heart failure (CHF), hyperlipidemia, mild cognitive impairment, and difficulty in walking. Resident 107 had an order, dated [DATE], to obtain daily weight for CHF daily and to notify the physician if there was a weight gain of 3 pounds a day or 5 pounds in a week. Resident's [DATE] medication administration record (MAR) was reviewed. He was missing weights for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Resident's [DATE] MAR was reviewed. He was missing the following weights: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 1:45 p.m. the Regional Nurse Consultant (RCS) provided an updated MAR for Resident 107. The MAR was complete with indications that he refused his weight. This was added after the weight concerns had been brought to her attention. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He had a care plan dated [DATE] which indicated he had the potential for impaired gas exchange related to respiratory failure, his head of bed is elevated while lying, CHF, oxygen use. On [DATE] his care plan was updated indicating he refuses to be weighed at times. This information was added after weights were brought to management's attention. On [DATE] at 2:00 p.m., during an interview with the Director of Nursing (DON), she indicated they need to do a better job at recording refusals. She wanted to continue with daily weights because Resident 107 had a new diagnosis of CHF. A policy titled, Resident Weight Monitoring with a date of ,d+[DATE] was provided by the DON on [DATE] at 9:29 a.m. It indicated, .It is the policy of this facility to weigh residents no less than monthly or per physician orders. Residents may exercise their right to refuse to be weighed . 38768 B. On [DATE] at 9:50 a.m. Resident C's wife was observed as she left the hall and stopped a nurse to ask about her husband's leg. She indicated to the unidentified nurse that his leg was still bleeding and had gotten all over his sheets. On [DATE] at 10:32 a.m., Resident C was observed as he laid in bed. He had a left below the knee amputation (BKA) which was wrapped up however, he had bleed through the dressing and bandage. A folded sheet had been placed under his soiled dressing and there was a moderate amount of bright red stains on the white sheet as well. Residnet C indicated, he admitted to the facility on Friday the 18th. Everything had been find at the hospital after his amputation, but shortly after he arrived to the facility, he noticed he started bleeding through the bandage. He and his wife, (who was also a resident) had talked to several staff member, but he still had not had a dressing change. On [DATE] at 10:44 a.m., Registered Nurse (RN) 12 indicated, he had not seen Resident C yet, but had been alerted that his bandage had bled through, so he was going to put a PRN (as needed) dressing in place since his bandage was soaked through. On [DATE] at 10:47 a.m., Resident C's physician's orders were reviewed and revealed no dressing/treatment orders schedule or as needed for his left BKA. On [DATE] at 8:55 a.m., Resident C was observed. He remained in bed and his dressing was observed soiled with bright red drainage. He indicated, he bled through his dressing and it seemed that the wound would not stop bleeding. On [DATE] at 1:33 p.m., Resident C was observed. He had a new bandage which appeared to be dry and intact. Resident C indicated, it seemed like it was under control now. On [DATE] at 9:15 a.m., Resident C was observed. His bandage remained dry and intact, and he indicated he had not needed it changed since the bleeding seemed to have stopped. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:50 a.m. Resident C's medical record was reviewed. He was a newly admitted resident for aftercare following a left BKA with a history of atherosclerosis of native arteries of extremities with gangrene, (a condition where hardened plaque buildup in the arteries of the legs and feet leads to poor blood flow and tissue death [gangrene]). and peripheral vascular disease ([PVD] a condition where blood flow to the extremities, primarily legs and feet, is restricted due to narrowed or blocked blood vessels). On [DATE] at 12:26 p.m., the Infection Preventionist (IP) provided a copy of Resident C's hospital discharge summary and instructions. The hospital record was dated [DATE] and indicated, continue daily dressing changes, wash with soap/water and pat dry. May leave open to air if no drainage and clean environment versus dry dressing. Staples to remain ,d+[DATE] weeks A physician's order for treatment and dressing to his left BKA was not placed in the order set until [DATE]. Resident C's Treatment Administration Record (TAR) was reviewed from his admission on [DATE] until [DATE] and revealed no treatments or wound dressings had been administered over the weekend after his admission. A late nursing progress note was added to his record on [DATE] at 3:16 p.m., (dated effective for [DATE] at 3:04 p.m.) which indicated, .changed wound dressing to resident's left BKA with a pressure wrap. His wound was bleeding out from the previous dressing onto his bed sheets. Wound has some staples still remaining, the oozing of blood was coming from one of the staples On [DATE] at 10:22 a.m., the Infection Preventionist (IP) provided a copy of current facility policy titled, Nursing Admission/Return Admission Policy and Procedure), revised ,d+[DATE]. The policy indicated, .Upon admission, physician orders must be