PRINTED: 10/19/2023
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OM						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	2201	FADDRESS, CITY, STATE, ZIP COD EAST ST TH MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R 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	
E 0000						
E 0039 SS=F Bldg	conducted by the Ir accordance with 42 Survey Date: 09/05 Facility Number: 06 Provider Number: 100 At this Emergency Timbercrest Church found not in complement of the comp	5/23 00448 155740 1275140 Preparedness survey, h of the Brethren Home was iance with Emergency irements for Medicare and ting Providers and Suppliers, 42 acility has a capacity of 65 and at the time of this survey. 42 CFR, Subpart 483.73 is not y: mpleted on 09/07/23 6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)	E 0000	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 Plan of Correction submitted the deficiencies cited during the Life Safety Code survey on 09/05/2023.	nts ode the	
		<u> </u>				

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

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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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155740	B. W	ING		09/05/	/2023
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY (DATE
	_	920, RHCs/FQHCs at RD Facilities at §494.62]:					
	3431.12, and E01	To racinties at 9494.02].					
	(2) Testing. The [f	facility] must conduct					
	exercises to test t	he emergency plan					
	•	ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
		l every 2 years; or					
		nunity-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					
	•	l or individual, facility-based					
		e following the onset of the					
	actual event.						
	(ii) Conduct an ad	lditional 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 l or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	' '	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a						
	1	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	mergency plan. acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ergency plan, as needed.					
	1	- • •	1				

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	, ,	UILDING	NSTRUCTION	COM	TE SURVEY MPLETED 05/2023		
	F PROVIDER OR SUPPLIE	R OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962						
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE		
	the patient's hom conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based functional (B) If the hospice man-made emerged for the emergency exempt from enguscale community facility-based functional exercise of this section is discussion using clinically-relevant set of problem stamessages, or preto challenge an exercises to test.	espices that provide care in the incent of t							

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Event ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIEI	R OF THE BRETHREN HOME	2	2201 EA	DDRESS, CITY, STATE, ZIP COD AST ST MANCHESTER, IN 46962		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NOT MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	(i) Participate in a that is community (A) When a commaccessible, conducted facility-based functional exercise mergency exempt from engatull-scale community functional exercise emergency event (ii) Conduct an authat may include, following: (A) A second full-community-based functional exercise functional exercis (B) A mock disast (C) A tabletop extenditator that inclusing a narrated, emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the firmaintain docume exercises, and enthe hospice's emergency exercises, and enthe hospice's emergency plan. (iii) Testing. The [inconduct exercises plan twice per year CAH] must do the community of the plan twice per year	an annual full-scale exercise a-based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or gency 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 -scale exercise that is or a facility based e; or ater drill; or ercise or workshop led by a udes a group discussion clinically-relevant ario, and a set of problem and the drills, tabletop and the drills, and revise are gency plan, as needed. 441.184(d), Hospitals at a sat §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency ar. The [PRTF, Hospital,					
	that is community	-hased: or					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING		COMPLE	
		155740	B. WIN	NG		09/05/2	2023
NAME OF E	PROVIDER OR SUPPLIER	• ?	<u> </u>		ADDRESS, CITY, STATE, ZIP COD		
				2201 EA			
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME		NORTH	MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	' '	nunity-based exercise is not					
		ict an annual individual,					
		ctional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
	-	ration of the emergency					
		is exempt from engaging in					
	· ·	ull-scale community based ity-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	, ,	nat may include, but is not					
	limited to the follow	-					
		scale exercise that is					
	community-based						
	_	ctional exercise; or					
		ock disaster drill; or					
	, ,	o exercise or workshop that					
	, ,	or and includes a group					
	discussion, using						
	_	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	·					
	_	he [facility's] response to					
	, ,	umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	, -1					
	*(Ear DACE at \$4/	SU 64/9/·1					
	*[For PACE at §46	, , -					
	· ,	PACE organization must					
		s to test the emergency					
	plan at least annu	-					
	organization must	_					
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ict an annual individual, ctional exercise: or					
1	i iaciiiiv-daseo iunc	alonal exercise. Of					

