STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155487	A. BUILDING 00 B. WING	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWN COUNTY HEALTH AND LIVING COMMUNITY	55 E WILLOW ST NASHVILLE, IN 47448

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 29, 30, 31, September 1 and 5, 2023 Facility number: 000479 Provider number: 155487 AIM number: 100290880 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 2 Medicaid: 59 Other: 31 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 11, 2023.	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tyler Motsinger | Administrator | 09/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to revise a care plan for a resident who fell and sustained an injury for 1 of 1 residents reviewed for accidents. (Resident 8) Findings include: During an interview on 8/30/23 at 10:30 A.M., Resident 8 indicated she had fallen in June while she was reaching for a snack. She was sent to the hospital where it was determined that she had broken her left hip. She did not recall meeting with staff regarding new interventions to her fall care plan. On 8/30/23 at 10:45 A.M., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, fracture of unspecified part of neck of left femur, cerebral infarction, and type 2 diabetes.	F 0657	**F 657 483.21 Care Plan Timing and Revision** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The careplan for Resident 43 has been updated to reflect the residents current care needs. Current resident's fall care plans will be audited for updated interventions. **II. The facility will identify other residents that may potentially be affected by the practice.** Current residents receiving care have the potential to be affected. Current resident's care plans have	09/19/2023

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	A progress note, dated 6/20/23 at 4:22 P.M., indicated, "Resident fell in room trying to get donuts. Resident has laceration above left eyebrow and complaints of left hip pain. Did not move resident from floor. Left leg appeared shortened. Notified [name of physician] and sent resident to [name of hospital] for eval [evaluation] and treatment." A hospital history and physical document, dated 6/20/23, indicated the resident had fallen in her room and sustained a fracture of the neck of the left femur. A fall care plan with start date of 10/10/22, indicated the resident was at risk for falls. An intervention for fall risk with a start date of 6/21/23 indicated, "Resident sent to ER [emergency room) for follow up." The fall care plan included no further fall interventions after the resident's fall on 6/20/23. During an interview on 9/1/23 at 11:50 P.M., the Administrator indicated the fall care plan interventions had not been revised following the resident's fall. On 9/1/23 at 12:20 P.M., the Director of Nursing provided the Fall Prevention Policy and Procedures, dated 5/6/16, and indicated this was the current policy used by the facility. A review of the policy indicated, "...it is the responsibility of the interdisciplinary team to document falls prevention, when a fall occurs, and interventions to avoid future falls..." and "...a member/designee of the interdisciplinary team will assist the team and update the care plan...". 3.1-35(d)(2)(B)		been reviewed for accuracy. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses will receive re-education regarding timing and revisions of careplans by 9/19/2023. **IV. The facility will monitor the corrective action by implementing the following measures.** DON/Designee will review 5 random resident's care plans weekly for 8 weeks, and 3 random resident's care plans weekly for 8 weeks, and then 2 random resident's care plans weekly for 36 weeks. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. **V. Plan of Correction completion date: 9/19/23** **Brown County Health and Living requests paper compliance for the following deficiencies. This plan of correction is to serve as Brown**	

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			County Health and Living's credible allegation of compliance. **Submission of this plan of correction does not constitute an admission by Brown County Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing sheet had the name of the facility and the actual hours worked by staff for 5 of 5 days of daily posted nurse staffing reviewed. Finding includes: During an observation on 8/29/23 at 11:39 a.m., the daily posted nursing staff sheet lacked the name of the facility or the actual hours worked by staff. On 9/1/23 at 2:46 p.m., the Administrator provided the daily posted nursing staff sheet dated 8/28/23 through 9/1/23. The daily posted nursing staff sheet lacked documentation of the name of the facility or the actual hours worked by staff. During an interview on 9/5/23 at 9:58 a.m., the	F 0732	F 732 Posted Nurse Staffing Information **I. The corrective actions to be accomplished for those residents found to be affected by the practice.** Nurse Staffing has been posted with the name of the facility and the actual hours worked by staff. II. **The facility will identify other residents that may potentially by affected by the** practice. Nurse Staffing continues to be posted with the corrected information.	09/19/2023

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	Corporate Nurse Consultant and Director of Nursing indicated the daily posted nursing lacked the name of the facility and the actual hours worked.		III. The facility will put into place the following systematic changes to ensure that the practice will not recur. Staff who participate in managing nursing hours are being educated regarding the posting of information. IV. The facility will monitor the corrective action by implementing the following measures. The DON or Designee will observe the nursing staffing posting weekly to ensure the correct information is posted. The results of these audits will be discussed at the facility Quality Assurance meetings monthly times 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance: 9/19/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	