STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Health Care Center	1010 Hornaday Rd 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 38767 Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on staff for meal service, toileting, bathing and dressing, and getting residents out of bed, received those services for 8 of 15 residents reviewed for Activities of Daily Living (ADL) assistance (Residents C, F, G, H, K, L, N, and S). Findings include: 1. Observations of Resident C included: a. On 4/27/25 at 9:50 a.m., Resident C was observed lying in bed with her eyes closed, the head of the bed was elevated, and the resident's upper torso was slumped to the right. There was paper debris on the floor around the bed. b. On 4/27/25 at 11:51 a.m., the resident remained in the same position with her eyes closed, the head of the bed was elevated, and the resident's upper torso slumped to the right. c. On 4/28/25 at 9:45 a.m., the resident was observed sitting in a manual wheelchair (WC) next to the bed, sitting on a blue transfer pad. The resident indicated she had not yet had breakfast. An untouched breakfast tray of food was observed sitting on top of a small black refrigerator on a dresser, out of reach of the resident. Resident C's record was reviewed on 4/28/25 at 11:29 a.m. Diagnoses on Resident C's profiled included, but not limited to, acute and chronic obstructive pulmonary disease (COPD - sudden onset and ongoing lung diseases including emphysema and bronchitis), muscle weakness, and reduced mobility. The admission Minimum Data Set (MDS) assessment and state optional assessments, completed on 3/9/25, assessed Resident C as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A Brief Interview for Mental Status (BIMS) score 12/15 indicated she had moderately impaired cognition. The resident was incontinent of bladder and bowel. Resident C required extensive assistance of one-person physical assist for bed mobility and toileting, supervision and two plus persons physical assist for transfers, and supervision and setup help only for eating. Adaptive equipment included a WC. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current care plan for ADL self-care performance deficit related to impaired balance, limited mobility, and limited range of motion, had a goal that the resident would maintain current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included encourage resident to discuss her feelings about self-care, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, and monitor/document/report to MD (physician) any changes. 2. Observations of Resident F included: a. On 4/27/25 at 9:36 a.m., the resident was observed lying in bed watching television (TV), his left forearm and hand resting on his waist, and a hand splint on a bedside table. The resident indicated he would like to be out of bed by 10:00 a.m. daily, but due to low staffing he had yet to get up or had his brief changed by the morning shift, and he was wet. b. On 4/27/25 at 10:09 a.m., a second observation of Resident F lying in bed in the same position and he indicated he was still waiting for care. c. On 4/27/25 at 10:37 a.m., a third observation of Resident F lying in bed in the same position when a visitor entered his room. The resident's relative indicated that it was not unusual for the resident to have to wait on care, especially on weekends. d. On 4/27/25 at 11:48 a.m., the resident was observed lying in bed visiting with a peer. The resident indicated he had not been given care per the day shift yet and his brief was still wet. e. On 4/27/25 at 12:02 p.m., there were no CNAs or nurses observed in the hallway. A visitor asked QMA 4 why the resident had not gotten out of bed or had his brief changed. Resident F was overheard telling QMA 4 he had asked the CNAs to change him that morning, but no one had come back. QMA 4 was observed to check the resident's brief, acknowledge it was soiled, indicated she was uncertain why he had not yet been cared for, and that she would make sure he got cleaned up and his linens changed. Resident F's record was reviewed on 4/29/25 at 10:19 a.m. Diagnoses on Resident F's profiled included, but not limited to, cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis) on left non-dominant side, reduced mobility, abnormalities of gait and mobility, and muscle weakness. The admission MDS and state optional assessments, completed on 2/16/25, assessed Resident F as having the ability to make himself understood and to understand others. He had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 14/15 indicated he was cognitively intact. The resident was frequently incontinent of bladder and bowel. Resident F required extensive assistance with two plus persons physical assist for bed mobility, transfers, toileting, and supervision and set-up help only for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to fatigue and limited mobility, had a goal that the resident would demonstrate the appropriate use of adaptive device(s) to increase ability in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included encourage resident to discuss her feelings about self-care, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, and monitor/document/report to MD (physician) any changes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observations of Resident G included: a. On 4/27/25 at 9:41 a.m., the resident was observed lying in the bed awake, smelling of urine, a breakfast tray of untouched food and drinks at the bedside and a cup of unidentified pills sitting on the bedside stand near his breakfast tray. The resident indicated the staff was supposed to have changed his brief and assisted him to bathe, dress, and be out of bed by 8:00 a.m. so he could have breakfast. Resident G indicated he had been lying in a urine-soaked brief for hours waiting on staff, and now his breakfast food was cold. The resident indicated he had no idea his medications were on the bedside stand out of sight, but the nurse had already taken his blood sugar earlier that morning. Resident G indicated the weekends were the worst as there were never enough staff to care for the residents, and it was pure hell. b. On 4/27/25 at 9:50 a.m., the Housekeeping Supervisor was observed telling CNA 8 that Resident G needed assistance with bathing and dressing when she had time. c. On 4/27/25 at 10:36 a.m., CNA 8 was observed leaving the resident's room, and the resident was in his WC at bedside. The resident pointed to his breakfast tray and indicated the food and his water for hot chocolate were now cold. The CNA indicated she would take his water to be heated in the employee breakroom; she wanted him to at least have a hot drink as he had a cold breakfast. The resident indicated by the time he was getting out of bed he was soaking wet, and his breakfast was cold, so he frequently sent it back. d. On 4/27/25 at 10:37 a.m., a visitor indicated the day before, on Saturday 4/26/25, Resident G had been observed in his WC, wheeling himself up and down the hallway right before noon wearing only a gown and holding his clothing awaiting care. Resident G's record was reviewed on 4/29/25 at 10:45 a.m. Diagnoses on Resident G's profile included, but not limited to, type 2 diabetes mellitus, age related physical disability, overactive bladder, depression, and muscle weakness. The admission MDS and state optional assessments, completed on 2/27/25, assessed Resident G as having the ability to make himself understood and to understand others. He had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated the resident was cognitively intact. