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	08/15/2018

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 7, 8, 9, 10, 13, 14, and 15, 2018. Facility number: 000448 Provider number: 1555740 AIM number: 100275140 Census Bed Type: SNF/NF: 59 Residential: 122 Total: 181 Census Payor Type: Medicare: 1 Medicaid: 13 Other: 45 Total: 59 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 22, 2018.	F 0000	Timbercrest Senior Living Community aims to provide the highest quality resident centered care to those living in our community. Timbercrest a desk review for plan of corrections included with this survey.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The			

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

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	facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;			

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	(ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility			

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	closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to provide a written Notice of Transfer for 1 of 2 residents reviewed for hospitalization (Resident 33). Findings include: During an interview, on 8/7/18 at 11:31 a.m., Resident 33 indicated she had been out to the hospital within the previous few months for treatment to rule out a heart attack. Review of Resident 33's clinical record was completed on 8/10/18 at 10:15 a.m. The record indicated she had been hospitalized from 4/3/18 through 4/5/18. There was no record of a Notice of Transfer being offered to the resident or their representative for the hospitalization. During an interview, on 8/13/18 at 2:04 p.m., the Social Service Director indicated she could not locate information regarding the resident being given a Notice of Transfer for her April 2018 hospitalization. Review of a current, undated policy, titled "Transfer and Discharge from Timbercrest Policy," provided by the Administrator on 8/14/18 at 11:13 a.m., indicated Timbercrest will provide a	F 0623	Resident's POA and daughter was notified of resident not receiving the notice of transfer or discharge. Timbercrest offered to complete and provide, daughter indicated that was not necessary. Grievance form was completed. All transfer and discharges in past 6 months were audited, there were four times the notice of transfer or discharge was not provided. Two were voluntary discharges and the other two were transfers to the hospital. Resident or responsible party were contacted and notified of error. In each incidence, Timbercrest offered to complete and provide. One of the four accepted the offer. Education was provided to nursing staff regarding the updated observations and the importance of the Notice of Transfer or Discharge. Discharge plan of care and transfer observations were modified so "Yes", indicating Transfer or Discharge notice was provided, before observation can be completed.	09/14/2018

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	written notice to the resident and resident representative in a manner and language in which it is understood before the resident is transferred or discharged. 3.1-12(a)(6)(A)		Director of Nursing or a member of the interdisciplinary team will audit all residents who transfer and discharge, within 72 hours, to ensure notice of transfer or discharge has been provided. Audit results will be discussed by the interdisciplinary team weekly until 95% compliance is achieved for 8 consecutive weeks. Audits will then be conducted weekly for 3 months, until 95% compliance is achieved. Monthly audits will be conducted for a period of no less than an additional 7 months. If 95% compliance is not maintained with monthly audit, then audits will return to weekly. Audit results will be provided to the QAA committee.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and			

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	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop careplans related to Anticoagulant usage and pain for 2 of 49 residents whose careplans were reviewed (Resident 47 and Resident 4). 1. On 8/9/18 at 4:06 p.m., Resident 47's clinical record was reviewed. Diagnoses included but were not limited to: unspecified atrial flutter. Resident 47's July 2018, physician orders included the following: On 7/12/18 (start date), the resident was ordered	F 0656	Care plans were added for identified residents. Audit was completed to ensure all resident's had a pain care plan and care plans were present for residents receiving anticoagulant therapy. As the audit was completed, care plans were added as necessary. Education was provided to nurses regarding the importance of care plans. New orders will be discussed by the interdisciplinary team (IDT) 4 out of 7 days to	09/14/2018

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	Eliquis (a medication to decrease the chance of blood clots forming) 5 mg take 1 tablet twice a day. Records indicated that Eliquis was administered 7/12/18, 7/13/18, 7/14/18, 7/15/18, 7/16/18, 7/17/18, 7/18/18, 7/19/18 and 7/20/18. Resident 47's clinical record lacked documentation of a care plan related to the medication Eliquis. The Wolters Kluwer Nursing 2015 Drug Handbook, 36th edition, copyright 2017, Nursing Consideration Alert for Eliquis included but are not limited to: "Evaluate signs and symptoms of excessive bruising and bleeding." On 8/13/18 at 2:17 p.m., the Director of Nursing (DON) indicated if a resident was taking Eliquis, a care plan should have been developed, however, Resident 47 did not have a care plan for the medication. 2. Review of Resident 4's clinical record was completed on 8/09/18 at 8:57 a.m. Diagnoses included, but were not limited to, other osteoporosis without current pathological fracture, low back pain, acute pain due to trauma, Alzheimer's disease with late onset, history of falling. Physicians order indicated tramadol (pain medication) 50 milligram (mg), one tablet, every six hours was started on 4/18/18 and start date for Tylenol (pain medication) 325 mg, two tablets, three times a day on 3/13/18. Resident 4's clinical record lacked a careplan for pain.		ensure care plans are present. IDT will review all resident's care plans upon admission and with each change in condition, to ensure all residents have up to date care plans for pain and anticoagulant (as needed). Director of Nursing or a member of the interdisciplinary team will audit all residents during MDS window, to ensure notice presence of pain and anticoagulant (as needed) care plans. Audit results will be discussed by the interdisciplinary team weekly until 95% compliance is achieved for 8 consecutive weeks. Audits will then be conducted weekly for 3 months, until 95% compliance is achieved. Monthly audits will be conducted for a period of no less than an additional 7 months. If 95% compliance is not maintained with monthly audit, then audits will return to weekly. Audit results will be provided to the QAA committee.	

