DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING -- B. WING	09/28/2018

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/28/18 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Emergency Preparedness survey, Timbercrest Church of The Brethren Home was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 65 and had a census of 61 at the time of this survey. Quality Review completed on 10/02/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	It is, and always has been the intent of Timbercrest that our building and practices are compliant with the Life Safety Code. Timbercrest requests desk review/paper compliance for plan of correction submitted for Life Safety Code survey exiting on 9/28/18	
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants.	E 0024	It is, and always has been the intent of Timbercrest to keep its residents safe and provide for their needs in times of disasters and emergencies. To this effect Timbercrest will work together with local, state and federal agencies. Corrective action was taken immediately by 1. conversation with Wabash County Emergency Management Deputy Manager;	10/28/2018

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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	Findings include: Based on record review with the Maintenance Director on 09/28/18 at 9:40 a.m., the facility's Emergency Preparedness plan provided did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Maintenance Director searched through the plan and stated the plan did not address the use of volunteers in an emergency.		2. drafting policy addressing the Use of Volunteers; and 3. including it in the Timbercrest Emergency Response Plan Manual. Compliance Date: 10/28/18. Timbercrest requests desk review/paper compliance for plan of correction submitted for E0024	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/28/18 at 10:15 a.m., the facility's Emergency Preparedness plan provided did not address the role of the LTC facility under a waiver declared by the Secretary. Based on an interview at the time of records review, the Maintenance Director stated the policy for the role of the LTC facility under a waiver declared by the Secretary could not be found.	E 0026	It is and always has been the intent of Timbercrest to keep its residents safe and cared for during and after any emergency or disaster and when necessary Timbercrest will request to operate under the authority of the 1135 Waiver. To this effect 1. Policy addressing 1135 Waiver written; and 2. Policy included in Timbercrest Emergency Response Plan manual. Compliance Date: 10/28/18. Timbercrest requests desk review/paper compliance for plan of correction submitted for E 0026.	10/28/2018
E 0037 SS=F Bldg. --	Based on record review and interview, the facility	E 0037	It is and always has been the	10/28/2018

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	failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings Include: Based on record review with the Administrator and Maintenance Director on 09/28/18 at 09:55 a.m., the facility did not provide documentation of initial or annual emergency preparedness training for staff. Based on interview at the time of records review, the Administrator and Maintenance Director stated initial or annual training has not been conducted for staff on the complete emergency preparedness program.		intent of Timbercrest to be in compliance with the Emergency Preparedness requirements and as such have its staff, volunteers and contractors to be informed about its specific means to work trough emergencies and disasters. Identified need for initial and annual training was addressed by: 1. Notification of all staff, volunteers and contractors to familiarize and be knowledgeable of content and purpose of TC Emergency Response Manual by 10/21/18. 2. Development of Post Test specific to TC Emergency Response Plan Manual. 3. Education of new hires on the Emergency Response Plan as part of their onboarding. 4. Annual Training scheduled to occur annually hereafter addressing Timbercrest specific identified emergencies, hazards and disasters. Compliance Date: 10/28/18. Timbercrest requests desk review/paper compliance for plan of correction submitted for E 0037.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).	K 0000	It is, and always has been the intent of Timbercrest that our building and practices are compliant with the Life Safety	

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	Survey Date: 09/28/18 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Life Safety Code survey, Timbercrest Church of The Brethren Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and areas open to the corridor. Battery operated smoke detectors were installed in the resident rooms on the 100, 200, 300 and 400 halls. The facility has a capacity of 65 and had a census of 61 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage. Quality Review completed on 10/02/18 - DA		Code. Timbercrest requests desk review/paper compliance for plan of correction submitted for Life Safety Code survey exiting on 9/28/18	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of			

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	Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to ensure 1 of 1 cooking facilities protected according to NFPA 96 per 9.2.3 was not open to the corridor. This deficient practice could affect over 30 residents in the main dining room Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/28/18 at 11:30 a.m., the two doors form the kitchen to the dining room were equipped with latching devices but did not latch into the frames when tested. This condition left the kitchen open to the corridor. Based on interview at the time of observation, the Maintenance Director stated the latches were stuck in the open position and would need to be fixed. 3.1-19(b)	K 0324	It is and always has been the intent of Timbercrest that our facilities doors are functioning properly at all times, and tested and maintained in proper working order. Immediate action was taken to address the identified problem by ordering the necessary parts to repair this door. Compliance Date: 10/28/18. Timbercrest requests desk review/paper compliance for plan of correction submitted for K 0324.	10/28/2018

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. NFPA 101 2012 edition 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC 8.5. 8.5.2.2 States smoke barriers required by this code shall be continuous from outside wall to outside wall, from floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 Requires penetrations for cable, conduit, pipe, or wire...of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. This deficient practice 30 residents in three smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/27/18 between 12:40 p.m. and 1:00 p.m. the following	K 0372	1. It is and always has been the intent of Timbercrest that all areas of health care occupancy are separated and maintained to ensure 2 hours of fires resistance. Timbercrest issued a work order for holes to be patched. 2. All other fire barriers were inspected during the Life Safety survey process, no other areas of concern were identified. 3. Maintenance staff educated on the policy and process for fire walls and doors being in proper order. 4. Checking smoke/fire barriers on monthly preventative maintenance schedule. 5. The Director of Maintenance or designee will review preventative maintenance work orders for completeness. 6. Concerns will be brought to the	10/28/2018