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. Resident G required extensive assistance of one-person physical assist for bed mobility, transfers, toileting, and supervision of one-person physical assist for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to fatigue and limited mobility, had a goal that the resident would improve the current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included encourage resident to discuss her feelings about self-care, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, and monitor/document/report to MD (physician) any changes. 4. Resident H was observed lying in bed with an over the bed table in front of her, watching TV. The resident indicated she had not yet had her bath, did not believe she'd had her brief changed, and was most likely wet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident H's record was reviewed on 4/29/25 at 1:45 p.m. Diagnoses on Resident H's profile included, but not limited to, cerebral infarction, altered mental status, type 2 diabetes mellitus, age related physical disability, and muscle weakness. The admission MDS and state optional assessments, completed on 3/24/25, assessed Resident H as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 10/15 indicated she had moderately impaired cognition. The resident was frequently incontinent of bladder and bowel. Resident H required extensive assistance of one-person physical assist for bed mobility, transfers, and toileting, and supervision of one-person physical assist for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to impaired balance, limited mobility, and limited range of motion (ROM) had a goal that the resident would improve the current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. 5. Resident K was observed lying in bed, wearing a gown, food crumbs on his gown and bedding, positioned with his contracted right hand and arm lying on his chest, and his left arm behind his head. The resident indicated he had fed himself the food from the breakfast tray in front of him on an over the bed tray stand. The resident indicated he had not yet had a bath or had his brief changed, and his adult brief was observed saturated with urine. Resident K's record was reviewed on 4/29/25 at 2:19 p.m. Diagnoses on Resident K's profile included, but not limited to, traumatic brain injury (brain dysfunction usually caused by a violent blow to the head), spastic hemiplegia (constant contraction of muscle) affecting right non-dominant side, aphasia (affects a person's ability to communicate), reduced mobility, muscle weakness, and difficulty walking. The admission MDS and state optional assessments, completed on 3/18/25, assessed Resident K as never/rarely having the ability to make himself understood and sometimes having the ability to understand others. He had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score of 99 indicated the resident was not able to complete the assessment. The resident was frequently incontinent of bladder and always incontinent of bowels. Resident K required extensive assistance of two plus persons physical assist for bed mobility, and transfers, extensive assistance of one-person physical assist for toileting, and supervision of one-person physical assist for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to hemiplegia, limited mobility, and limited ROM had a goal that the resident would maintain current level of unction in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included encourage resident to discuss her feelings about self-care, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, and monitor/document/report to MD (physician) any changes. 6. On 4/27/25 at 10:42 a.m., Resident L was observed lying in bed with her eyes closed, wearing a floral night gown. The resident indicated she went to the bathroom on her own, but was waiting on staff to help get her dressed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident L's record was reviewed on 4/29/25 at 3:30 p.m. Diagnoses on Resident L's profile included, but not limited to, Parkinson's disease (central nervous system disorder affecting movement and often included tremors), dementia (impairment of brain function such as memory loss and judgement), unsteadiness on feet, and muscle weakness. The admission MDS and state optional assessments, completed on 4/21/25, assessed Resident L as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 8/15 indicated she had moderately impaired cognition. The resident was occasionally incontinent of bladder and bowel. Resident L required limited assistance of one-person physical assist for bed mobility, transfers, eating, and toileting. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to the resident required extensive assistance with ADL's related Parkinson's, dementia, and other diagnoses. The goal was for the resident to present a neat, clean, odor free appearance daily. Interventions included, allow the resident to wear a gown during the day upon request, a bed baths per resident/family preference, encourage the resident to participate in ADL's as much as possible, provide clean clothes daily, and when approaching the resident about care, speak directly and state it is time for a shower/bed bath to reduce resistance. 7. On 4/27/25 at 10:51 a.m., Resident N was observed lying in bed wearing a hospital gown and watching TV. The resident indicated she had not yet been dressed, and her brief had not yet been changed. The resident indicated it was her understanding everyone had to stay in bed that day, but she was not sure why. Resident N's record was reviewed on 4/29/25 at 2:39 p.m. Diagnoses on Resident N's profile included, but not limited to, multiple sclerosis (central nervous system damage resulting in muscle weakness, vision changes, numbness, and memory issues), type 2 diabetes mellitus, neuromuscular disorder of the bladder, muscle weakness, and difficulty walking. The quarterly MDS and state optional assessments, completed on 3/12/25, assessed Resident N as usually having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 12/15 indicated the resident had moderately impaired cognition. The resident was always incontinent of bladder and bowel. Resident N required extensive assistance of two plus person physical assist for transfers, and toileting, extensive assistance of one-person physical assist for bed mobility, and supervision and one-person physical assist for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to resistance to doing care herself, and she preferred to wear gowns rather than regular clothing, had a goal that the resident would maintain her current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. 