

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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.			
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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. Based on observation, interview, and record review, the facility failed to assess residents' quarterly smoking assessments and store residents smoking supplies in a safe secure location for 5 of 5 residents reviewed for smoking (Resident K, L, M, N, and O). Findings include: 1. On 7/14/26 at 10:55 a.m., a record review was completed for Resident L. He had the following diagnoses which included, but were not limited to, tobacco use, chronic obstructive pulmonary disease (a progressive and irreversible lung condition that restricts airflow, making it difficult to breathe) (COPD), hypertension, and unsteadiness on feet. Resident L had a smoking assessment completed on 12/15/26. It indicated that Resident L smoked independently. He had a care plan, dated 9/26/25, indicating he had been advised of the smoking policy. The goal indicated he would be compliant with facility smoking policy. An intervention, dated 9/26/25, indicated reassess resident smoking ability quarterly and after reports of unsafe practices. Another intervention included to remind resident and family that all cigarettes, lighter, matches and smoking paraphernalia must be kept at nursing station. On 7/15/26 at 11:40 a.m., during an interview and observation Resident L indicated he had his cigarettes in a drawer and a lighter in his pocket. He pointed to his drawer, and it was noted that he had 2 packs of cigarettes in an unlocked black box in his nightstand. He indicated the key was down in the drawer if he wanted to lock it. He indicated when he wanted to smoke, he would go out the front door and walk to the side of the building where the smoking area was located. 2. On 7/14/26 at 10:12 a.m., a record review was completed for Resident K. He had the following diagnoses which included but were not limited to type I n diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal blood sugar levels), hemiplegia and hemiparesis following cerebral infarction (occur when an ischemic stroke or cerebral infarction damages the right hemisphere of the brain), interstitial pulmonary disease (an umbrella term for over 200 disorders that cause progressive inflammation and scarring (fibrosis) in the lungs), and hypertension (high blood pressure). On 7/14/26 at 11:32 a.m., during an interview Resident K indicated he had one cigarette and his lighter on his person. Sometimes he didn't have cigarettes due to a lack of money. He indicated he (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was an adult and did require supervision. Resident K had a care plan, dated 2/3/26, indicating he smoked and had been advised of the smoking policy. The resident required supervision with smoking. A goal indicated he would be compliant with the facility smoking policy. An intervention, dated 2/3/26, indicated that him and his family will be reminded to keep all cigarettes, lighter, matches, and smoking paraphernalia must be kept at the nursing station. 3. On 7/14/26 10:58 a.m., a record review was completed for Resident M. She had the following diagnoses which included but were not limited to COPD, hypertension, anxiety, and unknown psychosis, an altered state of the brain that creates a loss of contact with reality). On 2/5/26 Resident M had a smoking assessment that indicated she smoked. Resident M had a care plan indicating she smoked and she had been advised of the facility smoking policy. A goal indicated she would be compliant with the facility smoking policy. An intervention, dated 2/5/26, indicated she would have her smoking ability assessed quarterly and after reports of unsafe practices. On 7/15/26 at 11:11 a.m., during an interview Certified Nursing Aide (CNA) 11 indicated Resident M did not have cigarettes and did not smoke. She was on continuous oxygen. CNA 11 indicated if Resident M smoked, she probably did it when her daughter took her out of the facility. 4. On 7/14/26 at 11:10 a.m., a record review was completed for Resident N. He had the following diagnoses which included but were not limited to adult failure to thrive (FTT) (a condition where a child's physical growth falls significantly behind expected standards), limitation of activities due to disability, depression, and diabetes mellitus. On 6/9/26 he had a smoking assessment indicating he did not smoke. Resident N had a care plan, dated 9/17/25, indicating he smoked/vaped and that he had been advised of the facility smoking policy and required supervision with smoking. The goal indicated he would be compliant with the facility smoking policy. An intervention, dated 9/17/25, indicated to remind resident and family that all cigarettes, lighter, matches and smoking paraphernalia must be kept at nursing station. 5. On 7/14/26 at 11:30 a.m., a record review was completed for Resident O. He had the following diagnoses which included, but were not limited to, Alzheimer's disease, dementia, anxiety, fatigue, and interstitial pulmonary disease. On 2/10/26 Resident N had a smoking assessment. It indicated that he smoked. A care plan, dated 5/8/26, indicated Resident O smoked and had been advised of the facility smoking policy. The resident required supervision with smoking. A goal indicated Resident O would be compliant with the smoking policy. An intervention, dated 5/8/26, indicated Resident O would be (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reassessed on a quarterly basis and as needed after reports of unsafe practices. On 7/15/26 at 11:16 a.m., during an interview with Activity Staff 13. She indicated residents had a smoking schedule and they followed it. She indicated it may only be a few residents at a time. At this time the smoking area was observed. It was a gazebo with smoking receptables on the deck. A policy titled, Smoking by Residents dated 6/2020 indicated, .The interdisciplinary team (IDT) shall create a smoking care plan for the resident. See smoking care plan.All smoking materials will be stored in a secure area to ensure they are kept safe. This citation relates to Intake 3051915. 410 IAC (Indiana Administrative Code) 16.2-3.1-45.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observations, interviews, and record review, the facility failed to ensure Resident R received dementia-specific supervision, monitoring, interventions, and protections resulting in repeated attempts by Resident Q to enter Resident R's room for 1 of 3 residents reviewed for dementia care and the deficient practice affected 3 of 3 residents residing on the dementia unit (Residents Q, R, and S). Findings include: On 7/13/26 at 4:15 a.m., Licensed Practical Nurse (LPN) 5 and Certified Nursing Aide (CNA) 6 were observed in the memory care unit indicated they were not aware of any staff to resident, or resident to resident abuse concerns. On 7/13/26 at 7:50 a.m., Resident R was observed in the main dining room as she ate breakfast and enjoyed conversation with a peer. Resident R was observed to have thin, wispy, patches of hair in various stages of regrowth. A large scar was visible on her scalp. Resident R finished her breakfast and agreed to a confidential interview in her room. During an interview 7/13/26 at 8:15 a.m., Resident R indicated Resident Q repeatedly attempted to enter her room since she returned from the hospital after brain surgery. Resident R stated Resident Q disturbed her several times a day and took items from her room. She stated she complained to aides, nurses, and her family, but the targeting continued. On one occasion, Resident Q entered Resident R's room, staff were not available or didn't see her enter, so Resident R grabbed Resident Q by the wrist and yelled for staff, ya'll better come get her! Resident R expressed frustration and indicated she felt like she had no privacy, she was anxious to fall asleep, and was scared about what could happen if Resident Q went off on her. During an interview on 7/14/26 at 9:47 a.m., Qualified Medication Aide (QMA) 12 indicated Resident Q continued to fixate on Resident R's room and on Resident R. Sometimes she went into Resident S's room too. A 24-Hour Shift Report Logs, dated 6/17/26, indicated Resident Q targeted Resident R's room and Resident S's room and attempted to exit the unit. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. A 24-Hour Shift Report Logs, dated 6/23/26, indicated Resident Q refused medications and continued targeting Resident R's room. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. A 24-Hour Shift Report Logs, dated 7/6/26, indicated Resident Q continued Resident R's room. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. On 7/14/26 from 10:00 a.m. to 11:20 a.m., during a continuous observation, Resident Q repeatedly wandered the hallway, approached the front unit door, and moved close to Resident R's room. Four staff members, the Director of Nursing (DON), Medical Records Coordinator (MRC), Certified Nursing Aide (CNA) 10, and Activity Assistant 8, attempted to redirect her. Resident Q was offered a MedPass supplemental drink, a bag of chips, and was asked to take her Jello-shots and get ready for the rodeo. Resident Q resisted redirection, slapped away items offered to distract her, and refused engagement attempts. Resident Q was repeatedly surrounded by the four staff members which caused her to attempt to back away, or get away, by going to the end of the hall and pushing against the locked exit door, which set off the alarm. During an interview at 10:04 a.m., Activity Assistant 8 indicated the staff could not keep Resident Q away from Resident R's room. Activity Assistant 8 stated Resident Q rummaged through Resident R's belongings and took items from her room, and it upset Resident R. During an interview at 10:42 a.m., CNA 10 stated Resident Q attempted to enter Resident R's room daily and targeted Resident R and her belongings. At 11:00 a.m., the DON, MRC, and CNA 10 left the memory care unit. Two staff facilitated activities in the dining/activity room. Resident Q exited her room, walked up the hallway, and approached Resident R's room. She placed her hand on the door handle, noticed she was (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being observed, and walked away. At 11:07 a.m., Resident Q again approached Resident R's closed door and walked away when she noticed observation. At 11:20 a.m., Resident Q approached Resident R's closed door a third time and walked away when she noticed observation. During an interview on 7/14/26 at 11:24 a.m., CNA 11 stated Resident Q continued making regular attempts to enter Resident R's room and specifically focused on Residents R and S. CNA 11 did not know why Resident Q fixated on those rooms, but it upset Resident R mostly, because Resident S was less aware of her surroundings. During an interview on 7/14/26 at 12:28 p.m., the ED, DON, and Regional Clinical Support (RCS) indicated they were aware of Resident Q's continued targeting of Resident R. They indicated