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	04/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's right to dignity when she was kissed by a facility bus driver for 1 of 3 residents reviewed for resident abuse (Resident B). Findings include:A facility reported incident (FRI), dated 2/24/26 at 4:01 p.m., indicated Resident B reported a bus driver placed an unwanted kiss her on the forehead during transport. Bus Driver 5 was suspended pending investigation then later brought back with education. The resident care plan and profile were reviewed and updated, and the resident would be transported by third-party vendor to future appointments. Resident B's clinical record was reviewed on 4/15/26 at 11:32 a.m. Resident B was admitted on [DATE] with diagnoses that included spinal stenosis with fusion of the lumbosacral spine and admission for orthopedic aftercare. An admission Minimum Data Set (MDS) assessment, completed on 2/3/26, assessed Resident B as being cognitively intact with no documentation of behaviors or rejection of care. The resident required partial/moderate assistance with transfers to and from a wheelchair (WC), and ambulation of short distances. The resident utilized a manual WC for mobility. A late entry nursing progress note, effective date 2/23/26 at 2:40 p.m., created on 2/25/26 at 2:41 p.m., indicated Resident B continued to be seen by the wound care center in a nearby town. An Event (incident) tab in the electronic medical record, dated 2/24/26 at 4:58 p.m., indicated monitor for psychosocial distress related to any complaints while on appointment transfer. A progress note by the Social Service Director (SSD), dated 2/26/26 at 8:58 a.m., indicated she had gone to speak with Resident B for psychosocial follow-up. The resident stated that she did not want to talk to her and was only comfortable talking to the Executive Director (ED). A progress note by the former ED, dated 2/26/26 at 1:02 p.m., indicated he had met with Resident B. The resident and ED discussed forms the resident refused to sign for the Social Security Director (SSD), and the resident report of having upcoming appointments the following Monday. The resident's progress notes lacked documentation the SSD had followed the resident for psychosocial distress more than 1 day following the incident on 2/24/26. The Director of Nursing Services (DNS) indicated Resident B had not wanted to speak with the SSD, and the hot charting event meant nursing staff had been prompted and would have documented psychosocial distress if any had been observed. The resident record lacked documentation Resident B's care plan or profile had been updated to reflect that the resident was upset with Bus Driver 5 or that she would be transported by third-party vendor to future appointments. During an interview on 4/5/26 at 12:20 p.m., Resident B indicated that on 2/23/26 she had been taken to and picked up from an outside appointment on the facility bus. While she was being strapped onto the bus for transport back to the facility she had been upset at having to wait for the bus. Bus Driver 5 was talking to her, moving his feet like he was dancing, singing a silly song about getting a kiss to make it better, and while he stood in front he leaned forward and kissed her on the forehead. Resident B indicated she had not asked to be kissed, he did not apologize for it, and she was upset about the situation. There had been a female bus driver standing beside the resident at the time and she said nothing to Bus Driver 5 which the resident found weird. Resident B indicated she felt the male bus driver's actions were offensive and the situation had been uncalled for. Resident B indicated she had (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported the indicated, and it took 2 days for the Executive Director (ED) to get back with her. A Concern/Grievance Form filed by the former ED, dated 2/24/26, indicated Resident B complained of not being notified of an upcoming appointment until transportation came in and told her they needed to go. The Transportation Coordinator (TC) responded, on 2/23/26 the resident had an 11:00 a.m. wound care appointment and needed to leave at 9:00 a.m. with another appointment out. When the TC knocked on the resident's door and greeted her and stated you have an appointment, the resident was still in bed asleep and not ready to leave. A Witness Statement written by Bus Driver 5 on 2/24/26, incident, dated 2/23/26, indicated, I explain to the lady why I was late and I apologize to her and I listened to what she was saying because she was very frustrated about me being very late, so I listened to her and she went on talking then I asked her jokingly would it be okay if I kiss her on the forehead and her respond was I don't care it don't matter what you say to me then she went on still complaining.she did mention the next time this will not happen again. Because she will call 911 and let the police know to pick her up so I proceeded to put her on the bus and fasten her down in the wheelchair. So I started driving about two miles down the road then she switched the conversation. A Witness Statement written by the former ED, dated 2/24/26, incident date 2/23/26, indicated Bus Driver 5 had indicated he had been almost an hour late