8. Observations of Resident S included: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/27/25 at 11:15 a.m., Resident S was observed sitting in a manual WC at bedside, wearing a hospital gown with a fleece cardigan over her shoulders, her bare feet resting on the floor, and emitting a deep congested tight cough. The resident had a nasal cannula for oxygen in her nose attached to a bedside concentrator and gestured to her oxygen tubing which she took out of her brief, and indicated the CNA had put the oxygen tubing inside her brief and the resident had untaped her brief to get the tubing out. A tray of breakfast food was observed sitting on an over the bed table untouched. The resident indicated she preferred to eat breakfast after being out of bed, but most often did not get up until around 10:00 a.m., and by then the food was cold. b. On 4/28/25 at 10:02 a.m., Resident S was observed lying in bed on her right side facing the wall. An untouched breakfast tray was sitting on a table near the doorway out of the resident's reach. c. On 4/28/25 at 1:56 p.m., Resident S was observed sitting in a WC at bedside, wearing a hospital gown and her bare feet on the floor, sleeping, a TV remote in her right hand, and a breakfast tray in front of her with the food untouched. A tray of lunch foods sat on the bed near the resident with the food untouched. Resident S's record was reviewed on 4/29/25 at 3:30 p.m. Diagnoses on Resident S's profile included, but not limited to, emphysema (a type of COPD that worsens over time and makes breathing difficult), chronic respiratory failure with hypoxia, chronic COPD, difficulty walking, cognitive communication deficit, reduced mobility, unsteady on feet, age-related physical debility, and need for personal care. The annual MDS and state optional assessments, completed on 4/13/25, assessed Resident S as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated she was cognitively intact. The resident was always incontinent of bladder and bowel. Resident S required extensive assistance of 2 plus person physical assist for bed mobility and transfers, extensive assistance of one-person physical assist for toilet use, and supervision and set up help only for eating. Adaptive equipment included a WC. A current care plan for ADL self-care performance deficit related to resistance to doing care herself, and she preferred to wear gowns rather than regular clothes. The goal was for the resident to maintain her current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included, the resident required staff participation to use toilet, reposition and turn in bed, bathing, oral care, personal hygiene, transfers, and dressing. Encourage the resident to participate to the fullest extent possible with each interaction. On 4/27/25 during a continuous observation of the 500 hallway from 10:42 a.m. to 11:03 a.m., there were no CNAs or nurses on the hallway, and 13 of 25 residents were observed to still be in bed. On 4/27/25 during a continuous observation of the 700 and 800 hallways from 11:08 a.m. to 11:36 a.m., 4 of 30 residents were out of bed. CNA 17 did not respond when asked why most of the residents would be in bed for lunch, instead indicated there were 2 more residents that she would be getting up for lunch. On 4/27/25 at 11:42 a.m., there were 4 residents observed sitting in wheelchairs in the back dining room awaiting lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/25 at 1:45 p.m., nurses on the day shift were observed passing medications, documenting, and walking up and down the hallways. There was no observation of nurses providing direct resident care or assisting CNAs who were providing direct resident care. A list of residents per hallway that require assistance with feeding documented 12 of 78 (15%) residents: one on 300, three on 500, three on 600, and five on 700/800. A list of residents per hallway that required extensive to total assistance with toileting documented 51 of 78 (65%) residents: one on 100, three on 200, three on 400, eight on 500, ten on 600, and twenty-two on 700/800. During an interview on 4/27/25 at 11:52 a.m., the Dietary Manager (DM) indicated the front dining room was no longer used for meals as residents in the front preferred to eat in their rooms. She indicated meals were served at 12:00 p.m. on the 600 hallways, at 12:15 p.m. on the 700 and 800 hallways, around 12:35 p.m. on the 100, 200, and 300 hallways, and around 12:45 p.m. on the 400 and 500 hallways. The DM indicated on a good day 15 residents ate meals in the back dining room. During an interview on 4/28/25 at 2:11 p.m., CNA 15 indicated she was working on the 700 and 800 hallways as one of two CNAs that day, and lower staffing of CNAs generally happened 2 to 3 times weekly. CNA 15 indicated she had not sat down all day and had not had a break or lunch as there were 30 residents on the hallways of which 6 residents required assistance for eating and 15 required mechanical lifts for transfers. CNA 15 indicated it was not possible to get all 30 of the residents out of bed timely for lunch, and she had just finished getting her last resident out of bed. During an interview on 4/28/25 at 2:15 p.m., CNA 16 indicated she was working on the 700 and 800 hallways as one of two 2 CNAs that day. She indicated it took time management to get everyone done during the time allotted on her shift. If management were in the facility, line staff could request help, but if management was not in the facility the staff did the best they could; just one resident at a time. During an interview on 4/28/25 at 2:23 p.m., RN 14 indicated on days like today with just a nurse and 2 CNAs on the 700 and 800 hallways, no one got a break. They just banded together and did the best they could. It was not possible to get everyone taken care of, fed, and out of bed timely. During an interview on 4/30/25 at 2:35 p.m., CNA 5 indicated she had worked the front 100 and 200 hallways on 4/27/25. She had been unaware of the CNA scheduled to work the 300 and 400 hallways had called off until around 9:00 a.m. when the DM asked if she needed assistance passing the breakfast trays on the 300 and 400 hallways. The breakfast trays were usually delivered to the hallways to be passed no later than 8:00 a.m. and were still in the dietary transport cart. Confidential interviews were conducted during the course of the survey: a. The employee indicated when a CNA had not come in to work on a weekend, the remaining staff member for the hallway was not notified and was left to care for 30 residents that required assistance with eating, being changed and toileted, total dependent residents, and heavy lifting. The manager on duty, Qualified Medication Aide (QMA) 4, was out of town and couldn't come in and help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The employee indicated multiple residents were making complaints to the ADM about staff refusal to assist with changing wet briefs, refusing to empty urinals, and residents being left soiled and for the following shift to care for. c. The employee indicated nursing assistant hours had been cut, leaving 2 CNAs to work on 4 hallways, and the 500 hallways had been staffed with 1 CNA to care for multiple residents requiring showers and mechanical lifts for transfers. On 4/29/25 at 12:47 p.m., the Administrator (ADM) provided a Care and Services policy, dated 6/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth .V. The IDT [Interdisciplinary Team] facilitates opportunities for residents to exercise choice and self-determination during activities of daily living [ADLs] .VII. The IDT provides care and services to residents with reasonable accommodations of each resident's individual needs and preferences Cross reference tag F725. This citation relates to Complaints IN00452678 and IN00455563. 