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	10/16/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, and record review, the facility failed to ensure residents' narcotic medications were protected from diversion resulting in 21 missing Oxycodone (a Schedule II narcotic medication) tablets, for 1 of 3 residents reviewed for misappropriation (Resident B). This deficient practice was corrected by 9/29/25 prior to the start of the survey and was therefore Past Noncompliance.Findings include:A Facility Reported Incident (FRI), dated 9/19/25 at 3:59 p.m., indicated a medication discrepancy was found with Resident B's pain medication from the pharmacy. The Executive Director (ED), Director of Nursing Services (DNS), Physician (MD), Power of Attorney (POA), pharmacy, police department, and Adult Protective Services (APS) were notified, and a consumer complaint was filed. Registered Nurse (RN) 6 was suspended pending investigation and subsequently terminated. Resident B's clinical record was reviewed 10/16/25 at 10:45 a.m. Diagnoses on Resident B's profile included traumatic subdural hemorrhage with loss of consciousness (brain bleed), and chronic obstructive pulmonary disease.A physician's order for Resident B, dated 9/10/25, Oxycodone 5 milligrams (mg) give 1 tablet every 4 hours PRN (as wanted or needed) for pain. A Controlled Substance Record for Resident B indicated Registered Nurse (RN) 6 signed as having destroyed 21 Oxycodone 5 mg tablets on 9/17. The photocopied record was crumpled and had a rip and piece of the form missing through the destruction information section. There was no second witness signature, only an O visible on the signature line. A documented timeline related to narcotic diversion, dated 9/17/25 - 10/2/25, included, a. On 9/17/25, RN 7 identified Resident B was missing a card of Oxycodone 5 mg tablets. RN 6 was contacted at home and indicated she had destroyed the medication by mistake. b. On 9/18/25, the DNS contacted RN 6, who indicated she had destroyed the Oxycodone by mistake, and Qualified Medication Aide (QMA) 8 had witnessed her destroying the medication. RN 6 indicated she had the Controlled Substance Record (narcotic count sheet) on her person at home. c. On 9/18/25, QMA 8 was contacted to verify destruction of Resident B's Oxycodone the prior evening. QMA 8 indicated she had observed RN 6 administer flu vaccines to residents where she was working on the secured memory care unit, hallway 100, but she had not spoken with RN 6 on 9/17/25, nor had she witnessed any drug destruction. d. On 9/18/25, RN 6 was suspended pending investigation, and the local police department was notified. e. On 9/22/25, the Assistant Director of Nursing Services (ADNS) performed a record sweep searching for narcotic destruction sheets for 3 additional residents who had recently had their narcotic medications discontinued. One (1) of the 3 residents' records could not be located, leaving an additional 24 Oxycodone tablets unaccounted for. f. On 9/23/25, the Regional Director of Clinical Services began a narcotic audit, specifically looking for discrepancies of Oxycodone, with a date range of 7/1/25 - 9/23/25. g. On 9/26/25, a Record of Facility Inservice indicated 36 nursing staff signed as having received education regarding a new narcotic card removal sheet. h. On 9/29/25, 2 nurses from the facility pharmacy conducted a narcotic audit, with a date range of 8/22/25 - 9/22/25. Review of RN 6's employee file indicated on 12/5/19 she had signed as having received education on Resident Abuse, Resident Rights, and the Elder Justice Act. An Employee Communication Form, dated 9/29/25, indicated RN 6 had been suspended on 9/17/25 and terminated on 9/29/25. Details of the incident/performance/workplace conduct/policy violation, indicated, Employee suspended pending investigation for narcotic discrepancy 9/17/25 with resident in facility. It is substantiated that employee falsified/altered narcotic count sheet. It is found that staff member has misappropriated or taken resident narcotic medications. It is found that employee stated destroying medications with staff that report never destroying medications with employee. Employee returned 9/18/25 and resuspended due to new and updated information on 9/19/25. Employee sent attached notification via email or wish to resign. Communicated to employee that investigation will be ongoing. Employee to be terminated for this occurrence. A Plan of Action document, dated 9/26/25, indicated there had been alleged diversion of narcotics by a licensed nurse. The goal was to have no diversion of medications. Preventative actions included a 100% audit of narcotic count sheets for all residents with routine and PRN narcotic medications. Nurses were re-educated on medication destruction policy/procedure along with accurate counts for narcotics. A new form was initiated for adding/removal of narcotic cards. The DNS or ADNS was to be involved in all narcotic destruction. Preventative actions included audit of narcotic count sheets for all resident with routine and PRN narcotic medications utilizing pharmacy delivery manifests to be completed upon the following schedule: 5 times/week for 8 weeks, 3 times/week for 4 weeks, and weekly for 4 weeks. Spot audits were to be completed monthly x 6 months and PRN thereafter, with results presented in QAPI

