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	04/09/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to ensure enhanced barrier precautions were implemented per facility policy and ensure appropriate professional standards for infection prevention were implemented for 3 of 27 residents reviewed for infection control (Residents 105, 77, and 1). Findings include:1. On 4/6/26 at 10:32 a.m., Resident 105 was initially observed. He was lying in bed with an intravenous (IV) pole at bedside which ran to a peripherally inserted central catheter (PICC). A Foley catheter (urinary catheter) drainage bag was also noted to the side of his bed with dark yellow urine in it. On 4/8/26 at 9:30 a.m., Resident 105 was observed through his open door. Licensed Practical Nurse (LPN) 14 and an unidentified Certified Nursing Aide (CNA) were in his room with him. The CNA indicated she was finishing getting Resident 105 cleaned up and bathed and had called the nurse in to put a treatment on his bottom. LPN 14 was observed as she applied a zinc cream to his coccyx area. She was not wearing a gown. The CNA indicated she had not worn a gown to provide his bed bath. On 4/8/26 at 10:14 a.m., LPN 14 returned to Resident 105's room with a new bag of antibiotic medicine. She indicated he was receiving the antibiotic for a urinary tract infection and had a foley catheter. LPN 14 did not perform hand hygiene before she donned gloves and began to set up the bag of antibiotics. She touched multiple surfaces which included, the pump, the IV pole, the bathroom door handle, and the residents blankets. She did not remove her glove or perform hand hygiene before she inserted the IV line into the PICC port. She began to remove her gloves, then indicated she forgot to flush the PICC. She kept her old gloves on, removed the PICC line and dropped it to the bed as she picked up and opened a flush syringe. Performed the flush and then re-inserted the PICC line back into the port without re-cleaning the PICC port. On 4/7/26 at 11:36 a.m., Resident 105's record was reviewed. The most recent Minimum Data Set (MDS) assessment was an admission assessment, dated 3/31/26, which indicated he had a Foley catheter and received an antibiotic. His record lacked a baseline or comprehensive care plan for enhanced barrier precautions, however there was a sign posted on the resident's closet door which indicated he required enhanced barrier precautions. 2. On 4/8/26 at 11:10 a.m. Certified Nursing Aide (CNA) 8 was observed while he provided incontinent care for Resident 77. CNA 8 was observed taking the catheter bag that was attached to Resident 77's suprapubic catheter (a hollow, flexible tube inserted into the bladder through a small abdominal incision, typically a few inches below the navel), switching it to a leg collection bag and then carrying the old collection bag to the resident's bathroom with only gloves on. After switching the collection bags CNA 8 used the same gloved hands to go through Resident 77's drawers and closet searching for supplies to finish incontinent care. CNA 8 then continued to use the same gloved hands to finish (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent care for Resident 77. At no point during care did CNA 8 wear a gown or a mask. On 4/8/26 at 11:45 a.m. Resident 77's medical record was reviewed.He was a long-term care Resident who had a chronic suprapubic catheter. Resident 77's medical record showed an active order for Enhanced Barrier Precautions (EBP) related to his catheter. 3. During an observation, on 4/8/26 at 1:42 p.m., Licensed Practical Nurse (LPN) 13 provided wound care to Resident 1, while Qualified Medication Aide (QMA) 12 assisted with the resident's positioning. During the wound care the following was observed. LPN 13 applied an isolation gown and gloves. LPN 13 cleansed the resident's wound and used their gloved finger to apply zinc cream around the wound bed. After the zinc cream application, zinc cream remained on LPN 13's gloved finger. The gloves were not changed, and LPN 13 continued with the dressing change. LPN 13 used their metal scissors to cut the treatment and applied it to the wound bed. Zinc cream was left on the metal scissors from LPN 13's finger. LPN 13 placed a dressing over the resident's wound. With the same gloves, LPN 13 picked up the metal scissors, wiped off the visible soilage from the zinc cream with a paper towel, put them in their pocket, and indicated the scissors would be cleaned later. LPN 13 removed their gloves and washed their hands. After washing their hands, LPN 