STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	09/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Nursing Home Complaint IN00442484. This visit included a State Residential Licensure Survey. Complaint IN00442484 - No deficiency related to the allegation is cited. Survey dates: September 24, 25, 26, 27, and 30, 2024 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census Bed Type: SNF/NF: 58 Residential: 71 Total: 129 Census Payor Type: Medicare: 5 Medicaid: 26 Other: 27 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 7, 2024.	F 0000		
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions Based on interview and record review, the facility failed to follow an Indiana Physician Order for Scope of Treatment (POST) form indicating do not	F 0552	Preparation and/or execution of this plan do not constitute admission of or agreement by the	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa Miller | Director of Nursing | 10/19/2024

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	attempt resuscitation/DNR for a resident that received cardiopulmonary resuscitation (CPR) for 1 of 3 residents reviewed for Advanced Directives. (Resident 61) Findings include: Resident 61's clinical record was reviewed on 9/27/24 at 11:49 a.m. Diagnoses included unspecified systolic (congestive) heart failure, obstructive sleep apnea, dysphagia, oropharyngeal phase, and other pneumonia, unspecified organism. Current orders indicated the resident was a full code, pending POST form completion, dated 7/10/24. An Indiana Physician Order for Scope of Treatment (POST) form dated 8/9/24, and signed 8/12/24, indicated in section A that Resident 61 requested a do not attempt resuscitation (DNR) if he had no pulse and was not breathing. A progress note, dated 9/3/24 at 3:30 a.m., indicated resident had no pulse, was not breathing, and had no chest rising. Code status was verified by staff as a full code. CPR was initiated and 911 emergency services were called. A progress note, dated 9/3/24 at 3:38 a.m., indicated the resident's representative was notified that staff started chest compressions. Once EMS arrived, they administered medications, but the emergency medical technician (EMT) spoke with the resident representative, who indicated Resident 61 would not want chest compressions if he didn't have a heartbeat. Since there was no heartbeat, the decision was made to stop medications and ventilation.		provider that a deficiency exists. This response is also not 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 response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. An audit of all residents' charts was performed on 9/27/24 with no discrepancies found in documenting the residents' wishes in the relevant sections of their chart. The facility's Advance Directive Policy was reviewed and all nurses and social service staff were in-serviced on the policy by the Director of Nursing on 10/9/2024. The administrator/designee will audit charts of new admissions for the next three months for correct completion of the resident's code status. The findings will be reviewed by the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comment and suggestion. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. At the end of the first	

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	During an interview, on 9/27/24 at 12:19 p.m., the DON and Social Services indicated it wasn't a clear cut and dry DNR. The resident wanted to be a DNR, but with full interventions. The resident voiced that if he was found with no heartbeat and not breathing, he did not want CPR performed. During an interview, on 9/27/24 at 1:46 p.m., the DON indicated there was a note stating the resident still had respirations, but they were unable to provide those documents. She didn't know why his code status was not updated. Once a POST form was completed and in the chart, the order should be updated. Staff members verify a resident's code in the banner of their face sheet within the electronic clinical record. A printed resident face sheet, provided by the DON on 9/27/24 at 2:15 p.m., indicated Resident 61's status was DNR, but had a note attached stating full interventions. The alerts indicated full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs. During an interview, on 9/27/24 at 2:37 p.m., RN 11 indicated she found a resident's code status on the face sheet under the tab "continuance of care". During an interview, on 9/27/24 at 2:38 p.m., RN 12 indicated she looked at the banner for a resident's code status.		paragraph. Corrective action completion date: 10/18/2024	

