STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/14/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00383572 and IN00389866. Complaint IN00383572 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00389866 - Substantiated. State Residential Finding related to the allegations is cited at R0045. Unrelated deficiency is cited. Survey dates: September 12, 13 and 14, 2022 Facility number: 014548 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 19, 2022	R 0000	R0000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of alleged deficiencies. The plan of correction is prepared and submitted because of the requirements under state and federal law. The attachments hereto serves to support and provide evidence of compliance with the submitted plan of correction and to ensure the facility meets the requirements under state and federal law. The facility respectfully requests paper compliance. Respectfully, Angela M Mann HFA/RCA/CNA Facility Administrator	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form			

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

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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	prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered;			

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	(B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division.			

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	(F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to ensure 2 of 2 residents reviewed for discharge and transfer rights had the appropriate state-mandated transfer and discharge paperwork completed and appropriately distributed. (Residents C and D) Findings include: 1. The clinical record for Resident C was reviewed on 9-12-22 at 11:15 a.m. Her diagnoses included, but were not limited to cerebrovascular disease, atrial fibrillation, type 2 diabetes, hypertension, stage 3 chronic kidney disease and depression. In an interview on 9-12-22 at 11:50, with the Administrator, she indicated the reason the facility discharged Resident C to a nursing home was due to "her not meeting the level of care and she required more care than we can provide." In an interview on 9-12-22 at 1:05 p.m., with the facility's Director of Nursing (DON), indicated Resident C had a note from the resident's medical provider, dated 9-7-22, the resident was now requiring a higher level of care that could no longer be provided in an assisted living level of care and would require transfer to a nursing home level of care. She indicated she was unsure if the facility sent any transfer or discharge paperwork	R 0045	R 045 IAC 16.2-5-1.2 (r6-9) Residents' Rights; Deficiency: We respectfully request paper compliance for this alleged deficiency. The Rule: Based on an interview and record review, the facility failed to ensure 2 of 2 residents reviewed for discharge and transfer rights had the appropriate state-mandated transfer and discharge paperwork completed and appropriately distributed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice and what corrective action will be taken: Facility Administrator to In-Service the DONW, (Director of Nursing & Wellness) and designated staff on the: Required use and completion of the Indiana state mandated form #49669 (R8 / 1-19) "Notice of Transfer or Discharge" Proper and timely notification to the resident or	10/20/2022

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	with the resident at the time of her discharge. "I can't really find a specific discharge note." In an interview on 9-13-22 at 10:20 a.m., with the DON, she indicated she was unaware there were any specific guidelines or paperwork that needed to be completed prior to a transfer or discharge, and did not complete the state-mandated documentation for such. She reiterated she did not know to complete the state-mandated transfer and discharge paperwork that allows for appeal if so desired. She indicated she "has not even seen any paperwork like that." 2. The clinical record for Resident D was reviewed on 9-13-22 at 10:43 a.m. Her diagnoses included, but were not limited to, signs and symptoms involving musculoskeletal system, history of acute kidney failure, dysphagia, unsteadiness on feet, generalized weakness, history of urinary tract infection and shortness of breath, hypertension, orthostatic hypotension, osteoarthritis, syncope and collapse, calcification of the aorta, dyspnea on exertion, edema, hyponatremia, magnesium deficiency, osteoporosis and age-related physical debility. In an interview on 9-12-22 at 11:50 a.m., with the Administrator, she indicated Resident D was discharged due to her requiring more care than the facility could provide. She indicated the resident's family member and power-of-attorney was very upset about this situation and wished for the resident to remain at the facility. In an interview with the Director of Nursing (DON) on 9-12-22 at 4:10 p.m., she indicated Resident D had a change of condition and was requiring more care. "I was the one who had called the daughter about her mother not meeting		designated legal representative, prior to the transfer or discharge; including the reason for the transfer or discharge in written format and in a language and manner they understand. Required transfer or discharge documentation is entered in the resident clinical record and will include the reason for transfer or discharge and the notification was given to the resident or designated legal representative. 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: The residents of the community have the potential to be affected by the alleged Deficiency Facility Administrator to In-Service the DONW and designated staff on proper and timely documentation, use of state mandated form(s) and notification requirements to the resident or designated legal representative. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Facility Administrator to review and approve the discharge or transfers of residents, when a transfer or discharge is necessary; ensuring the required clinical record documentation is complete; that the required state mandated form(s) and written notification is	