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Event ID:

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl B. W	JILDING ING		COMPLETED 09/05/2023	
		155740	B. W	ING		09/05/	72023
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME		2201 EAST ST NORTH 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 APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
		gaging in its next required					
		nity based or individual,					
	· ·	ctional exercise following the					
	onset of the emer						
		in additional exercise every					
		the year the full-scale or e under paragraph (d)(2)(i)					
		e under paragraph (d)(z)(i) conducted that may include,					
	but is not limited to	-					
		scale exercise that is					
	1 ' '	or individual, a facility					
	based functional						
	(B) A mock disas						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using	- ·					
	_	emergency scenario, and a					
	set of problem sta						
	1	pared questions designed					
	to challenge an er	·					
	_	PACE's response to and					
		ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the PACE's emer	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	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund	ctional exercise.					
	(B) If the [LTC fac	ility] facility experiences an					

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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 SUPPLIER	OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962					
(X4) PRE TA	FIX	(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		requires activation LTC facility is exerequired a full-scalindividual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional of the community-based functional of the community of the co	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP C AST ST I MANCHESTER, IN 46		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	full-scale community-based functions for the emerical formulation on the transfer of the emerical facility-based functions following: (A) A second full-scommunity-based facility-based functions facility-based functions facility-based functions for the function of the f	nity-based or individual, stional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, stional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop in the gency events, and revise regency plan, as needed. 34.102] E HHA must conduct the emergency plan at e HHA must do the				

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onset of the emergency event.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155740	B. W			COMPL 09/05/	
		133740	B. W.			09/03/	2023
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
				2201 E/			
HMBER	CREST CHURCH C	OF THE BRETHREN HOME		NORTH	I MANCHESTER, IN 46962		
(X4) ID		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
	' '	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based	or an individual, ctional exercise; or					
		isaster drill; or					
	, ,	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	- ·					
		emergency scenario, and a					
	set of problem sta	•					
		pared questions designed					
	to challenge an er						
	_	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	**** 000 104	20.0001					
	*[For OPOs at §48	-					
		e OPO must conduct					
	OPO must do the	he emergency plan. The					
		er-based, tabletop exercise					
		ast annually. A tabletop					
	-	a facilitator and includes a					
	_	using a narrated, clinically					
		cy scenario, and a set of					
		its, directed messages, or					
	•	ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
		of the emergency plan, the					
	-	om engaging in its next					
	· ·	xercise following the onset					
	of the emergency	_					
		PO's response to and					
		ntation of all tabletop					