Resident Q was transferred to the facility because of her affection to males. Resident Q couldn't keep her hands off of them. She wanted to touch, she wanted to grab. So the thought was it would be better for Resident Q to be to be on an all female Memory care. Resident Q admitted around the time Resident R returned from a medical procedure that required her head to be shaved. The staff indicated it may have made Resident R appear more masculine, and gained the unwanted attention from Resident Q. The ED and DON confirmed an altercation between Resident Q and CNA 14 had occurred in Resident R's room. Resident Q had wandered into Resident R's room, refused to leave, and became combative during redirection. Cross reference F600.1. On 7/14/26 at 8:50 a.m., Resident Q's record was reviewed. She was a newly admitted resident who resided on the secured memory care unit with a diagnoses which included, but was not limited to, Alzheimer's dementia, generalized anxiety, and other malaise. A nursing progress note, dated 6/13/26 at 1:40 a.m., indicated, Resident Q wandered into another resident's room Resident R. She became agitated and combative with staff when they attempted to redirect her and CNA 14's hand made contact with Resident Q's face. A Social Service progress note, dated 6/15/26 at 11:30 a.m., indicated Interdisciplinary (IDT) post incident. Resident Q's agitation appeared to have been increased by poor de-escalation technique. Resident Q responds well to redirection involving her family photos, her life-like sensory tools and housekeeping tasks. A Medical Practitioner progress note, dated 6/15/26 at 2:12 p.m., indicated Resident Q had an acute behavioral change reported by facility staff over the weekend. Resident Q was observed with increased agitation, characterized by worsening confusion, wandering into other residents' rooms and combative behavior with redirected. The assessment and plan indicated: Continue dementia care interventions, redirection techniques, and structured environment. No new non-pharmacological interventions were discussed or implemented. A nursing progress note, dated 6/15/26 at 2:36 p.m., indicated a new order was received to give Resident Q Trazadone (an anti-depressant medication often prescribed off-label as a non-addictive sedative). The medication was ordered with the indication for use as dementia with agitation/anxiety and scheduled to give 25 milligrams (mg) three times a day. A nursing progress note, dated 6/16/26 at 10:40 a.m., indicated Resident Q continued to wander into another resident's room. She was redirected to come out of the other resident's room and became agitated and combative with staff. Activities offered a babydoll which was effective. Resident Q's comprehensive care plans were reviewed. The care plan lacked implementation and/or revisions to address her history of intrusive wandering and/or that she seemed to target Residents R and S. 2. On 7/14/26 at 9:00 a.m., Resident R's record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, traumatic brain injury and dementia. She returned to the facility on 5/12/26 after a medical procedure which required her head to be shaved. Resident R's nursing progress notes were reviewed and revealed no documentation of behavioral concerns related to her peers and no documentation of her repeated complaints about Resident Q wandering into her room. Resident R's comprehensive care plans were reviewed and lacked implementation/revision for her preference to keep others out of her (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. On 7/15/26 at 10:19 a.m., the ED provided a copy of current facility policy titled, Behavior - Management, dated 1/2026. The policy indicated, Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. To ensure that Facility Staff performs a timely and appropriate assessment of the resident's behavioral symptoms and implements appropriate interventions before and after the resident begins taking psychotherapeutic medications. The facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being meet each resident's needs and include individualized approaches to care. The concept of behavior management is an interdisciplinary process. The key components of this process are: Identifying residents whose behaviors may pose a risk to self or others; Developing individual and practical care strategies based on assessed needs; Implementing the behavior management program; and ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs. The goal of any behavior management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify behavior management issues and develop an effective management program. When a resident displays adverse behavioral symptoms (e.g., crying, yelling, hitting, biting etc.), Licensed Nursing Staff will assess the behavioral symptoms to determine possible causal factors, contact the Attending Physician, and implement non-drug interventions to alleviate the behavioral symptoms before initiating any psychotherapeutic agent(s). The facility must provide necessary behavioral health care and services which include: Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Ensuring that all staff interact and communicate in a manner that promotes mental and psychosocial well-being. Providing meaningful activities which promote engagement, and positive relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being. Providing an environment and atmosphere that is conducive to mental and psychosocial wellbeing. Ensuring that pharmacological interventions are only used when non- pharmacological interventions are ineffective or when clinically indicated. The Charge Nurse will assign a staff member(s) to monitor/shadow the resident as needed. Such monitoring is for the protection of the resident as well as all others and is not meant to restrict their movement or mobility. On 7/15/26 at 10:19 a.m., the ED provided a copy of current facility policy titled, Secure Care Neighborhood, dated 8/2020. The policy indicated, The goal of the Secure Care Neighborhood is to meet the individual needs of residents with dementia related illnesses. The Secure Care Neighborhood will provide a safe environment that maximizes independence and provides an activity intensive atmosphere. Resident eligible for admission for the Secure Care Neighborhood should have a cognitive deficit that could include Dementia related illnesses and is high risk for elopement. The IDT can make exceptions to this criteria on occasion and the decision must be specific to the resident safety and the safety of the other residents who reside in the Secure Neighborhood. On 7/15/26 at 10:19 a.m., the ED provided a copy of current facility policy titled, Resident Rights, dated 8/2020. The policy indicated, All residents have a right to a dignified existence, self-determination, and communication with and access to: persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source. This citation relates to Intakes 3043476 and 3054883.410 IAC (Indiana Administrative Code) 16.2-3.1-37.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, interviews, and record review, the facility failed to implement an effective QAPI plan that identified, investigated, analyzed, and corrected persistent dementia-related safety concerns on the secured memory care unit. This deficient practice had the potential to affect all 11 of 11 residents residing on the secured memory care unit. Findings include: In January 2026, the facility received an Immediate Jeopardy (IJ) citation for dementia care involving Resident 10 and Resident 29. Review of the prior IJ citation revealed the facility failed to identify escalating behaviors of Resident 10 toward Resident 29, resulting in Resident 29 sustaining a lip laceration, nasal fracture, and rib fractures after Resident 10 pushed her on 11/20/25. The IJ investigation documented: Resident 10 had a known history of delusional thinking, aggression, and fixation on Resident 29, whom she perceived as male. Resident 29 had documented intrusive wandering behaviors. The facility lacked behavior monitoring, failed to update care plans, failed to implement interventions to prevent resident-to-resident contact, lacked CNA assignment sheet instructions, and had no documented IDT follow-up. A document titled Abuse Allegation Timeline and Investigation Summary indicated on 6/12/26 at approximately 9:30 p.m. the charge nurse, Licensed Practical Nurse (LPN) 16, contacted the administrator to report CNA 14 for abusing Resident Q. CNA 14 was immediately removed from the facility. The document included a statement from CNA 18 that indicated CNA 14 was attempting to redirect Resident Q out of another Residents room when Resident Q pulled away and went further into the room. The statement indicated CNA 14 reached for Resident Q again and Resident Q hit CNA 14 with a closed hand in the face once and CNA 14 hit Resident Q in the face with an open hand twice. This action resulted in a scratch on Resident Q's face. The document included a statement from Qualified Medication Aide (QMA) 17 which indicated she was walking down the hall when she heard commotion coming from a Residents room. Upon her arrival to that room she witnessed CNA 14 strike Resident Q in the face twice. The document included a statement from LPN 16 which indicated she was contacted by QMA 17 by phone and was asked to go to the memory care unit. QMA 17 indicated to LPN 16 that CNA 14 hit Resident Q in the face. The document included a statement from CNA 14 which indicated she was attempting to redirect Resident Q out of another Residents room, but Resident Q refused to leave. CNA 14 indicated in her statement that she grabbed Resident Q's hands in an attempt to guide the Resident out of the room. CNA 14 initially denied striking Resident Q in her statement but later in questioning she admitted to striking the Resident. Cross reference F600. During an interview, on 7/13/26 at 8:15 a.m., Resident R indicated Resident Q repeatedly attempted to enter her room since she returned from the hospital after brain surgery. Resident R stated Resident Q disturbed her several times a day and took items from her room. She stated she complained to aides, nurses, and her family, but the targeting continued. On one occasion, Resident Q entered Resident R's room, staff were not available or didn't see her enter, so Resident R grabbed Resident Q by the wrist and yelled for staff, ya'll better come get her! Resident R expressed frustration and indicated she felt like she had no privacy, she was anxious to fall asleep, and was scared about what could happen if Resident Q went off on her. During an interview on 7/14/26 at 9:47 a.m., Qualified Medication Aide (QMA) 12 indicated Resident Q continued to fixate on Resident R's room and on Resident R. Sometimes she went into Resident S's room too. A 24-Hour Shift Report Logs, dated 6/17/26, indicated Resident Q targeted Resident R's room and Resident S's room and attempted to exit the unit. