

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 04/01/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to administer narcotic medication in accordance with physician's orders and manufactures instructions resulting in lethargy and increased tiredness for 1 of 3 residents reviewed for medication administration (Resident C). Findings include: During an interview on 3/31/26 at 3:15 p.m., Resident C and her daughter felt Resident C received her medication too close together causing her to be overmedicated. The resident indicated she sometimes could barely keep her eyes open and felt very fatigued. This happened off and on, but not everyday. The resident indicated her doses were not administered on time regularly, and sometimes were very late. She had spoken to the nursing staff about it, but it continued to happen sometimes. A record review for Resident C was completed on 3/31/26 at 1:38 p.m. Diagnoses included stage 3 hypertensive chronic kidney disease, polymyalgia rheumatica (an inflammatory rheumatic disease), lumbago with sciatica (low back pain (lumbago) paired with radiating pain, numbness, or tingling that travels down the leg, usually caused by irritation of the sciatic nerve from a herniated disc, bone spur, or muscle spasms), and gout. A quarterly Minimum Data Set (MDS) assessment, dated 12/12/25, indicated the resident was cognitively intact. She was able to make herself understood and was able to understand others. She used a motorized wheelchair for mobility. She was dependent on staff for toileting and bathing. She required substantial/maximum assistance from staff for transfers. A current, as of 3/19/26, health care plan indicated resident was on pain medication therapy related to osteoarthritis, lumbago, GERD, neuropathy, hammer toes, gout, and general discomfort and required the use of pain medication (tramadol). Interventions included administering pain medications as ordered by the physician. A current physicians order, dated 1/22/20, indicated to administer tramadol hydrochloride (an opioid pain medication) 50 mg (milligram) five times per day for pain related to polymyalgia rheumatic. Administration times were 1:00 a.m., 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. A review of Resident C's electronic Medication Administration Record (eMAR) indicated the tramadol was administered as follows: a) On 3/2/26, the medication was administered at 1:10 p.m., two hours and 10 minutes past the ordered time of 11:00 a.m. b) On 3/9/26, the medication was administered at 2:02 p.m.; three hours and two minutes past the ordered time of 11:00 a.m. The medication was next administered at 4:39 p.m.; two hours and 37 minutes after the previous dose administration. c) On 3/15/26, the medication was administered at 1:23 p.m.; two hours and 23 minutes past the ordered time of 11:00 a.m. d) On 3/23/26, two doses of the medication were administered at 7:48 a.m.; six hours and 48 minutes past the ordered time of 1:00 a.m., and one hour and 48 minutes after the ordered time 6:00 a.m. e) On 3/27/26, the medication was administered at 12:41 p.m.; one hour and 41 minutes past the ordered time of 11:00 a.m. The following administration was at 7:52 p.m.; three hours and 52 minutes past the ordered time of 4:00 p.m. A nurse practitioner progress note, dated 3/12/26, included Resident C reported increased fatigue over the past several days, but denied pain, shortness of breath, chest discomfort, dizziness, or gastrointestinal symptoms. She remained alert, oriented, and able to participate in conversation and follow commands appropriately. During an interview on 4/1/26 at 4:49 p.m., the DON indicated the medication was documented as being provided outside the policy time parameters for Resident C. The opioid medication the resident received should be given timely. A current facility policy, undated, titled, (continued on next page)</p>		

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Liberalized Medication Pass Times, provided by the DON on 3/31/26 at 11:15 a.m., indicated the following: Policy: It is the policy of the company to administer medications to residents in a safe manner that coincides with their daily activities and normal schedule. Administration window will be one hour prior to scheduled dose and one hour post scheduled dose.*Any physician orders for specific medication times will supersede facility policy for liberalized medication pass times.*A current facility policy, undated, titled, Medication - Administration, provided by the DON on 4/1/26 at 3:48 p.m., included the following: Purpose To provide practice standards for safe administration of medications for residents in the Facility. Policy.V. Medications may be administered one hour before or after the scheduled medication administration time.This citation relates to Intake 2744198.410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(2)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain sanitary conditions for catheter collection bags and tubing to prevent contamination for 2 of 2 residents reviewed for quality of care (Residents B and E). Findings include: 1. During an observation on 3/31/26 at 3:19 p.m., accompanied by QMA 2, Resident B's catheter bag and tubing were observed. The resident was in bed lying on his left side. His catheter bag was covered in a pillowcase, tied at the top of the bag around the tubing, lying on the floor. The tubing was lying on the floor and rising to, and under the sheet. During the observation, QMA 2 indicated that the catheter bag and tubing should not be on the floor due to risk of contamination. She indicated the catheter bag should be secured to the bed frame, and the tubing and the bag should be off the floor. The clinical record for Resident B was completed on 3/31/26 at 11:42 a.m. Diagnoses included urinary tract infection, obstructive and reflux uropathy (urinary blockage), urinary retention, hydronephrosis (swelling of one or both kidneys caused by a backup of urine). A current health care plan, revised on 1/13/26, indicated Resident B had a suprapubic catheter to his right lower abdomen. Interventions included checking the tubing for kinks and maintaining the drainage bag off the floor. An acute care hospital Discharge summary, dated [DATE], completed prior to Resident B's re-admission to the facility, included that the resident had a diagnoses of urinary tract infection and sepsis. Resident to be given methenamin hippurate, (a non-antibiotic antiseptic used to prevent recurring urinary tract infections by acidifying urine) 1 g (gram), twice daily for 30 days. 2. During an observation at 10:35 a.m., Resident E was observed down the hallway in his wheelchair. He was being assisted down the hallway by staff. His catheter bag was attached to the bottom of the wheelchair and the full bottom, approximately one quarter of the bag, was dragging across the floor. During an observation on 3/31/26 at 11:55 a.m., Resident E was seated across from the nurses' station with other residents. His catheter bag was observed hanging from the bottom of his wheelchair with the bottom of the bag resting on the floor and part of tubing was touching the floor. The clinical record for Resident E was completed 4/1/26 at 10:25 a.m. Diagnoses included kidney stones, obstructive and reflux uropathy, mild cognitive impairment, acute kidney failure, and bladder cancer. A nurse practitioner's note, dated 3/24/26, indicated the resident had admitted following a hospital stay for urinary retention and obstruction. A progress note, dated 3/31/26, indicated the resident's foley catheter bag was clamped off to collect a urine specimen for a urinalysis with culture and sensitivity. A Medication Administration Note, dated 3/31/26, indicated to administer phenazopyridine hydrochloride (a urinary tract analgesic used to relieve pain, burning, and urgency caused by infections) 100 mg (milligram) every 12 hours as needed for urinary discomfort. The clinical record lacked a care plan entry for the resident's urinary catheter. During an interview on 4/1/26 at 4:49 p.m., the Regional Nurse Consultant indicated resident catheter bags and tubing should not be placed or rested on the floor and should be handled in a sanitary manner to avoid infection. A current facility policy, revised 6/2020, titled, Catheter-Care of, provided by the DON on 4/1/26 at 3:48 p.m., included the following: Purpose To prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary. Procedure. III. Proper Techniques for Urinary Catheter Maintenance. F. Collection Bags- i. Take care to ensure the collection bag does not touch the floor at any time. This citation relates to Intake 2801884.410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)</p>		