13 touched the front of the isolation gown and pulled it off. LPN 13 left the resident's room without washing their hands after touching the front of the isolation gown. Resident 1's record was reviewed on 4/9/26 at 10:29 a.m. A 5-day Minimum Data Set (MDS) assessment, dated 3/6/26, indicated the resident had a moderate cognitive impairment and a pressure ulcer (localized damage to the skin and underlying tissue related to prolonged pressure) that had been present upon admission to the facility. A physician's order, dated 3/30/26, indicated the resident required enhanced barrier precautions (EBP) related to a feeding tube (tube inserted into the stomach for artificial nutrition) and wound care. A physician's order, dated 4/1/26, indicated cleanse the coccyx (tailbone) wound with normal saline, pat dry, apply zinc oxide paste (barrier cream) around the wound, apply collagen sheet (wound dressing used to treat chronic, stalling, or acute wounds) to the wound bed, cover with a hydrocolloid dressing (gel-forming, waterproof dressing that creates a protective environment), may secure with gauze and tape if necessary, and change every other day. A care plan, initiated on 3/30/26, indicated the resident required EBP during high contact care activities that provide opportunities for the transfer of multi-drug resistant organisms (MDROs). High contact care activities included, but were not limited to, wound care. During an interview, on 4/9/26 at 11:25 a.m., the Infection Preventionist (IP) indicated personal protective equipment (PPE) for EBP should have been removed by pulling off the isolation gown and removing the gloves as the gown is removed. After PPE removal, handwashing should have been completed. If the isolation gown was touched after handwashing, then hands should have been washed again. During an interview, on 4/9/26 at 12:14 p.m., QMA 12 indicated PPE should have been removed by taking off the isolation gown, removing the gloves, and washing hands. The isolation gown should not have been left on during handwashing or touched after handwashing was completed. Re-usable (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment, including scissors, should have been sanitized between each resident with sani-cloths (sanitizing wipes). Equipment should have been cleaned before it was placed in a pocket. Normally, staff brought the sani-wipes in the resident's room with them. If gloves were visibly soiled they should have been changed. On 4/9/26 at 1:33 p.m., the Administrator provided a document titled, Enhanced Barrier Precautions, dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Enhanced Barrier precautions.expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated. These precautions entail the use of gown and gloves during 'high-contact' resident care activities that provide opportunities for transfer of multi-drug resistant organisms.to staff hands and clothing to address the continued risk of transmission from residents with MDRO colonization. On 4/9/26 at 1:33 p.m., the Administrator provided a document titled, Dressing-Clean Technique, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: A clean dressing technique is used to provide an appropriate environment conducive to wound healing. Policy: All dressings are performed by licensed personnel per physician's order using clean technique, unless another technique is specified by the physician. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to accurately code a Minimum Data Set (MDS) (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) for 1 of 6 residents reviewed for MDS accuracy (Resident 11).Findings include:On 4/7/26 at 2:26 p.m., a record review was completed for Resident 11. She had the following diagnoses which included, but were not limited to, unspecified dementia, hallucinations, depression, and anxiety disorder.On 4/9/26 at 1:34 p.m., a Preadmission Screening and Resident Review (PASRR) level II (used to identify the specialized needs of individuals with mental illness (MI), dated 8/9/24, intellectual or developmental disability ID/DD, or both (MI/ID/DD) was provided. Resident 11's, MDS assessment, dated 6/17/25, indicated the resident did not have a PASRR level II.During an interview on 4/9/26 at 2:00 p.m., the Corporate MDS Coordinator indicated Resident 11's MDS was inaccurate. She corrected the MDS and provided a copy of the attestation form on 4/9/26. On 4/10/26 at 12:26 p.m., the Director of Nursing (DON) indicated they did not have a policy for MDS and followed the Resident Assessment Instrument (RAI) manual.