3.1-38(a)(2) 3.1-38(b)(2) 3.1-38(b)(5)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38767 Based on observation, interview, and record review, the facility failed to ensure all medications and wound treatment solutions were secured in the public hallway and in the resident rooms for 5 of 5 residents reviewed for potential accidents (Residents G, S, T, Y, and BB). Findings include: 1. On 4/27/25 at 9:41 a.m., Resident G was observed lying in the bed awake, and a cup of unidentified pills sitting on an over the bed table beside the bed. The resident indicated he had no idea his medications were on the bedside stand as they were out of sight. Resident G's record was reviewed on 4/29/25 at 10:45 a.m. Diagnoses on Resident G's profile included, but not limited to, type 2 diabetes mellitus, age related physical disability, overactive bladder, depression, and muscle weakness. The admission MDS and state optional assessments, completed on 2/27/25, assessed Resident G as having the ability to make himself understood and to understand others. He had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated the resident was cognitively intact. Physician's orders included: a. Aspirin 81 milligrams (mg) 1 tablet by mouth one time a day for hypertension. b. Daily -Vite Multivitamin give 1 tablet by mouth one time a day for supplement. c. Doxazosin Mesylate 4 mg give 1 tablet by mouth one time a day for hypertension. d. Fluoxetine HCl 20 mg give 1 tablet by mouth one time a day for depression. e. Oxybutynin Chloride ER 10 mg give 1 tablet by mouth one time a day for overactive bladder. f. Vitamin B Complex give 1 capsule by mouth one time a day for age related physical disability. g. Juvan Oral Packet give 1 packet by mouth two times a day for wound healing, mix 1 packet with 4-6 ounces (oz) of fluids. h. Metformin HCl 500 mg give 1 tablet by mouth two times a day for diabetes mellitus type 2. i. Omeprazole 40 mg give 1 tablet by mouth two times a day for gastroesophageal reflux disease (GERD) j. Gabapentin 100 mg give 1 capsule by mouth three times a day for neuropathy. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. Lactaid 3000 units give 1 tablet by mouth before meals for lactose intolerance. On 4/27/25 all 8:00 a.m., and 9:00 a.m. medications were documented as having been administered by RN 7. The resident record lacked documentation of an assessment for self-administration of medications, a physician's order for self-administration of medications or leave medications at bedside, or a care plan for self-administration of medications. 2. On 4/28/25 at 1:56 p.m., Resident S was observed sitting in a wheelchair (WC) at bedside, sleeping. A plastic medication cup with 5 unidentified pills and an Anoro Ellipta inhaler (bronchodilator) sat on the breakfast tray in front of her. Resident S's record was reviewed on 4/29/25 at 3:30 p.m. Diagnoses on Resident S's profile included, but not limited to, emphysema (a type of COPD that worsens over time and makes breathing difficult), chronic respiratory failure with hypoxia, chronic COPD, difficulty walking, cognitive communication deficit, reduced mobility, unsteady on feet, age-related physical debility, and need for personal care. The annual MDS and state optional assessments, completed on 4/13/25, assessed Resident S as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated she was cognitively intact. Physician's orders included: a. Anoro Ellipta Inhalation 62.5-25 micrograms (mcg) inhale 1 puff orally one time a day for respiratory failure. b. Aspirin 81 milligrams (mg) 1 tablet by mouth one time a day for prophylaxis heart health. c. Daily -Vite Multivitamin 400 mcg give 1 tablet by mouth one time a day for supplement. d. Ferrous Sulfate 325 mg give 1 tablet by mouth one time a day for iron supplement. e. FiberCon 625 mg give 1 tablet one time a day for constipation, give in 8 oz of water or juice. f. Omeprazole 20 mg give 1 tablet by mouth in the morning for dyspepsia (indigestion) g. Sertraline HCl 50 mg give 75 mg (1 1/2) tablets by mouth one time daily for major depressive disorder. h. Mucinex ER 600 mg give 1 tablet by mouth two times a day for congestion. i. Sulfasalazine DR 500 mg give 1500 mg (3 tablets) by mouth two times a day for rheumatoid arthritis. j. Albuterol Inhalation Solution 2.5 mg/3 ml 0.83% inhale 1 application via nebulizer three times a day for emphysema. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. Building B. Wing	04/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/25 all 8:00 a.m., and 9:00 a.m. medications were documented as having been administered by QMA 4. The resident record lacked documentation of an assessment for self-administration of medications, a physician's order for self-administration of medications or leave medications at bedside, or a care plan for self-administration of medications. On 4/28/25 at 2:23 p.m., Registered Nurse (RN) 14 observed the cup of medications sitting on the resident's breakfast tray and indicated Qualified Medication Aide (QMA) 4 had administered the medications that morning, and staff knew better than to leave medications at bedside. 3. On 4/28/25 at 1:58 p.m., Resident T was observed with medications sitting on an over the bed table among personal items to include 2 bottles of Therma tears (lubricating eye drops), Neo-Poly-Dex eye drops (antibiotic drops), a bottle of Systane (lubricating eye drops) and a Breo Ellita inhaler (corticosteroid). Resident T's record was reviewed on 4/30/25 at 10:19 p.m. Diagnoses on Resident T's profile included, but not limited to, COPD, asthma, major depressive disorder (mental health condition characterized by persistent low mood, loss of interest or pleasure in activities), change in retinal vascular appearance (can be caused by diabetes, and be a marker for cerebral vascular disease), dry eye syndrome (tears aren't able to provide adequate moisture to the eye), and need for personal care. The annual MDS and state optional assessments, completed on 3/18/25, assessed Resident T as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated she was cognitively intact. Physician's orders included: a. Thera tears Solution 0.25 % instill 1 drop in both eyes three times a day for dry eyes. b. Neomycin-Polymy-Dexameth 0.1 % instill 1 application in right eye two times a day along the eyelids and lashes for dry eyes. c. Systane Gel 0.4-0.3 % instill 1 drop in right eye two times a day for eye dryness. d. Breo Ellipta Inhalation Aerosol Powder 100-25 mcg 1 puff inhale orally in the morning related to chronic obstructive pulmonary disease (COPD), rinse mouth after use. On 4/27/25 all 8:00 a.m., and 12:00 p.m. medications were documented as having been administered by RN 14. The resident record lacked documentation of an assessment for self-administration of medications, a physician's order for self-administration of medications or leave medications at bedside, or a care plan for self-administration of medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 4/28/25 at 1:58 p.m., Resident Y was observed with medications sitting on a over the bed table among his personal items to include a bottle of Miralax laxative powder, Structured silver liquid (used as a dietary supplement or topically for wound care), a bottle of parasite liquid supplement drops (marketed as a way to