

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Brownsburg Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, and interview, the facility failed to follow Centers for Disease Control (CDC) guidance and ensure infection control practices were followed when a Qualified Medication Aid (QMA) passed medications to 5 residents (Residents E, R, S, T, and U), by touching medications and not properly sanitizing her hands. This deficient practice had the potential to affect 19 of 20 residents who resided on the 100, 200, and 300 hallways. Findings include: During a random medication observation on 9/30/25 at 9:28 a.m., QMA 9 was observed administering medications to Resident R. QMA 9 first performed a blood pressure check and used an ink pen to document the reading in the palm of her left hand. QMA 9 then popped medication tablets out of bubble packs into the palm of her left hand, placed them into a medication cup, and entered the resident's room to administer the medications. While preparing to place a transdermal patch onto Resident R's upper body, QMA 9 was observed to move both sleeves and the neck of Resident R's t-shirt while attempting to find a patch from the day before. The QMA left the resident's room, documented administering the medications, and immediately began setting up medications for Resident S. The QMA was not observed to wash her hands or apply hand sanitizer to disinfect before, during, or after the medication pass. On 9/30/25 at 9:47 a.m., observation of QMA 9 as she popped medications out of bubble packs into the palm of her left hand, placed them into a medication cup, and handed them to Resident S who was sitting in a wheelchair in the hallway waiting for her medications. The QMA documented administering the medications and immediately began setting up medications for Resident E. QMA 9 was not observed to wash her hands or apply hand sanitizer to disinfect before, during, or after the medication pass. On 9/30/25 at 9:55 a.m., observation of QMA 9 as she popped medications into the palm of her left hand, placed them into a medication cup, and then entered Resident E's room to administer the medications. The QMA left the resident's room, documented administering the medications, and immediately began setting up medications for Resident T. The QMA was not observed to wash her hands or apply hand sanitizer to disinfect before, during, or after the medication pass. On 9/30/25 at 10:12 a.m., observation of QMA 9 as she popped medications into the palm of her left hand, placed them into a medication cup, and handed them to Resident T who was sitting in a wheelchair in the hallway waiting for his medications. The QMA documented administering the medications and immediately began setting up medications for the next resident. QMA 9 was not observed to wash her hands or apply hand sanitizer to disinfect before, during, or after the medication pass. On 9/30/25 at 10:15 a.m., QMA 9 indicated, during morning medication pass, she routinely administered medications to 21 of the 22 residents that resided on the 100, 200, and 300 hallways. On 9/30/25 at 10:20 a.m., observation of QMA 9 administering medications to Resident U in the main therapy gym while the resident sat in a wheelchair among her peers. QMA 9 was not observed to wash or sanitize her hands before setting up medications for the next resident on the 200 hallway. On 9/30/25 at 10:52 a.m., observation of the front 100 and 200 hallways medication cart with Unit Manager 11. A pump bottle of hand sanitizer was observed stored on the left side of the medication cart with the medication cups. Unit Manager 11 indicated staff should sanitize their hands between each resident during a medication pass, and medications should never be dispensed by being popped into a staff member's hand. On 9/30/25 at 11:02 a.m., Unit Manager 11 and a visitor observed QMA 9 as she left Resident W's room and approached the medication cart. QMA 9 was not observed to sanitize her hands. A sign posted on Resident W's door indicated, Stop, Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. On 9/30/25 at 11:04 a.m., QMA 9 indicated she had cleaned her hands before preparing medications for Resident R, and therefore it was okay for her to pop pills into her hand, but she should have sanitized her hands after she had touched the resident's clothing. Enhanced Barrier Precautions (EBP) signs were taped to the doors of seven residents on the 100, 200, and 300 hallways. A Contact Precautions sign taped to one resident's door on the 200-hallway indicated, Stop Contact Precautions everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and gown before room entry. The CDC Guidance, dated 2/27/24, Clinical Safety: Hand Hygiene for Healthcare Workers- Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning hands with: handwashing with water and soap [e.g., plain soap or with an antiseptic], antiseptic hand rub [alcohol-based foam or gel hand sanitizer]. Some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep themselves, patients, and staff safe. Know when to clean your hands: Immediately before touching a patient. After touching a patient or</p>		