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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
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	STREET 2201 I NORT		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWDERIC DLAN OF 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	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the first of the exercises to test the result of the exercises of the exercise of the result of t	a LSC IDENTIFYING INFORMATION rergency events, and revise OPO's] emergency plan, as 3.748]: a RNHCI must conduct the emergency plan. The refollowing: er-based, tabletop exercise A tabletop exercise is a red by a facilitator, using a relevant emergency et of problem statements, s, or prepared questions renge an emergency plan. NHCI's response to and retation of all tabletop rergency events, and revise regency plan, as needed. riew and interview, the facility rercises to test the emergency rer year, including drills using the emergency		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 represent 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 submit as the facility's credible allegatof compliance.	n of 09/22/2023 not ion
		ext required full-scale in a or individual, facility-based		To address the preparedness staff in case of emergencies,	
	1	l exercise for 1 year following		missing person/elopement, m	
	the onset of the actual event.			drill was executed on 9/19/202	
	(ii) Conduct an add	itional exercise that may		The drill spanned across shift	
		imited to the following:		change. It includes a review of	
	a. A second full-sca	le exercise that is		policy and procedure. The fine	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey .eted /2023	
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	•	2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST I MANCHESTER, IN 46962		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROPER		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	community-based of functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or prepare challenge an emerge (iii) Analyze the LT maintain documents exercises, and emered LTC facility's emered accordance with 42 deficient practice of the facility of the exercise was available annual actual event available for review time of records review the facility did not preceded and the facility based emonths. There was of a second exercise.	drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to ency plan. To facility's response to and attorn of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. The work and interview with the 1/05/23 at 12:30 p.m., no community based annual ble, but documentation of one exercise on 04/05/23 was as a Based on interview at the ew, the Administrator stated participate in a full-scale amunity-based but completed exercise within the last 12 no documentation provided		TAG	will be discussed in the upcon Safety Committee and recommendations will be brouto the QAPI meeting for review the quarterly QAA meeting for approval.	ning ight v and	DATE
E 0041 SS=F Bldg	§482.15(e) Condit	(e), 485.625(e) LTC Emergency Power tion for Participation: d standby power systems.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	COM	TE SURVEY MPLETED 05/2023
	PROVIDER OR SUPPLIEI	OF THE BRETHREN HOME	2201	ET ADDRESS, CITY, STATE, 2 I EAST ST RTH MANCHESTER, IN		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	standby power sy emergency plan so this section and ir procedures plan so (i) and (ii) of this so §483.73(e), §485. (e) Emergency ar The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency genergenerator must be the location required Care Facilities Counterim Amendment 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or building 482.15(e)(2), §48 Emergency generator the [hospital, CA implement the eminspection, testing requirements four Facilities Code, N Code.	set forth in paragraphs (b)(1) section. 625(e) and standby power systems. and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The ise located in accordance with rements found in the Health inde (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, ind NFPA 110, when a new in when an existing				
	Emergency generand LTC facilities	rator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	
		155740	B. W	ING		09/05	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		2201 E			
TIMBER	CREST CHURCH C	OF THE BRETHREN HOME			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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ow it will keep emergency					
	power systems operational during the emergency, unless it evacuates.						
	emergency, unies	is it evacuates.					
	*IFor hospitals at	§482.15(h), LTC at					
		CAHs §485.625(g):]					
		corporated by reference in					
		oproved for incorporation by					
	·	Director of the Office of the					
	•	in accordance with 5 U.S.C.					
	_	R part 51. You may obtain					
	the material from the sources listed below.						
You may inspect a copy at the CMS							
		urce Center, 7500 Security					
	Boulevard, Baltim	ore, MD or at the National					
	Archives and Rec	ords Administration					
	(NARA). For infor	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
	http://www.archive	es.gov/federal_register/code					
	_of_federal_regul	ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	_					
	, ,	Protection Association, 1					
	Batterymarch Par						1
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
	. ,	th Care Facilities Code,					
		ed August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued						
		FPA 99, issued August 9,					
	2012.	FPA 99, issued March 7,					1
	(IV) TIA 12-4 to NI 2013.	FFA 33, ISSUEU IVIAICII /,					
		FPA 99, issued August 1,					
	(V) TIA 12-5 to NF 2013.	i A 33, issueu August I,					
		EDA 00 issued March 3					

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155740	B. WI	NG _		09/05	/2023
NAME OF P	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
		OF THE BRETHREN HOME			AST ST I MANCHESTER, IN 46962		
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	2014.						
	(vii) NFPA 101, Li	ife Safety Code, 2012					
	edition, issued August 11, 2011.						
	(viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October						
	30, 2012.						
	(x) TIA 12-3 to NFPA 101, issued October 22, 2013.(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,						
	including TIAs to a 2009	chapter 7, issued August 6,					
		to implement the emergency	E 00)41	The preparation and execution	n of	09/22/2023
	power system inspe	ection, testing and		this plan do not constitute			
	maintenance requir	rements found in the Health			admission or agreement by		
	Care Facilities Cod	le, 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	not	
		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		
					as the facility's credible allega	tion	
	Findings include:				of compliance.		
	Dagad or -1	on dyning a tayn of the feetilite.			To ensure the safety of its	_	
		on during a tour of the facility			residents, staff and visitors, th		
	with the Maintenance Tech (MT) on 09/05/23 at				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 the Health Care nurse's statio	-	
	Rosegarden which is an area not not readily observed by personnel. Based on interview at the time of observation, the Maintenance Tech stated that they have maintenance personnel working on						
					which is occupied 24/7. Until to completion of the installation of		
					this project, the panel will be	וע	
		ng out of an area located close			monitored twice during each s	hift	
	to the annunciator r	_			The staff tasked with the	,, ,,,,,,	

