STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	155740		B. WING		05/24/2	2021
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIE	ĒR		AST ST		
TIMBER	CREST CHURCH	OF THE BRETHREN HOME	NORTH	H MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG • 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE		DATE
- 0000						
Bldg. 00						
0	This visit was for	the Investigation of Complaint	F 0000	The submission of this plan of	f	
	IN00353801.	C .		correction does not indicate a		
				admission by Timbercrest Se		
	· ·	53801- Substantiated.		Living Community that the fin	-	
		iencies related to the		and allegations contained her		
	allegations are cite	ed at F600 and F609.		are a representation of the que of care provided to its resider	-	
	Survey date: May	24 2021		The facility hereby maintains		
	Survey date. May	24, 2021		in substantial compliance with		
	Facility number:	000448		requirements of participation		
	Provider number:			skilled health care facilities. T		
	AIM number: 100	0275140		this end, the plan of correctio	n	
				shall serve as credible assert		
	Census Bed Type:			of compliance with all state a		
	SNF/NF: 58			federal requirements governing	-	
	Residential: 97 Total: 155			the management of this facilit	.y.	
	10tal. 155					
	Census Payor Typ	e:				
	Medicare: 3					
	Medicaid: 27					
	Other: 28					
	Total: 58					
	These deficiencies	reflect State Findings cited in				
	accordance with 4					
		10 110 10.2 011				
	Quality review con	mpleted on May 25, 2021.				
- 0600	483.12(a)(1)					
SS=D	Free from Abuse	and Neglect				
Bldg. 00		n from Abuse, Neglect, and				
-	Exploitation	–				
		the right to be free from				
	-	nisappropriation of resident				
		ploitation as defined in this				
	subpart. This inc	cludes but is not limited to		1		

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Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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. DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155740 B. WING 05/24/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2201 EAST ST TIMBERCREST CHURCH OF THE BRETHREN HOME NORTH MANCHESTER, IN 46962 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the F 0600 The following actions were taken 06/03/2021 immediately on behalf of the facility failed to ensure the abuse of a resident did not occur in regards to a personal photograph resident: The accused staff member and/or video having been taken and posted on was immediately removed from social media without proper consent for 1 of 3 residents reviewed for abuse (Residents B). floor, temporarily suspended pending investigation, then terminated from Timbercrest Findings include: employment, and ineligible for An Indiana Department of Health (IDOH) rehire. Physical assessment incident report was provided by the Administrator on 5/24/21 at 9:18 a.m. head-to-toe of the resident was performed by both the DON and The incident investigation indicated the the ADON. Psychosocial assessments following: a. On 5/14/21 at 9:30 a.m., the Director of Food by Social Service began that Services (DFS) informed the Administrator one same day and were performed of his employees needed to talk to her regarding daily for seven days. Resident representative a reportable event. was notified. b. At 9:40 a.m., the Administrator, DFS and Incident report made to Dietary Aide 2 met. During the meeting, Dietary ISDH, Ombudsman, Adult Aide 2 shared a Snapchat (multimedia messaging Protection Agency, the local app) story by sending it to the Administrator's police department, and the email. resident's physician. In order to identify any other c. At 10:00 a.m., the Administrator and Assistant potential residents to be affected Director of Nursing (ADON) established CNA 3 the following actions were taken: was working at that time and was informed she All residents in the HC unit

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was suspended pending an investigation.

Event ID:

