DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	05/24/2021

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

(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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00353801. Complaint IN00353801- Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F609. Survey date: May 24, 2021 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census Bed Type: SNF/NF: 58 Residential: 97 Total: 155 Census Payor Type: Medicare: 3 Medicaid: 27 Other: 28 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 25, 2021.	F 0000	The submission of this plan of correction does not indicate an admission by Timbercrest Senior Living Community that the findings and allegations contained herein are a representation of the quality of care provided to its residents. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as credible assertion of compliance with all state and federal requirements governing the management of this facility.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

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 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.

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	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 facility failed to ensure the abuse of a resident did not occur in regards to a personal photograph and/or video having been taken and posted on social media without proper consent for 1 of 3 residents reviewed for abuse (Residents B). Findings include: An Indiana Department of Health (IDOH) incident report was provided by the Administrator on 5/24/21 at 9:18 a.m. The incident investigation indicated the following: a. On 5/14/21 at 9:30 a.m., the Director of Food Services (DFS) informed the Administrator one 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 Aide 2 shared a Snapchat (multimedia messaging app) story by sending it to the Administrator's email. c. At 10:00 a.m., the Administrator and Assistant Director of Nursing (ADON) established CNA 3 was working at that time and was informed she was suspended pending an investigation.	F 0600	The following actions were taken immediately on behalf of the resident: · The accused staff member was immediately removed from floor, temporarily suspended pending investigation, then terminated from Timbercrest employment, and ineligible for rehire. · Physical assessment head-to-toe of the resident was performed by both the DON and the ADON. · Psychosocial assessments by Social Service began that same day and were performed daily for seven days. · Resident representative was notified. · Incident report made to ISDH, Ombudsman, Adult Protection Agency, the local police department, and the resident's physician. In order to identify any other potential residents to be affected the following actions were taken: · All residents in the HC unit were interviewed for potential	06/03/2021

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	d. At 10:30 a.m., a physical assessment was completed on Resident B and the resident representative was informed of the incident. e. At 2:45 p.m., CNA 3 was notified by phone of her immediate termination. f. On 5/15/21 at 9:29 a.m., Dietary Aide 2 indicated the original date of receiving the Snapchat story was Friday, May 7th. g. Video surveillance was reviewed, and CNA 3 was noted to be alone in Resident B's room on 5/7/21. An incident investigation, dated 5/14/21 at 10:00 a.m., indicated the Administrator and ADON spoke to CNA 3. CNA 3 was informed they had received a report that she had taken a compromising picture of a resident and shared with others. CNA 3 denied taking any pictures, but indicated she may have taken a picture of a resident a long time ago when she was working as a dietary aide. Review of camera footage on 5/7/21 included the following timeframe: a. 9:02:10 p.m., CNA 3 took stand-up lift into the room and left the door open. b. 9:02:21 p.m., CNA 3 exited the room and returned with towels. c. 9:03:19 p.m., CNA 3 re-entered Resident B's room. d. 9:03:52 p.m., CNA 3 moved stand-up lift into hallway. e. 9:03:55 p.m., CNA 3 re-entered Resident B's room. f. 9:04:46 p.m., QMA 4 entered Resident B's room.		abuse. No concerns were identified. Completion date: 5/14/21 · HC Resident Meeting 5/14/21 · HC Residents educated on Resident Rights – Abuse, Neglect and Misappropriation of Property, including prohibition of pictures to be taken unless consented and at events. Resident Meeting on 5/20/21 · CEO addressed residents in all levels of living on campus via closed circuit tv and educated residents on abuse prevention and reporting on 6/3/21. Written information with facility and state 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 The following actions and measures were taken to prevent an adverse outcome from reoccurring: 1. Abuse policies were reviewed and revised to include all types of abuse including the unauthorized taking of pictures/videos and voice recordings of residents and/or their belongings. 2. Abuse reporting polices were reviewed and updated. 3. The Elder Justice Law Policy was reviewed and updated.	

