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	12/20/2022

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 the Investigation of Complaints IN00396338, IN00397426, and IN00395819. Complaint IN00396338 - Unsubstantiated due to lack of evidence. Complaint IN00397426 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00395819 - Substantiated. Federal/State deficiencies related to the allegations are cited at F740. Survey date: December 20, 2022 Facility number: 000479 Provider number: 155487 AIM number: 100290880 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 15 Medicaid: 69 Other: 24 Total: 108 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 28, 2022.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyler Motsinger	Administrator	01/09/2023

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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	Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to provide supervision to prevent resident to resident behaviors for 1 of 3 residents reviewed. This resulted in a resident sustaining a fracture following a resident to resident altercation. (Resident B, Resident C) Findings include: On 12/21/22 at 11:00 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder, Alzheimer's disease, and restlessness and agitation. The Quarterly MDS (Minimum Data Set) assessment, dated 11/22/22, indicated the resident was not cognitively intact. The resident's care plan indicated, "PROBLEM: Problem Start Date: 10/13/22...edited 12/20/22... Resident displays behavior of wandering/pacing, ongoing agitation...GOAL: Long Term Goal Target date: 2/22/23...edited 12/09/22...Resident will not cause or sustain injuries while wandering qd [every day] thru next review..." The resident's care plan indicated, "PROBLEM: Problem Start Date: 10/11/22...edited 12/14/22...Resident displays behavior of physical	F 0740	1. Resident B currently remains at an in-patient Psych facility, prior to sending the resident to in-patient Psych, the facility provided one to one supervision since her last in-patient psych stay. 2. All residents have the potential to be affected. An initial facility audit was done by the Administrator or designee to identify any other residents in the last 7 days that have behaviors that are not able to be re-directed or could require increased supervision. 3. The Policy and Procedures on one-to-one supervision, behavior management, and 15 min checks were reviewed. The facility nursing staff was re-educated on the policies/procedures for one to one supervision, 15 min checks and also re-educated on reporting behaviors that are not controlled or easily re-directed. The IDT team was educated on the practice of	01/13/2023

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	aggression, difficult to redirect...GOAL: Long Term Goal Target Date: 2/22/23...edited 12/9/22...Resident will not display physically abusive/aggressive behavior towards staff/visitors/residents qd [every day] thru the next review..." A nursing progress note, dated 10/4/22 at 7:37 p.m. indicated, "Resident approached a male resident in the dining area, began caressing his face and rubbing his shoulders..." A nursing progress note, dated 10/6/22 at 11:44 a.m. indicated, "...Resident was in the dining room with other residents...resident then walked over to another resident and poured her chocolate milk on the other residents head. Resident then went over to the other drinks that were poured for the other residents and threw them all on the floor. Resident then began to leave dining room...went in and out of other residents rooms and poured their waters on their bedding. Resident attempted to pull another resident out of her recliner. Resident then walked into another residents room and started yelling at her...Resident then left residents room and went into a male residents room and laid in his bed (male resident was in recliner at this time)..." A nursing progress note, dated 10/9/22 at 7:34 p.m. indicated, "Resident became agitated while in the dining room, grabbed wet floor sign and...tried to swing the sign in the direction of oncoming resident, staff intervened to keep [Resident B] from hitting resident with wet floor sign...Resident grabbed nurses hand tightly refusing to let go..." A nursing progress note, dated 10/12/22 at 9:15 a.m. indicated, "Resident wandering the unit. Resident seems to be agitated and pacing the unit. Resident went into another residents room and		reviewing documented behaviors daily in the IDT meeting for any worsening or behaviors that are not able to be re-directed. The IDT team was re-educated on accessing behavior documentation reports and progress notes which will be reviewed daily during IDT meeting. The IDT will utilize an audit tool to track any behaviors that are not controlled by redirection. A plan of action will be put into place for resident monitoring to prevent resident harm related to a behavior. The plan of action will include but not limited to one-to-one supervision, 15 minute observation, Psych notification, as well as any other needed intervention. 4. The Administrator or designee will complete a tracking tool to document the findings 5 times weekly for four weeks, then 3 times weekly for four weeks, then 2 times weekly for four weeks, then quarterly thereafter to ensure resident behaviors are being controlled within the facility. The tracking tools will be reviewed during the facility Quality Assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or	