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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	ILDING		COMPLI	ETED
		155740	B. WI	NG		09/05/	2023
NAME OF I	DOWNER OF CURRINE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			2201 E	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	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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	TELL: 0" 1"				monitoring of the panel has be		
	_	viewed with the Administrator			educated. The completion of s		
	and MT at the exit of	conference.			checks is being monitored wee	-	
					by the administrator/designee		
					the relocation project has been	1	
					completed. Findings will be	to 0	
					reported to the Safety Commit with a summary report to the 0		
					Committee.	*^^	
					Committee.		
K 0000							
-							
Bldg. 01	1 T C G C . G 1	D					
	-	Recertification and State	K 0	000	Timbercrest Senior Living		
	-	vas conducted by the Indiana			Community is dedicated to kee		
	-	th in accordance with 42 CFR			its residents, their families, gu	esis	
	483.90(a).				and staff safe at all times. As		
	Survey Date: 09/05	5/23			such, Timbercrest aims for its practices and building to be		
	Burvey Bate. 09/02	7.25			compliant with the requiremen	te	
	Facility Number: 0	00448			concerning the Life Safety Coo		
	Provider Number:				requirements.		
	AIM Number: 100				Timbercrest requests desk		
					review/paper compliance for the	ne	
	At this Life Safety	Code survey, Timbercrest			Plan of Correction submitted for		
	Church of The Bret	hren Home was found not in			the deficiencies cited during th		
	compliance with Re	equirements for Participation in			Life Safety Code survey on		
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			09/05/2023.		
	Life Safety from Fi	re, and the 2012 edition of the					
		ction Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one story facil-	ity was determined to be of					
		ruction and the basement was					
	• • • •	Type II (222). The facility was					
		as a fire alarm system with hard					
		ion in the corridors, areas open					
		in 16 resident rooms in					
	· ·	ery operated smoke detectors					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155740	B. W	ING		09/05/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF			2201 E	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	,	CY 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
		health care resident rooms.					
	of 57 at the time of	apacity of 65 and had a census					
	of 37 at the time of	tills survey.					
	All areas where the residents have customary						
		ered. All areas providing					
		re sprinklered except for a					
	detached maintenar	nce garage.					
	Quality Review cor	mpleted on 09/07/23					
K 0100	NFPA 101						
SS=E	General Requirem	nents - Other					
Bldg. 01							
	List in the REMAF	RKS section any LSC					
	Section 18.1 and	19.1 General Requirements					
	that are not addre	ssed by the provided					
	-	ficient. This information,					
		olicable Life Safety Code or					
		tation, should be included					
	on Form CMS-256					_	
		on and interview, the facility	K 0	100	The preparation and execution	ı of	09/22/2023
		atching hardware on 2 of 5			this plan do not constitute		
		s. LSC 4.6.12.3 requires existing obvious to the public if not			admission or agreement by		
	•	le, shall be either maintained or			Timbercrest Senior Living Community that a deficiency		
		cient practice could affect staff			exists. This response is also n	ot	
	and up to 30 resider				to be construed as an admissi		
	and up to 50 resider				of fault by the facility, its	0.1	
	Findings include:				employees, agents, or other		
					individuals who draft or may b	е	
	Based on observation	on with the Maintenance Tech			discussed in this plan of		
	(MT) on 09/05/23 a	at 1:50 p.m. and 2:35 p.m., the set			correction. This plan is submit	ted	
		ors to the 300 Hall and the set			as the facility's credible allega		
	of smoke barrier do	ors to the 400 Hall were			of compliance.		
	provided with latch	ing hardware but failed to			The two doors noted to not		
		en tested. Based on interview			properly latch when closing, w	ere	
		vation, the MT agreed the			repaired. Review of the annua	l Fire	
		equipped with latching devices,			Door Inspection showed both		
	but the doors did no	of properly close and latch	I		doors to have been in working	ı	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155740	B. WING		09/05/2023	
	PROVIDER OR SUPPLIE	R OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP COD EAST ST 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 DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	re reviewed with the MT during the exit conference.		order at that time. To ensure proper functioning of the doors Director of Facility Management/designee will revisionly findings from the Fire Drill Reposumentation and report to the Safety Committee.	view port	
K 0291 SS=F Bldg. 01	duration is provid accordance with 18.2.9.1, 19.2.9.1 Based on records refailed to ensure 1 or light was tested more annually for 90 min requires functional monthly, with a min maximum of 5 weet than 30 seconds, (3 conducted annually if the emergency lip powered and (5) Winspections and test for inspection by the jurisdiction. This coresidents in the fact based on records residents records records and the second	ang of at least 1-1/2-hour ed automatically in 7.9. eview and interview, the facility of 1 battery backup emergency onthly for 30 seconds and nutes. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a eks between tests, for not less between tests, for not less between tests, for not less for a minimum of 1 1/2 hours ghting system is battery written records of visual testing shall be kept by the owner ne authority having deficient practice could affect all	K 0291	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 admissi 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 submit as the facility's credible allegate of compliance. To ensure the safety of all its residents, staff and visitors, the annual test of the battery back emergency light was performed and found in good working order the safety and the	e ted tion e c up	
	the last 12 months interview at the tim stated the annual 90	ery backup emergency light for was unavailable. Based on the of records review, the MT 0 minute testing for the battery light has not been conducted		annual check in September wa generated using the facility's w order system. The newly creat Battery-operated Emergency Lights Test Log includes	vork	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155740		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>		SURVEY LETED 5/2023	
	PROVIDER OR SUPPLIER	OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP AST 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 Committed summary report to the Committee i to determine substantial compliance.	npletion 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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Event ID:

