STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING -- B. WING	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/04/21 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Emergency Preparedness survey, Timbercrest Church of The Brethren Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 65 and had a census of 50 at the time of this survey. Quality Review completed on 08/12/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/04/21 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Life Safety Code survey, Timbercrest Church of The Brethren Home was found not in compliance with Requirements for Participation in	K 0000		

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

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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	155740	A. BUILDING 01 B. WING	08/04/2021

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridor, and in 16 resident rooms in rehabilitation. Battery operated smoke detectors were installed in 45 health care resident rooms. The facility has a capacity of 65 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage. Quality Review completed on 08/12/21			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 30 residents in two halls.	K 0211	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not	08/23/2021

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	Findings include: Based on an observation during a tour of the facility with the Maintenance Director 08/04/21 at 12:00 p.m. and 12:30 p.m., in the 100 and 400 resident halls there were stationary shelving containing PPE against the wall protruding into the corridor about two feet. Based on an interview at the time of observations, the Maintenance Director agreed shelves were in the 100 and 400 corridors protruding 2 feet into the hall. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The stationary shelving was immediately removed from 100 and 400 hall. Rolling carts of were purchased for PPE which can be moved to any location where and as needed. The carts are 24 L x 18 W x 42 ½ H. Policy, "Means of Egress – Corridors and Exits" implemented and staff being educated on policy and procedures effective 8/18/21. Monitoring for violations added to daily rounding by maintenance staff with tool for documenting deficiencies and actions taken. Findings and corrective actions will be reported monthly the QAPI Committee with summary report to the QA Committee until it is determined that substantial compliance is maintained. Timbercrest Senior Living Community requests a desk review for compliance.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the			

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	Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 storage rooms with roof access. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 08/04/21 at 11:50 a.m., in the 100-hall storage room suspended ceiling there were no ceiling tiles around the ladder access to the roof and was exposed to the roof hatch about eight feet above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there were no ceiling tiles around the ladder opening.	K 0353	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The deficiency was addressed by covering the opening appropriately. No additional openings of such kind were identified by a walkthrough. A policy, "Sprinkler System" was implemented and maintenance and housekeeping staff are being educated on the policy and procedure to ensure the facility's	08/23/2021

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	The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		systems continue to be in proper working order. Timbercrest Senior Living Community requests desk review for compliance.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and	K 0372	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The deficiencies were corrected	08/23/2021

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	communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/04/21 at 1:07 p.m., above the drop ceiling of the 400-hall smoke wall there were two 3-inch pipe sleeves without the ends sealed. This condition does not stop the passage of smoke from one side of the barrier to the other. Based on interview at the time of observation, the Maintenance Director agree the pipe sleeves were not sealed. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		using approved materials. The policy, “Inspection of Fire/Smoke Walls” was reviewed and revised. Maintenance staff is being re-educated on the policy and procedure. The Director of Maintenance and/or designee will perform a weekly audit of work specifically involving fire walls and smoke barriers for the duration of the facility wide project currently in progress to upgrade TV and Internet. Final walk through with contractor will be end of weekly monitoring. Per policy monitoring will be initiated by new projects when fire walls and smoke barriers are involved. Findings and corrective actions will be reported to the QAPI Committee with summary report to the QA Committee until it is determined that substantial compliance is being maintained. Timbercrest Senior Living Community requests desk review for compliance.	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI			

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	A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review and interview, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would staff that use the evevator. Findings include: Based on record review of the form titled "Monthly Fire Service Test Log" with the Maintenance Director on 08/04/21 at 10:33 a.m., the monthly testing for the elevator firefighter recall for the Crestwood elevator was missing testing for 10 of 12 months from August 2020 to July 2021. Based on interview at the time of record review, the Maintenance Director confirmed the Crestwood elevator were equipped with a firefighter recall and the tests were conducted for 2 of the past 12 months.	K 0531	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The deficiency was addressed by an inspection through Murphy Elevator Company, Inc. on 8/11/21 and the system was found to be in proper working order. At that time maintenance staff was educated on how to perform the monthly test. Qualifying staff not yet trained will receive education on how to test the fire fighters' emergency operation system. A	08/23/2021

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	The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		preventative maintenance schedule has been established to alert maintenance staff for the monthly test. A policy, “Elevator Maintenance” was implemented to ensure required inspections, certifications and tests are completed and documented. Staff is being educated on the policy and procedure. Timbercrest Senior Living Community requests a desk review for compliance.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was			

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	installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect staff the basement. Findings include: Based on observation with the Maintenance Director on 08/04/21 at 11:30 a.m., in the service lounge a power strip was plugged into and supplied power by another power strip. Based on interview at the time of observation, the Maintenance Director agreed a power strip was daisy chained to another power strip and the extra power strip was removed. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0920	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The deficiency was immediately addressed by removal of the electrical cords from the employee lounge. Staff conducted a walkthrough of the health center and findings were addressed at the time. The policy, "Power Cords and Extension Cords" was reviewed and revised. All staff is being re-educated on the policy. Compliance with the facility's policy is being monitored by a weekly audit by the administrator and/or designee for six weeks. Findings and corrective actions will be reported monthly the QAPI Committee with summary report to the QA Committee until it is determined that substantial compliance is maintained. Timbercrest Senior Living	08/23/2021

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			Community requests a desk review for compliance.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs			

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	cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 20 residents in one smoke compartments. Findings include: Based on observation during the tour of the facility with the Maintenance Director on 08/04/21 at 12:02 p.m., plastic containers containing plastic supplies were stored within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Based on interview at the time of observation, the Maintenance Director agreed combustible materials were stored within five feet of stationary liquid oxygen containers. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0923	Preparation and/or execution of this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The cited deficiency was corrected 8/04/2021. A policy, "Oxygen Safety" to address proper storage and handling of oxygen and equipment was implemented. Staff is being educated on policy and procedures. As visual aide, a five-foot buffer zone has been marked on the floor. Compliance will be monitored weekly by administrator and/or designee for six weeks. Findings and corrective actions will be reported monthly to the QAPI Committee with summary report to the QA Committee until it is determined that substantial compliance is	08/23/2021

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			maintained. Timbercrest Senior Living Community requests desk review for compliance.	