]	DEPARTMENT OF HEALTH AND HUMAN SERVICES							
	CENTERS FOR MEDICARE & MEDICA	AID SERVICES						
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON					

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155740		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/05/2023		
	PROVIDER OR SUPPLIER CREST CHURCH O	F THE BRETHREN HOME		2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST I MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	MUST BE PRECEDED BY FULL PREFIX PREFIX PROVIDERS PLAN OF CORRECTIVE FROVIDERS PLAN OF CORREC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(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: 09/05/23 Facility Number: 000448		E 0000		Timbercrest Senior Living Community is dedicated to keep its residents, their families, guests and staff safe at all times. As such, Timbercrest aims for its practices and building to be compliant with the requirements		
	Provider Number: 1 AIM Number: 1002 At this Emergency I Timbercrest Church found not in complie Preparedness Requir Medicaid Participate CFR 483.73. The fa had a census of 57 a The requirement at a met as evidenced by Quality Review com	Preparedness survey, of the Brethren Home was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 cility has a capacity of 65 and at the time of this survey. 42 CFR, Subpart 483.73 is not c: upleted on 09/07/23			concerning the Life Safety Coorequirements. Timbercrest requests desk review/paper compliance for the Plan of Correction submitted for the deficiencies cited during the Life Safety Code survey on 09/05/2023.	de ne or	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 §460.84(d)(2), §48 §483.475(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)					
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	TITLE		(X6) DATE

Sabine A Thomas HFA 10/16/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIEF	R OF THE BRETHREN HOME		2201 EA	DDRESS, CITY, STATE, ZIP COD AST ST MANCHESTER, IN 46962	•	
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	20, RHCs/FQHCs at RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct he emergency plan illity] must do all of the					
ı	,,	full-scale exercise that is					
	community-based						
	` '	munity-based exercise is					
		onduct a facility-based					
		e every 2 years; or ility] experiences an actual					
	, , _ =	ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
	•	or individual, facility-based					
		e following the onset of the					
	actual event.	o renewing and enect or are					
		ditional exercise at least					
	` '	posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
	''	limited to the following:					
		scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise	e; or					
	(B) A mock disast	er drill; or					
	(C) A tabletop exe	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	1	emergency scenario, and a					
	set of problem sta		1				
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					

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Event ID:

LXHV21 Facility ID: 000448

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	l í	UILDING	NSTRUCTION	COMI	E SURVEY PLETED 5/2023	
	PROVIDER OR SUPPLIEI	R OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	the patient's home conduct exercises plan at least annuate following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emerged for the emergency exempt from engascale community-facility-based functional exercis of the emer (ii) Conduct an anyears, opposite the functional exercis of this section is continued, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an election of the care directly. The exercises to test to	aspices that provide care in the care that provide care in the care the hospice must as to test the emergency shally. The hospice must do the full-scale exercise that is a every 2 years; or annity based exercise is not not an individual facility exercise every 2 years; or experiences a natural or nency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Individual exercise every 2 he year the full-scale or the under paragraph (d)(2)(i) conducted, that may be called the following: Individual exercise that is a read a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a natements, directed pared questions designed						

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Event ID:

LXHV21 Facility ID: 000448

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLL AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIER	DF THE BRETHREN HOME		2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST I MANCHESTER, IN 46962		
(X4) ID PREFIX	·			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDED TO THE ABODDO).TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	(i) Participate in a that is community. (A) When a commaccessible, condutation facility-based functional exercise emergency exempt from engatull-scale community functional exercise emergency event. (ii) Conduct an activation may include, following: (A) A second full-community-based functional exercise functional exercise. (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the hamintain documer exercises, and emergency's emergen	an annual full-scale exercise -based; or nunity-based exercise is not loct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an espice's response to and intation of all drills, tabletop mergency events and revise ergency plan, as needed.					
	§482.15(d), CAHs (2) Testing. The [f conduct exercises plan twice per year CAH] must do the	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following:					

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Event ID:

LXHV21

Facility ID: 000448

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/05/2023	
	ROVIDER OR SUPPLIER CREST CHURCH C	OF THE BRETHREN HOME		2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST I MANCHESTER, IN 46962			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL)			(X5) COMPLETION	
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
	(A) When a commaccessible, conduct facility-based function (B) If the [PRTF, Han actual natural of that requires active plan, the [facility] its next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A money (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preper to challenge an error (iii) Analyze thand maintain documentation to tabletop exercises and revise the [factor of the conduct exercises and revise the plan at least annuor or ganization mustic (i) Participate in a that is community (A) When a commaccessible, conductive to the conduct exercises and revise the plan at least annuor or ganization mustic (ii) Participate in a that is community (A) When a commaccessible, conductive to the conduct exercises and revise the plan at least annuor or ganization mustic (ii) Participate in a that is community (A) When a commaccessible, conductive the conductive that is community (A) When a commaccessible, conductive the conductive that is community (A) When a commaccessible, conductive that is community (A) When a commaccessible, conductive that the conductive that is community (A) When a commaccessible, conductive that the conducti	nunity-based exercise is not ct an annual individual, ctional exercise; or clospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency is exempt from engaging in cull-scale community based ty-based functional exercise of the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a ctional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. The [facility's] response to cumentation of all drills, and emergency events cility's] emergency plan, as and emergency plan, as an annual full-scale exercise an annual full-scale exercise						