cleanse the body of parasites and improve gut health), liquid chlorophyll (a trending health supplement derived from the green pigment found in plants), detox drops (used to support the body's natural detoxification and overall well-being), and high blood pressure drops (antihypertensive medication), all with no pharmacy label for usage, soiled almost unreadable labels, and no readable expiration date. Resident Y's record was reviewed on 4/30/25 at 9:52 a.m. Diagnoses on Resident Y's profile included, but not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, major depressive disorder, and anxiety disorder. Physician's orders included: a. Miralax Oral Powder 17 grams (gm)/scoop give 1 scoop by mouth in the morning for constipation in 6-8 oz of fluid of choice. b. Chlorhexidine Gluconate Mouth/Throat Solution 0.12% give 15 ml by mouth two times a day for chronic gingivitis. The resident record lacked physician's orders for the high blood pressure drops, structured silver liquid, parasite liquid supplement drops, and the order for debrox drops had been discontinued on 2/17/25. The resident record lacked documentation of an assessment for self-administration of medications, a physician's order for self-administration of medications or leave medications at bedside, or a care plan for self-administration of medications. 5. On 4/28/25 at 1:58 p.m., Resident BB had a medication cup of unidentified white cream sitting on the handrail outside the resident room. Resident BB's record was reviewed on 4/30/25 at 12:08 p.m. Diagnoses on Resident BB's profile included, but not limited to, osteomyelitis unspecified (bone infection), acquired absence of left toes, acquired absence of right leg below the knee, and homelessness. Physician's orders included, apply house barrier cream to bilateral lower buttocks every shift and PRN (pro re nata - as needed) after incontinent episodes. The resident record lacked documentation of a physician order for prescription ointments or creams. During an interview on 4/28/25 at 4:00 p.m., the Administrator (ADM) indicated she had been unaware of residents having prescription medications at bedside, but professional staff were aware that prescription medications were not allowed to be kept at beside without an order. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 10:00 a.m., the Regional Nurse Consultant provided a Medication - Administration policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, . Medications will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner .XIV. Administer the medication to the resident. XV. The Licensed Nurse will remain with the resident until the medication is actually swallowed .XIX.A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administered the drug or treatment On 4/29/25 at 10:00 a.m., the Regional Nurse Consultant provided a Medication Storage in the Facility policy, dated 1-2024, and indicated the policy was the one currently being used by the facility. The policy indicated, .Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications Cross reference tag F725. This citation relates to Complaints IN00452678 and IN00455563. 3.1-45(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 38767 Based on observation, interview, and record review, the facility failed to properly clean and store nebulizer (small machine that turns liquid medication into a mist that can be easily inhaled) and oxygen equipment for 4 of 4 residents reviewed for respiratory care (Residents S, V, X, and Z). Findings include: 1. On 4/27/25 at 11:15 a.m., Resident S was observed sitting in a manual wheelchair (WC) at the bedside. The resident had a nasal cannula for oxygen in her nose attached to a bedside concentrator and gestured to her oxygen tubing which she took out of her brief, and indicated Certified Nursing Assistant (CNA) 15 had put the oxygen tubing inside her brief and the resident had untaped her brief to get the tubing out. The resident gestured to her nebulizer sitting on the bed beside her and the nebulizer handheld mouthpiece was unbagged and lying in the middle of the bed among her bedding. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, and the attached nasal cannula was laying on the floor. The resident indicated she used the portable concentrator when going out of her room. On 4/28/25 at 10:02 a.m., Resident S was observed lying in bed on her right side facing the wall. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, and the attached nasal cannula was laying on the floor. On 4/28/25 at 1:56 p.m., Resident S was observed sitting in a WC at bedside. A nebulizer sat on the bed beside the resident with the mouthpiece lying on the bare mattress. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, the attached nasal cannula was laying on the floor. Resident S's record was reviewed on 4/29/25 at 3:30 p.m. Diagnoses on Resident S's profile included, but not limited to, emphysema (a type of COPD that worsens over time and makes breathing difficult), chronic respiratory failure with hypoxia, chronic COPD, difficulty walking, cognitive communication deficit, reduced mobility, unsteady on feet, age-related physical debility, and need for personal care. The annual MDS and state optional assessments, completed on 4/13/25, assessed Resident S as having the ability to make herself understood and to understand others. She had no signs or symptoms of delirium, behavior, or rejection of care. A BIMS score 15/15 indicated she was cognitively intact. Physician's orders included: a. Anoro Ellipta Inhalation 62.5-25 micrograms (mcg) inhale 1 puff orally one time a day for respiratory failure. b. Aspirin 81 milligrams (mg) 1 tablet by mouth one time a day for prophylaxis heart health. c. Daily -Vite Multivitamin 400 mcg give 1 tablet by mouth one time a day for supplement. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Ferrous Sulfate 325 mg give 1 tablet by mouth one time a day for iron supplement. e. FiberCon 625 mg give 1 tablet one time a day for constipation, give in 8 oz of water or juice. f. Omeprazole 20 mg give 1 tablet by mouth in the morning for dyspepsia (indigestion) g. Sertraline HCl 50 mg give 75 mg (1 1/2) tablets by mouth one time daily for major depressive disorder. h. Mucinex ER 600 mg give 1 tablet by mouth two times a day for congestion. i. Sulfasalazine DR 500 mg give 1500 mg (3 tablets) by mouth two times a day for rheumatoid arthritis. j. Albuterol Inhalation Solution 2.5 mg/3 ml 0.83% inhale 1 application via nebulizer three times a day for emphysema. On 4/27/25 all 8:00 a.m., and 9:00 a.m. medications were documented as having been administered by QMA 4. 2. On 4/28/25 at 9:25 a.m., Resident V was observed lying in bed working on word puzzles. The resident indicated she was looking for a nurse to start her nebulizer treatment, the resident was slightly short of breath and wheezy when speaking. On 4/28/25 at 1:58 p.m., Resident V's nebulizer machine was observed sitting on the bedside table on the backside of the bed and the handheld mouthpiece was unbagged and clipped to the machine. The handheld mouthpiece was observed to have nebulizer liquid medication in the medication chamber. A physician's order, dated 3/17/25, indicated Ipratropium-Albuterol Solution 0.5-2.5 mg/ml inhale 3 ml orally three times a day for asthma at 9:00 a.m., 2:00 p.m., and 9 p.m. On 4/27/25 the 9:00 a.m. and 2:00 p.m. nebulizer treatments were documented as having been administered by Licensed Practical Nurse (LPN) 13. The resident record lacked documentation of an assessment for self-administration of medications, a physician's order for self-administration of medications or leave medications at bedside, or a care plan for self-administration of medications. A care plan indicated the resident had asthma, and the goal was for her to remain free from complications of asthma. Interventions included medications as ordered, give nebulizer treatments and oxygen therapy as ordered, and monitor for side effects and effectiveness. 