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	through [threw] breakfast tray onto the floor...Resident continues to get agitated. Unable to redirect with staff..." A nursing progress note, dated 10/12/22 at 4:03 p.m. indicated, "Resident noted to be wandering in and out of residents rooms. Agitation seems to be increasing...nothing has distracted her from wandering in other residents rooms. PRN [as needed] Haldol 2mg [milligrams] tab was administered at this time..." A nursing progress note, dated 10/13/22 at 9:15 a.m. indicated, "Resident has been noted to be pacing the unit this am [morning]. Banging on exit door from unit. Resident beginning to wander in and out of residents rooms...could not direct resident to a meaningful activity. PRN [as needed] Haldol 2mg [milligrams] PO [by mouth] administered at this time..." A nursing progress note, dated 10/13/22 at 4:55 p.m. indicated, "Resident noted to be pacing halls/other residents rooms. Unable to redirect. PRN [as needed] Haldol PO [by mouth] administered..." A nursing progress note, dated 11/19/22 at 12:35 p.m. indicated, "Resident attempted to enter a female resident's room, when the female resident told her to leave her room, resident smacked female resident in the face with the back of her hand. Resident escorted out of room and one on one supervision initiated..." A nursing progress note, dated 11/19/22 at 11:44 p.m. indicated, "Resident has been one on one all this shift tonight due to altercation today with other residents. She does not listen and wants to go wherever she wants to go. All you can do is		before 1/13/22.	

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	follow her and make sure she is not harming any of the residents." A nursing progress note, dated 11/26/22 at 1:39 p.m. indicated, "Displaying some aggressive behaviors in the common area this afternoon, throwing items. Not easily redirected. Very easily annoyed..." A nursing progress note, dated 11/29/22 at 4:45 p.m. indicated, "CNA [Certified Nurse Aide] witnessed resident having an altercation with another resident..." A Social Services progress note, dated 11/30/22 at 9:24 a.m. indicated, "Resident involved in altercation with another resident. Order obtained to refer to inpatient psych [psychiatric]for EVAL/TX [evaluation and treatment]..." A nursing progress note, dated 11/30/22 at 4:25 p.m. indicated, "[Name of] transportation here at this time to transport resident to facility, paperwork sent with resident..." A nursing note, dated 12/12/22 at 6:52 p.m. indicated, "Resident returned to facility this date. Shortly after return, resident began wandering in and out of residents' rooms. Unable to direct. Other residents becoming very agitated r/t [related to] resident's behavior. Resident was placed on 15-minute checks immediately upon returning to facility r/t [related to] previous incident. Resident unable to sit calmly. Wandering the unit...grabbing at papers and ripping them up, tearing down Christmas decorations on the walls and tree. Resident has been placed on 1:1 r/t [related to] residents uncertain behavior outbursts."			

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	On 12/20/22 at 11:45 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, weakness, and cognitive communication deficit. The Quarterly MDS assessment, dated 11/3/22, indicated the resident was not cognitively intact. A nursing progress note, dated 11/29/22 at 4:45 p.m. indicated, "QMA [Qualified Medication Aide] notified nurse of fall, nurse assessed resident c/o [complaint of] left sided pain and left wrist pain..." A nursing progress note, dated 11/30/22 at 10:15 a.m. indicated, "IDT [Interdisciplinary Team] fall review: Resident sustained fall on 11/29/22 while up ad lib [up and about as the resident desires]...was involved in an altercation with other resident on facility dementia unit. At this time, resident is at hospital for treatment..." A History and Physical Final Report from the hospital, dated 11/29/22 at 11:41 p.m. indicated, "...presents from said living facility after witnessed fall 2011-29-22 [11/29/22] and was brought to the emergency department and has sustained a left aceta Beller [sic] fracture [a break in the socket portion of the ball and socket hip joint], left inferior pubic ramus fracture [a break in a bone of the lower left pubis bone in the pelvic region], right superior pubic ramus fracture [a break in a bone of the upper right pubis bone in the pelvic region], and small retropubic hematoma [bruising in the space behind the pubic area]..." During an interview on 12/20/22 at 12:10 p.m., Qualified Medication Aide 1 indicated Resident B was unpredictable in her behaviors and frequently required one to one staff supervision. The			

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	resident could be pleasant one moment and then become aggressive with no provocation. During an interview on 12/20/22 at 12:30 p.m., the Corporate Nurse Consultant and acting Director of Nursing indicated Resident B was unpredictable in her behaviors and could be verbally aggressive without provocation. Following the altercation between Resident B and Resident C on 11/29/22, the resident was sent to an in-patient psychiatric care facility for evaluation and treatment The resident returned and was currently on 1:1 supervision for safety due to her erratic behaviors. The resident became agitated at being redirected to wear a mask as was required due to high county transmission rate. Following incidents of aggression, the resident was placed on 1:1 supervision for several days until the resident appeared stable and not aggressive. At that point, the resident was placed on 15 minute checks. During an interview Certified Nurse Aide 1 indicated on 11/29/22 around 4:45 p.m., she observed Resident B and Resident C in the hallway next to the dining area on the closed dementia unit. They were waving their arms at each other. Resident B then pushed Resident C to the floor, where Resident C grabbed her left hip and complaining of pain. Resident B had disruptive and aggressive behaviors prior to that incident, and after those behaviors she was placed on 1:1 supervision until her agitation decreased. After 1:1 supervision periods Resident B would be pleasant and not aggressive. Resident B was difficult to redirect and would have unpredictable aggressive behaviors. This Federal tag relates to Complaint IN00395819.			

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