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

	OF CORRECTION	IDENTIFICATION NUMBER 155740	ſ ′		01	COMPL 09/05/	LETED
	PROVIDER OR SUPPLIER	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	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	(over 50 square fe g. Laboratories (if Hazard - see K322 Based on observation failed to ensure 1 of	lons) brage Rooms/Spaces bet) classified as Severe 2) broand interview, the facility 1 storage rooms with large	K 03	321	The preparation and executio this plan do not constitute	n of	09/20/2023
	50 square feet was p	tible storage and greater than protected as a hazardous area. It is could affect 1 resident and			admission or agreement by Timbercrest Senior Living Community that a deficiency exists. This response is also r to be construed as an admiss of fault by the facility, its employees, agents, or other		
	with the Maintenand 1:05 p.m., the staff of storage room in the boxes of supplies ar feet making this a h room was not protect because the corridor close and latch whe at the time of observ storage room contai combustible storage feet, and the corridor self-close and latch				individuals who draft or may be discussed in this plan of correction. This plan is submit as the facility's credible allegatof compliance. Both doors to the storage area were equipped with self-close facility maintenance staff. To ensure compliance, this storagarea was added to the regular scheduled annual inspection a assigned to facility maintenant staff, and monitored by Direct Facility Maintenance/designed	atted tion ars by ge and ce or of	
	The finding was rev and the MT during to 3.1-19(b)	iewed with the Administrator the exit conference.					
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance	-					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION 01		SURVEY LETED 5/2023
	PROVIDER OR SUPPLIEF	OF THE BRETHREN HOME	STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH MANCHESTER, IN 46962				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
	in accordance with complying with the National Electric Contional Fire Alar Records of system and testing are re 9.6.1.3, 9.6.1.5, Notes 1. Based on record facility failed to main accordance with 101 Sections 19.3.4 14.3.1 states that up 14.3.2, visual insperace of the more often if requiring jurisdiction. Table must be visually in a. Control unit trought. 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 and was provided regar fire alarm system signal alarm inspection coop interview at the agreed a visual inspection.	review and interview, the sintain 1 of 1 fire alarm systems NFPA 72, as required by LSC 1.5.1 and 9.6. NFPA 72, Section aless otherwise permitted by ctions shall be performed in the schedules in Table 14.3.1, or tred by the authority having 14.3.1 states that the following spected semi-annually: ble signals actors at detectors, manual the earth detectors, smoke detectors, it iances to be performed in the semi-annual search detectors, and the semi-annual search detectors are devices in the semi-annual fire and the semi-annual fire annual fir	K 034	15	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 admiss of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this plan of correction. This plan is submas the facility's credible alleg of compliance. A task was created for a regoccurring 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 inspection in February in the facility's work order program follow the annual fire alarm inspection in August 2023 by contractor. The list of inspection in the purpose compliance. The completion these inspections is monitor the Director of Facility Maintenance/designee. The service provider contract perform the smoke detector sensitivity testing has confirm 10/3/2023 - 10/6/2023 as the dates testing will be completed.	o not sision be nitted gation ular I, to y the stion we work e of of ed by cted to med	10/06/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 09/05/2023			
	PROVIDER OR SUPPLIE	R OF THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP COD AST ST H MANCHESTER, IN 46962	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
ING		eviewed with the Administrator	ING		BAIL
	3.1-19(b)				
	facility failed to en was maintained in LSC 9.6.1.3 requir installed, tested, an with NFPA 70, Na 72, National Fire A 14.4.5 states unless sections of this Coin accordance with or more often if recipirisdiction. NFPA smoke detector ser 1 year after installations and the smoke detector ser alternate year there permitted by comp	d review and interview, the source 1 of 1 fire alarm systems accordance with LSC 9.6.1.3. es a fire alarm system to be and maintained in accordance tional Electrical Code and NFPA Alarm Code. NFPA 72, Section is otherwise permitted by other de, testing shall be performed at the schedules in Table 14.4.5, equired by the authority having A 72, Section 14.4.5.3.1 states institutely shall be checked within action. NFPA 72, 14.4.5.3.2 states institute shall be checked every eafter unless otherwise diance with Section 14.4.5.3.3. tice could affect all occupants.			
	Findings include:	view with the Maintenance			
	Tech (MT) on 09/0 documentation for test was available t at the time of recor acknowledged the	05/23 at 11:20 a.m., no a smoke detector sensitivity for review. Based on interview			
	This finding was re and MT at the exit	eviewed with the Administrator conference.			
	3.1-19(b)				