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Event ID:

LXHV21 Facility ID: 000448

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED 09/05/2023	
		155740	B. W	ING		09/05	/2023
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME		2201 E/	AST ST I MANCHESTER, IN 46962		
TIMBEROREST SHOREST OF THE BRETTINENTIONE				<u> </u>	I WANGILSTER, IN 40902		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	` '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	· ·	igaging in its next required					
		nity based or individual, ctional exercise following the					
	onset of the emer	_					
		n additional exercise every					
		the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited to	-					
		scale exercise that is					
	, ,	or individual, a facility					
	based functional e						
	(B) A mock disas						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	. ,	PACE's response to and					
		ntation of all drills, tabletop					
	· ·	nergency events and revise					
	the PACE's emerg	gency plan, as needed.					
	*[For LTC Facilitie	es at \$483.73(d):1					
	_	ity] must conduct exercises					
	` '	ency plan at least twice per					
	_	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t						
	_	an annual full-scale exercise					
	that is community						
	_	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund						
	(B) If the [LTC fac	ility] facility experiences an					

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Event ID:

LXHV21

Facility ID: 000448

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155740	B. W	ING		09/05/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2		2201 EA			
TIMBER	CREST CHURCH C	F THE BRETHREN HOME			MANCHESTER, IN 46962		
	T			<u> </u>	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION actual natural or man-made emergency that			TAG	DEFICIENCE!		DATE
		of the emergency plan, the					
	-	mpt from engaging its next					
	-	le community-based or					
	-	based functional exercise					
	-	et of the emergency event.					
	_	dditional annual exercise					
	' '	but is not limited to the					
	following:						
	_	scale exercise that is					
		or an individual, facility					
	based functional e						
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er						
		_TC facility] facility's					
	1	naintain documentation of					
	· ·	exercises, and emergency					
		the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*IF IOF/IID+ 0	2400 475/-1)1-					
	*[For ICF/IIDs at §	, ,=					
	· ,	CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:	n annual full-scale exercise					
	that is community	nunity-based exercise is not					
		ct an annual individual,					
		ctional exercise; or.					
		experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	l is exembrition en	gaging in its next required					

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Event ID:

LXHV21 Facility ID: 000448

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PRINTED: 10/19/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING			COMPLETED	
		155740	B. WIN	IG		09/05	/2023	
			- 	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIE	ER		2201 EA				
TIMBER	CREST CHURCH	OF THE BRETHREN HOME			MANCHESTER, IN 46962			
(X4) ID	SUMMARY	CREATED BET RECEDED BY TOPE TREETING CR		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	full-scale commu	nity-based or individual,						
	facility-based fun	ctional exercise following the						
	onset of the eme	rgency event.						
	(ii) Conduct an a	dditional annual exercise						
	that may include,	, but is not limited to the						
	following:							
	(A) A second full-	-scale exercise that is						
	community-base	d or an individual,						
	facility-based fun	ctional exercise; or						
	(B) A mock disas	ter drill; or						
	(C) A tabletop ex	ercise or workshop that is						
	led by a facilitato	r and includes a group						
	discussion, using	g a narrated,						
	clinically-relevant	t emergency scenario, and a						
		atements, directed						
	messages, or pre	epared questions designed						
	to challenge an e	emergency plan.						
	_	CF/IID's response to and						
		entation of all drills, tabletop						
		mergency events, and revise						
		ergency plan, as needed.						
	*[For HHAs at §4	.84 1021						
	-	ne HHA must conduct						
		the emergency plan at						
		he HHA must do the						
	following:	ile i ii i/ (iliast do tile						
	_	a full-scale exercise that is						
	community-base							
		community-based exercise						
	, ,	, conduct an annual						
		-based functional exercise						
	every 2 years; or							
		HA experiences an actual						
	, ,	· · · · · · · · · · · · · · · · · · ·					1	
		nade emergency that requires						
		emergency plan, the HHA is						
		aging in its next required						
	Tull-scale commu	nity-based or individual,						

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Event ID:

facility based functional exercise following the

onset of the emergency event.