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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 Based on observation, interview and record review, the facility failed to ensure baseline care plans were implemented for 1 of 5 residents reviewed for baseline care plans (Residents 105).Findings include:On 4/6/26 at 10:32 a.m., Resident 105 was initially observed. He was lying in bed with an intravenous (IV) pole at bedside which ran to a peripherally inserted central catheter (PICC). A foley catheter drainage bag was also noted to the side of his bed with dark yellow urine in it. Resident 105 indicated he was very tired, cold, and his arm hurt.On 4/6/26 at 12:00 p.m., Resident 105 was observed. He was lying in bed and indicated he was cold, and still had a little pain, or aches over his whole body.On 4/8/26 at 9:25 a.m., Resident 105's door was closed. He was heard calling out from the closed door.During an interview on 4/8/26 at 9:38 a.m., Licensed Practical Nurse (LPN) 14 exited his room. LPN 14 indicated his calling out during turning and repositioning was normal for him, he had general pain and aches, and experienced discomfort when care, turning, and repositioning.On 4/8/26 at 9:55 a.m., Physical Therapist (PT) 15 entered Resident 105's room. He began to assist Resident 105 by putting socks on, but Resident 105 called out in pain. PT stopped and asked if he was ok. At that time, LPN 14 entered the resident's room to adjust his IV. PT 15 attempted to put the resident's socks on again, but moving his foot and leg, the resident cried out in pain. LPN 14 and PT 15 stopped what they were doing and asked where his pain was and what level his pain was. Resident 105 indicated he was aching all over and his pain was a 7, 8 or 9, and he asked for some Tylenol. LPN 14 left the room to go get medicine.On 4/8/26 at 10:14 a.m., LPN 14 returned to Resident 105's room with a new bag of antibiotic medicine. She indicated he was receiving the antibiotic for a urinary tract infection and did not have an order for as needed or scheduled pain medication, so she called the Nurse Practitioner (NP) and was waiting for a response.On 4/7/26 at 11:36 a.m., Resident 105's record was reviewed. The most recent Minimum Data Set (MDS) assessment was an admission assessment, dated 3/31/26, which indicated he had a foley catheter, a PICC, and was at risk for pain.The record lacked backline care plans to address his immediate needs for his PICC, Foley, and/or pain.During an interview on 4/9/26 at 9:00 a.m., the Director of Nursing (DON) indicated baseline care plans were completed by the Social Service Director and kept in her office.During an interview on 4/9/26 at 9:07 a.m., the Social Service Director indicated she did not do baseline care plans, that was the nursing department.During an interview on 4/9/26 at 9:53 a.m., the DON indicated she looked for Resident 105's baseline care plan but could not find one and that there needed to be a better process for the baseline care plans moving forward.On 4/8/26 at 2:16 p.m. the Administrator provided a copy of current facility policy titled, Care Plan Development and Review, dated 9/2017. The policy indicated, .This facility shall develop and implement a baseline care plan within 48 hours of a resident's admission that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interview, the facility failed to correctly administer insulin for 1 of 1 resident observed for insulin administration (Resident 63).Findings include:On 4/7/26 at 12:12 p.m., RN 6 was observed prepping a Humalog insulin pen to administer to Resident 63. The order was for 2 units based on her blood sugar of 153. RN 6 dialed in 2 units of insulin and held up the insulin pen to be seen. RN 6 was intervened due to not priming the insulin pen with 2 units of insulin prior to dialing in the 2 units to administer to the resident. The correction was made and the insulin was administered to Resident 63's left lower abdomen. The Director of Nursing (DON) was present throughout the procedure. On 4/8/26 at 2:08 p.m. during an interview with the DON, she indicated she went through the steps of administering insulin prior to being observed and he did everything correctly. She indicated RN 6 was nervous being observed. On 4/10/26 at 10:20 a.m., RN 6's insulin administration competency checklist was reviewed. On the checklist, item number 8 indicated to dial a dose of 2 units to prime the pen. He demonstrated competency with this task. On 4/10/26 at 10:22 a.m., a policy was requested and not received at the time of exit.410 IAC (Indiana Administrative Code) 16.2-3.1-37

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interview, and record review, the facility failed to ensure activities of daily living (ADLs) nail care was provided for residents who were dependent on staff for person hygiene for 3 of 4 residents reviewed for nail care (Residents 51, 61, and 1).Findings include:1. On 4/6/26 at 10:54 a.m., Resident 51 was initially observed. He was lying in bed in a hospital gown, his hair was unbrushed and appeared greasy. His fingernails were long and had debris under them. He indicated his nails were long and jagged and wanted to get them cut down. On 4/7/26 at 9:45 a.m., Resident 51's nails were observed. They remained long, and had debris under them. He indicated no one had cut them yet, but maybe they would for his shower day. On 4/8/26 at 9:20 a.m., Resident 51's tube feeding pump was alarming. Licensed Practical Nurse, (LPN) 14 entered his room to check the pump. She observed his nails at that time and indicated they were jagged and needed to be cut, she would let the aide know. On 4/7/26 at 10:42 a.m., Resident 51's record was reviewed. The most recent Minimum Data Set (MDS) assessment was an admission assessment, dated 3/20/26, which indicated he was cognitively intact and requested maximum or total dependence on staff for all ADL care. Resident 51's point of care CNA documentation was reviewed and indicated nail care was provided each shift and checked off as completed. 