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	07/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 19, 20, 21, 22, 25 and 26, 2016. Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census bed type: SNF/NF: 53 Residential: 134 Total: 187 Census payor type: Medicare: 4 Medicaid: 10 Other: 39 Total: 53 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on August 1, 2016.	F 0000	Timbercrest requests desk review/paper compliance for stated deficiencies.	

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

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician orders were followed related to insulin administration and blood pressure parameters. (Resident #2, #11 and #65) Findings include: 1. Review of Resident #2's clinical record began on 7/19/16 at 2:26 p.m. Resident #2 had current physician's orders for, but not limited to, Novolog (insulin) 10 units with meals and for sliding scale, based on blood sugar readings. There were no prescribed parameters to hold administration of the routine insulin. Diagnoses included, but were not limited to, dementia with behavioral disturbance, age-related debility, chronic kidney disease, and diabetes. Resident #2 had a quarterly MDS (Minimum Data Set) assessment, dated 6/29/16, which indicated he was moderately cognitively impaired and required extensive assist for ADLs and locomotion.	F 0282	1.F-282 It is, and always has been the intent ofTimbercrest that all residents receive care that is provided by qualifiedindividuals in accordance to each resident's written plan of care. Immediatecorrective action taken to ensure resident receive care that is provided byqualified individuals is physician clarification was obtained for orders thatwere identified as concerns for residents 2, 11 and 65. 2.An audit of all residents receiving cardiacmedications (alpha and beta adrenergic blocking agents, calcium channelblockers, and hypotensive agents) and/or insulin. Audits were conducted in twosteps: 1. Residents receiving medications 2. Orders with hold parameters werechecked to ensure clarity. Audits indicated primarily one specific QualifiedMedication Aide administering medications, incidents were error where found.Director of Nursing provided one on one education with Qualified MedicationAide. 3.Timbercrest implemented the following practicesto ensure residents would not effected by unclear orders in the future: 1.	08/25/2016

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	Review of May 2016 medication administration records indicated Resident #2's 4 p.m. dose of Novolog 10 units was not administered on 5/13 and 5/19. A note indicated the 5/19 dose was held due to the resident's blood glucose of 96 mg/dL (milligrams per deciliter). Review of June 2016 medication administration records indicated Resident #2's 4 p.m. dose of Novolog 10 units was not administered on 6/4, 6/10 and 6/13. A note indicated the 6/10 dose was held due to the resident's blood glucose of 130 mg/dL. Review of July 2016 medication administration records indicated Resident #2's 4 p.m. dose of Novolog 10 units was not administered on 7/12, 7/17, and 7/21. The medication records indicated RN #39 had held the administration of all but one of the doses. During an interview, on 7/25/16 at 3:14 p.m., RN #39 indicated she would hold Resident #2's routine Novolog insulin if his blood sugar was under 150, based on her nursing judgement. She indicated she felt that his intakes varied and she did not feel he should receive the Novolog if his blood glucose was under this level. She further indicated the hospice nurse		Atask was added to our EMAR system titled “hold parameter reviewed” that must beaddressed prior to the medication being administered; 2. All insulin orders nowhave “MD notified” as a task. Stafflicensed to administer medications (Qualified Medication Aide; LicensedPractical Nurse; and Registered Nurse) were assigned in services (via ourelectric in servicing system) on Medication Pass and Medication Administration:Avoiding Common Errors, to be completed by August 25, 2016. 4.The Director of Nursing or designee will auditmedication administration records for cardiac medications and insulin to ensurephysician orders are carried out as prescribed. Audits will be conducted weeklyfor two weeks, then every other week for two weeks then monthly for 3 months,if any audit should be reveal a compliance rate of less than 95%, auditing willreturn to a weekly basis until 95% is obtained. Audit results will be reported through Timbercrest’s QAPI process duringthe resident at risk weekly meeting and at the quarterly clinical meeting. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review/ paper compliance for plan of correction submitted for F282.	

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	would, at times, tell her to hold the insulin if his glucose was under 150, but there was no physician's order to do so. She also indicated she did not notify the physician when she would not administer the insulin. 2. Resident #11's clinical record was reviewed on 7/20/2016 at 10:12 a.m. Resident #11 had current diagnoses which included, but were not limited to, hypertension, Alzheimer's disease and Vascular dementia. Resident #11 had a, 4/20/2016, quarterly, Minimum Data Set (MDS) assessment which indicated she was severely cognitively impaired and mildly depressed. Resident #11 had a current physician order for Atenolol (used to treat high blood pressure) 25 mg. "Special instructions: Hold for SBP [systolic blood pressure] < [less than]110" once a day at 9:00 a.m. This order originated 3/8/2015. The Medication Administration Record (MAR) for Resident #11 provided by the DON on 7/22/2016 at 7:58 a.m., indicated the following: On 2/13/2016 Resident #11's blood pressure was 103/65 when Atenolol was administered by QMA #40.			