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	g. 9:06:16 p.m., QMA 4 exited the room and closed the door behind her. h. 9:11:16 p.m., CNA 3 exited the room and entered another room. i. 9:30:17 p.m., CNA 3 was observed walking towards the camera with her personal cell phone in her right hand. During an interview on 5/24/21 at 9:57 a.m., the Administrator indicated CNA 3 denied taking the video, but they could hear her voice on the recording and she was saying "[name of resident] what are you doing?" The resident was sitting on the edge of her bed and she was visible from her torso up and did not have any clothing on. CNA 3 was also seen on video surveillance leaving Resident B's room with her personal cell phone in her hand. The clinical record for Resident B was reviewed on 5/24/21 at 8:48 a.m. Diagnosis included, but were not limited to, excoriation disorder (skin picking), diabetes mellitus, dementia without behaviors, heart failure, difficulty walking and pain. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/14/21, indicated the resident was severely cognitively impaired. She required one-person assist with bed mobility, dressing and hygiene. A health care plan, dated 1/22/20, indicated the resident had limited ability to do her own activities of daily living related to dementia. Interventions included, but were not limited to, extensive assistance with transfers and toilet use. A progress note, dated 5/14/21 at 6:30 p.m., indicated an allegation of inappropriate care of a		4. Postings regarding the Elder Justice Law were reviewed, updated and distributed to staff areas. 5. All staff received re-education on facility abuse polices, with emphasis on types of abuse and constituting a violation of resident rights. . 6. All staff received re-education on abuse prevention and reporting, emphasizing the reporting requirements, and who to report to, identifying key staff and means of contact. 7. All staff received mandatory re-education on Elder Justice Law, explaining the responsibility of each staff member to act within a specific timeframe. 8. Policy for Staff Cell Phone Use was reviewed and revised; effective 5/17/21 9. Policy addressing all 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 Identification, Prevention and Reporting: CMS Training Hand In Hand. Completion Date: 5/16/21 12. Mandatory All Staff Education: HIPAA Do's and Don'ts: Electronic Communication and social media. Completion date 5/19/21	

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	resident was reported earlier this morning. The resident was assessed and the appropriate authorities were notified. During a telephone interview on 5/24/21 at 11:57 a.m., CNA 3 denied taking any videos or pictures of any residents. She indicated she did not often have her phone on her while she was working. She was asked to come to the police department to give a statement but her family encouraged her to retain a lawyer, which she did. Her lawyer contacted the police to set up a meeting, but they were not ready to meet with her at this time. During a telephone call on 5/25/21 at 1:35 p.m., CNA 5 indicated she had received a photograph of a resident who was sitting in a chair. She indicated it was several months ago when CNA 3 was working as a dietary aide. Review of CNA 3's work summary log for May, she worked in the facility on 5/7/21, 5/8/21, 5/9/21, 5/10/21, 5/11/21, 5/13/21 and 5/14/21. Review of CNA 3's continuing education courses, she completed Abuse Investigation, Abuse Prohibition, Abuse Reporting, Elder Justice Act and Prevention of Abuse on 4/16/21. CNA 3 signed the "PHOTOGRAPHS (CAMERA OR CELL PHONE)" policy on 8/18/19. The policy stated "No photograph of a resident, staff member, or visitor may be taken without the permission of the person being photographed. A current facility policy, dated 9/4/17, titled "ABUSE PROHIBITION POLICY," provided by the Administrator on 5/24/21 at 9:18 a.m., indicated the following:		13. Mandatory All Staff Education: Timbercrest Code of Conduct: Abuse and Neglect. Completion Date: 5/16/21 14. Onboarding documentation for Timbercrest staff and Morrison contracted service staff reviewed and updated to reflect policy revisions. Completion Date: 6/3/21. 15. Educational interactive events for all staff for six months addressing different issues of abuse, neglect and misappropriation of property, Resident Rights and Elder Justice Law. This series of events will begin 6/30/21 with the 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 deficient 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 quiz 6 staff members daily per shift for 4 weeks, then 3 staff members per shift for 4 weeks, then 1 staff member per shift for 4 weeks. Questions will be focused on policy and most recent required educational sessions.	

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	"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.... ...c. Sexual abuse is a non-consensual sexual contact of any type....It also includes taking sexually explicit photographs and/or audio/video recordings of a resident and maintaining and/or distributing them (e.g. posting on social media)...." This Federal tag relates to Complaint IN00353801. 3.1-27(a)(1)		2. Mobile Devices - as a measure of ongoing compliance, the administrator/designee will use daily walk thru per each shift x 4 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 Device violations reported and addressed by supervisors/administrator (omitting employee identifiers), identifying unit locations and shift, to track frequency, location and shift of violations and to target further compliance efforts. 4. The administrator will provide monthly report to the QAPI committee of the Abuse and Elder Justice Act audits in order to identify need for targeted compliance efforts. 5. As a quality measure, the administrator/designee will provide summary reports to the QA committee; who will review reports and determine if corrective actions are being met and finally determine if facility is 100% compliant. Summary updates will be provided to the Corporate Compliance Committee of the Board of Directors.	