BZ9I11 Facility

Facility ID: 000448

were interviewed for potential

If continuation sheet

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	T OF HEALTH AND HU R MEDICARE & MEDI					I APPROVED NO. 0938-0391
	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 155740		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/24/2021	
NAME OF	PROVIDER OR SUPPLIE	CR		ADDRESS, CITY, STATE, ZIP CODE		
TIMBEF	RCREST CHURCH	OF THE BRETHREN HOME		EAST ST H MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	 d. At 10:30 a.m., a completed on Resirepresentative was e. At 2:45 p.m., Cherrier immediate terrier f. On 5/15/21 at 9: indicated the origined is story was g. Video surveillar was noted to be also 5/7/21. An incident invest a.m., indicated the spoke to CNA 3. Or received a report the compromising pict with others. CNA but indicated shere resident a long time a dietary aide. Review of camera the following time a. 9:02:10 p.m., Chero and left the or b. 9:03:52 p.m., Chero and 100 pressure of the component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned the spoke to CNA 3. Or returned shere resident a long time a dietary aide. Review of camera the following time a. 9:02:10 p.m., Chero and left the or b. 9:03:52 p.m., Chero and the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke to CNA 3. Or returned with toward component of the spoke toward	 a physical assessment was ident B and the resident informed of the incident. NA 3 was notified by phone of nination. 29 a.m., Dietary Aide 2 nal date of receiving the s Friday, May 7th. nce was reviewed, and CNA 3 one in Resident B's room on igation, dated 5/14/21 at 10:00 Administrator and ADON CNA 3 was informed they had hat she had taken a ture of a resident and shared 3 denied taking any pictures, nay have taken a picture of a te ago when she was working as footage on 5/7/21 included frame: NA 3 took stand-up lift into the loor open. NA 3 exited the room and 	TAG	 DEFICIENCY) abuse. No concerns were identified. Completion date: 5/14/21 HC Resident Meeting 5/14/21 HC Residents educated Resident Rights – Abuse, Neg and Misappropriation of Properincluding prohibition of picture be taken unless consented an events. Resident Meeting on 5/20/21 CEO addressed reside in all levels of living on campu- closed circuit tv and educated residents on abuse prevention reporting on 6/3/21. Written information with facility and st agency contact information provided to all residential and independent living residents. The accused CNA was reported to the Nurse Aide Registry. Completion Date: 5/17/21 Abuse policies were reviewed and revised to inclue types of abuse including the unauthorized taking of pictures/videos and voice recordings of residents and/or their belongings. Abuse reporting polices were reviewed and updated. The Elder Justice Law Policy was reviewed and updated.	glect erty, es to nd at nts us via d n and tate ent de all r	DATE

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Event ID: **BZ9111** Facility ID: 000448

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	R MEDICARE & MEDI				OMB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		155740	B. WING		05/24/2021
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				EAST ST	
TIMBER	CREST CHURCH	OF THE BRETHREN HOME	NORT	H MANCHESTER, IN 46962	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	g. 9:06:16 p.m., Q	MA 4 exited the room and		4. Postings regarding the	
	closed the door be	hind her.		Elder Justice Law were review	ved,
	h. 9:11:16 p.m., Cl	NA 3 exited the room and		updated and distributed to sta	ff
	entered another ro	om.		areas.	
	i. 9:30:17 p.m., CN	IA 3 was observed walking		5. All staff received	
	· ·	a with her personal cell phone		re-education on facility abuse	
	in her right hand.	_ ^		polices, with emphasis on type	
				abuse and constituting a viola	tion
	During an intervie	w on 5/24/21 at 9:57 a.m., the		of resident rights.	
	-	cated CNA 3 denied taking the		6. All staff received	
		ld hear her voice on the		re-education on abuse preven	ition
	recording and she was saying "[name of resident]			and reporting, emphasizing th	e
	-	what are you doing?" The resident was sitting on the edge of her bed and she was visible from her		reporting requirements, and w	
				to report to, identifying key sta	
	torso up and did not have any clothing on. CNA 3			and means of contact.	
	-	ideo surveillance leaving		7. All staff received	
		with her personal cell phone		mandatory re-education on El	der
	in her hand.			Justice Law, explaining the	
				responsibility of each staff	
	The clinical record	for Resident B was reviewed		member to act within a specifi	с
	on 5/24/21 at 8:48	a.m. Diagnosis included, but		timeframe.	
		, excoriation disorder (skin		8. Policy for Staff Cell Pho	one
		mellitus, dementia without		Use was reviewed and revise	
		ilure, difficulty walking and		effective 5/17/21	
	pain.			9. Policy addressing all	
	-			Mobile Devices was created;	
	The most recent qu	arterly Minimum Data Set		effective 6/3/21	
	(MDS) assessment	, dated 4/14/21, indicated the		10. Staff was educated on th	e
	resident was sever	ely cognitively impaired. She		Mobile Device Policy and its s	trict
	required one-perso	n assist with bed mobility,		enforcement.	
	dressing and hygie	ne.		11. Mandatory All Staff	
				Education on Abuse Identifica	tion,
	A health care plan	dated 1/22/20, indicated the		Prevention and Reporting: CM	
	-	d ability to do her own		Training Hand In Hand.	
		iving related to dementia.		Completion Date: 5/16/21	
		ded, but were not limited to,		12. Mandatory All Staff	
		e with transfers and toilet use.		Education: HIPAA Do's and	
				Don'ts: Electronic Communica	ation
	A progress note. d	ated 5/14/21 at 6:30 p.m.,		and social media. Completion	
		tion of inappropriate care of a		5/19/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155740 B. WING 05/24/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2201 EAST ST TIMBERCREST CHURCH OF THE BRETHREN HOME NORTH MANCHESTER, IN 46962 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) resident was reported earlier this morning. The 13. Mandatory All Staff resident was assessed and the appropriate Education: Timbercrest Code of Conduct: Abuse and Neglect. authorities were notified. Completion Date: 5/16/21 14. Onboarding documentation During a telephone interview on 5/24/21 at for Timbercrest staff and Morrison 11:57 a.m., CNA 3 denied taking any videos or contracted service staff reviewed pictures of any residents. She indicated she did not often have her phone on her while she was and updated to reflect policy working. She was asked to come to the police revisions. Completion Date: 6/3/21 department to give a statement but her family encouraged her to retain a lawyer, which she did. 15. Educational interactive Her lawyer contacted the police to set up a events for all staff for six months meeting, but they were not ready to meet with addressing different issues of abuse, neglect and her at this time. misappropriation of property, Resident Rights and Elder Justice During a telephone call on 5/25/21 at 1:35 p.m., CNA 5 indicated she had received a photograph Law. This series of events will begin 6/30/21 with the of a resident who was sitting in a chair. She indicated it was several months ago when CNA 3 presentation by the Area Five Ombudsman for all staff on the was working as a dietary aide. Elder Justice Law. Thereafter, Review of CNA 3's work summary log for May, quarterly training for the she worked in the facility on 5/7/21, 5/8/21, remainder of the year. 5/9/21, 5/10/21, 5/11/21, 5/13/21 and 5/14/21. The corrective actions will be monitored to ensure the deficient Review of CNA 3's continuing education courses, she completed Abuse Investigation, practice will not recur: Abuse Prohibition, Abuse Reporting, Elder 1. Abuse and Elder Justice Act Policies - monitoring Justice Act and Prevention of Abuse on 4/16/21. interdisciplinary staff for CNA 3 signed the "PHOTOGRAPHS (CAMERA understanding. As a measure of OR CELL PHONE)" policy on 8/18/19. The ongoing compliance, the policy stated "No photograph of a resident, staff administrator/designee will guiz 6 member, or visitor may be taken without the staff members daily per shift for 4 permission of the person being photographed. weeks, then 3 staff members per shift for 4 weeks, then 1 staff A current facility policy, dated 9/4/17, titled member per shift for 4 weeks. "ABUSE PROHIBITION POLICY," provided by Questions will be focused on the Administrator on 5/24/21 at 9:18 a.m., policy and most recent required indicated the following: educational sessions.