obtained. Transcribe the admission orders from the original orders sent from the hospital or physician's office C. A confidential interview during the survey indicated Resident B was taken to the hospital were they found two Nitroglycerin (ointment or skin patch is used to prevent angina [chest pain] caused by coronary artery disease [CAD]) patches on the resident. On [DATE] at 1:38 p.m., Resident B's medical record was reviewed. She had been a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Alzheimer's disease (an irreversible and degenerative brain disease which affects memory and cognition) hypertension (high blood pressure) and heart failure. She was discharged to the hospital on [DATE] and did not return to the facility. A nursing progress note, dated [DATE] at 1:10 p.m., indicated, Resident B's family requested she be sent to the ER for assessment and evaluation after a fall earlier that morning. Resident B was transferred to the hospital, but returned the same day with no major injuries or infections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:35 a.m., the Director of Nursing (DON) provided a copy of a hospital emergency room (ER) summary from [DATE]. The ER summary indicated, .she did have 2 nitroglycerin patches on, one of them was expired At the time of her hospitalization on [DATE] she had an order for the following, nitroglycerin patch 24 hour; 0. 2 mg/hr; Amount to Administer: 0.2 mg/ hr; transdermal every 12 hours. The order included specific instructions to place ON 12 hours during the day (y) OFF 12 hours at night A nursing progress note dated [DATE] at 3:23 p.m., indicated, Resident B had a Nitro patch on her left shoulder from yesterday. It was removed and replaced with a new patch on left shoulder. The note lacked documentation the physician had been notified. The physician's order active for her Nitro patch on [DATE] indicated specific instructions to remove the old patch at bedtime. Resident B's comprehensive care plan was reviewed and lacked implementation and/or revision to include person-centered goals and interventions related to her heart failure and the use of a nitro transdermal patch. On [DATE] at 9:50 a.m., the Director of Nursing (DON) provided a copy of a nursing in-service. The DON indicated that Resident B's family was upset when she returned to the facility and told the administrator (ADM) that two Nitro patches were on her back. The ADM told the DON, and the DON conducted an in-service and audit to correct the issue. The DON indicated they conducted the in-service and audits at the time they were made aware on [DATE]. The DON indicated, there was no specific policy, but it was basic nursing standards of care to follow physician's orders as written and to update the care plans with interventions as needed. The in-service material and audit tools were reviewed but had not been initiated until [DATE]. On [DATE] at 10:40 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, IDT Comprehensive Care Plan Policy, revised ,d+[DATE]. The policy indicated, It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on the resident's needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being . care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MSDS assessment This citation relates to Complaint IN00456348. 3XXX,d+[DATE]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46414 Based on observation and interview, the facility failed to prevent the potential for accidents when medications were left bedside with residents without self-administration assessments for 2 of 2 random observations (Residents 78 and 118), and when a nurse was observed leaving medications unattended on top of the medication cart during a medication pass observation which had the potential to affect 2 of 2 residents in the hallway when the medication was unattended. Findings include: 1. On 4/20/25 at 9:46 a.m. Resident 78 was observed sitting up in his wheelchair. On his bedside table was a clear cup and inside there were 7 pills ranging in color and size. Resident 78 indicated he had not taken them yet because he had an upset stomach. He indicated the nurse left them there for him to take. A record review was completed. Resident 78 had the following diagnoses which included but were not limited to cerebral infarction (stroke), type 2 diabetes, difficulty swallowing, hyperlipidemia, and hypertension. On 4/23/25 at 1:30 p.m., the Director of Nursing (DON) indicated Resident 78 lacked a self-administration assessment and the nurse should not have left the medications at bedside. 2. On 4/21/25 at 9:58 a.m., Resident 118 was observed as she laid in bed. As the resident explained that she had been constipated for the last week, she pulled a bottle of Dulcolax (an over the counter stool softener) out of her purse. On 4/24/25 at 11:04 a.m., Resident 118's medical record was reviewed. She was a rehabilitation resident whose diagnoses included but were not limited to malignant neoplasm of the larynx (throat cancer), constipation and Urinary Tract Infection (UTI). On 4/24/25 at 10:30 a.m., the Assistant Director of Nursing (ADON) indicated Resident 118 did not have a self-administration assessment and should not have any medications at bedside. 