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, and record review, the facility failed to maintain a system for the reconciliation of controlled medications, resulting in diversion of at least 369 Oxycodone (a Schedule II narcotic medication) tablets from 4 of 4 hallways reviewed for diversion of narcotics (100, 200, 300, and 400 hallways). This deficient practice was corrected by 9/29/25 prior to the start of the survey and was therefore Past NoncomplianceFindings include:A Facility Reported Incident (FRI), dated 9/19/25 at 3:59 p.m., indicated a medication discrepancy was found with Resident B's pain medication from the pharmacy. The Executive Director (ED), Director of Nursing Services (DNS), Physician (MD), Power of Attorney (POA), pharmacy, police department, and Adult Protective Services (APS) were notified, and a consumer complaint was filed. Registered Nurse (RN) 6 was suspended pending investigation and subsequently terminated.A Controlled Medication Reconciliation pharmacy audit report dated 8/22/25 - 9/22/25, documented 14 residents having been audited for narcotic medications. The audit indicated that 7 of the 14 residents did not have 2 nursing signatures present on Transfer/Destruction sheets, and 8 of the 14 residents were missing Reconciliation Forms from the narcotic logs. During an interview on 10/16/25 at 2:05 p.m., the ADNS indicated, the Regional Director of Clinical Services conducted a narcotic audit, specifically looking for discrepancies of Oxycodone, with a date range of 7/1/25 - 9/23/25. Upon conclusion of the audit, there were at least 7 additional residents found with discrepancies regarding their Oxycodone and around 348 tablets unaccounted for. The medication cards and narcotic sheets for discharged residents were missing. A list of the additional resident found with discrepancies and the exact count of Oxycodone tablets missing was not provided during the survey process. A Plan of Action document, dated 9/26/25, indicated there had been alleged diversion of narcotics by a licensed nurse. The goal was to have no diversion of medications. Preventative actions included a 100% audit of narcotic count sheets for all residents with routine and PRN narcotic medications. Nurses were re-educated on medication destruction policy/procedure along with accurate counts for narcotics. A new form was initiated for adding/removal of narcotic cards. The DNS or ADNS was to be involved in all narcotic destruction. Preventative actions included audit of narcotic count sheets for all resident with routine and PRN narcotic medications utilizing pharmacy delivery manifests to be completed upon the following schedule: 5 times/week for 8 weeks, 3 times/week for 4 weeks, and weekly for 4 weeks. Spot audits were to be completed monthly x 6 months and PRN thereafter, with results presented in QAPI meetings overseen by the Executive Director.On 10/16/25 at 4:15 p.m., the ADNS provided a Controlled Substances: Storage, Documentation, Inventory and Destruction policy, revised 10/25, and indicated the policy was the one currently being used by the facility. The policy indicated, It is the policy of this facility that all controlled substances will be stored, recorded, accounted for, and destroyed by state regulation.1. Facility will utilize the Shift Change Verification of Controlled Substances form to count all controlled substances for each medication cart in the facility. 2. The incoming nurse or QMA will count all controlled substances being stored at the facility while the outgoing nurse or QMA watches the process. Both staff members sign that the count sheets and verification have been completed with no discrepancies. Destruction: 1. When the resident's physician discontinues a controlled substance, all unused medication will be destroyed by the Director of Nursing or ADNS and a witnessing licensed nurse or QMA. a. Destruction will be documented on the residents' Controlled Substance Record. b. Copies of the records will be scanned into the resident's EMR [electronic medical record] . This deficient practice was corrected by 9/29/25 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included monitoring delivery, storage and counting of narcotic medications, staff education regarding accurate narcotic counts and policy and procedures for medication destruction, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI).Cross reference F602. This citation relates to Intake 2623477.3.1-25(e)(2)3.1-25(e)(3) 3.1-25(s)