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. A 24-Hour Shift Report Logs, dated 6/23/26, indicated Resident Q refused medications (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and continued targeting Resident R's room. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. A 24-Hour Shift Report Logs, dated 7/6/26, indicated Resident Q continued Resident R's room. The record lacked documentation that a staff member had been assigned to monitor/shadow Resident Q. On 7/14/26 from 10:00 a.m. to 11:20 a.m., during a continuous observation, Resident Q repeatedly wandered the hallway, approached the front unit door, and moved close to Resident R's room. Four staff members, the Director of Nursing (DON), Medical Records Coordinator (MRC), Certified Nursing Aide (CNA) 10, and Activity Assistant 8, attempted to redirect her. Resident Q was offered a MedPass supplemental drink, a bag of chips, and was asked to take her Jello-shots and get ready for the rodeo. Resident Q resisted redirection, slapped away items offered to distract her, and refused engagement attempts. Resident Q was repeatedly surrounded by the four staff members which caused her to attempt to back away, or get away, by going to the end of the hall and pushing against the locked exit door, which set off the alarm. During an interview at 10:04 a.m., Activity Assistant 8 indicated the staff could not keep Resident Q away from Resident R's room. Activity Assistant 8 stated Resident Q rummaged through Resident R's belongings and took items from her room, and it upset Resident R. During an interview at 10:42 a.m., CNA 10 stated Resident Q attempted to enter Resident R's room daily and targeted Resident R and her belongings. Cross reference F585 and F744. During an interview on 7/16/26 at 2:30 p.m., with the DON, ED and RCS present, the DON indicated the facility's QAPI plan for dementia care began in February 2026, had been reviewed monthly, and had been updated to address new concerns on the memory care unit. The DON indicated; The facility provided re-educated staff on de-escalation during resident agitation. The facility assigned preferred staff to Resident Q, provided her with increased one-to-one care, monitored her for behavioral triggers, and attempted to eliminate opportunities for escalation. The facility provided feminine hair products to Residents R and S to assist Resident Q in recognizing their gender. On 7/15/26 at 10:20 a.m., the ED provided a copy of the facility's investigation into the Staff to Resident altercation for Resident Q. It included an in-service record and sign-in log of staff who received the training. The In-service was dated 6/13/26 and included the topic of Abuse, Neglect Reporting and Redirecting- Resident Safety Deescalations. According to the in-service record, seven staff members who were observed interacting with Resident Q during the survey period, had not received the in-service on deescalation and resident agitation: LPN 5, CNA 6, QMA 12, Activity Assistant 8, CNA 10, CNA 11, and the Medical Records Coordinator. Upon Resident Q and R's record reviews, the records lacked documentation of assigned preferred staff for Resident Q, (who and when to be utilized) and lacked documentation of one-on-one supervision (when/why it was needed, and how long it was required). Upon review of Resident R and S's records, their plan of care lacked implementation and/or revision to include attempts to help them appear more feminine to avoid escalating behaviors from Resident Q. On 7/16/26 at 2:45 p.m., the ED provided a copy of an undated document titled, QAPI Performance Improvement Project: Ongoing Aggressive Behaviors on Memory Care Unit. The document indicated, The purpose of this QAPI Performance Improvement Project is to reduce ongoing aggressive behaviors on the memory care unit while protecting resident rights, dignity, psychosocial well-being, and safety. The project will focus on consistent identification of triggers, person-centered non-pharmacological interventions, timely care-plan updates, staff education, interdisciplinary communication, and monitoring for sustained improvement. Planned Interventions 1. Behavior tracking: Implement a daily behavior log that captures resident, time, location, trigger, staff response, outcome, injury, and follow-up needed. Care-plan revision: Update care plans within 24 hours after significant events with specific triggers, prevention strategies, staff approach, redirection techniques, and escalation steps. Once improvement is achieved, the facility (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/16/2026
NAME OF PROVIDER OR SUPPLIER Brownsburg Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Hornaday Rd Brownsburg, IN 46112	
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will continue monthly review of memory care behavior trends through QAPI, maintain behavior tracking for residents with repeated distress, educate new and agency staff before memory care assignment when feasible, and update individualized interventions whenever a resident experiences a significant change in behavior, condition, environment, or medication regimen. This citation relates to Intakes 3043476 and 3054883.410 IAC (Indiana Administrative Code) 16.2-3.1-52.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observations, interviews, and record review, the facility failed to ensure that Resident R, who resided on the secured memory care unit, had access to grievance forms or had grievances submitted on her behalf for 1 of 3 residents reviewed for resident rights. This deficient practice had the potential to affect 11 of 11 residents who resided on the secured memory care unit. B. Based on observation, record review, and interview, the facility failed to ensure a grievance related to a resident's mattress causing her discomfort and pain was submitted and investigated for 1 of 3 residents reviewed for resident rights (Resident F). Findings include: A. On 7/13/26 at 8:15 a.m., Resident R stated she had ongoing concerns that Resident Q repeatedly attempted to enter her room and disturb her. She reported the problem began when she returned from the hospital after brain surgery and continued thereafter. Resident R stated she had complained to aides, nurses, and her family members that Resident Q persistently and intrusively wandered into her room. Resident R reported she had seen bright orange grievance forms in the hallway outside the unit, but when she looked for forms after returning to her room, she did not find any available on the unit. Resident R stated she did not know if anyone had submitted a grievance on her behalf and believed none had been filed since Resident Q continued entering her room. These repeated intrusions and the constant worry that Resident Q would enter her room and take her belongings caused Resident R to feel anxious and unsafe. On 7/13/26 at 9:00 a.m., the secured memory care unit was observed. No grievance forms were available. During an interview on 7/14/26 at 9:47 a.m., Qualified Medication Aide (QMA) 12 stated Resident Q continued to fixate on Resident R's room and on Resident R. QMA 12 did not know why Resident Q targeted Resident R but reported the issue had continued since Resident R returned from the hospital after her brain surgery. On 7/14/26, during continuous observation from 10:00 a.m. to 11:20 a.m., Resident Q was observed as she repeatedly wander up and down the hallway. She approached the front unit door and moved close to Resident R's room. Four staff members; the Director of Nursing (DON), Medical Records Coordinator (MRC), Certified Nursing Aide (CNA) 10, and Activity Assistant 9, immediately surrounded her and attempted to redirect her away from Resident R's room. Resident Q resisted redirection and slapped away items offered to distract her, including a supplemental drink and snack chips. Staff also attempted to engage her verbally by asking if she wanted to get ready for the rodeo, but Resident Q continued wandering around the hallway. During an interview at 10:04 a.m., Activity Assistant 8 stated the staff could not keep Resident Q away from Resident R's room and stated Resident Q rummaged through Resident R's personal belongings and took items. During an interview on 7/14/26 at 11:42 a.m., CNA 11 indicated Resident Q continued to make regular (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempts to enter Resident R's room. CNA 11 expressed her personal belief that Resident Q may have been focusing specifically on Residents R and S. On 7/14/26 at 11:07 a.m., the Executive Director (ED) provided grievance logs for June and July. There was no documentation showing the facility submitted or investigated any grievance related to Resident R's ongoing concerns about Resident Q entering her room. During an interview on 7/14/26 at 12:28 p.m., with the ED, DON, and Regional Clinical Support (RCS) present, the ED and DON indicated they were aware of the ongoing issue of Resident Q targeting Resident R's room. The ED, DON, and RCS indicated grievance forms should be available for all residents, which included the memory care unit for residents capable of submitting grievances or for families visiting residents. They indicated residents or family members could verbally submit grievances, but all investigations and outcomes should have been documented. Cross reference F744. 2. On 7/14/26 at 10:12 a.m., Resident F was observed lying in her bed. She indicated her current bed was new, and she was thankful to be out of that horrible old bed. She indicated the old bed was a low air loss mattress that inflated and deflated in certain places on the mattress. It caused her to be in great pain. So much pain that she dialed 911 to help her and then went to the emergency room to get her body off that mattress for at least a little bit of time she was gone. She indicated everybody looked at her old bed and nobody knew anything about the operation of the bed. She indicated the mattress settings were at 350 and it was too high, indicating the settings went off of her weight and she was only 250 pounds. The doctor came in on 7/10/26 and ordered her a new mattress. The mattress was finally changed and now she was so much better and could move around in the bed without pain. On 7/14/26 at 1:33 p.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to obesity, osteoarthritis of both knees (a degenerative joint disease where the protective cartilage covering the ends of the bones gradually wears away), osteoarthritis of the both hips, spondylosis without myelopathy or radiculopathy, cervical region (spinal osteoarthritis, a degenerative condition caused by age-related wear and tear on the spine), sciatica (a symptom of nerve irritation rather than a standalone medical condition), and other chronic pain. Resident F admitted to the facility on [DATE]. Her Brief Interview for Mental Status (BIMS) was 15/15 indicating her cognition was intact on 5/6/26. Resident F had a care plan, dated 5/15/26, indicating she required pain management related to acute/chronic pain related to arthritis, back, and pelvic wound. The goal was not to have an interruption in normal activities due to pain. An intervention, dated 5/15/26, indicated to anticipate Resident F's need for pain relief and respond immediately to any complaint of pain. On 6/28/26 at 1:40 a.m., Resident requested sobbing and complaining of pain. She requested to go to the emergency room. 911 was notified and she was sent to the emergency room. