STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY, SHELBYVILLE, , 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: September 11 and 12, 2025 Facility number: 014548 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 15, 2025.	R 0000		
R 0033	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(h)(1-2) (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility.	R 0033	*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:A posting was immediately placed on the resident information bulletin board containing the following contact information: The most addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the	09/27/2025

	(2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure the addresses and telephone numbers of advocacy agencies were posted in an area accessible to residents for 40 of 40 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Administrator on 9/12/25 at 10:30 a.m. During the tour, there was no posting of the addresses and telephone numbers to the IDOH (Indiana Department of Health,) the office of the secretary of		division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services.*How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All 40 residents had the potential to be affected by the alleged deficient practice. A posting was immediately placed on the resident information bulletin board containing the following contact information: The most addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services*What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The administrator will provide a written notice to residents regarding the location of the required contact information posting as well as a request that the posting not be removed from that location. The Administrator will conduct an “All-Staff” training on the required postings as well as the specific location of the posting. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The administrator (or designee) will conduct an audit 4 times weekly for	

	family and social services, the area agency on aging, a local mental health center, and adult protective services observed. An interview was conducted with the Administrator on 9/12/25 at 10:30 a.m. during the environmental tour. She indicated the above information was not posted anywhere in the facility. Only the Ombudsman information was posted on the residents' rights poster. They only gave residents a copy of the above advocacy agencies' information, as it was included in their lease. On 9/12/25 at 11:15 a.m., the Administrator provided a blank copy of the resident lease. It included the above addresses and telephone numbers. Based on observation and interview, the facility failed to ensure the addresses and telephone numbers of advocacy agencies were posted in an area accessible to residents for 40 of 40 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Administrator on 9/12/25 at 10:30 a.m. During the tour, there was no posting of the addresses and telephone numbers to the IDOH (Indiana Department of Health,)		2 weeks, then 2 times weekly for 2 weeks then 1 time weekly for 2 weeks, then monthly on an ongoing basis to confirm the required posted contact information remains in place for all.	

	the office of the secretary of family and social services, the area agency on aging, a local mental health center, and adult protective services observed. An interview was conducted with the Administrator on 9/12/25 at 10:30 a.m. during the environmental tour. She indicated the above information was not posted anywhere in the facility. Only the Ombudsman information was posted on the residents' rights poster. They only gave residents a copy of the above advocacy agencies' information, as it was included in their lease. On 9/12/25 at 11:15 a.m., the Administrator provided a blank copy of the resident lease. It included the above addresses and telephone numbers.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:	R 0121	*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A pre-employment checklist was developed to include all appropriate health screenings, specifically the Two-Step TB screening to ensure this occurs within one month prior to or at the time of employment. This checklist will be completed prior	09/30/2025

(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on interview and record review, the facility failed to ensure a first and second step TB (tuberculin) skin test was

to
sending in new hire paperwork which is required to allow a new employee to
clock in for any shift.

*How the facility will identify other residents
having the potential to be affected by the same deficient practice and what
corrective action will be taken:

All residents had the potential to be affected by the deficient practice.

*What measures will be put into place or what
systemic changes the facility will make to ensure that the deficient practice
does not recur:

The new pre-employment checklist will be utilized to document and
confirm that the DON has conducted the 1st step TB skin tests at the
time of hire, to be read prior to the new employee beginning work (unless that
new hire provides documentation of the same having been conducted within the
previous month. The 2nd step TB

	completed upon hire for 2 of 5 employee records reviewed. (Cook 2 and Qualified Medication Aide 3) Findings include: The completed Employee Records form and employee files were provided by the Administrator on 9/12/25 at 10:15 a.m. The Employee Records form indicated Cook 2 started working at the facility on 5/7/25, and Qualified Medication Aide (QMA) 3 started working at the facility on 2/20/25. Cook 2's employee file included the Two Step Mantoux Skin Test form. It indicated the 1st step TB test was administered on 9/3/25 and read on 9/5/25. His 2nd step TB test was administered on 9/11/25 and had not yet been read. QMA 3's employee file included the Two Step Mantoux Skin Test form. It indicated the 1st step TB test was administered on 3/14/25 and read on 3/17/25. Her 2nd step TB test was administered on 4/8/25 and read on 4/10/25. An interview was conducted with the Administrator on 9/12/25 at 10:30 a.m. She indicated QMA 3 did not have any more TB testing verification. Cook 2 and QMA 3 should have their 1st step TB test completed upon hire. Cook 2 previously		skin test will be scheduled by the DON during the first 3 weeks of employment. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will conduct monthly audits on 25% of all employee files for those newly hired (since 9/12/2025) to confirm employees have completed all required TB screenings prior to beginning work.	

worked at the facility and was rehired on 5/7/25, so had TB testing at the time of his first hire.

On 9/12/25 at 1:12 p.m., the Administrator provided the Two Step Mantoux Skin Test form from when Cook 2 previously worked at the facility. An interview was conducted with the Administrator at this time. The 1st step TB test was administered on 3/13/24 and read on 3/15/24. The 2nd step TB was administered on 3/25/24 and read on 3/17/24. The Administrator indicated Cook 2 only worked at the facility for a month in 2024.

The Orientation/Training/Health Screenings/TB policy was provided by the Administrator on 9/12/25 at 12:01 p.m. It indicated, "Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code. This test must be completed at the time of employment or no more than 1 month prior to employment. The first TB test must be read prior to employee starting work. For healthcare workers who have not had a documented negative TB test result during the preceding 12 months, they need a 2 step TB test."

Based on interview and record review, the facility failed to ensure a first and second step

TB (tuberculin) skin test was completed upon hire for 2 of 5 employee records reviewed. (Cook 2 and Qualified Medication Aide 3)

Findings include:

The completed Employee Records form and employee files were provided by the Administrator on 9/12/25 at 10:15 a.m. The Employee Records form indicated Cook 2 started working at the facility on 5/7/25, and Qualified Medication Aide (QMA) 3 started working at the facility on 2/20/25.

Cook 2's employee file included the Two Step Mantoux Skin Test form. It indicated the 1st step TB test was administered on 9/3/25 and read on 9/5/25. His 2nd step TB test was administered on 9/11/25 and had not yet been read.

QMA 3's employee file included the Two Step Mantoux Skin Test form. It indicated the 1st step TB test was administered on 3/14/25 and read on 3/17/25. Her 2nd step TB test was administered on 4/8/25 and read on 4/10/25.

An interview was conducted with the Administrator on 9/12/25 at 10:30 a.m. She indicated QMA 3 did not have any more TB testing verification. Cook 2 and QMA 3 should have their 1st step TB test completed

upon hire. Cook 2 previously worked at the facility and was rehired on 5/7/25, so had TB testing at the time of his first hire.

On 9/12/25 at 1:12 p.m., the Administrator provided the Two Step Mantoux Skin Test form from when Cook 2 previously worked at the facility. An interview was conducted with the Administrator at this time. The 1st step TB test was administered on 3/13/24 and read on 3/15/24. The 2nd step TB was administered on 3/25/24 and read on 3/17/24. The Administrator indicated Cook 2 only worked at the facility for a month in 2024.

The Orientation/Training/Health Screenings/TB policy was provided by the Administrator on 9/12/25 at 12:01 p.m. It indicated, "Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code. This test must be completed at the time of employment or no more than 1 month prior to employment. The first TB test must be read prior to employee starting work. For healthcare workers who have not had a documented negative TB test result during the preceding 12 months, they need a 2 step TB test."

correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURECrystal L Werner	TITLEAdministrator	(X6) DATE09/26/2025