2. During an observation, on 4/6/26 at 12:32 p.m., Resident 61 had an unshaved beard and mustache growth. At the same time, the resident indicated he wanted to be shaved and did not like having the beard and mustache growth. During an observation, on 4/8/26 at 9:36 a.m., Resident 61 had unshaved beard and mustache growth. At the same time, the resident indicated no one had offered to help him shave. During an observation, on 4/9/26 at 9:51 a.m., Resident 61 had unshaved beard and mustache growth. At the same time, the resident indicated a couple of days ago the staff helped him shower, but no one had offered to help him shave. He wanted to be shaved. Resident 61's record was reviewed on 4/8/26 at 2:28 p.m. Diagnoses on the resident's profile included, but were not limited to, need for assistance with personal care and hemiplegia (complete paralysis or severe dysfunction of one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke caused by a blockage in an artery supplying the brain) affecting right dominant side. A 5-day Minimum Data Set (MDS) assessment, dated 2/14/26, indicated the resident was cognitively intact, had not rejected care during the look back period, had impairment on one side of upper and lower extremities, and required substantial/maximal staff assistance with showering and bathing. A care plan, initiated on 1/23/26, indicated the resident required long-term care due to being dependent on others for all ADLs. A care plan, initiated on 1/27/26, indicated the resident required one or two staff assistance with activities of daily living (ADLs). Interventions included, but were not limited to, provide assistance (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with ADLs as the resident required and showers/baths per schedule and more frequently as needed or requested. Point of care documentation in the electronic record, dated 3/1/26 to 4/8/26, indicated the resident received five showers and one complete bed bath during the timeframe. The bathing documentation did not specifically address shaving. Progress notes, dated 3/1/26 to 4/8/26, lacked documentation shaving was offered, provided, or refused. Shower sheets, dated March and April 2026, indicated the resident received a shower or bath on 3/1/26, 3/3/26, 3/4/26, 3/7/26, 3/11/26, 3/14/26, 3/21/26, 4/1/26, and 4/8/26. The resident refused a shower or bath on 3/28/26. The shower sheets lacked documentation shaving was offered, provided, or refused with the showers. On 4/9/26 at 1:33 p.m., the Administrator provided a document titled, Shaving Male, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To remove facial hair and improve sense of well-being. Policy: Male residents may shave their own facial hair, if capable, or personnel will assist residents to shave with an electric or safety razor, as indicated or requested. 3. During an observation, on 4/6/26 at 10:59 a.m., Resident 1 had long fingernails on both hands with chipped nail polish and dark debris underneath them. During an observation, on 4/7/26 at 9:10 a.m., Resident 1 had long fingernails on both hands with chipped nail polish and dark debris underneath them. During an observation, on 4/8/26 at 9:38 a.m., Resident 1 had long fingernails on both hands with chipped nail polish and dark debris underneath them. Resident 1's record was reviewed on 4/9/26 at 10:29 a.m. Diagnoses on the resident's profile included, but were not limited to, multiple sclerosis (a disease that causes breakdown of the protective covering of nerves) unspecified and need for assistance with personal care. A 5-day Minimum Data Set (MDS) assessment, dated 3/6/26, indicated the resident had a moderate cognitive impairment, had not rejected care during the look back period, and was dependent on staff assistance for showering/bathing. A care plan, initiated on 6/20/25, indicated the resident required the assistance of two staff members with activities of daily living (ADLs). Interventions included, but were not limited to, nail care as needed. Progress notes, dated March and April 2026, lacked documentation fingernail care was offered, provided, or refused. Shower sheets, dated March and April 2026, indicated the resident received a shower or bath on 3/2/26, 3/16/26, 3/25/26, 3/30/36, 4/1/26, 4/6/26, and 4/8/26. Shower sheets lacked documentation fingernail care was offered, provided, or refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/9/26 at 12:13 p.m., CNAs 10 and 11 indicated fingernail care and shaving should have been provided with showers and as needed. If a resident refused ADL care the nurse should have been notified and the refusals documented. During an interview, on 4/9/26 at 12:14 p.m., Qualified Medication Aide (QMA) 12 indicated fingernail care and shaving should have been provided with showers and as needed. If a resident refused ADLs the nurse should have been notified and the care reattempted at a later time. Refusals should have been documented. During an interview, on 4/9/26 at 12:50 p.m., the Director of Nursing (DON) indicated fingernail care and shaving should have been provided with showers and as needed. If ADL care was refused, it should have been documented. On 4/9/26 at 1:33 p.m., the Administrator provided a document titled, Fingernail Care, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Cleanliness and good grooming contribute to the dignity and self-esteem of resident. Policy: Nails should be kept short, clean, and free of rough or jagged edges. Fingernail care is provided when assigned, if fingernails appear soiled or have jagged edges, and as indicated. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)(D) 410 IAC 16.2-3.1-38(a)(3)(E)

