STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooke Knoll Village	1108 Kingwood Drive Avon, IN 46123

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews, the facility failed to ensure controlled substances were appropriately stored in a medication cart for 1 of 2 narcotic count observations. Findings include:On 8/14/25 at 10:43 a.m. the medication cart on 500 hall was observed for a narcotic count with Qualified Medication Aide (QMA) 7. Resident B had a bottle of Tramadol 50 milligrams (mg) tablets with an order to take 1/2 a tablet twice daily. QMA 7 took the contents out of the bottle. There were three pill crush sleeves stapled together with 20 half tablets in each of the sleeves, one pill crusher sleeve that was stapled with 20 half tablets in it and 1 pill crusher sleeve open with 14 half tablets in it. QMA 7 indicated the three sleeves that were stapled together were from another full bottle of the same prescription, and the other two were from the current bottle. The QMA indicated sometimes the nurse who received the bottle would pre count the pills to make counting easier. They would put 20 pills each into a pill crusher sleeve and then staple them shut.During an interview on 8/14/25 at 12:00 p.m. the Executive Director (ED) indicated that the practice of pre counting pills and storing multiple bottles of pills in one bottle was not best standard practice and he would expect the nursing staff to follow the facilities policy on medication storage.On 8/14/25 at 12:15 p.m. the ED provided a copy of a current facility policy titled, Storing Drugs, dated 7/2025. This policy indicated, . each drug must be kept and stored in the labeled dispensing container. Drugs may not be transferred from one container to another.3. 1-25 (j)3.1-25 (m) 3.1-25 (n)

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