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/4/26 at 12:10 a.m., a progress noted indicated resident was crying and stating that she was uncomfortable in the bed and wanted the bed changed. The Director of Nursing (DON) was notified. The resident was informed that her bed was unable to be replaced or changed. On 7/16/26 at 10:15 a.m., during an interview with the Executive Director (ED) she indicated they attempted to try multiple mattresses for Resident F. She indicated she would look into further details related to the resident and her mattress concerns. On 7/15/26 at 10:19 a.m., the ED provided the current facility policy titled, Grievances and Complaints, dated 8/2020. The policy stated, The Facility advises residents and their representatives (including family, legal representatives, and advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievances or complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint Log. Any resident, representative, family member, staff, visitor, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, theft of property, etc., without fear of threat or reprisal in any form. Grievances and/or complaints may be submitted orally or in writing and can be made anonymously through the Compliance Hotline. Individuals will use Facility complaint forms or may use Resident Grievance/Complaint Form to submit written grievance reports. Duties and Obligations of Staff. When a Facility Staff member overhears or receives a complaint from a resident, a resident's representative, another interested family member or visitor of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the Facility Staff member is encouraged to advise the resident/concerned party that they may file a complaint or grievance without fear of reprisal or discrimination, and will assist the resident, or person acting on the resident's behalf, in filing a written complaint with the Facility. This Federal tag related to Intake 3049390 and 3054883. 410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)		

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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 record reviews and interviews, the facility failed to protect the residents' rights to be free from physical abuse by a Certified Nursing Aide (CNA) and verbal abuse by a Housekeeping Supervisor for 2 of 9 residents reviewed for abuse (Residents Q and H). This deficient practice was corrected on 6/13/26, prior to the start of the survey, and was therefore past noncompliance. Findings include: 1. On 7/15/26 at 10:20 a.m. a copy of an investigation into an allegation of staff to resident abuse was provided. A document titled Abuse Allegation Timeline and Investigation Summary indicated on 6/12/26 at approximately 9:30 p.m., Licensed Practical Nurse (LPN) 16, contacted the Administrator to report CNA 14 for abusing Resident Q. CNA 14 was immediately removed from the facility. The document included a statement from CNA 18 that indicated CNA 14 was attempting to redirect Resident Q out of another Residents room when Resident Q pulled away and went further into the room. The statement indicated CNA 14 reached for Resident Q again and Resident Q hit CNA 14 with a closed hand in the face once and CNA 14 hit Resident Q in the face with an open hand twice. This action resulted in a scratch on Resident Q's face. The document included a statement from Qualified Medication Aide (QMA) 17 which indicated she was walking down the hall when she heard commotion coming from a resident's room. Upon her arrival to that room she witnessed CNA 14 struck Resident Q in the face twice. The document included a statement from LPN 16 which indicated she was contacted by QMA 17 by phone and was asked to go to the memory care unit. QMA 17 indicated to LPN 16 that CNA 14 hit Resident Q in the face. The document included a statement from CNA 14 which indicated she was attempting to redirect Resident Q out of another Residents room, but Resident Q refused to leave. CNA 14 indicated in her statement that she grabbed Resident Q's hands in an attempt to guide the Resident out of the room. CNA14 initially denied striking Resident Q in her statement but later in questioning she admitted to striking the Resident. A corrective action form from the Director of Nursing to CNA 14, dated 6/13/26, indicated CNA 14 was terminated as a result of the investigation of alleged abuse. The form indicated CNA 14 had failed to use safe redirection techniques with an agitated resident and had made contact with the Resident causing the situation to escalate. 2. On 7/20/26 a copy of a corrective action form was provided, that form indicated on 2/4/26 the Housekeeping Supervisor was suspended pending the investigation into an allegation of verbal abuse towards Resident H. The form indicated on 2/4/26 the Administrator was made aware that the Housekeeping Supervisor had been overheard speaking to Resident H in an elevated voice and being argumentative with the resident related to white plastic hangers and who owned them. When the Housekeeping Supervisor was interviewed about the incident, she admitted she lost her temper. As a result of the incident the Housekeeping Supervisor received a final warning. On 7/20/26 a copy of a Performance Improvement Plan (PIP), dated 2/20/26, indicated the Housekeeping Supervisor had failed to do multiple facets of her role including, but not limited to, failure to interact with staff, residents, and visitors in a positive, respectful and professional manner. The PIP indicated on 2/4/26 the Housekeeping Supervisor was suspended pending investigation into alleged verbal abuse. The allegation was substantiated, and as a result of that the Housekeeping Supervisor did several customer service trainings and received her final warning. During an interview 7/16/26 at 12:00 p.m. the Administrator indicated when she got here the current Housekeeping Supervisor was not the supervisor. She had stepped down after the verbal altercation with Resident H and a new Housekeeping Supervisor was in orientation when the Administrator started. That new supervisor was hired on 3/3/26 and resigned on 4/11/26. At that time the Administrator asked the Regional (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Operations why the current Housekeeping Supervisor had stepped down, because she was the Administrator's go to person for any housekeeping. The Administrator indicated she was told it was because the Housekeeping Supervisor was in a verbal altercation with a resident. She indicated she was never told it was an allegation of abuse. The Administrator indicated she was unaware of the PIP and wasn't sure why they chose to bring the current Housekeeping Supervisor back if there was substantiated abuse. During an interview on 7/16/26 at 12:39 p.m. the Administrator indicated the information they gave her was that the Housekeeping Supervisor was suspended pending the investigation, but it appeared to she was brought back because poor customer service was substantiated not abuse. The Administrator indicated she hadn't had any corrective action or grievances submitted about her behavior since the incident. On 7/15/26 at 10:20 a.m. a copy of a current facility policy titled Abuse-Reportable Events, dated 5/2017, was provided. That policy indicated .It is the policy of this home to prohibit resident abuse or neglect in any form. Abuse: The willful infliction of injury,. intimidation,. resulting in physical harm,. This includes. verbal,. or physical abuse. Physical abuse: Physical action within the definition of abuse, including, but not limited to, hitting, slapping,. Verbal abuse: The use of oral,. language that includes disparaging derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability. This deficient practice was corrected by 6/13/26 after the facility implemented a systemic plan that included the following actions: assessment of all memory care residents for injuries of unknown origin, immediate reeducation of abuse prevention for all staff members, corrective action for the CNA and Housekeeping Supervisor involved in the abuse, ongoing in-servicing education to staff related to abuse prevention, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). This citation relates to Intakes 3043476, 3044848, 3046310, and 3054883 410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's discharge was adequately planned and safe for 1 of 5 residents reviewed for discharges (Resident D). Findings include: During an interview, on 7/13/26 at 12:03 p.m., Resident D indicated he was discharged from the facility to an unsafe place because he voiced too many grievances. Resident D indicated the discharge was in retaliation for him voicing so many grievances to the facility. Resident D's record was reviewed on 7/13/26 at 11:55 a.m. Diagnoses on the resident's profile included, but were not limited to, cellulitis (skin infection) of the left lower limb, peripheral vascular disease (progressive blood circulation disorder), non-pressure chronic ulcer (open area) of other part of left lower leg with fat layer exposed, non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, and acquired absence of right leg above knee. Census information indicated the resident initially admitted to the facility on [DATE] and was discharged on 7/6/26. Hospital documentation, dated 4/1/26, indicated the resident had been homeless. The resident had a previous substance abuse disorder and was being discharged on this day from an extended care facility to a sober living facility. At the time of the transfer, the resident attempted to get in his ride-share, fell, and was considered too medically complex to go to the sober living facility. He was brought to the emergency room (ER) and required observation related to a lack of safe discharge options. A care plan, initiated on 4/9/26, indicated the resident had a right above knee amputation. An admission Minimum Data Set (MDS) assessment, dated 5/31/26, indicated the resident was cognitively intact, had an overall goal to remain in the facility, and there was no active discharge planning occurring for the resident to return to the community. A review of grievances indicated the resident filed a grievance on 6/4/26, 6/5/26, four times on 6/8/26, 6/15/26, and 6/16/26. A quarterly MDS assessment, dated 6/12/26, indicated the assessment information was obtained for the resident. The resident declined wanting to talk to someone about the possibility of returning to live and receive services in the community and no active discharge planning was occurring for the resident to return to the community. A physician's order, dated 6/12/26, indicated cleanse the left dorsal (top) foot with normal saline soaked gauze, apply calcium alginate (absorbent wound treatment) to open area, secure with foam