3. On 4/28/25 at 1:58 p.m., Resident X was observed sitting in a WC at bedside. A Continuous Positive Airway Pressure (CPAP) machine was sitting on a stand beside the bed, with the CPAP mask unbagged and lying among his personal items on the bedside stand. The resident indicated he used the CPAP at night when he needed it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident X's record was reviewed on 4/30/25 at 9:52 a.m. Diagnoses on Resident X's profile included, but not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, obstructive sleep apnea, and tobacco use. The resident record lacked documentation of physician's orders for cleaning and storage of the CPAP machine. A care plan for CPAP therapy related to obstructive sleep apnea had a goal of the resident would adhere to the CPAP/BiPAP regimen. The care plan lacked interventions related to the CPAP regiment and instructions for staff and the residents' use. 4. On 4/28/25 at 1:58 p.m., Resident Z was observed to be out of his room. A nebulizer machine was observed on the bedside stand, and the handheld mouthpiece was lying unbagged among his personal items, covered with a soiled winter coat. Resident Z's record was reviewed on 4/30/25 at 11:48 a.m. Diagnoses on Resident Z's profile included, but not limited to, myocardial infarction (heart attack), and paranoid schizophrenia (prominent delusions and hallucinations, particularly auditory ones). The resident record lacked documentation of physician's orders for cleaning and storage of the nebulizer machine, tubing, and mask. On 4/29/25 at 10:00 a.m., the Regional Nurse Consultant provided an Oral and Nasal Inhalation Administration policy, dated 1-2024, and indicated the policy was the one currently being used by the facility. The policy indicated, .6. Pour medication into nebulizer cup .12. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer .18. Administer therapy until medication is gone [mist has stopped] or until the designated time of treatment has been reached. 19. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup .21. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations .23. When equipment is completely dry, store in a plastic bag with the resident's name and date on it On 4/30/25 at 12:02 p.m. the Administrator (ADM) provided a BiPap/CPAP policy, dated 5/2017, and indicated the policy was the one currently being used by the facility. The policy indicated, .1. Clean the unit weekly .6. Clean the mask as needed for soiling .Clean head gear, chin strap, and/or soft cap as needed for soiling .Allow items to air dry on a line - if possible On 4/30/25 at 12:02 p.m. the ADM provided a Respiratory Care Policy, dated 1/2025, and indicated the policy was the one currently being used by the facility. The policy indicated, .3. Administer medications or other respiratory services as prescribed by a physician or non-physician practitioner including but not limited inhalers, nebulizers, oxygen therapy, and oral medications. 4. BiPAP [Bilevel Positive Airway Pressure] and CPAP services to be provided as ordered by physician or non-physician practitioner .III. Weekly observation of respiratory equipment to ensure proper functioning and cleanliness .V. Ensure proper storage, handling, and sanitation of all respiratory equipment Cross reference tag F725. This citation relates to Complaints IN00452678 and IN00455563. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-47(a)(6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38767 Based on observation, interview, and record reviews, the facility failed to ensure adequate staffing levels to ensure residents received activities of daily living (ADL) care for meal service, toileting, bathing and dressing, medication administration, and getting residents out of bed for 14 of 16 residents reviewed for sufficient nurse staffing (Residents C, F, G, H, J, K, L, N, S, T, V, X, Y, and BB) and for 5 of 7 hallways (200, 400, 500, 700, and 800) observed for sufficient nurse staffing. Findings include: On 4/27/25 at 9:13 a.m., Certified Nursing Assistant (CNA) 5 indicated she was assigned to care for 7 residents on the 100 and 200 hallways by herself. There was no CNA in the facility to care for residents on the 300 and 400 hallways, but she was not sure why. The nursing scheduler QMA 4 had been called in to cover for a nurse call-off on the 400 hallways, but CNA 5 had yet to hear the backup plan to cover the CNA's hours. On 4/27/25 at 9:27 a.m., Registered Nurse (RN) 7 was observed administering medications on the 300 hallway. He indicated he usually worked double shifts on Tuesdays, Thursdays and every other weekend, and on this date he was responsible for the 100, 200, and 300 hallways. RN 7 indicated the CNA for the 300 and 400 hallways had not shown up, there were 12 residents total, and staff were handling the situation as a group. RN 7 indicated staffing problems usually happened mostly on the weekends, but the 700 and 800 hallways were usually staffed with 3 CNAs, and one would be pulled to help where needed. He indicated the day shift started at 7:00 a.m., and at that time the 5 residents on the 300 hallway were not yet out of bed. On 4/27/25 at 9:29 a.m., CNA 8 was observed arriving on the 300 hallway. The CNA indicated, she was a new employee of about 3 weeks in the facility and had just been re-assigned this morning from the 700 and 800 hallways to the 300 and 400 hallways where she had never worked. Observations of Resident C, included: a. On 4/27/25 at 9:50 a.m., Resident C was observed lying in bed with her eyes closed, the head of the bed was elevated, and the resident's upper torso was slumped to the right. There was paper debris on the floor around the bed. b. On 4/27/25 at 11:51 a.m., the resident remained in the same position with her eyes closed, the head of the bed was elevated, and the resident's upper torso slumped to the right. c. On 4/28/25 at 9:45 a.m., the resident was observed sitting in a manual wheelchair (WC) next to the bed, sitting on a blue transfer pad. The resident indicated she had not yet had breakfast. An untouched breakfast tray of food was observed sitting on top of a small black refrigerator on a dresser, out of reach of the resident. Observations of Resident F included: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/27/25 at 9:36 a.m., the resident was observed lying in bed watching television (TV), his left forearm and hand resting on his waist, and a hand splint on a bedside table. The resident indicated he would like to be out of bed by 10:00 a.m. daily, but due to low staffing he had yet to get up or had his brief changed by the morning shift, and he was wet. b. On 4/27/25 at 10:09 a.m., a second observation of Resident F lying