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	05/27/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure falls were coded on a Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for accidents (Resident K). Findings include:Resident K's record was reviewed on 5/26/26 at 10:06 p.m. A quarterly Minimum Data Set (MDS) assessment was dated 3/2/26. A progress note, dated 3/11/26, indicated the resident had a witnessed fall in the dining room and had a laceration to the forehead and back of head. Follow-up progress notes, dated 3/11/26, indicated the resident was sent to the hospital and returned to the facility with three sutures to the left side of her forehead. A progress note, dated 3/30/26, indicated the resident fell in the bathroom and had a bruise on her forehead. A progress note, dated 4/17/26, indicated the resident stood up from the dining room table, tripped, and fell on her right side. There was no visible injury, but the resident was guarding the right lower extremity and would not straighten the leg. A progress note, dated 4/18/26, indicated the resident's power of attorney (POA) requested the resident be sent out to the hospital related to the previous fall. An x-ray report, dated 4/18/26, indicated the resident had a right femur (thighbone) fracture. A discharge, return not anticipated, MDS assessment, dated 4/18/26, indicated the resident had no falls since the prior assessment. During an interview, on 5/27/26 at 11:21 a.m., the Corporate MDS Coordinator indicated she reviewed the discharge MDS assessment, dated 4/18/26, and indicated the resident's falls were not coded on the assessment. The falls should have been included on the MDS assessment. The facility used the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual as the facility policy for MDS assessment accuracy. The CMS MDS RAI manual, version 3.0, dated October 2025, indicated, J1900: Number of Falls Since.Prior Assessment.Coding Instructions for J1900: Determine the number of falls that occurred since.prior assessment.and code the level of fall-related injury for each. Code each fall only once. This citation relates to Intake 3002927. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(c)(1)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure a resident received ordered monitoring of orthostatic blood pressures and failed to ensure prompt treatment for a fracture after a fall for 1 of 3 residents reviewed for accidents (Resident K). Findings include:Resident K's record was reviewed on 5/26/26 at 10:06 p.m. Diagnoses on the resident's profile included, but were not limited to, dementia (a decline in mental ability severe enough to interfere with daily life) with mood disturbance and repeated falls. A physician's order, dated 12/8/21, indicated monitor the resident's pain on a scale of 0 to 10 every shift and document non-pharmacological and pharmacological interventions for pain. A physician's order, dated 11/11/22, indicated acetaminophen (pain medication) 325 milligrams (mg), give 2 tablets by mouth every 4 hours as needed for pain. A quarterly Minimum Data Set (MDS) assessment, dated 3/2/26, indicated the resident had a severe cognitive impairment. A progress note, dated 3/11/26, indicated the resident had a witnessed fall in the dining room and had a laceration to the forehead and back of head. Follow-up progress notes, dated 3/11/26, indicated the resident was sent to the hospital and returned to the facility with three sutures to the left side of her forehead. A progress note, dated 3/30/26, indicated the resident fell in the bathroom and had a bruise on her forehead. An IDT progress note, dated 3/31/26, indicated the IDT reviewed the resident's witnessed fall. The resident was found on the bathroom floor in front of the toilet. The resident had a skin tear to the right knee and a bruise to the forehead. The resident was ambulatory and unable to give an explanation of what happened. Immediate interventions included obtain vital signs, assess for pain and injury, and cleanse the skin tear to the right knee. The Nurse Practitioner (NP) was notified and ordered orthostatic blood pressures (measurement of blood pressure while lying, sitting, standing) for three days. A Treatment Administration Record (TAR), dated 3/31/26, indicated the resident's orthostatic blood pressure was scheduled to be checked on day, evening, and night shift. The TAR included an area to document lying, sitting, and standing blood pressures; however, the areas only included one number and did not include a blood pressure value. There was one blood pressure recorded each shift. The TAR lacked documentation orthostatic blood pressures were completed. A TAR, dated 4/1/26 and 4/2/26, indicated the same schedule for the resident's orthostatic blood pressures. On 4/1/26, day and evening shift, the orthostatic blood pressure documentation was left blank and lacked documentation vital signs were completed. On 4/1/26, night shift, the documentation included one blood pressure, but lacked documentation orthostatic blood pressures were completed. On 4/2/26, the documentation included one blood pressure and lacked documentation the orthostatic blood pressures were completed. Progress notes, dated 4/2/26 to 4/17/26, lacked documentation the NP was notified regarding the orthostatic blood pressures. A progress note, dated 4/17/26 at 5:30 p.m., indicated the staff witnessed the resident stand up from the dining room table to ambulate with the walker. The resident tripped, fell, and landed on her right side. The resident was assessed