wound dressing, change three times weekly, and as needed if soiled or dislodged. A physician's order, dated 6/12/26, indicated cleanse the left lateral (outer) lower leg with normal saline, apply collagen (promotes wound healing) to wound bed, cover with bordered gauze, and change daily. A physician's order, dated 6/12/26, indicated apply Santyl (medication to remove dead tissue) to left dorsal foot topically daily. The order lacked documentation if this was for the same wound on the left dorsal foot, and if so, why the other order was three times weekly and not daily. A care plan, initiated on 6/17/26, indicated the resident exhibited attention-seeking behavior. The intervention was staff would anticipate and meet the resident's needs. A care plan, initiated on 6/19/26, indicated the resident exhibited verbal aggression and profane language. Interventions included, but were not limited to, assist the resident in avoiding other residents that may incite outbursts. A progress note, dated 7/1/26, indicated Social Services talked to the resident about his financial liability to the facility. The resident stated he would pay the liability but wanted to talk to the Business Office Manager (BOM). A progress note, dated 7/3/26, indicated the resident was starting to mess with dietary staff. The resident gave the Dietary Manager a selective menu, and the resident was able to choose what he wanted. The resident always indicated he only wanted milk at breakfast and not at lunch or dinner. The prior night, the Dietary Manger (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received a call from the cook who was very upset because the resident came down to dietary yelling and cursing and asked the cook if she could read because he did not have milk on his tray. The cook told the resident he had not written down milk as a request, but he could have the milk now if he wanted it. The resident called the cook a dumb b----. The resident will, also not put items on his menu purposely and then come and yell he didn't get it. The Dietary Manager educated the resident on selecting his menu options and instructed staff to keep a copy of the menu selections. A progress note, dated 7/6/26 at 9:15 a.m., indicated the resident was verbally aggressive towards another resident when the other resident was asking for soda. The residents were separated with no concerns. The resident was placed on one on one observation, family and physician notified, and the physician gave an order for the resident to be transferred to an inpatient psychiatric facility. The resident refused an inpatient psychiatric facility and indicated he would go to the address given. The physician ordered the resident's discharge, three days of narcotics, and education given to the resident about his wound treatment to be changed three times weekly. The note lacked documentation the resident demonstrated being able to do the treatment himself, who lived at the address given, and if the person who lived there was OK with the resident being discharged there. A progress note, dated 7/6/26 at 11:03 a.m., indicated the resident wanted to discharge and refused in-house services. The resident was educated on the treatment, and the family was notified. The note lacked documentation of why the resident wanted to discharge, or what other options were provided to the resident. A progress note, dated 7/6/26 at 11:50 a.m., indicated the Social Services submitted four referrals to inpatient behavioral/psychiatric facilities due to the resident's behavior towards staff and other residents. No response was received. The resident declined to voluntarily participate in psychiatric services. The note lacked documentation of why referrals were made if the resident actually wanted to voluntarily discharge from the facility. A progress note, dated 7/6/26 at 12:48 p.m., indicated all inpatient psychiatric facilities had declined to admit the resident. The note lacked documentation of why referrals were made if the resident actually wanted to voluntarily discharge from the facility. A nurse practitioner (NP) progress note, dated 7/6/26 at 2:51 p.m. The progress note indicated, .seen today for discharge evaluation and medical management following a skilled nursing facility stay after hospitalization for sepsis [body's extreme, life-threatening response to infection] secondary to left lower extremity cellulitis with wound infections.During his SNF [skilled nursing facility] stay, the resident received ongoing wound care, therapy services, pain management, and management of multiple chronic medical conditions.Despite medical stabilization, the resident has demonstrated repeated behaviors that have significantly disrupted the safe operation of the facility, including verbal threats and threatening behavior directed toward facility staff and other residents. Documentation reflects these behaviors persisted despite interdisciplinary interventions, staff education, behavioral redirection, care planning, and attempts to safely manage his care within the facility. Due to ongoing threats that present a safety risk to others and cannot be safely managed within the current setting, the facility has determined discharge is medically and administratively necessary.Resident is medically stable for discharge. Facility discharge is necessitated by persistent threatening behavior toward staff and fellow residents creating a safety concern despite interdisciplinary interventions and behavioral management efforts. The note lacked documentation the resident's prior homelessness was addressed as a safety barrier for discharge. A progress note, dated 7/6/26 at 4:01 p.m., indicated the resident discharged from the facility to the provided address. The progress note lacked documentation the resident was provided with written discharge instructions. An undated discharge planning review indicated the resident was being discharged home. The document included a section for self-care evaluation and equipment, all were marked (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-applicable, including walking, wheelchair use, transfers, bathing, dressing, using the restroom, preparing meals, eating, grocery shopping, housekeeping, performing home maintenance, obtaining transportation, scheduling medical appointments, getting and taking medications, and performing special treatments/procedures. Medications sent with resident indicated, med list, meds, 3 days of narcs [narcotics], tx [treatment supplies]. A section indicated, Indicate whether resident verbalized/demonstrated understanding of instructions, and was left blank. The contact section included an area to document names of providers and who the resident should contact and was left blank. A signature section for resident and staff signatures was left blank. The review lacked documentation a copy was provided to the resident at discharge. A progress note, dated 7/9/26, indicated the resident's preferred hospital wound center was notified, and the representative stated the resident needed to call and make future appointments. The note lacked documentation the preferred provider was notified prior to the resident's discharge or the resident was given information about how and when to contact them. Progress notes lacked documentation the resident's discharge was planned, including documented evidence the resident understood and was able to provide care for his wounds, how and when to take his medications, and how to obtain additional wound care products or medications. During an interview, on 7/13/26 at 11:48 a.m., the Executive Director (ED) indicated the discharge planning review document was what was used to prepare the resident for the discharge. During an interview, on 7/13/26 at 1:46 p.m., the Regional Clinical Support Nurse indicated the recapitulation of stay document was what should have been used for the resident's discharge instructions, and it had not been done. The document should have been reviewed and signed by the resident. During an interview, on 7/14/26 at 11:22 a.m., Certified Nurse Aide (CNA) 15 indicated she took the resident to the address he discharged to. When they arrived at the house, CNA 15 helped the resident get off the facility bus with his belongings. When CNA 15 knocked on the door, no one answered, so the resident was left on the front porch with his belongings. The resident was on the phone with someone and told CNA 15 his friend was on the way to the house. CNA 15 did not talk to the person on the phone, stay with the resident, or notify authorities he was being left alone on a porch. During an interview on 7/14/26 at 12:08 p.m., the Executive Director (ED) indicated the resident told her he was not staying at the facility because he did not want to see psychiatric services. CNA 15 told the ED she had knocked on the door when she dropped the resident off, but no one answered, and the resident was left on the porch. The ED indicated she was not sure where the resident was now and had not followed up with him. The resident was upset about having to pay his liability. During an interview, on 7/14/26 at 12:30 p.m., the Director of Nursing (DON) indicated the resident told them where he wanted to go to [hospital name] wound center for wound care after he discharged from the facility. The resident had not been receiving wound care from the wound center prior to his discharge from the facility. On 7/14/26 at 2:28 p.m., the ED provided a document titled, Transfer and Discharge Planning, last revised in August 2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure that adequate preparation and assistance is provided to residents prior to transfer or discharge from the facility.Social Services Staff will conduct a Discharge Planning Assessment and will help orient the resident to the impending discharge.Discharge Planning: A. Discharge planning will begin on the residents' admission to the Facility.C. If the IDT [interdisciplinary team] and the Attending Physician determine that the resident may soon be discharged , Social Services Staff will coordinate the discussion of discharge with the IDT team, the resident, and the resident's personal representative.D. Social Services Staff will communicate with Facility Staff, the resident and resident's family members as the time for discharge approaches. E. Social Services Staff will document the discharge (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brownsburg Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Hornaday Rd Brownsburg, IN 46112	