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	level of care because she was eating poorly and was needing more and more help with her care in general. I can't tell you I necessarily charted those conversations." She indicated Resident B was sent out to the hospital, related to the above health concerns, around 8-6-22, and did not return to the facility, as the hospital also determined she required skilled-level nursing care. The DON could not recall if the facility had sent any type of state-mandated transfer or discharge paperwork with the resident when she was transferred to a local hospital. In an interview on 9-13-22 at 10:20 a.m., with the DON, she indicated she was unaware there were any specific guidelines or paperwork that needed to be completed prior to a transfer or discharge. She reiterated she did not know to complete the state-mandated transfer and discharge paperwork that allows for appeal if so desired. She indicated she "has not even seen any paperwork like that." As a part of Resident D's "Resident Rights," document, signed 2-23-22 by Resident D's power-of-attorney, the following was located, "The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, 'interfacility transfer and discharge' means the movement of a resident to a bed outside of the licensed facility...(3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...(5) When the facility proposes to transfer or discharge a resident under any		completed and distributed to the resident or designated legal representative in a proper and timely manner. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; A CQI monitoring tool will be implemented, on or before 10/20/2022, to ensure compliance is maintained; the Facility Administrator will monitor daily for 2 weeks; weekly for 4 weeks, then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds compliance has been met. By what date be completed: 10/20/2022	

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	circumstances...the resident's clinical records must be documented...(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident's legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only. (v) The person or agency responsible for the resident's placement, maintenance, and care in the facility...(vii) The resident's physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident's clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when...(D) an immediate transfer or discharge is required for the resident's urgent medical needs. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, 'You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a			

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	hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached...(10) If the resident appeals the transfer or discharge, the health facility may not transfer or discharge the resident within thirty-four (34) days after the resident receives the initial transfer or discharge notice..." In an interview on 9-14-22 at 2:18 p.m., the Regional Corporate Support staff, she indicated she was unable to locate any particular policies or procedures related to transfer or discharge. This Residential tag relates to Complaint IN00389866. 2-5-1.2(r)(6)			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review, the facility failed to ensure staff were wearing any type of facial coverings/masks. This deficient practice has the potential to adversely affect all 42 residents, related to Covid-19.	R 0406	**R 406 410 IAC 16.2-5-12(a) Infection Control Offense** **(a) The facility must establish**	10/20/2022

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	Finding include: During entrance on 9-12-22 at 10:05 a.m., an observation was conducted in which none of the staff were wearing any type of facial mask at this time. As of 11:00 a.m., on the same date, all of the staff were observed without facial coverings. In an interview on 9-12-22 at 10:15 a.m., with the Administrator, she indicated, due to this facility being an Assisted Living facility, "staff are not required to wear facial masks if they are fully vaccinated." In an interview on 9-12-22 at 10:45 a.m. with the Director of Nursing (DON), she indicated she follows all information provided to her by her corporate staff, specific to Covid guidelines. She indicated she does not have access to Indiana State Department of Health's Long Term Care's newsletter, but the Administrator does receive the newsletter. The DON indicated she has been at this facility for approximately 3 months and is learning the regulations. She indicated the facility recently had 1 resident who had been Covid-positive last week, but had tested negative as of this morning. She indicated no other residents or staff have tested positive in a while (timeframe unclear.) She indicated the resident did not come out of his room. During a tour of the facility, the resident who had recently tested Covid-positive did have a red stop sign posted on his door with information about not entering the room without appropriate personal protective equipment and the personal protective equipment required for entry was available outside of his room door. An observation on 9-12-22 at 2:10 p.m., indicated		**and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.** **Rule is not met: Based on observation, interview and record review, the facility failed to ensure staff were wearing any type of facial covering/masks. This deficient practice has the potential to adversely affect all 42 residents, related to Covid-19.** **I respectfully disagree with the alleged finding of this rule and request a paper compliance Informal Dispute Resolution.** **It is the practice of the facility to follow the guidance and protocol of the CDC and the ISDH as it relates to Covid-19. In view of the written guidance and protocol of the CDC and the ISDH, there exists no mandate for facial covering/masks by staff. In further researching for the specific state and federal regulations as it pertains to face coverings /mask mandates guidance and protocol, I contacted and spoke with a representative from the CDC, the office of the Governor for**	