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	On 2/24/2016 Resident #11's blood pressure was 97/54 when Atenolol was administered. On 4/23/2016 Resident #11's blood pressure was 106/65 when Atenolol was administered by QMA #40. On 5/8/2016 Resident #11's blood pressure was 103/62 when Atenolol was administered by QMA #40. On 5/21/2016 Resident #11's blood pressure was 101/63 when Atenolol was administered by QMA #40. On 6/14/2016 resident #11's blood pressure was 109/61 when Atenolol was administered by QMA #40. During an interview with QMA #40 on 7/22/2016 at 1:00 p.m., she indicated she does not have to get preauthorization to give Resident #11 any medication. QMA #40 indicated in general she knew about medication parameters because they were listed in the Medication Administration Record (MAR) with the order for the medication. QMA #40 indicated when medications are not given or if they are held due to a physician order, she made a note on the MAR. QMA #40 indicated she knew the parameters for giving Atenolol to Resident #11 and did not			

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	realize she had given it when the order indicated to hold the medication. During an interview with DON on 7/22/2016 at 1:07 p.m., she indicated she did not know the Atenolol was not being held when the systolic blood pressure was less than 110 mmHg for Resident #11. 3. Resident #65's clinical record review began on 7/20/16 at 10:30 A.M. Resident #65 current diagnoses included, but were not limited to, hypertension and cerebrovascular disease. Resident #65's current medications included, but were not limited to, metoprolol tartrate (a blood pressure medication) 50 mg (milligrams) daily and metoprolol tartrate 100 mg twice a day. Special instructions for the metoprolol tartrate were, "hold if B/P [blood pressure] < [less than] 90/60 or pulse <60." These medications had a start date of 8/11/15. Review of Resident #65's "Medications Administration History," dated 5/1/16 - 5/31/16, and provided by the Director of Nursing (DON) on 7/21/16 at 2:18 P.M., indicated on 5/5/16 Resident #65's pulse was 56 and the metoprolol tartrate 50 mg was given. On 5/12/16 Resident #65's pulse was 59 and the metoprolol tartrate			

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	50 mg was given. On 5/21/16 Resident #65's pulse was 57 and the metoprolol tartrate 50 mg was given. On 5/26/16 Resident #65's pulse was 54 and the metoprolol tartrate 50 mg was given. Review of Resident #65's "Medications Administration History" for the month of May 2016 also indicated the metoprolol tartrate 50 mg was not given four times when the diastolic pressure [bottom number of a blood pressure reading] was below 60, but the systolic pressure [top number of a blood pressure reading] was above 90 and the pulse was above 60. It further indicated the metoprolol tartrate 50 mg was given two times when the diastolic pressure was below 60, but the systolic pressure was above 90 and the pulse was above 60. Furthermore, it indicated the metoprolol tartrate 100 mg was given three times when the diastolic pressure was below 60, but the systolic pressure was above 90 and the pulse was above 60. Review of Resident #65's "Medications Administration History," dated 6/1/16 - 6/30/16, and provided by the DON on 7/21/16 at 2:18 P.M., indicated on 6/4/16 Resident #65's pulse was 53 and metoprolol tartrate 50 mg was given. On 6/23/16 Resident #65's pulse was 56 and metoprolol tartrate 50 mg was given.			

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Further review of Resident #65's "Medications Administration History" for the month of June 2016 also indicated metoprolol tartrate 50 mg was given one time when the diastolic pressure was below 60, but the systolic pressure was above 90 and the pulse was above 60. It also indicated metoprolol tartrate 50 mg was not given one time when the diastolic pressure was below 60, but the systolic pressure was above 90 and the pulse was above 60. Furthermore, it indicated the metoprolol tartrate 100 mg was not given three times when the diastolic pressure was below 60, but the systolic pressure was above 90 and the pulse was above 60.

During an interview with Qualified Medication Aide (QMA) #18 on 7/22/16 at 1:00 P.M., she indicated if a medication was out of parameters, she would not give the medication and report it to the nurse. She further indicated she did not know why she administered Resident #65's metoprolol tartrate when her pulse was below 60.