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planning, preparation, and the resident's post-discharge needs in the electronic health record. i. In preparation for discharge, Social Services will document referrals to local contact agencies, the Ombudsman or other relevant support services and the response of the resident/representative to those referrals. F. Social Services Staff will orient the resident to the impending discharge. G. Social Services Staff will coordinate resident family conferences to discuss discharge needs, plans, and teaching, and will coordinate with other IDT members as appropriate. H. If the resident/representative wishes to be discharged to a setting that does not appear to meet the resident's post-discharge needs or appears unsafe, the Facility will treat this request similarly to a refusal of care.ii. The facility will attempt to determine why the resident/representative is choosing that location.iv.If indicated, the referral to Adult Protective Services.will be made at the time of discharge.Documentation.A copy of the Discharge Summary will be provided to the resident.upon discharge when return is not anticipated. Cross reference F628. This citation relates to Intake 3091378.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a 30-day notice was issued to a resident prior to a facility-initiated discharge for 1 of 5 discharges reviewed (Resident D). Findings include: During an interview, on 7/13/26 at 12:03 p.m., Resident D indicated he was discharged from the facility to an unsafe place because he voiced too many grievances. Resident D indicated the discharge was in retaliation for him voicing so many grievances to the facility. During an interview on 7/14/26 at 12:08 p.m., the Executive Director (ED) indicated the resident told her he was not staying at the facility because he did not want to see psychiatric services. CNA 15 told the ED she had knocked on the door when she dropped the resident off, but no one answered, and the resident was left on the porch. The ED indicated she was not sure where the resident was now and had not followed up with him. The resident was upset about having to pay his liability. The ED indicated she did not give the resident a 30-day notice of transfer or discharge and did not feel it was required. The ED indicated she was aware the NP documented the resident's discharge was facility-initiated. Resident D's record was reviewed on 7/13/26 at 11:55 a.m. Diagnoses on the resident's profile included, but were not limited to, cellulitis (skin infection) of the left lower limb, peripheral vascular disease (progressive blood circulation disorder), non-pressure chronic ulcer (open area) of other part of left lower leg with fat layer exposed, non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, and acquired absence of right leg above knee. Census information indicated the resident initially admitted to the facility on [DATE] and was discharged on 7/6/26. Hospital documentation, dated 4/1/26, indicated the resident had been homeless. The resident had a previous substance abuse disorder and was being discharged on this day from an extended care facility to a sober living facility. At the time of the transfer, the resident attempted to get in his ride-share, fell, and was considered too medically complex to go to the sober living facility. He was brought to the emergency room (ER) and required observation related to a lack of safe discharge options. An admission Minimum Data Set (MDS) assessment, dated 5/31/26, indicated the resident was cognitively intact, had an overall goal to remain in the facility, and there was no active discharge planning occurring for the resident to return to the community. A quarterly MDS assessment, dated 6/12/26, indicated the assessment information was obtained for the resident. The resident declined wanting to talk to someone about the possibility of returning to live and receive services in the community and no active discharge planning was occurring for the resident to return to the community. A review of grievances indicated the resident filed a grievance on 6/4/26, 6/5/26, four times on 6/8/26, 6/15/26, and 6/16/26. A progress note, dated 7/1/26, indicated Social Services talked to the resident about his financial liability to the facility. The resident stated he would pay the liability but wanted to talk to the Business Office Manager (BOM). A progress note, dated 7/3/26, indicated the resident was starting to mess with dietary staff. The resident gave the Dietary Manager a selective menu, and the resident was able to choose what he wanted. The resident always indicated he only wanted milk at breakfast and not at lunch or dinner. The prior night, the Dietary Manager received a call from the cook who was very upset because the resident came down to dietary yelling and cursing and asked the cook if she could read because he did not have milk on his tray. The cook told the resident he had not written down milk as a request, but he could have the milk now if he wanted it. The resident called the cook a dumb b****. The resident will, also not put items on his menu purposely and then come and yell he didn't get it. The Dietary Manager educated the resident on (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	selecting his menu options and instructed staff to keep a copy of the menu selections. A progress note, dated 7/6/26 at 9:15 a.m., indicated the resident was verbally aggressive towards another resident when the other resident was asking for soda. The residents were separated with no concerns. The resident was placed on one on one observation, family and physician notified, and the physician gave an order for the resident to be transferred to an inpatient psychiatric facility. The resident refused an inpatient psychiatric facility and indicated he would go to the address given. The physician ordered the resident's discharge, three days of narcotics, and education given to the resident about his wound treatment to be changed three times weekly. The note lacked documentation the resident demonstrated being able to do the treatment himself, who lived at the address given, and if the person who lived there was OK with the resident being discharged there. A progress note, dated 7/6/26 at 11:03 a.m., indicated the resident wanted to discharge and refused in-house services. The resident was educated on the treatment, and the family was notified. The note lacked documentation of why the resident wanted to discharge, or what other options were provided to the resident. A progress note, dated 7/6/26 at 11:50 a.m., indicated the Social Services submitted four referrals to inpatient behavioral/psychiatric facilities due to the resident's behavior towards staff and other residents. No response was received. The resident declined to voluntarily participate in psychiatric services. The note lacked documentation of why referrals were made if the resident actually wanted to voluntarily discharge from the facility. A progress note, dated 7/6/26 at 12:48 p.m., indicated all inpatient psychiatric facilities had declined to admit the resident. The note lacked documentation of why referrals were made if the resident actually wanted to voluntarily discharge from the facility. A nurse practitioner (NP) progress note, dated 7/6/26 at 2:51 p.m. The progress note indicated, .seen today for discharge evaluation and medical management following a skilled nursing facility stay after hospitalization for sepsis [body's extreme, life-threatening response to infection] secondary to left lower extremity cellulitis with wound infections.During his SNF [skilled nursing facility] stay, the resident received ongoing wound care, therapy services, pain management, and management of multiple chronic medical conditions.Despite medical stabilization, the resident has demonstrated repeated behaviors that have significantly disrupted the safe operation of the facility, including verbal threats and threatening behavior directed toward facility staff and other residents. Documentation reflects these behaviors persisted despite interdisciplinary interventions, staff education, behavioral redirection, care planning, and attempts to safely manage his care within the facility. Due to ongoing threats that present a safety risk to others and cannot be safely managed within the current setting, the facility has determined discharge is medically and administratively necessary.Resident is medically stable for discharge. Facility discharge is necessitated by persistent threatening behavior toward staff and fellow residents creating a safety concern despite interdisciplinary interventions and behavioral management efforts. The note lacked documentation the resident's prior homelessness was addressed as a safety barrier for discharge or that a 30-day notice of transfer or discharge was issued before the facility-initiated discharge was initiated. A progress note, dated 7/6/26 at 4:01 p.m., indicated the resident discharged from the facility to the provided address. The note lacked documentation a 30-day notice of transfer or discharge was provided to the resident for the facility-initiated discharge. On 7/14/26 at 2:28 p.m., the ED provided a document titled, Transfer and Discharge, dated 10/24/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Residents are transferred/discharged based on physician order unless they sign themselves out against medical advice.Facility staff will provide the resident with reasonable advance notice of the transfer or discharge before it occurs. Unless exigent circumstances exist, the notice should be provided 30 days prior to the proposed date of (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer/discharge.Cases in which 30 days' notice is not possible, notice of transfer or discharge should be provided to the resident of his/her responsible party as soon as practicable. Cross reference F627. This citation relates to Intake 3091378.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's change in condition was treated in a timely manner, was effectively monitored, and was communicated accurately to the medical provider for 1 of 10 residents reviewed for quality of care (Resident J). Findings include: Resident J's record was reviewed on 7/13/26 at 2:00 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, mild cognitive impairment. A significant change Minimum Data Set (MDS) assessment, dated 4/22/26, indicated the resident had a moderate cognitive impairment and an indwelling urinary catheter (tube inserted into the bladder). A nutrition assessment, dated 5/29/26, indicated the resident had an estimated need of 1,677 milliliters (ml) of fluid daily. A physician's order, dated 6/11/26, indicated obtain urine sample to rule out UTI, one time only, for worsening confusion. A Medication Administration Record (MAR), dated June 2026, indicated the urine sample collection was scheduled on 6/12/26, but was documented as not completed. The medical record lacked documentation of why the sample was not collected. A progress note, dated 6/25/26, indicated the resident's urine was collected and sent to the laboratory for a urinalysis (UA). The note lacked documentation of why the sample was collected, including if it was related to the missed sample from 6/12/26. The UA and culture and sensitivity (C&S) results were reported on 6/27/26 and indicated greater than 100,000 colony-forming units (CFU)/milliliters (ml) (an amount of bacteria which indicates a UTI) of <i>Enterobacter cloacae</i> (bacteria) and <i>Escherichia coli</i> (bacteria). The results indicated Resident J had a urinary tract infection (UTI). Progress notes, dated 6/27/26 