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155740	A. BU	A. BUILDING 01 CO			(3) DATE SURVEY COMPLETED 09/05/2023	
	ROVIDER OR SUPPLIEI	R DF THE BRETHREN HOME		STREET ADDRESS, CITY, STATE, ZIP COD 2201 EAST ST NORTH 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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0511	NFPA 101							
SS=E	Utilities - Gas and							
Bldg. 01	Utilities - Gas and							
		gas or related gas piping PA 54, National Fuel Gas						
	-	riring and equipment						
		PA 70, National Electric						
	•	stallations can continue in						
	service provided i							
	18.5.1.1, 19.5.1.1							
	Based on observation and interview, the facility			511	The preparation and executio	n of	09/14/2023	
		f 1 electrical panel in the 200	110	011	this plan do not constitute		09/11/2023	
		om non-authorized personnel.			admission or agreement by			
		ition states 230.62 Energized			Timbercrest Senior Living			
	parts of service equipment shall be enclosed as				Community that a deficiency			
	-	(A) or guarded as specified in			exists. This response is also r	not		
	230.62(B).				to be construed as an admiss			
	(A) Enclosed. Ener	gized parts shall be enclosed			of fault by the facility, its			
	so that they will no	t be exposed to accidental			employees, agents, or other			
	contact or shall be	guarded as in 230.62(B).			individuals who draft or may b	е		
	(B) Guarded. Energ	gized parts that are not enclosed			discussed in this plan of			
	shall be installed or	n a switchboard, panelboard, or			correction. This plan is submi	tted		
	control board and g	guarded in accordance with			as the facility's credible allega	ition		
		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	anels		
	_	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 immed	iately		
					and installed. To ensure			
	Findings include:				compliance, a regular schedu			
	n 1 ' '	Maria mat			monthly work order was creat			
		on with Maintenance Tech			and assigned to maintenance			
		at 2:15 p.m., the electrical panel			for checking all electrical pane			
		unlocked when tested. The			Health Care and Crestwood to			
	•	akers to the lights and outlets			doors are locked and locks ar	_		
		sed on interview at the time of			functional. The Director of Fac	-		
		T stated the electrical panel			Maintenance/designee will mo	אוווטוי		
	lock is broken and	needs to be replaced.			completion of work order for	ath a		
			1		compliance monthly for 3 mor	1U15	ĺ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155740	B. W	ING		09/05/	/2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD AST ST		
TIMBED	ODEST CHIIDCH C	OF THE BRETHREN HOME			H MANCHESTER, IN 46962		
TIMBER	- CHUNCITO	THE BRETTIKEN HOME		NORTI	I WANCIESTER, IN 40902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator			and report to Safety Committe		
	and MT at the exit	conference.			with a summary report to QAA		
					committee until substantial		
	3.1-19(b)				compliance has been achieve	d.	
14 0740	NEDA 404						
K 0712	NFPA 101						
SS=C	Fire Drills						
Bldg. 01							
		the transmission of a fire					
	_	simulation of emergency fire					
conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.							
		ar with procedures and is					
		re part of established					
		rills 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	19717					