LXHV21

Facility ID: 000448

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		X1) PROVIDER/SUPPLIER/CLIA				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155740	B. W	ING		09/05/	2023
NAME OF F	PROVIDER OR SUPPLIER	· }	_		ADDRESS, CITY, STATE, ZIP COD		
				2201 E/			
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME		NORTH	I MANCHESTER, IN 46962		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	, ,	Iditional exercise every 2 le year the full-scale or					
	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may						
	include, but is not limited to the following:						
		full-scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	, ,	isaster drill; or					
		p exercise or workshop that					
	· ·	tor and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta	pared questions designed					
	to challenge an e						
	_	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*15 000+ 04	00.0001					
	*[For OPOs at §48	e OPO must conduct					
	` ' ' '	he emergency plan. The					
	OPO must do the						
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a					
	-	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemer	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
		om engaging in its next					
	of the emergency	xercise following the onset					
		PO's response to and					
	1 ' '	ntation of all tableton					

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

Event ID:

LXHV21 Facility ID: 000448

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/05/2023			
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
PREFIX	exercises, and en the [RNHCl's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test to RNHCl must do the conduct a paper at least annually. Group discussion narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RI maintain document exercises, and en the RNHCl's eme Based on record refailed to conduct explan at least twice punannounced staff or procedures. The LT following: (i) Participate in an is community-based a. When a community-based funct b. If the LTC facility	R LSC IDENTIFYING INFORMATION Dergency events, and revise OPO's] emergency plan, as 3.748]: e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. riew and interview, the facility tercises to test the emergency er year, including drills using the emergency TC facility must do the annual full-scale exercise that d; or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	ion of 09/22/2023 O not ssion be		
	of the emergency p from engaging its n community-based of full-scale functiona the onset of the acti (ii) Conduct an add	gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based l exercise for 1 year following ual event. itional exercise that may imited to the following:		as the facility's credible alleg of compliance. To address the preparedness staff in case of emergencies missing person/elopement, a drill was executed on 9/19/2 The drill spanned across shi change. It includes a review	es of s, a mock 023.		
	a. A second full-sca	_		policy and procedure. The fi			

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Event ID: LXHV21 Facility ID: 000448 If continuation sheet Page 10 of 27

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

155740	A. BUILDING B. WING	COMPLETED 09/05/2023
NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION DATE DATE
community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Adminstrator on 09/05/23 at 12:30 p.m., no documentation of a community based annual exercise was available, but documentation of one	will be discussed in the up Safety Committee and recommendations will be to the QAPI meeting for rethe quarterly QAA meeting approval.	pcoming brought eview and
annual actual event exercise on 04/05/23 was available for review. Based on interview at the time of records review, the Administrator stated the facility did not participate in a full-scale exercise that is community-based but completed one facility based exercise within the last 12 months. There was no documentation provided of a second exercise.		
This finding was reviewed with the Administrator and Maintenance Tech at the exit conference.		
3.1-19(b) E 0041 SS=F Bldg Bldg S3.1-19(b) 482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems.		

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

Event ID:

LXHV21

Facility ID: 000448

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740			 UILDING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIEF	OF THE BRETHREN HOME	2201 EA	NDDRESS, CITY, STATE, ZIP COD AST ST MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIATE		LD BE	(X5) COMPLETION DATE	
	standby power sy emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485. (e) Emergency and The [LTC facility a implement emerging systems based or forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location required Care Facilities Counterim Amendments TIA and TIA 12-4), and Structure is built of structure or building 482.15(e)(2), §48 Emergency generator the [hospital, CAI implement the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §48 Emergency generator code.	set forth in paragraphs (b)(1) section. 625(e) d standby power systems. and the CAH] must sency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) section of the emerts found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) attor inspection and testing. Health Care in the Health					
	_	that maintain an onsite fuel mergency generators must					

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

Event ID:

LXHV21 Facility ID: 000448

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155740	B. WING		09/05/2023	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u> S		ADDRESS, CITY, STATE, ZIP COD	•	
				EAST ST		
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME	NORT	TH MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
		w it will keep emergency				
	1 ' '	perational during the				
	emergency, unless it evacuates.					
	*[For hospitals at	§482.15(h), LTC at				
		CAHs §485.625(g):]				
		corporated by reference in				
	this section are ap	pproved for incorporation by				
	reference by the D	Director of the Office of the				
	_	n accordance with 5 U.S.C.				
	1 ' '	l part 51. You may obtain				
		the sources listed below.				
		a copy at the CMS				
		urce Center, 7500 Security				
		ore, MD or at the National				
		ords Administration				
	l '	mation on the availability of				
		ARA, call 202-741-6030, or				
	go to:	<i>(</i> ,)				
		es.gov/federal_register/code				
	1	ations/ibr_locations.html.				
		this edition of the Code are				
	1	eference, CMS will publish a				
	announce the cha	ederal Register to				
		Protection Association, 1				
	Batterymarch Parl					
	Quincy, MA 02169					
	1.617.770.3000.	o,				
		th Care Facilities Code,				
		ed August 11, 2011.				
		im amendment (TIA) 12-2 to				
	NFPA 99, issued	` ,				
		FPA 99, issued August 9,				
	2012.	,				
	(iv) TIA 12-4 to NF	FPA 99, issued March 7,				
	2013.					
	(v) TIA 12-5 to NF	PA 99, issued August 1,				
	2013.					
	(vi) TIA 12-6 to NE	FPA 99 issued March 3	1			