to 6/28/26, lacked documentation the physician was notified of the UA C&S results. A fluid intake report, dated 6/28/26, indicated the resident had 300 ml of fluid that day. A fluid intake report, dated 6/29/26, indicated the resident had 1,070 ml of fluid that day. A Nurse Practitioner (NP) progress note, dated 6/29/26, indicated the resident was being seen due to an acute (current) UTI. The NP reviewed the urine culture results and indicated the resident required antibiotic therapy and ongoing monitoring of an acute complicated UTI related to the Foley catheterization (tube inserted into the bladder) and multiple chronic medical comorbidities. The resident's temperature was 97.6 degrees Fahrenheit (F) blood pressure (B/P) 157/93, heart rate 62 beats per minute (bpm), oxygen saturation (amount of oxygen in blood) on room air 98 percent. The NP's plan was to order nitrofurantoin (antibiotic) 100 milligrams (mg) twice daily for 7 days, monitor closely for fever, worsening suprapubic pain (pain in the lower central part of the abdomen), flank pain (just below rib cage and above waist), altered mental status, decreased urine output, or other evidence of treatment failure or sepsis, and notify the provider of clinical deterioration. A MAR, dated June 2026, indicated the nitrofurantoin was scheduled to be started, on 6/29/26, in the evening, but the dose was not administered. The resident received two doses of nitrofurantoin on 6/30/26. A fluid intake report, dated 6/30/26, indicated the resident had 1,240 ml of fluid that day. A MAR, dated July 2026, indicated the resident received one dose of nitrofurantoin on the morning of 7/1/26, but the evening shift had not administered. A progress note, dated 7/1/26 at 10:50 a.m., indicated the resident was unable to take her medications, and her temperature was 100 degrees F. The note lacked documentation the physician was notified. Text conversation between the resident's nurse and the provider was dated 7/1/26 at 11:51 a.m. The nurse indicated the resident had a temperature of 100.1 degrees F, oxygen saturation of 89 percent, blood pressure 96/66, and pulse 93 bpm. The resident was on nitrofurantoin for UTI for seven days. The nurse requested the medical provider advise. The medical provider responded and indicated give Tylenol stat (immediately), (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered labs, and Rocephin (ceftriaxone) one gram (gm) intramuscularly (IM) for five days for upper respiratory infection (URI), elevated temperature, and hypoxia (low oxygen saturation). The conversation did not indicate the nurse told the on-call provider she felt the resident needed to go to the hospital. A situation, background, assessment, recommendation (SBAR) summary for providers, dated 7/1/26 at 12:09 p.m., indicated the resident's blood pressure was 99/66, pulse 93 bpm, temperature 100.1 degrees F, and oxygen saturation of 89 percent. The provider ordered labs, Rocephin one gm IM daily for five days for URI, and a chest x-ray. The SBAR did not indicate the nurse requested the resident be sent to the hospital. An order change progress note, dated 7/1/26 at 3:25 p.m., indicated the system identified a possible drug allergy for the ceftriaxone injection order. The area to document notification of the provider and responsible party was left blank. The medical record lacked documentation the provider was notified. A MAR, dated July 2026, indicated the ceftriaxone was scheduled to be started on 7/2/26, in the morning, and was not administered on 7/1/26. An undated Emergency Drug Kit (EDK) inventory indicated ceftriaxone 1 gm vials were included in the EDK. A report, dated 7/1/26, indicated there was no ceftriaxone removed from the EDK on 7/1/26. A chest x-ray, dated 7/1/26, was completed at 3:01 p.m. and reported at 6:33 p.m., showed no acute findings. A progress note, dated 7/1/26 at 5:00 p.m., indicated the resident had a temperature of 100.1 degrees F. The nurse spoke with the on-call provider, and they ordered labs, chest x-ray, and Rocephin. The resident's lung sounds were diminished with crackles. The resident had barely eaten that day. The resident was hard to wake up, even for her family member. The note indicated, The resident would benefit from being sent to the ER [emergency room] for eval [evaluation]. [On-call provider name] has not recommended this at this time. The note lacked documentation, the nurse notified the on-call provider the nurse thought the resident would benefit from being sent to the ER. A text conversation between the resident's nurse and the medical provider was dated 7/1/26 at 11:58 p.m. The nurse indicated the resident was not arousable with attempts to give medication. Vital signs were temperature 102 degrees F, pulse 106 bpm, blood pressure 118/76, and oxygen saturation 94 percent. The nurse indicated, .She also has an order for ceftriaxone.to start tomorrow at 9am [9:00 a.m.] and is on nitrofurantoin 100 mg bid [twice daily].only allergy is to penicillin, still want me to give Rocephin now? I think she possibly had a dose today, her pulse is weak, respirations shallow, can't get her to wake up with sternal rub. The physician responded if the nurse was unable to get the resident to wake up, to send her to the emergency room. A fluid intake report, dated 7/1/26, indicated the resident had 840 ml of fluid that day. A progress note, dated 7/2/26, indicated the resident was had an elevated temperature and was unarousable. The resident was sent to the ER. An ER hospital history and physical, dated 7/2/26, indicated the following regarding the resident's condition when she arrived in the ER. -The resident's family member reported the resident sounded gurgly over the last three days and her responsiveness decreased. -The resident was apparently started on Rocephin earlier today, but this evening had an elevated temperature and was not responsive to a sternal rub so she was sent to the ER. -A computed tomography (CT) of the abdomen and pelvis indicated there was occlusive debris (material blocking the airway) in the bronchus intermedius (a short airway in the right lung that connects the upper airway to the middle and lower lobes) and bronchi (the large, branching tubes that air travels down to reach your lungs) to the right lower and upper lobes, and post-obstructive atelectasis (collapsed lung) in the right lower lobe that might be due to aspiration (accidental inhalation of solid or liquid material) or infection, and moderate to large volume colonic stool with rectal wall thickening (large amount of stool in the colon). -The resident was diagnosed with sepsis secondary to aspiration pneumonia, stercoral colitis (a dangerous inflammatory condition of the colon caused by severe fecal impaction),UTI, and possible wound infection. -Aspiration (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pneumonia with hypoxia, as noted on the CT scan, was suspected to be due to medications and food being given while the resident was obtunded (decreased level of consciousness). The resident was ordered to have strictly nothing by mouth. -The resident was severely dehydrated with a sodium level of 152 milliequivalents (mEq)/liter (L) (normal is 135-145 mEq/L). The resident's family member reported the resident had virtually no intake for at least three days. During an interview, on 7/14/26 at 9:24 a.m., Resident J's family member indicated the resident started acting like she had a UTI, around 6/12/26, and the family member thought the facility was going to check the resident's urine. The resident had been in the intensive care unit (ICU) since she left the facility and was still there. On 7/1/26, the resident's family member was at the facility from around 3:30 p.m. to 8:30 p.m. During that time, she found the resident with food sitting and being held in her mouth while the resident was asleep. She saw the staff feeding the resident dinner, but she did not think the resident was able to swallow it. The resident was not responding to her. The family member returned to the facility around midnight and told them she wanted the resident sent to the hospital. When she returned to the facility at midnight, staff had to help her remove spoonfuls of pudding from the resident's mouth. During an interview, on 7/15/26 at 9:25 a.m., Licensed Practical Nurse (LPN) 19 indicated she was working as a unit manager on 7/1/26. LPN 19 acknowledged she documented that the resident would have benefited from being transferred to the hospital. LPN 19 indicated she asked for the resident to go to the hospital, but Registered Nurse (RN) 20 was in charge and did not think the resident needed to go to the hospital because they had other interventions in place. Later, the resident's family member ended up insisting the resident be sent out to the hospital. The resident was running a fever and was not acting normally. Around 2:00 p.m., on 7/1/26, the resident became less responsive. Antibiotics should have been pulled from the EDK and administered immediately when they were ordered. If an antibiotic was not available in the EDK, it should have been ordered from the back-up pharmacy and administered upon arrival. LPN 19 indicated she received the order for Rocephin for the resident. She had not administered it because, for some reason, the system would not let her schedule the first administration until the following morning. She indicated she was aware of the resident's penicillin allergy, and the physician was also aware. She was not sure if the allergy was the reason why the system would not let her schedule it until the next day. If a resident experienced a change in condition, unless it was life-threatening, the staff was supposed to contact the Director of Nursing (DON) first and then call the physician. LPN 19 indicated she had not discussed the possibility of sending the resident to the hospital with the DON. During an interview, on 7/15/26 at 11:36 a.m., RN 20 indicated she had not taken care of Resident J on 7/1/26. RN 20 indicated she was not aware of any interventions or care Resident J received and had not given any guidance to LPN 19 about whether or not Resident J should have been sent to the hospital. During an interview, on 7/15/26 at 12:21 p.m., the Regional Nurse Consultant indicated labs should have been reviewed by the physician the same day they were reported. The providers were able to access their own labs for review. When the physician ordered an antibiotic it should have been pulled from the EDK and administered. During an interview, on 7/16/26 at 9:21 a.m., Nurse Practitioner (NP) 21 indicated she was familiar with Resident J but was not on call the night she was sent to the hospital. NP 21 indicated if a nurse communicated with the on-call provider that the nurse felt the resident needed to go to the hospital, then the on-call provider most likely would have ordered a hospital transfer. If that information was not effectively communicated to the on-call provider service, then there would have been no way for the on-call provider to know the nurse thought the resident needed to go to