

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TIMBERCREST CHURCH OF THE BRETHREN HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 EAST ST NORTH MANCHESTER, IN 46962</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00361965. This visit included a Residential COVID-19 Quality Assurance Walk Through.</p> <p>Complaint IN00361965- Unsubstantiated due to lack of evidence.</p> <p>Survey date: October 27, 2021</p> <p>Facility number: 000448</p> <p>Residential Census: 95</p> <p>Timbercrest Church of the Brethren Home was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00361965 and the Residential COVID-19 Quality Assurance Walk Through.</p> <p>Quality review completed on November 5, 2021.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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