		view and interview, the facility	$ _{K0}$	712	Preparation and/or execution	of	09/22/2023
		f 12 fire drills included the	K o	/12	this plan do not constitute	J1	07/22/2023
		smission of the fire alarm signal			admission or agreement by the	e	
		tation in fire drills conducted			provider that a deficiency exis		
		and 9:00 p.m. for the last 4			This response is also not to be		
		1.1.4 requires fire drills in health			construed as an admission of		
	_	nall include the transmission of			by the facility, its employees,		
	_	and simulation of emergency fire			agents or other individuals wh	0	
	conditions. This de	ficient practice affects all			draft or may be discussed in the		
	residents in the faci	lity as well as staff and			response and plan of correction		
	visitors.				This plan of correction is		
					submitted with the facility's		
	Findings include:				credible allegation of compliar	ıce.	
					In order to ensure the safety o	f its	1
	Based on record rev	view of titled " Fire Drill			residents, staff and visitors		
	Report" with the M	aintenance Tech (MT) and the			Timbercrest Senior Living		
	Administrator on 09	9/05/23 at 11:45 a.m., the fire			Community has entered an		
	drill forms had no d	locumentation of verification of			agreement with VFP, the Fire		
	transmission of sign	nal to the monitoring company			Alarm System Monitoring		
	on 4 of the fire drill	reports. Based on interview at			Company, to provide an email	and	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155740		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/05/2023	
	PROVIDER OR SUPPLIER	F THE BRETHREN HOME	2201 E	ADDRESS, CITY, STATE, ZIP COD FAST ST H MANCHESTER, IN 46962	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRIA DEFICIENCY)	DATE
	was missing docum signal transmission 4 of the fire drill rep section on the fire d scenario of the fire These findings were			text verifying the transmission the fire alarm signal to the monitoring station. The Fire D Report document was revised prompt attachment of the verification report, as well as added field for the scenario of each drill. Compliance of completing the forms will be monitored by the administrator/designee for the 3 months. Findings will be sha with the Safety Committee and summary report will be submit to QAA Committee until substantial compliance is determined.	rill to next ared d
K 0761 SS=E Bldg. 01	interview; the facili inspection and testin assemblies were con 19.1.1.4.1.1 commu fire barriers required permitted only in compartment of the permitted on the permitted on the permitted of the permitted on the p	on, records review, and ty failed to ensure annual ng of 1 of 12 fire door mpleted in accordance of LSC micating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table sected by approved, listed, semblies and fire window r accompanying hardware, s, closing devices, anchorage, nee with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not	K 0761	Preparation and/or execution this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals where discussed in the response and plan of correction. This plan of correction is submitted with the facility's credible allegation of compliant. The fire door to the oxygen rowas inspected and found to be compliance. The work order for Annual Fire Door Inspection were vised by adding door #50 (Croom). The completion of these	e ts. e fault o his on. nce. om e in or the vas