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	smoke barrier walls had unsealed penetrations: a) Above the ceiling tiles of the 200 hall smoke barrier wall there were two unsealed quarter inch penetrations around pipes. b) Above the ceiling tiles of the 300 hall smoke barrier wall there were three unsealed quarter inch penetrations around a pipe, a wire and a conduit. Based on interview at the time of observation, the Maintenance Director provided and agreed to the measurements of the unsealed penetrations. 3.1-19(b)		attention of Timbercrest QAPI - safety meeting. Preventative maintenance task will be ongoing for no less than three years. 7. Compliance Date: 10/28/18. Timbercrest requests desk review/paper compliance for plan of correction submitted for K0372	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			
	Based on observation, record review, and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department	K 0711	1. It is and always has been the intent of Timbercrest that its Fire Safety Plan provide complete information to enable staff to respond and to move residents to safe locations in case of a fire emergency. 2. The need for inclusion of a map depicting fire walls and smoke barriers was addressed	10/28/2018

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	(4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Director on 11/27/17 at 10:11 a.m., the following information was missing from the provided Fire Safety Plan: a) The facility provided information indicating to evacuate beyond smoke/fire barriers, but the fire safety plan did not address which doors were or were not part of a fire/smoke wall. Based on observation during a tour of the facility with the Maintenance Director between 11:30 a.m. and 1:00.p.m., there were four cross corridor doors in the facility that were a part of a fire/smoke barrier and a separation door to memory care that was not a complete smoke or fire barrier which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. b) The fire safety plan did not address the use of the K-class fire extinguisher located in the kitchen. Based on interview during records review and observation, the Maintenance Director agreed there the plan did not address the use of the K-class fire extinguisher and the location of the smoke/fire barriers. 3.1-19(b)		immediately and has been added to the Fire Events section of the Timbercrest Emergency Response Manual. 3. Although, the K class fire extinguisher is and was present during the time of the Life Safety Code survey, the K class fire extinguisher was not listed in the Fire Event Section of the Emergency Response Manual; This has been addressed immediately by adding this information on page 180 and 181 in said manual. 4. During the Life Safety Survey no other areas of concern were identified. 5. Timbercrest QAPI - Safety Committee will annually review and update the Emergency Response Manual as needed. 6. Compliance Date: 10/28/18 Timbercrest requests desk review/paper compliance for plan of correction submitted for K0711.	
K 0761 SS=E				

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Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual testing of 3 of 3 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 40 residents. Findings include: Based on record review with the Maintenance Director on 09/28/18 at 9:30 a.m., no annual inspection of the fire door assembly that separated health care from assisted living and the two stair doors that protect the basement form health care were available for review. Based on observation during the tour between 11:00 a.m. and 12:40 p.m., there was a fire door assembly in the 400 hall that was in an occupancy separation two hour fire barrier and there were two vertical openings protected with a two hour barriers. Based on interview at the time of records review, the Maintenance Director stated an annual inspection was not conducted for the fire door	K 0761	1. It is and always has been the intent of Timbercrest that our facilities fire doors are maintained and tested. 2. All other doors were inspected during the Life Safety Code survey process, no other areas of concern were identified. 3. A certified Door Inspection Contractor has been contacted and was scheduled to perform the annual inspection on all smoke and fire doors of the Health Care Center. 4. Compliance Date: 10/28/18 Timbercrest requests desk review/paper compliance for plan of correction submitted for K 0761.	10/28/2018

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	assemblies in the last year and stated the aforementioned doors were in a two hour fire barrier. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips that were used for patient-care-related electrical equipment (PCREE) met UL 1363A or UL 60601-1. This deficient practice could affect up to 2 residents one room.	K 0920	1. It is and always has been the intent of Timbercrest that power strips and electrical cords are not used as substitute for fixed wiring or for use with patient care related electrical equipment in its Health	10/28/2018

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	Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/28/17 at 10:39 a.m., in room 406 an oxygen concentrator was plugged into and supplied power by a power strip that did not meet UL 1363A or UL 60601-1. Based on interview at the time of observations, the Maintenance Director agreed that PCREE was plugged in to power strips that were not rated at UL 1363A or UL 60601-1. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 power strips plugged into the other were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 10 outside the conference office. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/28/17 at 10:49 a.m., in room 103 one power strip was providing power to another power strip. Based on interview at the time of observation, the Maintenance Director acknowledged one power strip was plugged into another power strip. 3.1-19(b)		Care. 2. The identified power strips were removed immediately and the patient-care-related electrical equipment was plugged into its proper and outlet. 3. A monitoring protocol involving all health care staff has been initiated by educating each staff member to the Policy regarding Electrical Cords and Power Strips. 4. The Director of Maintenance or designee will address need for more electrical outlets in t Health Care and Crestwood by conducting a walk through. 5. Compliance Date: 10/28/18 Timbercrest requests desk review/paper compliance for plan of correction submitted for K-0920.	