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Event ID:

BZ9I11 Facility II

Facility ID: 000448

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STATEMENT OF DEFICIENCIESX1) PROVIDER/SUPPLIER/CLIAX2) MULTIPLE CONSTRUCTIONAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:A. BUILDING00	(X3) DATE COMP	
155740 B. WING	05/24	LETED 2/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST TIMBERCREST CHURCH OF THE BRETHREN HOME NORTH MANCHESTER, IN 46962	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROFIX TAG "POLICY STATEMENT: It shall be the policy of Timbercrest to provide protection for the health, welfare, and rights of each resident residing at Timbercrest. Our resident have the right to be free from abuse, neglect, exploitation 2. Mobile Devices - as a measure of ongoing complia the administrator/designee daily walk thru per each shi weeks; then twice weekly for four weeks;	A ance, will use ft x 4 or 4 ill e Device ressed r rs), d shift, and get l e se and order , the provide reports inally es will e	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000448

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155740	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	CON	(X3) DATE SURVEY COMPLETED 05/24/2021	
	PROVIDER OR SUPPLIE	R OF THE BRETHREN HOME	2201	T ADDRESS, CITY, STATE, ZIP COI EAST ST IH MANCHESTER, IN 4696			
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
⁻ 0609 SS=D Bldg. 00		ged Violations ponse to allegations of xploitation, or mistreatment,					
	violations involvin exploitation or mi of unknown sour- resident property but not later than is made, if the ev allegation involve bodily injury, or m events that cause abuse and do no injury, to the adm to other officials Survey Agency a where state law p long-term care fa	sure that all alleged ng abuse, neglect, streatment, including injuries ce and misappropriation of , are reported immediately, 2 hours after the allegation ents that cause the e abuse or result in serious ot later than 24 hours if the e the allegation do not involve t result in serious bodily inistrator of the facility and including to the State nd adult protective services provides for jurisdiction in cilities) in accordance with n established procedures.					
	investigations to her designated re officials in accord including to the S 5 working days of alleged violation corrective action Based on record re facility failed to er had knowledge of resident posted to	view and interview, the sure that a staff member who a inappropriate video of a	F 0609	The following actions we immediately on behalf of resident: • The accused staff was immediately remove	the member	06/03/202	
		tor for 1 of 3 residents		floor, temporarily susper pending investigation, th terminated from Timberc	nded en		