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	A current policy titled "Advanced Directive Policy", provided by the ADON on 9/25/24 at 2:48 p.m., indicated the following: " ...Changes to the residents choices for advanced directives will be documented, included in the residents plan of care, state specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care ...."			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on observation, record review, and interview, the facility failed to allow a resident with the ability to make their own decisions to formulate an advance directive. (Resident 50) Findings include: On 9/26/24 at 8:55 a.m., Resident 50's clinical record was reviewed. Diagnoses included essential hypertension, heart failure, acute kidney failure, and Type 2 diabetes mellitus. A Minimum Data Set (MDS) assessment, dated 6/30/24, did not include a BIMS (Brief Interview for Mental Status) assessment to evaluate cognition. On 6/27/24, Resident 50's family member signed a Do Not Resuscitate (DNR) form. A progress note, on 6/27/24 at 8:47 p.m., indicated Resident 50 was alert and oriented. A POST form (a physician's order for scope of treatment based on the resident's medical conditions and preferences),dated 7/5/24,	F 0578	Preparation and/or execution of this plan do not constitute admission of or agreement by the provider that a deficiency exists. This response is also not 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 response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. An audit of all residents' charts was performed on 9/27/24 with no discrepancies found in documenting the residents' wishes in the relevant sections of their chart. The facility's Advance Directive Policy was reviewed and all nurses and social service staff were in-serviced on the policy by the Director of Nursing on 10/9/2024. The administrator/designee will	10/18/2024

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	indicated the resident had a DNR code status. During an interview with the Admissions Coordinator (AC) on 9/27/24 at 9:45 a.m., she indicated the resident's family member had completed the admission paperwork. At the time of admission, Resident 50 had come from the hospital and was tired. Each admission was different, dependent upon her assessment of a person's ability to sign advance directives at that time. When she visited residents at the hospital, before they were admitted to the facility, she would also assess family dynamics to determine if the resident could sign the advance directives. On 9/25/24, at 10:24 a.m., Resident 50's clinical record indicated a BIMS score of 14, which indicated she was cognitively intact and capable of making reasonable and consistent decisions. During an interview with the Administrator on 9/30/24 at 2:42 p.m., she indicated the resident would have been competent enough to sign the Advance Directive at admission. A current facility policy, titled Advance Directive Policy, with a revision date of 6/23/23, was provided by the Director of Nursing (DON) on 9/25/24 at 2:48 p.m. The policy indicated the following: "It is the policy of (the facility) to establish, implement and maintain written policies and procedures for advance directives. The resident has the right and the facility will assist the resident to formulate an advance directive...a) Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive...c) ...The facility will identify the primary decision maker (e.g., assess the resident's decision-making capacity....)"		complete audits of the Care Plan meetings for compliance with addressing resident's Advance Directives and necessary changes. The audit will be done weekly for three months. The findings will be reviewed by the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comment and suggestion. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. At the end of the first paragraph.	

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F 0761 SS=D Bldg. 00	3.1-4 (f)(1)(A)(ii) 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure medications stored in the medication carts were labeled with resident identifiers and directions for 2 of 3 medication carts reviewed. (Hall 100 Medication Cart and Hall 400 Medication Cart). Findings include: During an observation of the Hall 100 medication cart on 9/26/24 at 3:30 p.m., accompanied by QMA 6, the bottom drawer contained an unlabeled bottle of Vanadium Complex (a supplement used to support blood glucose levels), an unlabeled bottle of Stasis Liver Detox (a liver supplement), and an unlabeled bottle of Thytrophin PMG (a thyroid supplement). QMA 6 indicated all supplements belonged to one resident and each should have a label with resident identifiers. During an observation of the Hall 400 medication cart on 9/26/24 at 3:42 p.m., accompanied by QMA 8, an unlabeled bottle of acetaminophen 500 mg tablets and an unlabeled bottle of Juice Plus Fruit & Vegetable Blend supplement were in the cart. QMA 8 indicated both should be labeled. During an interview with RN 9 on 9/26/24 at 3:57 p.m., she indicated all bottles and containers in the medication carts should have a label containing the name of the resident, their date of birth, instructions for use, and the name of a provider.	F 0761	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not 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 response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. Thank you** **The medications that were found in the 2 med carts were removed and properly labeled. All medication carts in Health Care were audited to determine if any additional medications were improperly labeled. All improperly labeled medications were removed or properly labeled. Education was provided to nurses and QMAs during the 10-9-24 staff meeting presented by the DON. Education included review of the actual**	10/18/2024