3. On 4/24/25 at 8:15 a.m., Registered Nurse (RN) 6 was observed as she passed medications. When preparing medications for a resident she separated the residents blood pressure medication from all the other medications and put it in its own medication cup. When taking the medications to the resident RN 6 left the medication cup with the blood pressure medication in it on top of the medication cart unattended. At the time the medication was left unattended there were two unidentified residents in the hallway. A policy titled, Storage and Expiration Dating of Medications and Biologicals was provided by the Assistant Director of Nursing (ADON) on 4/24/25 at 1:35 p.m. It indicated, .Facility should not administer/provide bedside medications or biologicals without a physician/prescriber order and approval by the interdisciplinary team and facility administration . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 Based on observations and interviews, the facility failed to date insulin and eye drops when opened and failed to remove expired tuberculin serum and insulin from the refrigerator for 3 of 6 medication carts and 2 of 4 medication rooms. Findings include: On [DATE] at 1:03 p.m., 200 hall medication cart was observed. Resident 282 had an insulin pen dated [DATE]. Resident 281 had a vial of folic acid inside the refrigerator on 200-hall that was undated. The 300-hall medication cart was observed. Resident 25 had a NovoLog insulin pen undated, and glargine insulin pen undated. Resident 86 had an insulin pen Semglee with no date to indicate when it was opened. Resident 38 had a bottle of brimodine 0.2% with no date to indicate when it was opened. The 300-hall medication room was observed. Inside the refrigerator was a vial of tuberculin serum that had a date of [DATE] on it. The 400-hall back medication cart was observed. Resident 1 had a insulin pen glargine with no date to indicate when it was opened. On [DATE] at 11:32 a.m., during an interview with the Director of Nursing (DON), she indicated they had been auditing the carts to ensure items had dates on them. A policy titled Storage and Expiration Dating of Medications and Biologicals was provided by the Assistant Director of Nursing (ADON) on [DATE] at 1:35 p.m. It indicated, .Facility should ensure medications and biologicals that 1) have an expired date on the label .Once any medication or biological package is opened, the facility should follow manufacturer/suppliers guidelines with respect to open dates for opened medications . 3XXX,d+[DATE](j) 3XXX,d+[DATE](m) 3XXX,d+[DATE](n)

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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. 51296 Based on observations, interviews and record review the facility failed to ensure the medical record reflected accurate documentation of a pressure injury for a resident for 1 of 25 residents reviewed for accurate documentation (Resident 16). Findings include: On 4/22/25 at 10:15 a.m., Resident 16 was observed as he lay in bed. He was pleasantly confused at times, but he could answer most questions appropriately. He had a pressure-relieving boot on his right heel and another pressure-relieving boot was on the floor at the foot of the bed. On 4/24/25 at 1:35 p.m., Resident 16's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to Type 2 Diabetes and Urinary Tract Infections (UTI). A progress note, dated 11/15/24 at 10:35 p.m., indicated Resident 16 arrived at the facility in a wheelchair with bilateral edema in his lower extremities and a pressure ulcer on his right heel. A progress note, dated 3/16/25 9:59 p.m., indicated Resident 16 had a dressing changed to his right heel ulcer. An admission assessment, dated 11/15/24, indicated Resident 16 had a pressure ulcer on his right heel. A weekly skin assessment, dated 11/26/24, indicated Resident 16 had open areas on his left foot. A weekly skin assessment, dated 12/3/24, indicated Resident 16 had open areas on his left foot with eschar (a hardened crust of black or brown dead tissue, that forms over a wound). A weekly skin assessment, dated 12/10/24, indicated Resident 16 had open areas on his left heel. A weekly skin assessment, dated 12/24/24, indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 12/31/24, indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 1/14/25, indicated Resident 16 had open areas on his heel, it did not specify which heel. A weekly skin assessment, dated 1/28/25, indicated Resident 16 had open areas on his left heel. A weekly skin assessment, dated 3/4/25, indicated Resident 16 had open areas on his left, it did not specify where the open areas were located. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Meadows	2 E Tilden Brownsburg, IN 46112

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission assessment, dated 3/13/24, indicated Resident 16 had a pressure ulcer on his right heel. In an interview on 4/24/25 at 12:00 p.m., Registered Nurse (RN) 11 indicated Resident 16 has a pressure ulcer on his right heel only. In an interview on 4/25/25 at 11:00 a.m., the Director of Nursing (DON) indicated Resident 16 did not have open areas anywhere but his right heel. She indicated that the skin assessments that say he had a wound on his left heel were incorrectly charted and she was going to have the nurses who charted incorrectly fix the mistakes. On 4/24/25 at 1:35 p.m. the Assistant Director of Nursing (ADON) provided a copy of a current facility policy titled, Documentation Guidelines for Nursing dated 7/2024. The policy indicated, .Purpose: to accurately document in an organized manner all information related to the resident in the medical record 3.1-50(f)