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	none of the staff were wearing any type of facial coverings. An observation and interview with the DON on 9-12-22 at 3:05 p.m., indicated the DON was wearing a surgical mask. She was requesting information on the wearing of facial coverings for the nursing staff at this time. She indicated she would plan to wear a surgical mask for any interactions with residents until further detailed information could be obtained and would encourage her staff to do the same. Upon entry to the facility on 9-13-22 at 9:00 a.m., an observation of mask-wearing by staff when within six feet of residents indicated approximately 50 percent of staff were wearing any type of facial covering. Random observations were made throughout the day with similar outcomes. Random observations were conducted on 9-14-22 of mask-wearing by staff when within six feet of residents indicated approximately 50 percent of staff were wearing any type of facial covering. On 9-14-22 at 2:50 p.m., the Administrator provided a copy of policy and procedure, entitled, "Covid-19." This policy in its entirety was indicated to be the current policy utilized by the facility. It indicated, "Procedure: Follow the guidance and protocol of the Centers of Disease Control (CDC) and the Indiana State Dept. of Health (ISDH) as it relates to Covid-19." This policy's review and approval date was identified as 3-2021. 2-5-12(a)		**the State of Indiana, Eric Holcomb and the office of the Indiana Attorney General, Todd Rokita. All confirmed there exists no face covering/mask mandate on the federal or state level.** **During an interview conducted by the surveyor with the DON, the DON shared that we had (1) resident who had been in isolation due to a positive COVID-19 test, the resident had just tested negative earlier that morning and was released from isolation. This was a vaccinated resident, who was in isolation for 10 days the resident displayed no sign, symptoms or fever for the previous 72 hours. Appropriate Universal Precaution PPE was available just outside his apartment door and proper isolation signage was placed on the door at the time of his positive test.** **It is the practice of the facility to follow Universal Precautions as it relates to Infection Control, i.e. donning appropriate PPE when caring for a resident(s) who has tested positive for COVID-19 and/or has been diagnosed with an infectious disease.** The facility will continue the current practices that satisfy the	

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			requirements of the governing regulations. The facility maintains documentation that satisfies the requirement of the governing regulation **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice.** The residents of the facility have the potential to affected by the alleged deficient practice. There were no residents required to be in isolation on the days of the survey and no known residents requiring masking. It is the practice of this facility and in compliance with the CDC and ISDH guidelines to allow individual rights to residents and staff regarding face coverings/masks. The facility will continue the current practices that satisfy the requirements of the governing regulations. The facility maintains documentation that satisfies the requirement of the governing regulation How the facility will identify other resienets having the potential to be affected by the same alleged deficient practice and what corrective action will be taken It **is the practice of the facility to follow the guidance and**	

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			protocol of the CDC and the ISDH as it relates to Covid-19. It is the practice of the facility to follow Universal Precautions as it relates to Infection Control, i.e. donning appropriate PPE when caring for a resident(s) who has tested positive for COVID-19 and/or has been diagnosed with an infectious disease. It is the practice of this facility and in compliance with the CDC and ISDH guidelines to allow individual rights to residents and staff regarding face coverings/masks. The facility will continue the current practices that satisfy the requirements of the governing regulations. The facility maintains documentation that satisfies the requirement of the governing regulation What measures will be put into place or what systemic changes the facility will make to ensure that the alleged practice does ot recur. It **is the practice of the facility to follow the guidance and protocol of the CDC and the ISDH as it relates to Covid-19. It is the practice of the facility to follow Universal Precautions as it relates to Infection Control, i.e. donning appropriate PPE when caring for a resident(s) who has tested**	

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

(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
			positive for COVID-19 and/or has been diagnosed with an infectious disease. It is the practice of this facility and in compliance with the CDC and ISDH guidelines to allow individual rights to residents and staff regarding face coverings/masks. The facility will continue the current practices that satisfy the requirements of the governing regulations. The facility maintains documentation that satisfies the requirement of the governing regulation How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put in place A CQI monitoring tool will be implemented, on or before 10/20/2022, to ensure compliance is maintained; the Facility Administrator will monitor daily for 2 weeks, weekly for 4 weeks and then monthly for 3 months to ensure compliance is maintained **By what be completed:** 10/20/2022 **I respectfully request an IDR paper compliance.**	