		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		155740	B. WING		01/14/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				AST ST	
TIMBERCREST CHURCH OF THE BRETHREN HOME			H MANCHESTER, IN 46962		
	CREST CHORCH C	OF THE BRETTIKEN HOWE	NORTI	TIMANCHESTER, IN 40902	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
		COVID-19 Focused Infection	F 0000		
		is visit included a Residential			
	COVID-19 Quality	Assurance Walk Through.			
	Survey dates: Janua	ry 14, 2022.			
	Facility number: 00				
	Provider number: 1				
	AIM number: 1002	75140			
	Census Bed Type:				
	SNF/NF: 39				
	Residential: 88				
	Total: 127				
	Census Payor Type				
	Medicaid: 20	•			
	Other: 19				
	Total: 39				
	10111. 37				
	This deficiency refl	ects State Findings cited in			
	accordance with 41	e e e e e e e e e e e e e e e e e e e			
	Quality review com	upleted on January 21, 2022.			
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F 0880	483.80(a)(1)(2)(4)	(e)(f)			
SS=D	Infection Prevention	on & Control			
Bldg. 00	§483.80 Infection	Control			
	The facility must e	establish and maintain an			
	infection prevention	on and control program			
		de a safe, sanitary and			
		onment and to help prevent			
		and transmission of			
	communicable dis	seases and infections.			
	§483.80(a) Infection	on prevention and control			
	program.				
			1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

A BUILDING 00 COMPLETED 01/14/2022  NAME OF PROVIDER OR SUPPLIER  THIS STREET ADDRESS. CITY, STATE, ZIP CODE 201 EAST ST NORTH MANCHESTER, IN 46962  IXA ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards;  \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections before they can spread to other persons in the facility;  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv)When and how isolation should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident	STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
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precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			transmission based					
of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident		` '						
(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			Tollowed to proverit spread					
for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident		,	isolation should be used					
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident								
depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident								
organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
(B) A requirement that the isolation should be the least restrictive possible for the resident		1						
the least restrictive possible for the resident		I -						
under the circumstances.		under the circumstances.						
(v) The circumstances under which the								
facility must prohibit employees with a		, ,						
communicable disease or infected skin		•						
lesions from direct contact with residents or								

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

Event ID:

W5NJ11 Facility ID: 000448

If continuation sheet Page 2 of 6

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED	
155740		155740	B. W	NG		01/14	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					AST ST			
TIMBERCREST CHURCH OF THE BRETHREN HOME					H MANCHESTER, IN 46962			
TIMBER	JNEST CHUNCH	OF THE BRETTIKEN HOWE		NORTI	I MANCHESTER, IN 40902			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY 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	
		contact will transmit the						
	disease; and							
		ene procedures to be						
	· ·	nvolved in direct resident						
	contact.							
	• ',',	ystem for recording						
		d under the facility's IPCP						
		actions taken by the						
	facility.							
	0400 00/ \\							
	§483.80(e) Linens.							
		andle, store, process, and						
	transport linens so as to prevent the spread							
	of infection.							
	\$492 90/f) Appud	roviou						
	§483.80(f) Annual review.							
	The facility will conduct an annual review of its IPCP and update their program, as							
	necessary.	nte trieli program, as						
	,	on and interview, the facility	F 08	280	Preparation or execution of his	2	02/05/2022	
		revent and/or contain	1 00	300	plan does not constitute admis		02/03/2022	
		f not wearing face masks			nor agreement by the provider			
		Crestwood Unit and in a TBP			that a deficiency exists. This			
		ased Precaution) room on the			response is also not to be			
	*	leaning eye protection			construed as an admission of	fault		
		ot performing hand hygiene			by the facility, its employees,			
		(Personal Protective			agents or other individuals wh	0		
	_	random observations.			draft or may be discussed in the			
					response and plan of correction			
	Findings include:				This plan of correction is			
	-				submitted as the facility's cred	ible		
	On 1/14/22 at 9:34	a.m., Activity Aide 33 was			allegation of compliance.			
	observed reading to	six residents in the common			DON immediately in-serviced	CNA		
	area, across from th	e nurses station, on the			13 on proper masking; CNA 1	7 on		
	Crestwood Unit. He	er mask was pulled down and			proper cleaning of protective e	eye		
	exposed her nose as	nd mouth.			wear including hand hygiene			
					protocol; Activity Aide 33 on			
	On 1/14/22 at 11:29	a.m., CNA 13 wore a			masking at all times, and Laur	ndry		
	surgical mask and a	applied an N95 mask over the			Aide 21 on properly wearing N	195.		