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155740	B. W	ING		09/05/	/2023
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
TIMEED		SE THE DESTRUCTIONS			AST ST		
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME		NORTH	H MANCHESTER, IN 46962		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2014.						
	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.						
	(viii) TIA 12-1 to N	IFPA 101, issued August					
	11, 2011.						
	(ix) TIA 12-2 to NI	FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NF	FPA 101, issued October					
	22, 2013.						
	(xi) TIA 12-4 to NI	FPA 101, issued October					
	22, 2013.						
	(xiii) NFPA 110, S	Standard for Emergency and					
	Standby Power S	ystems, 2010 edition,					
	including TIAs to	chapter 7, issued August 6,					
	2009						
	1	to implement the emergency	E 0041		The preparation and execution	n of	09/22/2023
	power system inspe	_			this plan do not constitute		
	_	ements found in the Health			admission or agreement by		
		e, NFPA 110, and Life Safety			Timbercrest Senior Living		
	Code in accordance	e with 42 CFR 483.73(e)(2).			Community that a deficiency		
					exists. This response is also r		
		on and interview, the facility			to be construed as an admiss	ion	
		f 1 emergency generator			of fault by the facility, its		
		was readily observed by			employees, agents, or other		
		l. This deficient practice could			individuals who draft or may b	е	
		nts, as well as staff and visitors			discussed in this plan of		
	in the facility.				correction. This plan is submit		
	E' 1' ' 1 1				as the facility's credible allega	tion	
	Findings include:				of compliance.		
	Dagad on abase	on during a tour of the facility			To ensure the safety of its		
		on during a tour of the facility ace Tech (MT) on 09/05/23 at			residents, staff and visitors, th Timbercrest has contracted w		
		erator's annunciator panel was					
		dor by the kitchen and			E.R.G LLC to move the gener annunciator panel to the vicini		
		is an area not not readily			the Health Care nurse's statio	-	
					which is occupied 24/7. Until t		
	observed by personnel. Based on interview at the time of observation, the Maintenance Tech stated				completion of the installation of		
	time of observation, the Maintenance Tech stated that they have maintenance personnel working on				-	וכ	
	I -	ng out of an area located close			this project, the panel will be	hift	
	to the annunciator p	_			monitored twice during each s The staff tasked with the	orillt.	
		Junei.	1		THE Stall tasked With the		I

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/05/2023		
	PROVIDER OR SUPPLIER	F THE BRETHREN HOME		STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	This finding was reand MT at the exit of	viewed with the Administrator conference.			monitoring of the panel has be educated. The completion of schecks is being monitored we by the administrator/designee the relocation project has bee completed. Findings will be reported to the Safety Commit with a summary report to the Committee.	such ekly until en ttee,	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/05 Facility Number: 0 Provider Number: 1002 At this Life Safety 0 Church of The Brett compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facilit Type V (111) construct determined to be of fully sprinklered, ha wired smoke detect to the corridor, and	00448 155740	K 00	000	Timbercrest Senior Living Community is dedicated to ke its residents, their families, gu and staff safe at all times. As such, Timbercrest aims for its practices and building to be compliant with the requirement concerning the Life Safety Corequirements. Timbercrest requests desk review/paper compliance for the deficiencies cited during the deficiencies cited during the Life Safety Code survey on 09/05/2023.	nts de	

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155740	B. W	NG		09/05/	2023
	PROVIDER OR SUPPLIER	F THE BRETHREN HOME		STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
K 0100 SS=E Bldg. 01	were installed in 45 health care resident rooms. The facility has a capacity of 65 and had a census of 57 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 09/07/23 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or						
	I -		K 0	100	The preparation and execution this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also n to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this plan of correction. This plan is submitt as the facility's credible allegate of compliance. The two doors noted to not properly latch when closing, we repaired. Review of the annual Door Inspection showed both doors to have been in working	ot on e ted tion ere I Fire	09/22/2023