picking up Resident B from an appointment due to securing the resident on the bus. The bus driver had tried to smooth things over, stating things like it's going to be alright and sorry for being late. The resident stated she did not care and she knew it would not happen again as she would call the police. Bus Driver 5 indicated he did not know when, but thought after they were ready to take off, he pecked the resident on the forehead. About 2 miles down the road, the resident requested something to eat from a fast-food restaurant, and even though he knew he was not supposed to and trying to do the right thing to smooth the being late out for her, he stopped at the restuarant. An Employee Communication Form, dated 2/24/26, indicated Bus Driver 5 was suspended from 2/22/26 - 2/27/26, when he returned to work. It was reported that the bus driver had kissed a resident on the forehead during transport. The employee was suspended pending investigation and then returned. The employee was educated on expectations as it results in contact with or comforting residents. The employee received a final written warning for this incident of workplace misconduct. An In-Service sign-in log, dated 3/11/26, indicated 26 staff members had signed as having attended the all-staff meeting and receiving information to include abuse training. Bus Driver 5 had not signed as having attended the meeting. The Director of Nursing Services (DNS) indicated Bus Driver 5 had completed on-line abuse training on 1/5/26 and his file lacked documentation of having completed abuse or resident rights training after the incident on 2/23/26. Bus Driver 5 was on vacation during the survey process and was unavailable for interview. The ED on record in February 2026 no longer worked in the facility and did not respond to a call with request for an interview. During an interview on 4/15/26 at 9:38 a.m., the Assistant Director of Nursing Services (ADNS) indicated when there were reports of abuse, staff were to immediately assure the resident was safe, then notify the ED as that person was the abuse coordinator. Abuse training was offered upon employee hire, then presented at least annually on the computerized training site, and more often as needed. During an interview on 4/15/26 at 10:43 a.m., Registered Nurse (RN) 8 indicated she had not had any residents complain of abuse in recent months. If so, she would have reported the information. During an interview on 4/16/26 at 9:43 a.m., Bus Driver 9 indicated on 2/23/26, she had been on the bus with Bus Driver 5 and assisting residents for transport, but once the bus was ready to leave the facility, she had left for a personal appointment. Bus Driver 9 indicated she had not witnessed any inappropriate interaction between Bus Driver 5 and Resident B, and she did not have any details to share. During an interview on 4/16/26 at 10:03 a.m., the DNS indicated that Resident B had unspecified complaints, so the prior ED had gone to speak with her. Resident B told the ED that Bus Driver 5 had kissed her on the forehead when on the bus. The resident had already been unhappy about being late for her appointment that day. The resident did not think the incident was anything sexual, but she did not like it. An investigation had been conducted and residents that used the bus (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been interviewed with no new concerns regarding Bus Driver 5. The bus driver had indicated he was just trying to smooth things over and make things right as the resident was upset, and he did not think he'd done anything wrong as the resident did not say anything. During an interview on 4/16/26 at 10:30 a.m., the ADNS indicated the day of the incident, Resident B had told an aide on the floor she wanted to speak with the ED in the next 5 minutes, or she was calling the Ombudsman. The resident did not specify what she wanted to speak to the ED about, but she wanted to speak only to him. Within minutes before the ED got down to speak with Resident B, 3 town policemen entered the facility. The resident had been mad as she had to wait for the bus driver to pick her up from an appointment but not mad enough that she hadn't requested to stop at a fast-food restaurant on the way back for a burger, and the driver complied. During an interview on 4/16/26 at 11:32 a.m., the SSD indicated she had gone to speak to Resident B on 2/26/26 regarding psychosocial related to her being upset with the bus driver, but the resident only wanted to speak with the ED. The SSD indicated she had not gone back to follow up psychosocial that incident but had spoken with the resident multiple times during her stay, mostly regarding her discharge planning. Any documentation she might have done could be found in the progress notes. On 4/16/26 at 12:44 p.m., the ED provided a Resident Rights policy, revised 7/2023, and indicated the policy was the one currently being used by the facility. The policy indicated, Facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.All staff members recognize the rights of residents at all times and residents assume their responsibility to enable personal dignity, wellbeing, and proper delivery of care. This citation relates to Incident 2788928. 410 IAC (Indiana Administrative Code) 16.2 - 3.1-3(a)