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

Event ID: W5NJ11 Facility ID: 000448

If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPLETED	
15		155740	B. W	B. WING		01/14/2022	
				OTT FET	A DDDDGG CKEY CEATE THE CODE		
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
					AST ST		
TIMBER	CREST CHURCH (	OF THE BRETHREN HOME		NORTH	H MANCHESTER, IN 46962		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	surgical mask to en	ter a room on the 300 hall			The facility has determined th	at all	
	that had signage on	the door to indicate the			residents have the potential to	be l	
	resident was in TB	Р.			affected.		
					A root cause analysis of the		
	During an interview	v, with the IP (Infection			identified deficiencies was		
	Prevention) nurse v	vith the DON present, on			conducted, as was a review o	f the	
	1/14/22 at 11:50 a.i	m., he indicated staff should			most recent Infection Control		
		N95 over a surgical mask.			Assessment dated 11/09/202	1.	
	1170	S			Policies were reviewed and		
	On 1/14/22 at 12:58	8 p.m., CNA 17 was standing			revised as needed;		
		a on the 300 hall, as she talked			communication tools regardin	a the	
		sed her shirt to wipe off her			appropriate type of PPE and	9	
	1	aced them on her face. She			donning and doffing guidance		
		f she was ready, without			were reviewed and distributed		
					staff and within the facility.		
	performing hand hygiene, she assisted the resident as she held onto her gait belt and walked				Based on the root cause anal	veie	
	her down the hall to her room.				all staff was in-serviced on pro	•	
	her down the han to her room.				hand hygiene, and on how an	•	
	During on intervious	v with CNA 13, on 1/14/22 at			when to don and doff PPE wit		
	1	cated she normally took off			return demonstrations and	.11	
	her surgical mask a	-				and	
	ilei suigicai iliask a	nd applied all N93.			understand when to perform h	iaiiu	
	ъ	'.1 CNIA 17 1/14/22 4			hygiene. All staff was re-	4-:-	
	_	v with CNA 17, on 1/14/22 at			educated on the need to main		
		cated she would not normally			face covering over the mouth		
		n her shirt, she was just trying			nose as well as use of approp		
		ormally perform hand hygiene			covering. Staff received training	•	
	after touching her g	goggies.			on the cleaning and reusable	PPE	
					according to CDC guidelines.		
		p.m., Laundry Aide 21,			Daily random observations		
	applied an N95 over her surgical mask to enter a				executed by DON, IP, and/or		
	room on the 300 hall that had signage on the				designee, of personnel adheri	ing	
door to indicate the resident was in TBP.				to proper COVID-19 infection			
					control measures. The daily		
	During an interview, with the Activity Director,				monitoring includes but is not		
	on 1/14/22 at 1:20 p.m., she indicated she would				limited to hand hygiene, donn	-	
	not normally pull her mask down when she talked				and doffing technique, protect	ive	
	with the residents.	One of the residents indicated			eye wear, respirator devices,		
	they could not hear	her and asked her to pull her			mask use. Findings are review	ved	
	mask down, it was	something she would not			with all personnel observed.		
	normally do and it was a real quick thing.				Corrective action provided as		

STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED			
155740		B. WING 01/14/2022			/2022				
				CTREET	ADDRESS OF A STATE ZID CODE				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
				2201 EAST ST					
TIMBERG	CREST CHURCH C	OF THE BRETHREN HOME		NORTH	I MANCHESTER, IN 46962				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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		
					need.				
	Signage titled "Curi	rent PPE Requirements,"			Monitoring for compliance will				
	dated 1/13/22 and p	provided by the Administrator,			include, the Director of Nursing	g,			
	-	o.m., indicated the following:			the Infection Preventionist, or				
	"Green zones, Face	masks: surgical grade or			designee, will completing daily	,			
	better. Eye protection	on: Goggles or Face Shields			random Validation Checklists	of			
		within 6 feet of an individual.			personnel performing hand	ļ			
	Yellow and Red Zo	nes: Follow PPE instructions			hygiene, proper use of PPE ar	nd			
	posted on resident of				donning/doffing procedures. T				
					ensure staff are complying wit	h			
	A 7/7/21 revised po	olicy titled, "20210707 FOR			our facility's protocol, this rand				
	STAFF WORKING	G IN DESIGNATED CARE			monitoring will occur daily for	six			
	UNITS GREEN, Y	ELLOW AND RED ZONES,"			(6) weeks, then weekly x 18.				
		ministrator, on 1/14/22 at			The Director of Nursing, the				
	2:39 p.m., indicated the following: "Procedure:				Infection Preventionist, or				
	Green Zone: 1. Standard Based Precautions. 2.				designee, will complete daily				
	PPE required: Universal surgical mask issued by				rounding throughout the facility	y to			
	Timbercrest (unless instructed to wear KN95 by				ensure that PPE is distributed				
		ventionist/HR). Staff who			readily available were needed	and			
		doses of the COVID vaccine			signage is up to date. To ensu	re			
	and have submitted	proof thereof are permitted			staff are complying with our				
		ide facemasks issued by			facility's protocol, this random				
		ow zone 2. PPE required:			monitoring will occur daily for	six			
	Approved KN95 M	ask or KN95 covered with			(6) weeks, then weekly x 18.				
	cloth facemask (ma	y be used for entire shift			Results of the audits will be				
	unless were or visib	oly soiled). Staff who have			discussed monthly with the QA	₹PI			
	received both doses	s of the COVID vaccine and			committee and summary repo				
	have submitted pro-	of thereof are permitted to			provided to the QAA committe	е			
	wear surgical grade	facemasks issued by			until such time it is determined				
	Timbercrest"	·			that substantial compliance is				
					maintained	ļ			
	3.1-18(b)(1)					ļ			
						ļ			
R 0000						İ			
Bldg. 00						ļ			
	This visit was for a	Residential COVID-19	R 0	000		ļ			
		Walk Through. This visit				ļ			
	included a Nursing	Home COVID-19 Focused				ļ			
	Infection Control S	urvey.							

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

PRINTED: 02/10/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		155740	B. WI	NG		01/14	/2022
NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF THE BRETHREN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  2201 EAST ST  NORTH MANCHESTER, IN 46962				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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			DATE
	Survey dates: Janua Facility number: 00 Residential Census:	0448					
	Timbercrest Church	of the Brethren Home was					
	found to be in comp	pliance with 410 IAC 16.2-5					
	in regard to the CO	VID-19 Quality Assurance					
	Walk Through.						
	Quality review com	upleted on January 21, 2022.					

State Form Event ID: W5NJ11 Facility ID: 000448 If continuation sheet Page 6 of 6