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	On 9/26/24, at 4:00 p.m., the Assistant Director of Nursing (ADON) indicated medications in the medication carts should have a resident name, physician name, an open date, and directions for use on the bottle. The DON provided a current facility policy, titled "Storage and Expiration Dating of Medications and Biologicals" on 9/27/24 at 12:34. This policy did not contain information regarding labeling of medications. 3.1-25(j)(k)		**regulation section "Labeling of Medications and Biologicals" section. Also reviewed the Omnicare policies: 3.2 Medications Brought into the Facility, 4.8 Medication Labels, and 5.3 Storage and Expiration Dating of Medications and Biologicals.** **To ensure compliance, the DON or designee will audit the HealthCare med carts weekly x4, every other week x2, then once a month x1. The findings will be reviewed by the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comment and suggestion.** **Corrective action completion date: 10/18/2024**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 by not wearing appropriate personal protective equipment (PPE) in areas requiring transmission-based precautions (TBP) during random observations on the 300 Hall. Findings include:	F 0880	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft**	10/18/2024

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	During a random observation, on 9/24/24 at 10:59 a.m., CNA 14 entered room 307 while wearing gloves, an N95 mask placed over a surgical mask, and a gown. No face shield and/or eye protection was worn before entering the resident's room. Signage on the door indicated the resident was in transmission-based precautions, and required a gown, gloves, N95 mask and a face shield/goggles before entering the room. During a random observation, on 9/24/24 at 11:05 a.m., CNA 14 was wearing a gown, gloves, and an N95 mask overtop of a surgical mask while entering room 307. During an interview, on 9/24/24 at 12:12 p.m., CNA 14 indicated she only wore gloves, a gown, and placed an N95 mask over a surgical mask. No face shield/ goggles were worn before entering the resident's room. During a random observation, on 9/26/24 at 9:11 a.m., CNA 3 entered room 307 while wearing gloves, a gown, goggles, and an N95 mask over a surgical mask. During an interview, on 9/26/24 at 9:15 a.m., CNA 3 indicated she wore a gown, gloves, face shield and placed an N95 mask overtop a surgical mask before entering the resident's room. During an interview, on 9/26/24 at 11:44 a.m., the ADON indicated staff should not be wearing both a surgical mask and N95 before entering a resident's room who was on transmission-based precautions. A current facility policy titled "COVID-19 PREVENTION AND RESPONSE and		**or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. Thank you.** **Immediate re-education by DON/ADON occurred to the 2 employees who self-reporting that they were identified to be wearing a surgical mask under their N95. At this time there are no residents in TBP isolation. To ensure that this practice does not recur, education was provided, by ADON, to all department including the use of "CDC How to Use Your N95 Respirator: Wear your N95 Respirator Properly so it is Effective."** **DON provided re-education during the nursing department staff meeting on 10-9-24.** **DON or designee will audit appropriate N95 mask usage with any residents in TBP isolation during the next 3 months up to 10 audits. The findings will be reviewed by the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the**	

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	REPORTING", provided in the entrance survey binder on 9/25/24 at 10:45 a.m., indicated the following: " ...16. HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filers or higher, gown, gloves, and eye protection ...." 3.1-18(a)		**committee. Audit results will be shared with the Resident Council for comment and suggestion.** **Corrective action completion date: 10/18/2024**	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording 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 tuberculin skin test must be read prior to the employee starting work. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure baseline tuberculin skin testing employed the two-step method for 2 of 10 employee records reviewed (CNA 3 and RN 5). Findings include:	F 9999	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not 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 response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. Thank you** **Both identified employees restarted their 2 step Tb process. Along with this an audit occurred of employees still requiring any portion of the 2-step Tb process upon hire. Any employees identified were**	10/18/2024