the hospital. If an antibiotic was ordered, and available in the EDK, then NP 21 would have expected the nurse to pull the antibiotic from the EDK and administer it soon after it was ordered. During an interview, on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/16/26 at 9:45 a.m., the Regional Nurse Consultant indicated the NP saw Resident J on 6/29/26, reviewed the positive urine culture, and ordered the nitrofurantoin. The Regional Nurse Consultant indicated the nitrofurantoin was not administered until 6/30/26. She was not sure why the urine culture was not collected, as ordered, on 6/12/26. The Regional Nurse Consultant referenced the text conversations between the nurses and the on-call provider. The Regional Nurse Consultant indicated LPN 19 had not communicated with the on-call provider that the nurse thought the resident needed to be sent to the hospital. The on-call provider was not familiar with the resident. The Regional Nurse Consultant indicated she thought the system had delayed the start time for the Rocephin because of the Penicillin allergy. The nurse should have contacted the on-call provider to ensure they were aware of the allergy and determine if they wanted the medication administered or changed. She was unable to find documentation the on-call provider was notified. On 7/16/26 at 12:35 p.m., the Director of Nursing (DON) provided a document titled, Change of Condition Notification, dated June 2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. Policy: Definition: an acute change in condition.is a sudden, clinically important deviation from a patient's baseline physical, cognitive, behavioral, or functional domains. ?Clinically important' means a deviation that, without intervention, may result in complications or death.III. Notifying the Attending Physician: A. The Attending Physician will be notified timely with a resident's change in condition. B. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required.IV. Reporting Information to the Attending Physician: A. Emergency Situations.If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital. On 7/16/26 at 12:46 p.m., the DON provided a document titled, Laboratory, Diagnostic, and Radiology Services, dated January 2026, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure that laboratory.services are provided in a timely, safe, and effective manner to meet residents' medical needs.The Facility is responsible for the quality and timeliness of services provided by the laboratory.The ordering practitioner will be notified of results that fall outside of clinical reference or expected ?normal' ranges per the ordering practitioner's order. On 7/16/26 at 12:50 p.m., the DON provided an undated document titled, .Receiving Medications from Pharmacy, and indicated it was the policy currently being used by the facility. The policy indicated, .Medications.are received from the pharmacy supplier on a timely basis. This citation relates to Intake 3069737. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		

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 07/16/2026
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a urinary tract infection (UTI) was treated timely for 1 of 5 residents reviewed for transfers and discharges (Resident J). Findings include: Resident J's record was reviewed on 7/13/26 at 2:00 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, mild cognitive impairment. A significant change Minimum Data Set (MDS) assessment, dated 4/22/26, indicated the resident had a moderate cognitive impairment and an indwelling urinary catheter (tube inserted into the bladder). A physician's progress note, dated 5/28/26, indicated a urinalysis (UA) culture and sensitivity (C&S) was ordered due to increased lethargy. A lab report, dated 5/29/26, indicated a UA was completed with no C&S. The UA indicated 3+ leukocytes (large, moderate-to-high concentration of white blood cells in the urine, a strong sign that the immune system is actively fighting an infection or significant inflammation in the urinary tract) in the urine. Progress notes, dated 5/29/26 to 5/31/26, lacked documentation the physician was notified of the UA results. A progress note, dated 5/31/26 at 8:39 p.m., indicated the resident had a decreased blood pressure, increased lethargy, and was not eating. The resident was sent to the hospital. A progress note, dated 5/31/26 at 11:58 p.m., indicated the resident was enroute back to the facility from the hospital. The resident was diagnosed with a urinary tract infection (UTI) and yeast infection. The resident received Rocephin (antibiotic) in the emergency room (ER), and new orders for Keflex (antibiotic) and Diflucan (anti-fungal) were expected. A physician's progress note, dated 6/1/26, indicated the resident's leukocytosis (elevated white blood cell count which indicates possible infection) identified during the evaluation was likely related to the UTI. The plan was to continue cephalexin (Keflex) 500 milligrams (mg) by mouth every 6 hours for 7 days. The resident had altered mental status/acute metabolic encephalopathy (a sudden, reversible brain dysfunction which can be caused by infections) related to the infection, and it was improving following treatment. The note indicated, Monitor neurological status closely. Progress notes lacked documentation of increased monitoring of the resident's neurological status. A physician's order, dated 6/11/26, indicated obtain urine sample to rule out UTI, one time only, for worsening confusion. A Medication Administration Record (MAR), dated June 2026, indicated the urine sample collection was scheduled on 6/12/26, but was documented as not completed. The medical record lacked documentation of why the sample was not collected. A progress note, dated 6/25/26, indicated the resident's urine was collected and sent to the laboratory for a UA. The note lacked documentation of why the sample was collected, including if it was related to the missed sample from 6/12/26. The UA C&S results were reported on 6/27/26 and indicated greater than 100,000 colony-forming units (CFU)/milliliters (ml) (an amount of bacteria which indicates a UTI) of Enterobacter cloacae (bacteria) and Escherichia coli (bacteria). Progress notes, dated 6/27/26 to 6/28/26, lacked documentation the physician was notified of the UA C&S results. A Nurse Practitioner (NP) progress note, dated 6/29/26, indicated the resident was being seen due to an acute (current) UTI. The NP reviewed the urine culture results and indicated the resident required antibiotic therapy and ongoing monitoring of an acute complicated UTI related to the Foley catheterization (tube inserted into the bladder) and multiple chronic medical comorbidities. The resident's temperature was 97.6 degrees Fahrenheit (F) blood pressure (B/P) 157/93, heart rate 62 beats per minute (bpm), oxygen saturation (amount of oxygen in blood) on room air 98 percent. The NP's plan was to order nitrofurantoin (antibiotic) 100 mg twice daily for 7 days, monitor closely for (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brownsburg Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Hornaday Rd Brownsburg, IN 46112	
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fever, worsening suprapubic pain (pain in the lower central part of the abdomen), flank pain (just below rib cage and above waist), altered mental status, decreased urine output, or other evidence of treatment failure or sepsis, and notify the provider of clinical deterioration. A MAR, dated June 2026, indicated the nitrofurantoin was scheduled to be started, on 6/29/26, in the evening, but the dose was not administered. The resident received two doses of nitrofurantoin on 6/30/26. A MAR, dated July 2026, indicated the resident received one dose of nitrofurantoin on the morning of 7/1/26, but the evening shift did not administer the dose. A progress note, dated 7/1/26 at 10:50 a.m., indicated the resident was unable to take her medications, and her temperature was 100 degrees F. The note lacked documentation the physician was notified. A situation, background, assessment, recommendation (SBAR) summary for providers, dated 7/1/26 at 12:09 p.m., indicated the resident's blood pressure was 99/66, pulse 93 bpm, temperature 100.1 degrees F, and oxygen saturation of 89 percent. The provider ordered labs, and Rocephin one gram (gm) daily for five days. A progress note, dated 7/2/26, indicated the resident was had an elevated temperature and was unarousable. The resident was sent to the emergency room (ER). An undated emergency drug kit (EDK) inventory sheet indicated there were 12 tablets of nitrofurantoin 100 mg in the facility's EDK. An EDK report, dated 6/29/26 to 7/1/26, indicated there was no nitrofurantoin removed from the EDK on those dates. A hospital history and physical, dated 7/2/26, indicated the resident was septic with several possible concurrent contributing factors, including UTI. During an interview, on 7/14/26 at 9:24 a.m., Resident J's family member indicated the facility told the family member they would check the resident for a UTI around 6/12/26 because the resident was acting like she usually did when she had a UTI. This testing was not done. The resident has been in the intensive care unit since she left the facility. The evening of 7/1/26, the resident's family member was in the facility, from 3:30 p.m. to 8:30 p.m., and then went home. The family member returned to the facility around midnight the same night. The resident was non-responsive and not able to swallow. During an interview, on 7/15/26 at 12:21 p.m., the Regional Nurse Consultant indicated labs should have been reviewed by the physician the same day they were reported. The providers were able to access their own labs for review. When the physician ordered an antibiotic it should have been pulled from the EDK and administered. During an interview on 7/16/26 at 9:45 a.m., the Regional Nurse Consultant indicated she was not sure why the UA C&S was not done on 6/12/26, but it should have been. The NP saw the resident on 6/29/26 and ordered nitrofurantoin, but it was not started until 6/30/26. On 7/16/26 at 12:46 p.m., the Director of Nursing (DON) provided a document titled, Laboratory, Diagnostic, and Radiology Services, dated January 2026, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure that laboratory.services are provided in a timely, safe, and effective manner to meet residents' medical needs.The Facility is responsible for the quality and timeliness of services provided by the laboratory.The ordering practitioner will be notified of results that fall outside of clinical reference or expected ?normal' ranges per the ordering practitioner's order. On 7/16/26 at 12:50 p.m., the DON provided an undated document titled, .Receiving Medications from Pharmacy, and indicated it was the policy currently being used by the facility. The policy indicated, .Medications.are received from the pharmacy supplier on a timely basis. Cross reference F684. This citation relates to Intake 3069737. 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)		