in bed in the same position and he indicated he was still waiting for care. c. On 4/27/25 at 10:37 a.m., a third observation of Resident F lying in bed in the same position when a visitor entered his room. The resident's relative indicated that it was not unusual for the resident to have to wait on care, especially on weekends. d. On 4/27/25 at 11:48 a.m., the resident was observed lying in bed visiting with a peer. The resident indicated he had not been given care per the day shift yet and his brief was still wet. e. On 4/27/25 at 12:02 p.m., there were no CNAs or nurses observed in the hallway. A visitor asked QMA 4 why the resident had not gotten out of bed or had his brief changed. Resident F was overheard telling QMA 4 he had asked the CNAs to change him that morning, but no one had come back. QMA 4 was observed to check the resident's brief, acknowledge it was soiled, indicated she was uncertain why he had not yet been cared for, and that she would make sure he got cleaned up and his linens changed. Observations of Resident G included: a. On 4/27/25 at 9:41 a.m., the resident was observed lying in the bed awake, smelling of urine, a breakfast tray of untouched food and drinks at the bedside and a cup of unidentified pills sitting on the bedside stand near his breakfast tray. The resident indicated the staff was supposed to have changed his brief and assisted him to bathe, dress, and be out of bed by 8:00 a.m. so he could have breakfast. Resident G indicated he had been lying in a urine-soaked brief for hours waiting on staff, and now his breakfast food was cold. The resident indicated he had no idea his medications were on the bedside stand out of sight, but the nurse had already taken his blood sugar earlier that morning. Resident G indicated the weekends were the worst as there were never enough staff to care for the residents, and it was pure hell. b. On 4/27/25 at 9:50 a.m., the Housekeeping Supervisor was observed telling CNA 8 that Resident G needed assistance with bathing and dressing when she had time. c. On 4/27/25 at 10:36 a.m., CNA 8 was observed leaving the resident's room, and the resident was in his WC at bedside. The resident pointed to his breakfast tray and indicated the food and his water for hot chocolate were now cold. The CNA indicated she would take his water to be heated in the employee breakroom; she wanted him to at least have a hot drink as he had a cold breakfast. The resident indicated by the time he was getting out of bed he was soaking wet, and his breakfast was cold, so he frequently sent it back. d. On 4/27/25 at 10:37 a.m., a visitor indicated the day before, on Saturday 4/26/25, Resident G had been observed in his wheelchair, wheeling himself up and down the hallway right before noon wearing only a gown and holding his clothing awaiting care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/25 at 10:12 a.m., QMA 4 was observed passing medications on the 400 hallway, and indicated she had been called in to cover the 400 and 500 hallways, and CNA 8 had been pulled from the 700 and 800 hallways to cover the 300 and 400 hallways for employees that had called off. QMA 4 indicated that CNA 8 had a total of 13 residents to care for between the 300 and 400 hallways, but there were only 3 residents on the 400 hallway that needed hands on care, including Residents H, J, and K, the rest would use their call lights to call for assistance when needed. a. Resident H was observed lying in bed with an over the bed table in front of her, watching TV. The resident indicated she had not yet had her bath, did not believe she'd had her brief changed, and was most likely wet. b. Resident J was observed lying in bed watching TV and wearing a gown. c. Resident K was observed lying in bed, wearing a gown, food crumbs on his gown and bedding, positioned with his contracted right hand/arm lying on his chest, and his left arm behind his head. The resident indicated he had fed himself the food from the breakfast tray in front of him on an over the bed tray stand. The resident indicated he had not yet had a bath or had his brief changed, and his adult brief was observed saturated with urine. On 4/27/25 at 10:42 a.m., Resident L was observed lying in bed with her eyes closed, wearing a floral night gown. The resident indicated she went to the bathroom on her own, but was waiting on staff to help get her dressed. On 4/27/25 at 10:51 a.m., Resident N was observed lying in bed wearing a hospital gown and watching TV. The resident indicated she had not yet been dressed, and her brief had not yet been changed. The resident indicated it was her understanding everyone had to stay in bed that day, but she was not sure why. During a continuous observation on 4/27/25 from 10:42 a.m. to 11:03 a.m., there were no CNA's or nurses on the 500 hallway, and 13 of 25 residents were observed to still be in bed. Observations of Resident S included, a. On 4/27/25 at 11:15 a.m., Resident S was observed sitting in a manual wheelchair at bedside, wearing a hospital gown with a fleece cardigan over her shoulders, her bare feet resting on the floor, and emitting a deep congested tight cough. The resident had a nasal cannula for oxygen in her nose attached to a bedside concentrator and gestured to her oxygen tubing which she took out of her brief, and indicated the CNA had put the oxygen tubing inside her brief and the resident had untaped her brief to get the tubing out. A tray of breakfast food was observed sitting on an over the bed table untouched. The resident indicated she preferred to eat breakfast after being out of bed, but most often did not get up until around 10:00 a.m., and by then the food was cold. The resident gestured to her nebulizer sitting on the bed beside her and the nebulizer handheld mouthpiece was unbagged and lying in the middle of the bed among her bedding. Resident S indicated the nurse had put the nebulizer handpiece on the bedside table that morning, and after she was assisted out of bed, CNA 17 handed her the nebulizer handpiece, spilled half of the medication, and turned on the machine, therefore she did not get her full treatment. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, and the attached nasal cannula was laying on the floor. The resident indicated she used the portable concentrator when going out of her room. (continued on next page)

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	155206	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Health Care Center	1010 Hornaday Rd Brownsburg, IN 46112