with no visible injuries but was guarding the right lower extremity and would not straighten the leg. The Nurse Practitioner (NP) was notified and ordered an x-ray of the right lower extremity. The resident was assisted to bed by staff, and as needed pain medication was administered. A progress note, dated 4/17/26 at 11:13 p.m., indicated the mobile x-ray company called and stated the earliest they were able to complete the resident's x-ray was the following day (4/18/26), in the afternoon. The nurse was awaiting a return call from the NP, and the resident continued to complain of pain guarded the right lower extremity and was unable to extend the leg. Progress notes lacked documentation of further follow-up with the NP regarding the delay in the resident's x-ray. A physician's order, dated 4/18/26 at 8:42 a.m., indicated oxycodone (an opioid pain medication) 5 mg every 4 hours as needed for right hip pain. A progress note, dated 4/18/26, indicated the resident's power of attorney (POA) requested the resident be sent out to the hospital related to the previous fall. An x-ray report, dated 4/18/26, indicated the resident had a right femur (thighbone) fracture. A Medication Administration Record (MAR), dated April 2026, indicated the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's pain was assessed every shift. The assessments indicated the resident had no pain until the night shift of 4/17/26, when a pain assessment of 4 out of 10 was documented. The resident was administered acetaminophen, on 4/17/26 at 6:59 p.m., for pain at 6 out of 10 which was effective. The resident was administered oxycodone, on 4/18/26 at 8:45 a.m., for pain at 8 out of 10 which was effective. The MAR lacked documentation the resident received pain medication between, 6:59 p.m. on 4/17/26 and 8:45 a.m. on 4/18/26, despite the resident having pain assessed at a 4 out of 10 on night shift. A hospital history and physical, dated 4/18/26, indicated the resident was admitted to the hospital for evaluation of hip pain following a fall. The resident's family member stated they were notified at 10:30 p.m. the previous night that the resident fell and completed of hip pain. An x-ray was ordered, but no results were communicated with the family overnight. The family arrived at the facility the following morning, at 7:30 a.m., and found the resident in bed experiencing significant pain, with only acetaminophen available. The x-ray company had not yet arrived at the facility to complete the x-ray. The family requested additional pain medication, and arrangements were made to send the resident to the hospital. The physician discussed risks and benefits of surgery for the fracture. The family chose comfort care and would pursue hospice care. A progress note, dated 4/19/26, indicated the resident's POA notified the facility the resident was being moved to a hospice facility. During an interview, on 5/27/26 at 10:03 a.m., Licensed Practical Nurse (LPN) 13 indicated an intervention should have been put in place immediately to prevent further falls. When a resident fell, the nurse assessed the resident while they were still on the floor. If there was a potential hip fracture, such as guarding or not extending the leg, and pain, the resident should not have been moved off the floor and should have been sent to the hospital immediately. During an interview, on 5/27/26 at 10:35 a.m., the Registered Nurse (RN) Corporate Consultant indicated if a resident fell and was guarding or not extending their leg and complaining of pain, then they should not have been moved from the floor and been sent out to the hospital. During an interview, on 5/27/26 at 2:18 p.m., the Registered Nurse (RN) Corporate Consultant indicated she reviewed the resident's orthostatic blood pressure documentation. She was not sure why a single number was all that was documented on the TAR instead of the full blood pressure. During an interview, on 5/27/26 at 2:40 p.m., the RN Corporate Consultant indicated she was not able to find documentation the NP was notified regarding the orthostatic blood pressures. The RN Corporate Consultant indicated she talked to the NP, and the NP had not remembered regarding Resident K specifically, but things like that were normally reviewed at the next NP visit. On 5/27/26 at 12:23 p.m., the Executive Director (ED) provided a document titled, Fall Evaluation and Prevention, last revised August 2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention.The IDT team will review the plan of care and update the interventions as appropriate. The policy also indicated, .Procedure.Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition. This citation relates to Intake 3002927. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, record review, and interview, the facility failed to have competent and sufficient staff to administer medications and insulin timely to residents as ordered for 5 of 5 residents observed during 1 of 1 medication observation (Residents B, C, E, D, and F). Findings include:On 5/26/26 at 7:08 p.m., Registered Nurse (RN) 6 was observed at the medication cart. He indicated he was passing medications. The electronic medication administration record was on the computer screen for Resident B. He had medications hi-lighted in red indicating they were overdue. RN 6 prepped Resident B's medications and administered them to the resident at 7:22 p.m. RN 6 indicated he had two new admissions and was running behind. When asked if other nursing staff helped him so he wouldn't be late, he indicated he had assistance