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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 label over the counter medications and failed to date medications when opened for 3 of 5 medication carts reviewed and 1 of 1 medication room (Residents 103, 7, 24, and 18).Findings include: On 4/7/26 at 12:28 p.m. the 200 hall, 300 hall, and medication room were observed for medication storage.On the 200 Hall Medication Cart, Resident 103 had Tylenol 650 mg (milligrams), B12 1000 mcg (micrograms), and Vitamin D3 without a label to indicate her name, room number, or physician's name.On the 300 Hall Medication Cart, Resident 7 had azelastine 137 mcg (a nasal spray used for allergies) in the cart without a date to indicate when it was opened.In the Medication Room Refrigerator, Resident 24 had a bottle of lorazepam 2 mg/ml (milliliter) without a date to indicate when it was opened.Resident 18 had a bottle of lorazepam 3vmg/ml without a date to indicate when it was opened.A policy titled, Storing Drugs dated 7/2025 indicated, .Any outdated, contaminated, or deteriorated drugs, or those drugs that have containers that are cracked, soiled or without secure closures must be removed from stock and destroyed according to policy.410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC (Indiana Administrative Code) 16.2-3.1-25(m)410 IAC (Indiana Administrative Code) 16.2-3.1-25(n)

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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	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 record review and interview, the facility failed to ensure documentation in a resident's medical record was accurate for 1 of 18 resident records reviewed (Resident 4). Findings include:Resident 4's record was reviewed on 4/8/26 at 12:56 p.m. Census information indicated the resident was hospitalized from [DATE] to 2/22/26. A progress note from Licensed Practical Nurse (LPN) 14, dated 2/19/26 at 5:57 p.m., indicated, Medicare: Resident is A&O [alert and oriented] x4. VSS [vital signs stable]. C/o [complaints of] pain to lower/upper back specifically muscle spasms. Staff makes multiple attempts to reposition with pillows, mostly effective. Continues on scheduled lyrica [nerve pain medication], hydromorphone [pain medication], diazepam [medication for anxiety and muscle spasms], and oxycodone [pain medication], somewhat effective. No increased pain noted at this time. Dependent with all ADL's [activities of daily living], able to consume meals with set up and meds given po [by mouth] crushed.Staff continues to anticipate wants and needs. Resident continues on OT/PT [occupational therapy/physical therapy]. A progress note from LPN 14, dated 2/20/26 at 5:57 p.m., indicated, Medicare: Resident is A&O x4. VSS. C/o pain to lower/upper back specifically muscle spasms. Staff makes multiple attempts to reposition with pillows, mostly effective. Continues on scheduled lyrica, hydromorphone, diazepam, and oxycodone, somewhat effective. No increased pain noted at this time. Dependent with all ADL's, able to consume meals with set up and meds given po crushed.Staff continues to anticipate wants and needs. Resident continues on OT/PT. A progress note from LPN 14, dated 2/21/26 at 5:57 p.m., indicated, Medicare: Resident is A&O x4. VSS. C/o pain to lower/upper back specifically muscle spasms. Staff makes multiple attempts to reposition with pillows, mostly effective. Continues on scheduled lyrica, hydromorphone, diazepam, and oxycodone, somewhat effective. No increased pain noted at this time. Dependent with all ADL's, able to consume meals with set up and meds given po crushed.Staff continues to anticipate wants and needs. Resident continues on OT/PT, compliant with med admin [administration] and therapies. During an interview, on 4/8/26 at 1:15 p.m., LPN 14 indicated Medicare charting required a hands-on physical assessment of the resident. The charting should have included how alert and oriented the resident was, any complaints of pain, scheduled medications if the residents were in pain, how ADLs were completed, vital signs, and information about any resident specific care needs. If a resident was not in the facility, Medicare charting should not have been documented. An assessment was not able to be completed if a resident was not in the facility. During an interview, on 4/826 at 2:05 p.m., the Director of Nursing (DON) indicated Medicare charting was a progress note related to the resident's specific care needs. The nurses should have completed a hands-on physical assessment and charted it to complete the Medicare note. There should not have been Medicare notes documented if a resident was not in the facility. During an interview, on 4/9/26 at 10:03 a.m., the DON indicated she reviewed the resident's chart and saw the Medicare notes entered on the days the resident was hospitalized . The notes should not have been put in the resident's record. On 4/9/26 at 9:45 a.m., the Administrator provided a document titled, Medicare ?A' Nursing Documentation Use of Guidelines/Prompts, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: This facility shall document on skilled services rendered to a resident receiving Medicare Part A services on an, at least, daily basis. Background: When a resident's stay is covered by Medicare Part A, there is a specific condition or combination of conditions which make it necessary for the resident's care to be overseen by a licensed nurse. In an effort to affirm that the licensed nurse is monitoring the resident's medical status, response to treatment, etc., the charting guidelines/prompts have been developed. 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)