STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Meadows	2 E Tilden 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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, interview, and record review, the facility failed to ensure a resident was mechanically transferred using proper technique, resulting in harm when a resident had a fall resulting in an avulsion fracture at the tip of the distal fibula for 1 of 3 residents reviewed for falls with injury (Resident D). Findings include: A Facility Reported Incident (FRI), dated 8/30/25 at 4:39 p.m., indicated on 8/29/25 Resident D was being assisted with a transfer out of her wheelchair by Certified Nursing Assistant (CNA) 10 when the resident began to experience pain in her right foot. The resident was gently lowered to the floor. On 8/31/25 Resident D was diagnosed with a probable subacute nondisplaced demineralized medial cuneiform (bones between the toes and ankle) fracture. The resident's activity level was upgraded to include non-weight bearing on the right lower extremity (RLE), and total mechanical lift for all transfers. On 9/3/25 at 2:28 p.m., Resident D was observed in a wheelchair (WC) at bedside, wearing a controlled ankle motion boot (CAM boot - a specialized walking boot designed for injuries to the foot, ankle and lower leg) on her right foot that extended to her knee, and her call light had been activated. The resident indicated she was waiting for staff to come and help change her brief. An unidentified staff member was observed entering the resident's room with a Hoyer lift (a mechanical device with a sling used to lift and transfer a resident from one surface to another) and indicated she would return with help. On 9/3/25 at 2:35 p.m., Resident D indicated, on 8/29/25, CNA 10 who was a new CNA and who had not been assigned to her care before, had responded to her call light for assistance. During the process of hooking the resident to a standup mechanical lift, the CNA had not properly strapped the resident to the lift, and ultimately the resident had been on the floor with pain in her right foot. Resident D had been to an orthopedic appointment on 9/3/25, and the orthopedic physician had confirmed she had a fractured bone located on the outside of her right foot. The physician had explained, when her foot had been twisted and bent at an odd angle, the ligaments had stretched so far that the bone was pulled away from the other bone. Resident D's clinical record was reviewed on 9/3/25 at 2:30 p.m. Diagnoses on Resident D's profile included osteopenia (low bone mineral density), osteoporosis (decreased bone mass and density), paraparesis (partial loss of motor function in both lower legs), monoplegia (paralysis or weakness) of the right lower limb, dependence on a wheelchair, and obesity (body mass index [BMI] over 33.0). A quarterly Minimum Data Set (MDS) assessment, completed on 6/11/25, assessed the resident as being cognitively intact. The resident required substantial/maximum assistance for bed mobility, was dependent on staff for transfers, and did not walk. A WC was used for mobility. There was no documentation of falls in the six months prior to the assessment. A care plan, dated 3/19/23, indicated Resident D required assistance with activities of daily living (ADLs) to include bed mobility and transfers. An approach, dated 9/28/23, indicated two people assist with transfers with use of a stand-up lift. A physical therapy (PT) discharge note, dated 2/12/25, indicated Resident D had multiple long-term goals to include, but not limited to: to safely perform WC to bed or WC to toilet transfers using assistive equipment with minimum assistance of one person, safely transition from supine to sitting position with minimum assistance of one person, and to improve bed mobility from supine to sitting position with maximum assistance of one person. These goals were not achieved due to the resident reaching maximum rehab potential. The clinical impression indicated PT services were discontinued due to the resident reaching her maximum rehab potential and would require maximum assistance of one to two people for bed mobility and stand up lift. A nursing progress note, dated 8/29/25 at 4:42 p.m., indicated the nurse was called to Resident D's room by CNA 10, and when she entered the resident's room, she observed the resident on the floor. CNA 10 stated that she was transferring the resident but had to lower her to the floor when Resident D started complaining about her leg hurting. A care plan for resident falls was updated on 8/29/25 to include resident to use passive mechanical lift for all transfers. A physician's order for activity level, dated 8/30/25, indicated up ad lib (as wanted or requested) with total mechanical lift with assistance of two members to wheelchair, and non- weight bearing (NWB) to the right foot. Mobile x-ray diagnostics reports included,a. On 8/29/25 at 7:33 p.m., concern for a nondisplaced medial cuneiform fracture.b. On 8/30/25 at 3:26 p.m., an addendum was added to include, there was a minimally displaced fracture of the first cuneiform bone.c. On 8/30/25 at 4:39 p.m., an addendum was added to include, there was a slight step off medial aspect cuneiform, margins not sharp. Subacute fracture cannot be excluded. Stress type injury cannot be excluded.d. On 9/2/25 at 1:03 a.m., images of the right foot demonstrate normal osseous alignment. No definite fracture, including the medial cuneiform. An orthopedic physician report, dated 9/3/25, indicated Resident D presented today for evaluation of her right