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155740	B. W	ING _		09/05/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			AST ST		
TIMBERO	CREST CHURCH C	OF THE BRETHREN HOME			H MANCHESTER, IN 46962		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	when tested.				order at that time. To ensure		
					proper functioning of the doors	s, the	
	These findings were				Director of Facility		
	Administrator and I	MT during the exit conference.			Management/designee will rev		
	3.1-19(b)				findings from the Fire Drill Rep		
					documentation and report to the	ne	
					Safety Committee.		
14 0004							
K 0291	NFPA 101						
SS=F	Emergency Lightin	-					
Bldg. 01	Emergency Lightin	-					
		g of at least 1-1/2-hour					
	·	ed automatically in					
	accordance with 7	7.9.					
	18.2.9.1, 19.2.9.1	eview and intermiers the facility	17.0	201	The managedian and everytics	6	00/22/2022
		eview and interview, the facility f 1 battery backup emergency	K 0	291	The preparation and execution	1 01	09/22/2023
		nthly for 30 seconds and			this plan do not constitute		
		nutes. Section 7.9.3.1.1 (1)			admission or agreement by Timbercrest Senior Living		
	-	testing shall be conducted			Community that a deficiency		
	_	nimum of 3 weeks and a			exists. This response is also n	ot	
		ks between tests, for not less			to be construed as an admissi		
) Functional testing shall be			of fault by the facility, its	OH	
		for a minimum of 1 1/2 hours			employees, agents, or other		
	-	ghting system is battery			individuals who draft or may b	Δ.	
		ritten records of visual			discussed in this plan of	-	
	-	s shall be kept by the owner			correction. This plan is submit	ted	
	for inspection by th				as the facility's credible allega		
	• •	eficient practice could affect all			of compliance.		
	residents in the faci	-			To ensure the safety of all its		
		•			residents, staff and visitors, th	е	
	Findings include:				annual test of the battery back		
					emergency light was performe	-	
	Based on records re	eview with the Maintenance			and found in good working ord		
	Tech (MT) on 09/0:	5/23 at 11:00 a.m., annual			new Task for monthly and the		
		ry backup emergency light for			annual check in September was		
	-	was unavailable. Based on			generated using the facility's v		
	interview at the tim	e of records review, the MT			order system. The newly crea		
		minute testing for the battery			Battery-operated Emergency		
	backup emergency light has not been conducted				Lights Test Log includes		

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155740		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP FAST ST H MANCHESTER, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	in the last 12 month. This finding was re and MT at the exit of 3.1-19(b)	viewed with the Administrator		instructions for specific to be noted. The complete logs will be monitored. Director of Facility Management/designed a months and report the Safety Committee summary report to the Committee i to determine substantial compliance.	apletion of the d by the ee for the next findings to e with e QAA mine	
K 0321 SS=D Bldg. 01	barrier having 1-h- (with 3/4 hour fire automatic fire exti- accordance with 8 approved automat- option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas t REMARKS. 19.3.2.1, 19.3.5.9 Area	are protected by a fire our fire resistance rating rated doors) or an anguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of that are deficient in				
	a. Boiler and Fuel- b. Laundries (large c. Repair, Mainter	N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops boms (exceeding 64				

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION ING <u>01</u>	COM	e survey pleted 5/2023
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	22 NO			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREI TA	FIX PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	(over 50 square fe g. Laboratories (if Hazard - see K32 Based on observation failed to ensure 1 or	lons) orage Rooms/Spaces eet) classified as Severe	K 0321	The preparation and e this plan do not constit admission or agreeme	ute	09/20/2023
	This deficient pract 2 staff in the area. Findings include:	protected as a hazardous area. ice could affect 1 resident and		Timbercrest Senior Liv Community that a defice exists. This response in to be construed as an of fault by the facility, in employees, agents, or	ciency s also not admission ts other	
	with the Maintenan 1:05 p.m., the staff storage room in the boxes of supplies at feet making this a h room was not prote because the corrido close and latch whe at the time of obser storage room contain combustible storage	on during a tour of the facility on 09/05/23 at training room, being used as a basement contained over 30 and was greater than 50 square azardous area. The storage of the tested as a hazardous area or door to the room did not self on tested. Based on interview evation, the MT agreed the fined a large amount of the ey, was larger than 50 square or door to the room did not when tested.		individuals who draft of discussed in this plan is correction. This plan is as the facility's credible of compliance. Both doors to the storal were equipped with see facility maintenance steensure compliance, this area was added to the scheduled annual inspections assigned to facility maintenance by Facility Maintenance/discussions.	of a submitted a allegation age area alf-closers by aff. To as storage regular rection and intenance y Director of	
	The finding was revand the MT during 3.1-19(b)	viewed with the Administrator the exit conference.				
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm Systen Maintenance Fire Alarm Systen Maintenance	-				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/05/2023	
	ROVIDER OR SUPPLIER	F THE BRETHREN HOME	2201	T ADDRESS, CITY, STATE, ZIP COD EAST ST TH MANCHESTER, IN 46962	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	A fire alarm syster in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are ready. 6.1.3, 9.6.1.5, Nower alarm accordance with a secondance with a secondance with a secondance with a secondance with the more often if requiringuisdiction. Table must be visually insurable accordance with the more often if requiringuisdiction. Table must be visually insurable. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification applies. Magnetic hold-op This deficient practifacility. Findings include: During records review (MT) on 09/05/23 a was provided regard fire alarm system signalarm inspection coon interview at the tagreed a visual inspection coon interview at the tagreed a visual inspection.	m is tested and maintained in an approved program are requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 review and interview, the intain 1 of 1 fire alarm systems NFPA 72, as required by LSC in and 9.6. NFPA 72, Section aless otherwise permitted by ections shall be performed in the schedules in Table 14.3.1, or ead by the authority having 14.3.1 states that the following spected semi-annually: the signals items (e.g. duct detectors, manual at detectors, smoke detectors, sinness	K 0345	The preparation and execution this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this plan of correction. This plan is submast he facility's credible allegated of compliance. A task was created for a regulation occurring semi-annual visual inspection in February in the facility's work order program, follow the annual fire alarm inspection in August 2023 by contractor. The list of inspect points is provided through the order system for the purpose compliance. The completion these inspections is monitored the Director of Facility Maintenance/designee. The service provider contract perform the smoke detector sensitivity testing has confirm	not sion be itted ation ular to the ion e work of of ed by ted to med
	was not conducted.			10/3/2023 - 10/6/2023 as the dates testing will be complete	