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	Employee records were reviewed on 9/25/24 at 3:15 p.m., and indicated the following: CNA 3 and RN 5's records lacked a second step tuberculin test upon hire. CNA 3's hire date was 3/27/24. Days worked included 9/24/24, 9/26/24, 9/27/24 and 9/30/24. RN 5's hire date was 4/10/24. Days worked included 9/28/24 and 9/29/24. During an interview, on 9/25/24 at 4:22 p.m., the DON indicated RN 5 was a positive reactor, but did not have documentation of that positive reaction. They should have completed the second step TB test. During an interview, on 9/25/24 at 4:26 p.m., the DON indicated CNA 3 only had the first step completed. They were unable to provide documentation of the second step being completed. A current undated facility policy titled "Guideline for TB Results Summary Documentation: Staff", provided by the ADON on 9/25/24 at 2:48 p.m., indicated the following: " ...upon hire each employee shall receive a two-step PPD test to ensure they are free of tuberculosis ...."		**reported to their specific manager who contacted them and the 2 step Tb process was restarted. Education was provided by DON at Management Meeting on 10-8-24 reviewing the 410 IAC 16.2-5-1.4 Personnel regulation. Also discussed the Timbercrest policy "Guidelines for TB results Summary Documentation: Staff" and the Tuberculosis Screening Decision Tree. Team agreed that each manager is responsible for their department employees to complete the 2-step Tb skin test upon hire. Nursing will review Mantoux Records pending on a weekly basis and report to managers for follow up.** **To ensure compliance, the DON or designee will audit the Mantoux Screening binder weekly x4, every other week x2, then once a month x1. The findings will be reviewed by the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comment and suggestion.** **Corrective action completion date: 10/18/2024**	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Nursing Home Complaint IN00442484. Complaint IN00442484 - No deficiency related to the allegation is cited. Survey dates: September 24, 25, 26, 27, and 30, 2024 Facility number: 000448 Residential Census: 71 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed October 7, 2024.	R 0000		
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure advance directives were completed by a resident who indicated a choice to have directives in place for 1 of 7 residents reviewed for advance directives. (Resident 6) Findings include: Resident 6's clinical record was reviewed on 9/27/24 at 9:36 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Barrett's esophagus, and hearing loss.	R 0356	Preparation and/or execution of this plan do not constitute admission of or agreement by the provider that a deficiency exists. This response is also not 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 response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The administrator completed the	10/18/2024

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TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/12/24, an admission service plan indicated Resident 6 did not want cardiopulmonary resuscitation if she was unresponsive, had no pulse, and was not breathing. There were no signed advance directives in the clinical record. During an interview on 9/27/24, at 3:33 p.m., the Administrator indicated the facility had not yet obtained a signed advance directives from the resident. The resident was a very busy person. She was aware of the resident's verbal wishes to not receive CPR if she was unresponsive, not breathing, and had no pulse. On 9/30/24, at 9:08 a.m., the Director of Nursing (DON) indicated the resident had not signed the advance directives because she had been too busy and had other concerns not related to the DNR. The staff did not follow through as they should have with the advance directive. During an interview with the Admissions Coordinator (AC), on 9/30/24 at 9:16 a.m., she indicated advance directives were required upon admission. Until the resident's wishes were obtained, full interventions (CPR) would be performed. A current facility policy, titled Advance Directive Policy, with a revision date of 6/23/23, was provided by the Director of Nursing (DON) on 9/25/24 at 2:48 p.m. The policy indicated the following: "...It is the policy of (the facility) to establish, implement and maintain written policies and procedures for advance directives. The resident has the right and the facility will assist the resident to formulate an advance directive...a) Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance		Advance Directives with the resident identified for the facility's deficient preparation of the resident's Advance Directives. The resident's chart was updated immediately and according to the resident's wishes. All residents' charts were audited on 9/27/24 and all areas of the residents' charts were completed as identified. The facility's Advance Directive Policy was reviewed and the residential nurses were in-serviced on the policy on 9/27/24 and 10/9/2024 by the Director of Nursing. The administrator/designee will audit charts of new admissions for the next three months for correct completion of the resident's code status and execution of Advance Directives. Audit results will be reviewed the QAPI committee. Audit records will be submitted to the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comment and suggestion. Timbercrest respectfully requests desk review for substantial compliance for this Plan of Correction. At the end of the first paragraph.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	09/30/2024

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	directive...."			