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F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure that a staff member who had knowledge of a inappropriate video of a resident posted to a social media site immediately reported those concerns to the facility Administrator for 1 of 3 residents reviewed for abuse. (Resident B)	F 0609	The following actions were taken immediately on behalf of the resident: · The accused staff member was immediately removed from floor, temporarily suspended pending investigation, then terminated from Timbercrest	06/03/2021

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	Findings include: An Indiana Department of Health (IDOH) incident report was provided by the Administrator on 5/24/21 at 9:18 a.m. The incident investigation indicated the following: a. On 5/14/21 at 9:30 a.m., the Director of Food Services (DFS) informed the Administrator one 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 Aide 2 shared a Snapchat (multimedia messaging app) story by sending it to the Administrator's email. c. On 5/15/21 at 9:29 a.m., Dietary Aide 2 indicated the original date of receiving the Snapchat story was Friday, May 7th. d. Video surveillance was reviewed, and CNA 3 was noted to be alone in Resident B's room on 5/7/21. During an interview on 5/24/21 at 10:10 a.m., Dietary Aide 2 indicated she had received the social media video from CNA 3. She was not aware if anyone else saw the video. She was not sure about how to go about reporting the concern even though she knew she should. She did report a prior picture of a resident to her boss with the contracted dietary company, but that person no longer worked for the company. The clinical record for Resident B was reviewed on 5/24/21 at 8:48 a.m. Diagnosis included, but were not limited to, excoriation disorder (skin		employment, and ineligible for rehire. · Physical assessment head-to-toe of the resident was performed by both the DON and the ADON. · Psychosocial assessments by Social Service began that same day and were performed daily for seven days. · Resident representative was notified. · Incident report made to ISDH, Ombudsman, Adult Protection Agency, the local police department, and the resident's physician. In order to identify any other potential residents to be affected the following actions were taken: · All residents in the HC unit were interviewed for potential abuse. No concerns were identified. Completion date: 5/14/21 · HC Resident Meeting 5/14/21 · HC Residents educated on Resident Rights – Abuse, Neglect and Misappropriation of Property, including prohibition of pictures to be taken unless consented and at events. Resident Meeting on 5/20/21 · CEO addressed residents in all levels of living on campus via closed circuit tv and educated residents on abuse prevention and reporting on 6/3/21. Written information with facility and state	

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	picking), diabetes mellitus, dementia without behaviors, heart failure, difficulty walking and pain. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/14/21, indicated the resident was severely cognitively impaired. She required one-person assist with bed mobility, dressing and hygiene. A current facility policy, dated 5/18/20, titled "REPORTING SUSPECTED CRIMES UNDER THE ELDER JUSTICE ACT," provided by the Administrator on 4/15/19 at 8:40 a.m., indicated the following: "POLICY: It is Timbercrest's policy to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime.... 1. Annually notify all covered individuals of their reporting obligations under the EJA to report a suspicion of a crime against any individual who is a resident.... 2. Ensuring each covered individual shall report immediately, but not later than 2 hours after forming the suspicion...." This Federal Tag relates to complaint IN00353801. 3.1-28(c)		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 The following actions and measures were taken to prevent an adverse outcome from reoccurring: 1. Abuse policies were reviewed and revised to include all types of abuse including the unauthorized taking of pictures/videos and voice recordings of residents and/or their belongings. 2. Abuse reporting polices were reviewed and updated. 3. The Elder Justice Law Policy was reviewed and updated. 4. Postings regarding the Elder Justice Law were reviewed, updated and distributed to staff areas. 5. All staff received re-education on facility abuse polices, with emphasis on types of abuse and constituting a violation of resident rights. . 6. All staff received re-education on abuse prevention and reporting, emphasizing the reporting requirements, and who to report to, identifying key staff and means of contact. 7. All staff received mandatory re-education on Elder Justice Law, explaining the	

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			responsibility of each staff member to act within a specific timeframe. 8. Policy for Staff Cell Phone Use was reviewed and revised; effective 5/17/21 9. Policy addressing all 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 Identification, Prevention and Reporting: CMS Training Hand In Hand. Completion Date: 5/16/21 12. Mandatory All Staff Education: HIPAA Do's and Don'ts: Electronic Communication and social media. Completion date 5/19/21 13. Mandatory All Staff Education: Timbercrest Code of Conduct: Abuse and Neglect. Completion Date: 5/16/21 14. Onboarding documentation for Timbercrest staff and Morrison contracted service staff reviewed and updated to reflect policy revisions. Completion Date: 6/3/21. 15. Educational interactive events for all staff for six months addressing different issues of abuse, neglect and misappropriation of property, Resident Rights and Elder Justice Law. This series of events will begin 6/30/21 with the	

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			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 deficient 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 quiz 6 staff members daily per shift for 4 weeks, then 3 staff members per shift for 4 weeks, then 1 staff member per shift for 4 weeks. Questions will be focused on policy and most recent required educational sessions. 2. Mobile Devices - as a measure of ongoing compliance, the administrator/designee will use daily walk thru per each shift x 4 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 Device violations reported and addressed by supervisors/administrator (omitting employee identifiers), identifying unit locations and shift, to track frequency, location and shift of violations and to target	

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			further compliance efforts. 4. The administrator will provide monthly report to the QAPI committee of the Abuse and Elder Justice Act audits in order to identify need for targeted compliance efforts. 5. As a quality measure, the administrator/designee will provide summary reports to the QA committee; who will review reports and determine if corrective actions are being met and finally determine if facility is 100% compliant. Summary updates will be provided to the Corporate Compliance Committee of the Board of Directors.	