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	During an interview, on 8/14/18 at 8:50 a.m., Employee 21 indicated resident's pain medication was effective and resident does not complain of pain. She was achy prior to tramadol and Tylenol regimen. She received tramadol at 6:00 a.m. to help her get going in the morning, she is her frequent faller. During an interview, on 8/14/18 at 1:42 p.m., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON indicated there was not a careplan for pain prior to record review, ADON indicated there should have been a careplan just for pain. 3.1-35(a) 3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to assess and monitor a resident's medical condition and failed to notify the physician following a significant weight gain for 1 of 2 residents reviewed for change of condition (Resident 39). Findings include: Review of Resident 39's clinical record was	F 0684	Physician was notified of resident's gain weight. No new orders were received at the time of notification. Weights for all residents with CHF were audit to ensure, physician had been notified of weight gains. Weight policy was updated to include physician notification. Nursing staff were educated on	09/14/2018

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	completed on 8/8/18 at 9:31 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), transient ischemic attack (TIA), and cardiac arrhythmia. He had current physician orders for weekly weights for CHF, notify physician of a weight gain or loss of five pounds or more. His current medications included, but were not limited to, bumetanide 2 mg (water pill) daily and spironolactone 50 mg (water pill) daily. A 7/4/18, quarterly, Minimum Data Set (MDS) assessment indicated he was moderately cognitively impaired and required extensive assistance for ADLs and mobility. He had a current careplan problem of CHF, reviewed/revised on 8/6/18. Interventions included keeping the head of bed elevated 30-40 degrees, weighed weekly, and report any significant increase to MD (physician). Review of the resident's weights indicated the following: 7/2/18- 192 pounds 7/9/18- 194 pounds (+2lbs from initial July weight) 7/16/18- 194 pounds 7/23/18- 197 pounds (+5lbs from initial July weight) 7/30/18- 195 pounds 8/1/18- 224 pounds (+32 lbs from initial July weight) 8/2/18- 206 pounds 8/6/18- 205 pounds 8/13/18- 205 pounds Review of Progress Notes and Observations indicated the following:		new policy. Director of Nursing or a member of the interdisciplinary team will audit for notification for all residents with weight gains, as described in updated policy. Audit results will be discussed by the interdisciplinary team weekly until 95% compliance is achieved for 8 consecutive weeks. Audits will then be conducted weekly for 3 months, until 95% compliance is achieved. Monthly audits will be conducted for a period of no less than an additional 7 months. If 95% compliance is not maintained with monthly audit, then audits will return to weekly. Audit results will be provided to the QAA committee.	

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A 7/30/18 weekly summary indicated he had 1+ edema (swelling) to his bilateral legs.

An 8/6/18 weekly summary indicated 1 to 2+ edema to his bilateral legs.

On 8/13/18, he had a noted weight gain of 6.8% in 30 days. His lungs were clear, with his lower lobes diminished. He had 1+ to 2+ edema to his bilateral legs. His physician was notified of the weight gain.

There was no record of the physician being notified of any other weight gain in August 2018, until 8/13/18.

During an interview, on 8/13/18 at 11:35 a.m., LPN 34 indicated the physician should be notified of any weight loss or gain of five pounds for Resident 39, who was weighed weekly on Mondays. She was not able to identify any physician notification of the weight gain in August until 8/13/18.

During an interview, on 8/13/18 at 1:15 p.m., the DON indicated the 7/30/18 was a weekly weight and the 8/1/18 was a monthly weight, so the resident wasn't re-weighed until 8/2/18, which was lower but still more than a five pound weight gain. On 8/6/18, they went back to weekly weights, so the nurse did not notify the physician of the weight gain due to the previous weight having been within the parameters. The facility policy didn't allude to physician notification on weekly, just for a 5% weight change in a month and a 10% weight change for a six month period.