STATEMENT OF DE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MULT A. BUILI B. WING	DING	nstruction 01	COMP	E SURVEY PLETED 5/2023
NAME OF PROVIDE		F THE BRETHREN HOME	2	2201 EA	DDRESS, CITY, STATE, ZIP ST ST MANCHESTER, IN 40		_
TAG RE	EACH DEFICIEN EGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION viewed with the Administrator onference.	PR	EFIX CAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
facilit was n LSC 9 install with 1 72, N 14.4.5 section in accord or mono jurisd smoke altern permi This of Findin Based Tech docur test w at the acknow confin for re This f	ased on record by failed to ensinaintained in a 9.6.1.3 require led, tested, and NFPA 70, National Fire Alford States unless ons of this Code cordance with the ore often if requisition. NFPA de detector sensinate year therea atted by complideficient practions in the complete of the properties of the	review and interview, the ure 1 of 1 fire alarm systems coordance with LSC 9.6.1.3. Is a fire alarm system to be a maintained in accordance onal Electrical Code and NFPA arm Code. NFPA 72, Section otherwise permitted by other expected, the schedules in Table 14.4.5, uired by the authority having 72, Section 14.4.5.3.1 states itivity shall be checked within ion. NFPA 72, 14.4.5.3.2 states itivity shall be checked every after unless otherwise ance with Section 14.4.5.3.3. It is ce could affect all occupants. The with the Maintenance of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01		COMPLETED	
		155740	B. Wl	ING		09/05/	/2023
	ROVIDER OR SUPPLIER	OF THE BRETHREN HOME		2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST I MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					
		gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
	Code, electrical wi	iring and equipment					
	•	PA 70, National Electric					
	Code. Existing ins	tallations can continue in					
	service provided n	no hazard to life.					
	18.5.1.1, 19.5.1.1,						
		on and interview, the facility	K 0	511			09/14/2023
		f 1 electrical panel in the 200			this plan do not constitute		
	hall was secured fro	om non-authorized personnel.			admission or agreement by		
	NFPA 70, 2011 edit	tion states 230.62 Energized			Timbercrest Senior Living		
	parts of service equi	ipment shall be enclosed as			Community that a deficiency		
	specified in 230.62((A) or guarded as specified in			exists. This response is also n	ot	
	230.62(B).				to be construed as an admissi	on	
	(A) Enclosed. Energ	gized parts shall be enclosed			of fault by the facility, its		
	-	t be exposed to accidental			employees, agents, or other		
	_	guarded as in 230.62(B).			individuals who draft or may b	е	
	(B) Guarded. Energ	fized parts that are not enclosed			discussed in this plan of		
	shall be installed on	a switchboard, panelboard, or			correction. This plan is submit	ted	
		uarded in accordance with			as the facility's credible allega	tion	
		Where energized parts are			of compliance.		
		d in 110.27(A)(1) and (A)(2), a					
	_	or sealing doors providing			A check of all other electric pa	nels	
		parts shall be provided. This			was performed for proper		
	-	ould affect up to 6 residents			functioning. A lock for the pan-		
	and 2 staff in the 20	00 hall.			200 hall was procured immedi	ately	
					and installed. To ensure		
	Findings include:				compliance, a regular schedul		
					monthly work order was create		
		on with Maintenance Tech			and assigned to maintenance		
		t 2:15 p.m., the electrical panel			for checking all electrical pane		
		unlocked when tested. The			Health Care and Crestwood th		
	_	kers to the lights and outlets			doors are locked and locks are		
		sed on interview at the time of			functional. The Director of Fac	-	
		Γ stated the electrical panel			Maintenance/designee will mo	nitor	
	lock is broken and r	needs to be replaced.			completion of work order for		
	1				compliance monthly for 3 mon	ths	l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155740	B. W	ING	_	09/05/	/2023
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
				2201 E			
TIMBERO	CREST CHURCH C	F THE BRETHREN HOME		NORTH	I MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator			and report to Safety Committe		
	and MT at the exit of	conference.			with a summary report to QAA		
	3.1-19(b)				committee until substantial compliance has been achieve	d.	
K 0712	NFPA 101						
SS=C	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include t	the transmission of a fire					
	alarm signal and s	simulation of emergency fire					
		ills are held at expected					
	•	mes under varying					
		t quarterly on each shift.					
		r with procedures and is					
		re part of established					
		ills are conducted between					
	9:00 PM and 6:00	ay be used instead of					
	audible alarms.	ay be used instead of					
	19.7.1.4 through 1	9717					
		riew and interview, the facility	K 0	712	Preparation and/or execution	of	09/22/2023
		12 fire drills included the	110	/12	this plan do not constitute		07/22/2023
		mission of the fire alarm signal			admission or agreement by the	е	
	to the monitoring st	ation in fire drills conducted			provider that a deficiency exis		
	between 6:00 a.m. a	and 9:00 p.m. for the last 4			This response is also not to be	Э	
	quarters. LSC 19.7.	.1.4 requires fire drills in health			construed as an admission of	fault	
	care occupancies sh	all include the transmission of			by the facility, its employees,		
	_	nd simulation of emergency fire			agents or other individuals wh		
		icient practice affects all			draft or may be discussed in the		
		lity as well as staff and			response and plan of correction	n.	
	visitors.				This plan of correction is		
	Findings include:				submitted with the facility's credible allegation of compliar	ıce.	
					In order to ensure the safety o	of its	
		riew of titled " Fire Drill			residents, staff and visitors		
	•	aintenance Tech (MT) and the			Timbercrest Senior Living		
		0/05/23 at 11:45 a.m., the fire			Community has entered an		
		ocumentation of verification of			agreement with VFP, the Fire		
		nal to the monitoring company			Alarm System Monitoring	احما	
	on 4 of the fire drill	reports. Based on interview at			Company, to provide an email	and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155740 B. WING 09/05/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2201 EAST ST** TIMBERCREST CHURCH OF THE BRETHREN HOME NORTH MANCHESTER, IN 46962 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the time of record review, the MT agreed there text verifying the transmission of was missing documentation of verification of the fire alarm signal to the signal transmission to the monitoring company on monitoring station. The Fire Drill 4 of the fire drill reports. There also was no Report document was revised to section on the fire drill report to describe the prompt attachment of the scenario of the fire drill. verification report, as well as added field for the scenario of These findings were reviewed with the each drill. Administrator and MT at the exit conference. Compliance of completing the forms will be monitored by the 3.1-19(b) administrator/designee for the next 3.1-51(c)3 months. Findings will be shared with the Safety Committee and summary report will be submitted to QAA Committee until substantial compliance is determined. K 0761 SS=E Bldg. 01 Based on observation, records review, and K 0761 Preparation and/or execution of 09/18/2023 interview; the facility failed to ensure annual this plan do not constitute inspection and testing of 1 of 12 fire door admission or agreement by the assemblies were completed in accordance of LSC provider that a deficiency exists. 19.1.1.4.1.1 communicating openings in dividing This response is also not to be fire barriers required by 19.1.1.4.1 shall be construed as an admission of fault permitted only in corridors and shall be protected by the facility, its employees, by approved self-closing fire door assemblies. agents or other individuals who (See also Section 8.3.) LSC 8.3.3.1 Openings draft or may be discussed in this required to have a fire protection rating by Table response and plan of correction. 8.3.4.2 shall be protected by approved, listed, This plan of correction is labeled fire door assemblies and fire window submitted with the facility's assemblies and their accompanying hardware, credible allegation of compliance. including all frames, closing devices, anchorage, The fire door to the oxygen room and sills in accordance with the requirements of was inspected and found to be in NFPA 80, Standard for Fire Doors and Other compliance. The work order for the Opening Protectives, except as otherwise Annual Fire Door Inspection was specified in this Code. NFPA 80 5.2.1 states fire revised by adding door #50 (O2 door assemblies shall be inspected and tested not room). The completion of these