available. On 5/26/26 at 7:28 p.m., RN 6 indicated he needed to check Resident C's blood sugar that was due at 5:00 p.m. He took out the monitor and checked Resident C's blood sugar. It was 459, outside of his ordered parameters. Per his sliding scale orders, it indicated to notify the physician if blood sugar was greater than 400. RN 6 left the cart to notify the Nurse Practitioner (NP) due to the high blood sugar. The NP ordered 12 units of lispro insulin, and the insulin was administered as ordered. RN 6 indicated he would redo his blood sugar at 9:00 p.m. as ordered and administer the ordered amount of insulin required. On 5/26/26 at 7:45 p.m. RN 6 administered routine ordered morphine to Resident E. He did not sign the morphine out after administering the medication. On 5/26/26 at 7:55 p.m., RN 6 prepped Resident D's medications. He indicated that morphine was out of stock due to using on another resident earlier in the day. He prepped the resident's lorazepam. He did not prep the omeprazole that was ordered. He crushed the lorazepam (an antianxiety) tablet and administered it to the resident. He did not sign the lorazepam out after administering it. On 5/26/26 at 8:10 p.m., The Director of Nursing (DON) indicated she would call the NP to make her aware of RN 6 administering late medications due to admitting new residents. On 5/26/26 at 8:12 p.m., Resident D was yelling out. He had new orders for morphine but there was none available to administer to him. The DON indicated she would call the NP and get a one-time order for oxycodone (a pain medication) for Resident D. On 5/26/26 at 8:15 p.m., the DON walked by the cart with a pill cup and indicated it was oxycodone for Resident D. On 5/26/26 at 8:16 p.m., RN 6 was prepping Resident F's medications. Resident F needed his blood sugar checked at 5:00 p.m. RN 6 checked Resident F's blood sugar and it was 177. He prepared his medications metformin (for blood sugar), atorvastatin (for high cholesterol), and apixaban (a blood thinner) and administered the medications. His ordered insulin Lispro 5 units was not administered as ordered for 5:00 p.m. RN 6 indicated he would talk to the NP about the blood sugar as it was due to be checked again at 9:00 p.m. On 5/27/26 at 11:12 a.m., the Resident's records were reviewed. The records did not contain orders or notes for Resident C, D or F medications being administered late or omitted. Resident D's record lacked an order for the one-time oxycodone that was administered. On 5/27/26 at 2:13 p.m., the DON indicated she would go back and put orders in for the residents. A policy titled, Medication Administration and General Guidelines was provided by the DON on 5/27/26 at 2:41 p.m. It indicated, .Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise). Before or after meals orders are administered precisely as ordered. Unless other specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. This citation relates to Intake 3002927. 410 IAC (Indiana Administrative Code) 16.2-3.1-14(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to effectively cleanse a glucometer (used to check blood sugar) after its usage for 1 of 1 glucometer observed (Residents B and G).Findings include:On 5/26/26 at 7:45 p.m., RN 6 had just finished checking Resident B's blood sugar. He brought the monitor to the cart and pulled out an alcohol prep pad with an ungloved hand and wiped down the strip insertion area for a couple of seconds. Then he left the monitor sitting on the medication cart and continued passing medications to the resident.When asked about cleaning procedures, RN 6 indicated he was out of the wipes they usually used to clean the machine.On 5/26/26 at 8:10 p.m., the Director of Nursing (DON) arrived and provided a tub of purple top wipes to cleanse the glucometer machine with. RN 6 placed the wipes in the bottom drawer of the medication cart.On 5/26/26 at 8:15 p.m., RN 6 went to Resident G to check his blood sugar without cleaning the monitor with the purple top wipes. RN 6 returned to the medication cart after checking Resident 6's blood sugar and pulled out the tub of wipes. He pulled out a wipe and rubbed it with an ungloved hand onto the glucometer monitor for approximately 20 seconds, then placed the wipe in the trash and left the monitor on top of the medication cart.Per the manufacturer of the Even Care glucometer machine, Medline, they recommend cleaning and disinfecting using a EPA-registered (U.S. Environmental Protection Agency) disinfecting wipes. The purple top wipes were PDI wipes (Professional Disposables International). The tub contained directions indicating .Contact Time: Allow surface to remain wet for 1 full minute.A policy titled Blood Glucose Monitoring was provided by the DON on 5/27/26 at 2:41 p.m. It indicated, .If the blood glucose monitor is multi-patient use: A. clean and disinfect the blood glucose machine according to manufacturer's directions with an appropriate cleaning product. The disinfection solvent should be effective against HIV (Human Immunodeficiency Virus), Hepatitis C, and Hepatitis B virus. Note that 70% of ethanol solutions are not effective against viral blood borne pathogens. B. If the manufacturer of the device in use does not specify how the device should be cleaned and disinfected, then it should not be shared or reused with a different resident. C. [NAME] gloves prior to cleaning the blood glucose monitor. D. Following the cleaning, remove gloves and wash hands.This citation relates to Intake 3002927.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)