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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 <u>01</u>		COMPLETED			
		155740	B. WING			09/05/2023		
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹		2201 EA				
TIMBERCREST CHURCH OF THE BRETHREN HOME				NORTH MANCHESTER, IN 46962				
				L				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION FACH COPPECTIVE ACTION SHOULD BE			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		-	TAG			DATE	
		and a written record of the			tasks is monitored by the Direc	ctor		
	-	signed and kept for inspection		of Facility Maintenance.				
	-	80, 5.2.4.1 states fire door						
		visually inspected from both overall condition of door						
		0, 5.2.4.2 states as a minimum,						
	the following items							
	(1) No open holes or breaks exist in surfaces of either the door or frame.							
		light frames, and glazing beads						
		ely fastened in place, if so						
	equipped.	ory rustoriou in privot, it so						
		e, hinges, hardware, and						
		eshold are secured, aligned,						
		er 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	5.3.1.7.						
	(6) The self-closing	device is operational; that is,						
	the active door com	pletely closes when operated						
	from the full open p	oosition.						
	(7) If a coordinator	is installed, the inactive leaf						
	closes before the ac							
	. ,	are operates and secures the						
	door when it is in the	-						
		vare items that interfere or						
		are not installed on the door or						
	frame.							
		fications 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	ement.						
	Findings :11							
	Findings include:							
	Based on record review of the Fire Door							
		ntation with the Maintenance						
	mspection documen	nanon with the Maintenance						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			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		DROWIDERIC DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY) DA	
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 of 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		nstruction 01	(X3) DATE SURVEY COMPLETED	
		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 PREFIX TAG	(EACH DEFICIEN		PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 1:40 p.m., the generator's annunciator panel was located in the corridor by the kitchen and Rosegarden which is an area not not readily observed by personnel. Based on interview at the time of observation, the Maintenance Tech stated that they have maintenance personnel working on all shifts and working out of an area located close to the annunciator panel. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)			AU	correction. This plan is submitt as the facility's credible allegat of compliance. To ensure the safety of its residents, staff and visitors, the Timbercrest has contracted wi Votaw Electric to move the generator annunciator panel to vicinity of the Health Care nurs station which is occupied 24/7 Due to the extend of moving the panel and material needs, the contractor is not able to guarant the project to be completed wi 90 days of the citation dated 9/5/2023. Therefore a Tempor Waiver is being submitted. Unter the project is completed, the pwill be monitored twice during each shift by maintenance stated The staff tasked with the monitoring of the panel has been implemented. These checks a addition to the already occurring weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator. The completion of checks is being monitored weekly checks of the emergent generator.	tion e tith to the se's thin eary till anel ff. een een re in ng ncy daily ekly until n	DATE

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