Review of a current facility policy, titled "WEIGHT AND HEIGHT," revised 4/2015 and

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	provided by the DON on 8/14/18 at 8:58 a.m., indicated residents with CHF would be weighed weekly and would be re-weighed if there was a five pound weight change. 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were properly stored and labeled for 1 of 5 medication carts (Crestwood hall cart).	F 0761	Medications without open dates where discarded. All treatment carts were audited to ensure all medications had open	09/14/2018

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	Findings include: On 8/9/18 at 10:31 a.m., during observation of Crestwood hall medication cart accompanied by LPN 11 the following was observed: a. Travatan Z drops 0.004% (an eye drop to decrease the pressure in the eye) did not have an open date on it. b. Nasacort (a nasal spray) 55 micrograms/spray did not have an open date on it. c. Nitroglycerin sublingual (under the tongue) 0.4 milligram did not have an open date on it. On 8/9/18 at 11:00 a.m., Licensed Practical Nurse (LPN) 11 indicated that all medications when opened should be dated with an open date. Review of a current policy, titled "Administration Procedures for all Medications," effective 7/2012 and provided by the Assistant Director of Nursing (ADON) on 8/14/18 at 1:58 p.m., indicated the following: " ...8) When opening a multi-dose container, place the date on the container of injectable medications, eye/ear drops, nasal sprays, and specific medications where stability is based on the date opened per the package guidelines ...." 3.1-25(j)		dates. No other treatment medications without open dates were found. Nursing staff were re-educated on importance of labeling medications with open dates. Cart audit schedule was modified to allow better implementation with normal workflow. Director of Nursing or a member of the interdisciplinary team will review treatment cart audit record 4 out of 7 days a week. Additionally, random cart audits will be conducted by the Director of Nursing or designee. Audit (regular and random) results will be discussed by the interdisciplinary team and random cart audits conducted weekly until 95% compliance is achieved for 8 consecutive weeks. Audit (regular and random) reviews will then be conducted weekly for 3 months, until 95% compliance is achieved. Monthly audits (regular and random) will be conducted for a period of no less than an additional 7 months. If 95% compliance is not maintained with monthly audit, then audits will return to weekly. Audit results will be provided to the QAA committee.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	155740	A. BUILDING 00 B. WING	08/15/2018

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure hygienic storage of resident care items and labeling of chemicals for 2 of 2 central tub rooms. (200 hall and Crestwood Unit) Findings include: 1. During an initial tour of the Crestwood Unit, on 8/7/18 at 10:36 a.m., the following was observed: a. A cabinet contained, but was not limited to, two tubes of skin repair, one bottle of Suave shampoo, one bottle of nourishing skin cream, one bottle of	F 0880	Items were removed and discarded. Cabinet on 200 hall bathing room was removed and locks were placed on the cabinet in Crestwood, so items cannot be stored in bathing rooms. Staff were re-educated that resident's personal items need to be stored in their bathroom. Bathing rooms will be checked/audited daily by nurse on duty.	09/14/2018

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	VO5 conditioner. None of the items had resident identifiers on them, and were all partially used. b. A drawer contained, an opened package of wipes and an opened box of Dove bar soap. Neither had resident identifiers on them and were partially used. c. A lower cabinet contained, an unlabeled spray bottle containing a yellow colored liquid. During an interview, with Employee 27, on 8/07/18 at 10:43 a.m., indicated she does not know who the items belong to and that they are used for everybody. The wipes are charged to the facility, and she thought the unlabeled bottle was disinfectant. During an interview, with Employee 21, on 8/07/18 at 2:49 p.m., indicated the wipes and bar soap are to be resident specific. During an interview, on 8/13/18 at 1:14 p.m., with Director of Nursing (DON), she indicated they do not have a policy for co-horting due to the fact residents bathe in their own personal rooms. 2. During a random observation of the 200 hall central tub room, on 8/13/18 at 8:52 a.m., the following was observed: a. A cabinet next to the tub contained, but was not limited to, a 3 ounce bottle of antifungal powder with an expiration date of 8/2017, a bottle of no rinse shampoo, two spray bottles of body wash, a bottle of shaving cream, a tube of calazime, a pair of nail clippers, two blue soap containers containing a bar of soap, one yellow soap container containing a bar of soap and an orange stick. None of the items had resident		Director of Nursing or a member of the interdisciplinary team will review check/audit record 4 out of 7 days a week. Additionally, random checks will be conducted by the Director of Nursing or designee. Check/audit (regular and random) results will be discussed by the interdisciplinary team and random cart audits conducted weekly until 95% compliance is achieved for 8 consecutive weeks. Check/audit (regular and random) reviews will then be conducted weekly for 3 months, until 95% compliance is achieved. Monthly review of checks/audit (regular and random) will be conducted for a period of no less than an additional 7 months. If 95% compliance is not maintained with monthly review, then audits will return to weekly. Audit results will be provided to the QAA committee.	

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	identifiers on them, and were all partially used. b. On the top of the central tub was a pair of nail clippers and an emery board with no resident identifiers on them, and they were partially used. During an interview with Employee 25, on 8/13/18 at 8:59 a.m., he indicated the shower room should be closed and locked. He would not be able to tell whose personal items were in the cabinet. During an interview, on 8/13/18 at 1:14 p.m., with Director of Nursing (DON), she indicated they do not have a policy for co-horting due to the fact residents bathe in their own personal rooms. 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: August 7, 8, 9, 10, 13, 14,15, 2018 Facility number: 000448 Residential Census: 122 Timbercrest Church of the Brethren Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on August 22, 2018.	R 0000	Timbercrest Senior Living Community aims to provide the highest quality resident centered care to those living in our community. Timbercrest a desk review for plan of corrections included with this survey.	