PRINTED: 06/07/2021

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155740		A. BUILDING B. WING	ONSTRUCTION (X. 00	3) DATE SURVEY COMPLETED 05/24/2021
NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF THE BRETHREN HOME			2201 E	ADDRESS, CITY, STATE, ZIP CODE EAST ST H MANCHESTER, IN 46962	
(X4) ID		STATEMENT OF DEFICIENCIES		1	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	Findings include:			employment, and ineligible for	
	An Indiana Danast			rehire.	
	-	ment of Health (IDOH)		Physical assessment	
	incident report was			head-to-toe of the resident was	
	Administrator on 5	7/24/21 at 9:18 a.m.		performed by both the DON and	
		e e e e e e e e		the ADON.	
		tigation indicated the		Psychosocial assessment	s
	following:			by Social Service began that	
		30 a.m., the Director of Food		same day and were performed	
		ormed the Administrator one		daily for seven days.	
	of his employees needed to talk to her regarding a reportable event. b. At 9:40 a.m., the Administrator, DFS and Dietary Aide 2 met. During the meeting, Dietary			· Resident representative	
				was notified.	
				Incident report made to	
				ISDH, Ombudsman, Adult	
				Protection Agency, the local	
		apchat (multimedia messaging		police department, and the	
		ing it to the Administrator's		resident's physician.	
	email.			In order to identify any other	
				potential residents to be affected	
		29 a.m., Dietary Aide 2		the following actions were taken:	
	-	hal date of receiving the		All residents in the HC uni	t
	Snapchat story was	s Friday, May 7th.		were interviewed for potential	
				abuse. No concerns were	
		ce was reviewed, and CNA 3		identified. Completion date:	
	was noted to be alo	one in Resident B's room on		5/14/21	
	5/7/21.			HC Resident Meeting	
				5/14/21	
	-	w on 5/24/21 at 10:10 a.m.,		 HC Residents educated or 	
		icated she had received the		Resident Rights – Abuse, Negle	
		from CNA 3. She was not		and Misappropriation of Property	
	-	se saw the video. She was not		including prohibition of pictures t	
		go about reporting the concern		be taken unless consented and a	at
	even though she knew she should. She did report			events. Resident Meeting on	
		resident to her boss with the		5/20/21	
	-	company, but that person no		CEO addressed residents	
	longer worked for	the company.		in all levels of living on campus v	/ia
				closed circuit tv and educated	
		for Resident B was reviewed		residents on abuse prevention a	nd
		a.m. Diagnosis included, but		reporting on 6/3/21. Written	
	were not limited to	, excoriation disorder (skin		information with facility and state)

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DEPARTMENT OF HEALTH AND HU	MAN SERVICES			
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00
	155740	B. W.	NG	
NAME OF PROVIDED OD CURPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP CODE

PRINTED: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	PROVIDER OR SUPPLIE	R OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP CO AST ST HMANCHESTER, IN 4690	
TIMBER (X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIE) REGULATORY O picking), diabetes : behaviors, heart fa pain. The most recent qu (MDS) assessment resident was seven required one-perso dressing and hygie A current facility p "REPORTING SU THE ELDER JUS' Administrator on 4 the following: "POLICY: It is Timbercrest's Elder Justice Act (reasonable suspicie 1. Annually notify reporting obligatio	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) mellitus, dementia without ilure, difficulty walking and harterly Minimum Data Set t, dated 4/14/21, indicated the ely cognitively impaired. She n assist with bed mobility, ne. policy, dated 5/18/20, titled SPECTED CRIMES UNDER TICE ACT," provided by the h/15/19 at 8:40 a.m., indicated policy to comply with the EJA) about reporting a			ECTION DULD BE PROPRIATE (X5) COMPLET: DATE ide DATE tion al and al and lents. A was lide ide bate: nd prevent proprivate g the cce and/or policices ated. Law updated.
	forming the suspic	ot later than 2 hours after ion" elates to complaint		 updated and distributed areas. 5. All staff received re-education on facility a polices, with emphasis of abuse and constituting a of resident rights 6. All staff received re-education on abuse pand reporting, emphasiz reporting requirements, to report to, identifying k and means of contact. 7. All staff received mandatory re-education Justice Law, explaining 	abuse on types of a violation prevention zing the and who key staff

	MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION		MB NO. 0938-0 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		00	ì í	PLETED	
		155740	B. WIN	G	<u></u>	05/24	4/2021
				STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIE	ER		2201 EA			
TIMBERC	REST CHURCH	OF THE BRETHREN HOME		NORTH	MANCHESTER, IN 46962		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF	E	COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NATE	DATE
					responsibility of each staff		
					member to act within a spec	ific	
					timeframe.		
					8. Policy for Staff Cell Ph		
					Use was reviewed and revis	ed;	1
					effective 5/17/21 9. Policy addressing all		1
					Mobile Devices was created		
					effective 6/3/21	,	
					10. Staff was educated on	the	
					Mobile Device Policy and its	strict	
					enforcement.		
					11. Mandatory All Staff		
					Education on Abuse Identific		
					Prevention and Reporting: C	CMS	
					Training Hand In Hand.		
					Completion Date: 5/16/21 12. Mandatory All Staff		
					Education: HIPAA Do's and		
					Don'ts: Electronic Communi	cation	
					and social media. Completic		
					5/19/21		
					13. Mandatory All Staff		
					Education: Timbercrest Cod		
					Conduct: Abuse and Neglec	t.	
					Completion Date: 5/16/21		
					14. Onboarding documenta for Timbercrest staff and Mo		
					contracted service staff revie		
					and updated to reflect policy		
					revisions. Completion Date:		
					6/3/21.		
					15. Educational interactive		1
					events for all staff for six mo		
					addressing different issues of	of	
					abuse, neglect and		1
					misappropriation of property		
					Resident Rights and Elder J Law. This series of events w		1
					begin 6/30/21 with the		
							1

	MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CO	ONSTRUCTION	(X3) DATE	IB NO. 0938-0. SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	ì í	ILDING	00	COMPI	
		155740	B. WI	NG	<u></u>	05/24	/2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PF	OVIDER OR SUPPLIE	ER			AST ST		
TIMBERC	REST CHURCH	OF THE BRETHREN HOME			H MANCHESTER, IN 46962		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
					presentation by the Area Five		
					Ombudsman for all staff on the	;	
					Elder Justice Law. Thereafter,		
					quarterly training for the		
					remainder of the year.		
					The corrective actions will be		
					monitored to ensure the deficie	nt	
					practice will not recur:		
					1. Abuse and Elder Justice	•	
					Act Policies – monitoring		
					interdisciplinary staff for		
					understanding. As a measure	of	
					ongoing compliance, the		
					administrator/designee will qui		
					staff members daily per shift fo		
					weeks, then 3 staff members p	ber	
					shift for 4 weeks, then 1 staff		
					member per shift for 4 weeks.		
					Questions will be focused on policy and most recent required	d	
					educational sessions.	u	
					2. Mobile Devices - as a		
					measure of ongoing compliance the administrator/designee will		
					daily walk thru per each shift x		
					weeks; then twice weekly for 4		
					weeks; then weekly for four		
					weeks.		
					3. Human Resources will		
					provide monthly report to the QAPI committee of Mobile Dev	vico	
					violations reported and addres		
					by supervisors/administrator	JEU	
					(omitting employee identifiers),		
					identifying unit locations and sl		
					to track frequency, location and		
					shift of violations and to target		

					PRIN	TED: 06/07/2021
	T OF HEALTH AND HU					RM APPROVED
	R MEDICARE & MEDIC NT OF DEFICIENCIES	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	IB NO. 0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
		155740	B. WING		05/24	/2021
	PROVIDER OR SUPPLIEI	R DF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP CODE AST ST I MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROVIDEDIC DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
				 further compliance efforts. 4. The administrator will provide monthly report to the QAPI committee of the Abuse Elder Justice Act audits in ord to identify need for targeted compliance efforts. 5. As a quality measure, the administrator/designee will put summary reports to the QA committee; who will review re- and determine if corrective actions are being met and find determine if facility is 100% compliant. Summary updates be provided to the Corporate Compliance Committee of the Board of Directors. 	e and der the rovide eports ally s will	

BZ9I11 Facility ID: 000448

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If continuation sheet Page 12 of 12