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	06/30/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record reviews, the facility failed to protect the resident's right to be free from verbal and physical abuse by staff for 1 of 3 resident reviewed for abuse (Resident B). This deficient practice was corrected on 6/27/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: On 6/30/25 at 10:30 a.m., a record review was completed for Resident B. He had the following diagnoses which included but were not limited to, amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease that affects motor nerve cells the nerve cells that control voluntary muscle movement), dysphagia (difficulty speaking), and facial weakness. The facility self-reported incident, dated 6/23/25, indicated two Certified Nursing Aides (CNA) pulled on Resident B's arms during care while he shook his head no and expressed discomfort. Resident B indicated the CNA on his right side yanked his arm in bed to pull him to the ground, but the other CNA stopped her. On 6/30/25 at 10:45 a.m., Resident B was interviewed. Resident B indicated the CNAs moved his eye gaze machine (a machine that uses his eyes to communicate via a computer) away from him, therefore, he could not communicate his needs to them. He indicated the CNAs pulled on his arms and caused him pain and his minor aged family member, who was visiting, had to tell the CNAs to stop pulling on his arms because he was in pain. He indicated the CNAs stopped finally and left him in his shirt for bedtime. He indicated the CNAs changed his brief in front of his minor aged family member. He indicated the CNAs were trying to put him too bed too early. He indicated the CNAs used a mechanical lift to put him to bed when he can stand and shuffle his feet to where he needed to go. He indicated he could not lie flat in bed, the CNAs were pulling him down in bed and it felt like he was going to fall onto the floor, and his minor aged family member had to tell the CNAs he could not lie flat because his communication machine was away from him. He indicated one CNA indicated to roll him onto his side and drop him and it will look like an accident. He indicated he did not want the two CNAs to care for him in the future. On 6/30/35 at 10:24 a.m., during an interview, the Hospice Case Manager indicated the CNAs were unfamiliar with the care of an ALS resident. She indicated the situation was corrected rather quickly. The two CNAs were suspended. The resident's adult family member and the Executive Director (ED) came into the facility immediately following the incident to assist Resident B. (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
	155206	A. Building B. Wing	06/30/2025

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 the ED indicated she came into the facility and CNAs 6 and 7 were immediately suspended pending an investigation. She indicated she interviewed the resident, and he indicated he felt safe and was satisfied with the results. She indicated if the CNAs returned to duty, they would no longer care for Resident B. On 6/30/25 at 1:40 p.m., during an interview with CNA 7, she indicated Resident B was not ready to go to bed when the incident occurred. She took her break and came back. She indicated Resident B cried out when they took off his pants and continued tp cry with removing his shirt, so they left it on. She indicated that when the resident started to cry out, they stopped what they were doing. On 6/30/25 at 1:46 p.m., during an interview with CNA 6, she indicated she was not on Resident B's assignment, but two people were required when using a mechanical lift. She attempted to take off his shirt, but he started crying so she left him in his shirt. When they hooked up the mechanical lift he was crying, they got him to bed when his minor aged family member indicated he did not like to lay flat in bed. Resident B was upset and wanted to call 911. She indicated four people were in his room and the resident's adult family member took over his care. The deficient practice was corrected by 6/27/25 after the facility implemented a systemic plan that included the following actions: the two CNAs were suspended pending an investigation, a complete and thorough investigation was completed, interviews were completed, staff were educated on ALS, turning, repositioning, and provision of ADL care and prevention of discomfort during provision of care. The identified CNAs received one on one education, Resident B will have care in pairs (two persons will care for him), a care plan meeting was scheduled for him to include his hospice care givers, and social services continued to follow up with Resident B. A policy titled, Abuse Prevention and Prohibition Program, was provided by the Regional Director of Operations (RDO) on 6/30/25 at 1:04 p.m. It indicated, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property This citation relates to Complaint IN00462259. 3.1-27(a)(1)