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
15		155740	B. WING			09/05/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	2		2201 EA				
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME			MANCHESTER, IN 46962			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CAMPERIO DE LA CONTRETA DE	Ī	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	O THE APPROPRIATE		
	less than annually,	and a written record of the			tasks is monitored by the Dire	ctor		
	inspection shall be	signed and kept for inspection		of Facility Maintenance.				
	_	80, 5.2.4.1 states fire door						
	1 -	visually inspected from both						
	sides to assess the overall condition of door							
	assembly. NFPA 8	0, 5.2.4.2 states as a minimum,						
	the following items							
	1	or breaks exist in surfaces of						
	either the door or fr	rame.						
	(2) Glazing, vision	light frames, and glazing beads						
	are intact and secur	ely fastened in place, if so						
	equipped.							
		e, hinges, hardware, and						
		eshold are secured, aligned,						
	and in working order with no visible signs of							
	damage.							
	(4) No parts are missing or broken.							
	(5) Door clearances do not exceed clearances							
	listed in 4.8.4 and 6							
	1 ' '	device is operational; that is,						
		pletely closes when operated						
	from the full open p							
	` '	is installed, the inactive leaf						
	closes before the ac							
	(8) Latching hardware operates and secures the door when it is in the closed position.(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.							
		ications to the door assembly						
		ed that void the label.						
		edge seals, where required, are						
		their presence and integrity.						
		ice could affect 10 residents in						
	one smoke compart							
	Findings include:							
	-							
	Based on record review of the Fire Door inspection documentation with the Maintenance							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155740		155740	B. WING			09/05/2023	
NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF THE BRETHREN HOME			STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDENCE N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
K 0916	Tech (MT) on 09/05/23 at 11:45 a.m., the form listed fire door assemblies inspected annually. When examining the annual fire door inspection documentation there was not an inspection completed on the oxygen storage room door. Based on interview at the time of records review, the MT stated the oxygen storage room door was not on the inspection list and was not inspected in the last year. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)						
SS=F Bldg. 01	Electrical Systems System Alarm Ann A remote annuncia powered is provide generating room in observed by opera annunciator is har conditions of the e centralized compu- information system for the alarm annu- 6.4.1.1.17, 6.4.1.1 Based on observation failed to ensure 1 of annunciator panel w operating personnel affect all the resider in the facility. Findings include: Based on observation	ator that is storage battery ed to operate outside of the n a location readily ating personnel. The d-wired to indicate alarm emergency power source. A atter system (e.g., building n) is not to be substituted unciator.	K 09	916	The preparation and execution this plan do not constitute admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also not be construed as an admission fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this plan of	ot on	01/05/2024

