STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155487	A. BUILDING _____ B. WING _____	**10/06/2020**

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

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent staff to resident abuse for 1 of 1 resident reviewed for abuse in a sample of 3. (Resident D). The isolated event, with no actual harm, but had the potential for more than minimal harm began on 6/27/2020, when CNA (Certified Nursing Assistant) 3 responded to a cognitively impaired and combative resident by having gotten on Resident D's bed and forcefully placed his knee on the resident's chest and face. The deficient practice was corrected on 6/28/2020, prior to the start of the survey and was therefore Past Noncompliance. Findings include. On 10/5/2020 at 3:15 p.m., the Administrator provided an Initial Incident Report Form, dated 6/28/2020, regarding Resident D. The report indicated on 6/27/2020 at 11:45 p.m., CNA 4 and CNA 5 were attempting to assist Resident D with changing clothes and linens when Resident D became agitated. CNA 5 then requested CNA 3 to assist with Resident D. CNA 3 approached Resident D's bed on the left side, at which time Resident D hit CNA 3 in his genitals. CNA 3 then jumped up on Resident D's bed and placed his knee on Resident D's face and chest. CNA's present pulled CNA 3 off of Resident D and removed him from the room and reported the incident to their unit manager. On 10/5/2020 at 3:15 p.m., the Administrator provided a Follow-Up report, dated 6/28/2020, which indicated on 6/27/2020 at approximately 11:45 p.m. Resident D became combative during care and CNA 3 was witnessed jumping onto Resident D's bed, and placing their knee on Resident D's chest and face after Resident D kicked them in the genitals. CNA 3 was immediately removed from the resident's room. Administrator was notified immediately. CNA 3 was suspended immediately and removed from the schedule. A written statement sent via e-mail by CNA 3, dated 6/29/2020 at 10:05 a.m., indicated, I was assigned to D hall from 2:00 p.m. to 6:00 a.m. As I was working a CNA . requested my assistance with a difficult patient on the dementia unit. As I made my way with both CNA's admitted they were unable to get the patient changed due to him being combative. . As I was preparing to assist to help putting my gloves on and the patient immediately began to berate the CNA's as we entered, he verbally assaulted me an 'a--h---' then with feces and his hand physically assaulted me with a fist to my crotch. I simply restrained the patient physically so the aides were able to change . A written statement by CNA 5, dated 6/28/2020 at 12:15 a.m., indicated CNA's 3, 4, and 5, went into Resident D's room to change the resident. CNA 3 walked up to Resident D's bed and Resident D hit CNA 3. I saw CNA 3's knee on Resident D. Myself and CNA 4 removed CNA 3's knee from Resident D's face. A written statement by CNA 4, dated 6/28/2020 at 12:15 a.m., indicated, they had asked CNA 3 to come and assist with Resident D. CNA 3 came up to the bed and Resident D hit CNA 3 in his private parts. CNA 3 then jumped up and put their knee on his chest. A written statement by LPN (Licensed Practical Nurse) 2, dated 6/27/2020 (no time given), indicated CNA 4 and 5 told her CNA 3 was attempting to provide care and Resident D punched CNA 3 in his private parts and CNA 3 forcefully placed his knee on Resident D's chest and face to hold him down. CNA 3 was asked to leave the room and I notified on the on call manager, the DON. The DON advised me to escort CNA 3 from the building. A interview with the ADON (Assistant Director of Nursing) on 10/6/2020 at 1:30 p.m., indicated having reviewed the statements given by the staff, all written statements were exactly what each staff member had told her. An incident narrative completed by a Patrolman of the Nashville Police Department, created date 07/07/2020 at 10:32 a.m., indicated, On June 29th I, (Patrolman) of the Nashville Police Department received witnessed statements regarding a battery incident. The incident involved a Certified Nursing Assistant (CNA) and a resident at Brown County Health and Living. There are a total of witness statements that summarizes what had occurred there on June 27, 2020. According to all of the statements provided, the CNA who is in question is (Name CNA 3 and DOB (date of birth)). The victim (Name Resident D), who is a resident of Brown County Health and Living. (Name Resident D) was receiving care from (Name CNA 3) when (Name Resident D) punched (Name CNA 3) in the groin area. Which then (Name CNA 3) then forcefully placed his knee on (Name Resident D's) chest and face to hold him down. At which point the other two CNA's (Name CNA 4 and DOB) and (Name CNA 5 and DOB) who was also in the room told (Name CNA 3) to stop and leave the room. . After, the incident occurred the manager and administrator were notified. When all the administrators was made aware of the situation (Name CNA 3's) employment was terminated. . The clinical record of Resident D was reviewed on 10/05/2020 at 2:00 p.m. [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 7/28/2020, indicated the resident had severe impairment and required extensive assistance from staff for activities of daily living care. On 10/05/2020 at 11:00 a.m., the Administrator provided the current facility policy on Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy, revised date 6/4/2020. A review of the policy indicated, Physical abuse is defined as hitting, slapping, pinching kicking, etc. it also includes controlling behavior through corporal punishment. Review, on 10/5/2020 at 11:00 a.m., of CNA 3's facility's employee discipline form, dated 6/27/2020, indicated CNA 3 was suspended immediately following an incident on 6/27/2020 and would remain suspended until investigation was completed. Staff member (CNA 3) was advised not to be on the premises during their suspension. Review, on 10/5/2020 at 11:00 a.m., of the follow up employee discipline form for CNA 3, dated 6/29/2020, indicated CNA 3's employment was terminated due to violation of resident rights/abuse during personal care. The Past Noncompliance isolated event, with no actual harm, but had the potential for more than minimal harm began on 6/27/2020. The deficient practice was removed and corrected by 6/28/2020, after the facility implemented a systemic plan the included the following actions: Termination of employment for CNA 3. Re-education to all staff regarding dementia care and responding to difficult situations, re-education to all staff on abuse, re-education to all staff on residents' rights. Monitoring of staff through the facility's Quality Assurance and Performance improvement Program to ensure compliance of residents' right to be free from abuse. This Federal tag relates to Complaint IN 458. 3.1-27(b)

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

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.