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 4/28/25 at 10:02 a.m., Resident S was observed lying in bed on her right side facing the wall. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, and the attached nasal cannula was laying on the floor. An untouched breakfast tray was sitting on a table near the doorway out of the resident's reach. c. On 4/28/25 at 1:56 p.m., Resident S was observed sitting in a WC at bedside, wearing a hospital gown and her bare feet on the floor, sleeping, a TV remote in her right hand, and a breakfast tray in front of her with the food untouched. A plastic medication cup with 5 unidentified medications and an Anoro Ellipta inhaler (bronchodilator) sat on the breakfast tray. A tray of lunch foods sat on the bed near the resident with the food untouched. A nebulizer sat on the bed beside the resident with the mouthpiece on the bare mattress. A portable oxygen concentrator was observed on a bedside table on the back side of the bed, in the on position, the attached nasal cannula was laying on the floor. d. On 4/28/25 at 2:23 p.m., Registered Nurse (RN) 14 observed the medications sitting on the resident's breakfast tray and indicated QMA 4 had administered the medications that morning, and staff knew better than to leave medications at bedside. On 4/27/25 at 11:33 a.m., Resident T was observed at bedside reading a book, and indicated on Friday 4/25/25 she had not received her bedtime medications until she called up front, and a nurse came and gave her the medication right at shift change at 11:00 p.m. On 4/27/25 a continuous observation of the 700 and 800 hallways from 11:08 a.m. to 11:36 a.m., 4 of 30 residents were out of bed. CNA 17 did not respond when asked why most of the residents would be in bed for lunch, instead indicated there were 2 more residents that she would be getting up for lunch. On 4/27/25 at 11:42 a.m., there were 4 residents observed sitting in WCs in the back dining room awaiting lunch. During an interview on 4/27/25 at 11:52 a.m., the Dietary Manager (DM) indicated the front dining room was no longer used for meals as residents in the front preferred to eat in their rooms. She indicated meals were served at 12:00 p.m. on the 600 hallways, at 12:15 p.m. on the 700 and 800 hallways, around 12:35 p.m. on the 100, 200, and 300 hallways, and around 12:45 p.m. on the 400 and 500 hallways. The DM indicated, on a good day 15 residents ate meals in the back dining room. On 4/27/25 at 1:15 p.m., CNA 5 who was responsible for residents on the 100 and 200 hallways was observed most of this day one on one (1:1) with Resident D at the front of the facility, to include entertaining her and feeding her lunch. On 4/27/25 at 1:45 p.m., nurses on the day shift were observed passing medications, documenting, and walking up and down the hallways. There was no observation of nurses providing direct resident care or assisting CNAs who were providing direct resident care. Observations of Resident V included, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/28/25 at 9:25 a.m., Resident V was observed lying in bed working on word puzzles. The resident indicated she was looking for a nurse to start her nebulizer treatment, the resident was slightly short of breath and wheezy when speaking. b. On 4/28/25 at 1:58 p.m., Resident V's nebulizer machine was observed sitting on the bedside table on the backside of the bed and the handheld mouthpiece was unbagged and clipped to the machine. The handheld mouthpiece was observed to have nebulizer liquid medication in the medication chamber. On 4/28/25 at 10:01 a.m., observation of QMA 4 passing medications on the 800 hallway, and 2 CNAs working together on the 700 and 800 hallways. QMA 4 indicated, a CNA had called off that morning and the 3rd CNA from the 700 and 800 hallways had been moved to cover. QMA 4 indicated that the facility was not currently hiring more staff as all positions had been filled. There used to be more pro re nata (prn - as needed) staff, but due to not working at least 1 shift per month, those positions had been terminated. QMA 4 indicated that if all staff came in to work their scheduled shifts there was no need to hire more staff. QMA 4 indicated 2 aides were working together to care for the 30 residents on the 700 and 800 hallways, of which 15 required mechanical lifting from bed. She would come out of her office and assist when residents were being mechanically transferred. During an interview on 4/28/25 at 2:11 p.m., CNA 15 indicated she was working on the 700 and 800 hallways as one of two 2 CNAs that day, and lower staffing of CNAs generally happened 2-3 times weekly. CNA 15 indicated she had not sat down all day and had not had a break or lunch as there were 30 residents on the hallways of which 6 residents required assistance for eating and 15 required mechanical lifts for transfers. CNA 15 indicated it was not possible to get all 30 of the residents out of bed timely for lunch, and she had just finished getting her last resident out of bed. During an interview on 4/28/25 at 2:15 p.m., CNA 16 indicated she was working on the 700 and 800 hallways as one of two 2 CNAs that day. She indicated it took time management to get everyone done during the time allotted on her shift. If management were in the facility, line staff could request help, but if management was not in the facility the staff did the best they could; just one resident at a time. During an interview on 4/28/25 at 2:23 p.m., RN 14 indicated on days like today with just a nurse and 2 CNAs on the 700 and 800 hallways, no one got a break. They just banded together and did the best they could. It was not possible to get everyone taken care of, fed, and out of bed timely. Confidential interviews were conducted during the course of the survey: a. The employee indicated when a CNA had not come in to work on a weekend, the remaining staff member for the hallway was not notified and was left to care for 30 residents that required assistance with eating, being changed and toileted, total dependent residents, and heavy lifting. The manager on duty, Qualified Medication Aide (QMA) 4, was out of town and couldn't come in and help. b. The employee indicated multiple residents were making complaints to the ADM about staff refusal to assist with changing wet briefs, refusing to empty urinals, and residents being left soiled and for the following shift to care for. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The schedules for March 2025 were reviewed to determine if CNAs were staffed per the Facility Assessment numbers. There were 9 days out of 31 days on day shift that the facility did not have seven CNAs. There were 4 days out of 31 days that the facility did not have five CNAs on night shift. The schedules for April 2025 were reviewed to determine if CNAs were staffed per the Facility Assessment numbers. There were 9 days out of 28 days that the facility did not have seven CNAs on day shift. There were 18 days out of 28 days that the facility did not have five CNAs on night shift. On 4/30/25 at 12:02 p.m. the Administrator (ADM) provided a Nursing Department - Staffing, Scheduling, & Posting policy, dated 10/24/11, and indicated the policy was the one currently being used by the facility. The policy indicated, .I. The Facility will employee sufficient Nursing Staff on a 24-hour basis that meet the appropriate competencies, skill set and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident. II. In staffing an adequate number of nursing service personnel, scheduling will be done as needed to meet resident needs and will account for the number, acuity and diagnoses the facilities resident populations .C. The Facility will employee and schedule sufficient nursing staff as determined by resident assessments and individual plans of care. i. Nursing staffing will take into account the number, acuity, and diagnosis of the Facility's resident population. This will be documented in the Resident Assessment. D. The Facility will utilize the Facility Assessment to identify competency needs of Nursing Staff Cross reference F677, F689, and F695. This citation relates to Complaints IN00452678 and IN00455563. 3.1-17(a)