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

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-039

CE. TEROTOR	THE WHEET	THE SELL TODA					2110102000	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED		
	155740			B. WING			09/05/2023	
						1 33,30,		
NAME OF D	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
TWINL OF I	NO TIDEN ON SOIT EIEI			2201 E	AST ST			
TIMBERCREST CHURCH OF THE BRETHREN HOME			NORTH MANCHESTER, IN 46962					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
	1:40 p.m., the generator's annunciator panel was				correction. This plan is submitted			
	located in the corridor by the kitchen and				as the facility's credible allegation			
	Rosegarden which is an area not not readily				of compliance.			
	observed by person	inel. Based on interview at the			To ensure the safety of its			
	time of observation, the Maintenance Tech stated				residents, staff and visitors, th			
	that they have maintenance personnel working on				Timbercrest has contracted with			
		ng out of an area located close			Votaw Electric to move the			
	to the annunciator p			generator annunciator panel to the				
	1				vicinity of the Health Care nur			
	This finding was re	eviewed with the Administrator			station which is occupied 24/7.			
	and MT at the exit			Due to the extend of moving the				
	and WIT at the exit conference.				panel and material needs, the			
	3.1-19(b)				contractor is not able to guara			
	3.1-17(0)				the project to be completed w			
					90 days of the citation dated			
					9/5/2023. Therefore a Tempor	rarv		
					Waiver is being submitted. Un	-		
					the project is completed, the p			
					will be monitored twice during			
					each shift by maintenance staff.			
					The staff tasked with the			
				monitoring of the panel has been				
				educated and the plan has been				
					implemented. These checks a			
					addition to the already occurri			
					_	_		
					weekly checks of the emerger	-		
					generator. The completion of	-		
					checks is being monitored we	-		
					by the administrator/designee			
					the relocation project has bee	T1		
					completed. Findings will be			
					reported to the Safety Commi			
					with a summary report to the	QAA		
l	I		1		Committee		I	

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