During an interview with the DON on 7/22/16 at 1:07 P.M., she indicated she was unclear when the metoprolol tartrate should be given or not given related to the systolic and diastolic pressures. She

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	further indicated she would get a clarification from the cardiologist who wrote the order and special instructions. Review of a "Progress Note," dated 7/22/16 at 2:02 P.M., included the following: "Writer placed call to [Name] @ [at] [Name of Cardiologist] (cardio) office. Informed parameters for [metoprolol tartrate] read: Hold if B/P <90/60 or Pulse <60. Writer request [sic] clarification for Systolic, diastolic & pulse parameters for more clear order. [Name] states she will check with doctor & return call." Review of a "Progress Note," dated 7/22/16 at 2:40 P.M., included the following: "Writer received call from [Name] @ [Name of Cardiologist] office. Clarification received for parameters for [metoprolol tartrate]. Hold if any number of parameters is out of range. Call doctor if medication has to be held 3 day's [sic] in a row." During an interview with the DON on 7/25/16 at 2:14 P.M., she indicated before the clarification of the metoprolol tartrate order on 7/22/16, the nurses she spoke to believed it was if both numbers were below 90/60 they would not give it. She also indicated there was no clear consensus and therefore she believed			

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	clarifications were in order. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to assess and monitor bruises for 2 of 2 residents reviewed for skin conditions (Residents #47 and #2). Findings include: 1. On 7/20/16 at 10:01 a.m., dark purple discoloration was observed covering the tops of both of Resident #2's hands. Resident #2 indicated he was not aware of the discoloration. Review of Resident #2's clinical record began on 7/19/16 at 2:26 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, age-related debility, chronic kidney disease, and diabetes.	F 0309	1.F-309 It is, and always has been the intent ofTimbercrest that to provide care and services for residents highest well-being.Immediate corrective actions were residents 47 and 2 were assessed andmonitoring of bruises initiated. 2.An audit of weekly skin assessments wasconducted to ensure all residents had been received proper care. All residentshad received a weekly skin assessment within a week of the previous week's. 3.Timbercrest will implement a policy for SkinAssessment and Wound Evaluation, to include specific guidelines when tocomplete an investigation. Timbercrest revised its Weekly Nursing Skin Summaryto trigger a nurse's note if the following are present: abrasions, skin tearswithin past week, bruises,	08/25/2016

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	Resident #2 had a quarterly MDS (Minimum Data Set) assessment, dated 6/29/16, which indicated he was moderately cognitively impaired and required extensive assist for ADLs and locomotion. Resident #2's clinical record did not indicate an assessment had been completed for the discoloration to his hands. During an interview, on 7/22/16 at 8:50 a.m., the DON indicated the discoloration was not assessed until 7/21/16. Review of a progress note, dated 7/21/16 at 3:30 p.m. indicated the following: "...Writer has observed discoloration to the posterior of bilateral hands for multiple months...normal aging or age spots... did observe three new bruises to fingers on left hand...The first bruise is located on the ring finger and is 0.3cm [centimeters] ht [height] x 0.4cm w [width]...The second bruise is located on the middle finger and is 3cm ht x 1.1cm w...The third bruise is located on the index finger and is 1.4cm ht x 1cm w...All three bruises are dark purple in color...Etiology of all three bruises on the fingers of the left hand is unknown...."		other skin problems, sign and symptoms of hematomaand/or infection. Certified Nursing Assistants, LicensedPractical Nurses and Registered nurses will be in-serviced on the new policyand all will receive a copy of the policy. 4.The Director of Nursing or designee will audit WeeklyNurse Skin Summary. Audits will be conducted weekly for two weeks, then everyother week for two weeks then monthly for 3 months, if any audit should bereveal a compliance rate of less than 95%, auditing will return to a weeklybasis until 95% is obtained. Auditresults will be reported through Timbercrest's QAPI process during the residentat risk weekly meeting and at the quarterly clinical meeting. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review / paper compliance for plan of correction submitted for F309.	

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	Review of a progress note, dated 7/22/16 at 12:34 a.m., indicated the following: "...res [resident] bil [bilateral] hands have looked purple discoloration [sic] for long time...." During an interview, on 7/25/16 at 10:49 a.m., the DON indicated the bruising should have been assessed timely. 2. During an observation of Resident #14 on 7/19/16 at 2:24 P.M., there was a dark purple bruise to the top of her left hand. During an observation of Resident #14 on 7/21/16 at 10:48 A.M., the purple bruise covered the top of her left hand and had a darker discoloration that was the size of a half dollar at the bottom of her forefinger and middle finger. During an interview with Resident #14 on 7/21/16 at 10:48 A.M., she indicated she did not remember how she got the bruise on the top of her left hand. During an interview with the Director of Nursing (DON) on 7/21/16 at 2:44 P.M., she indicated she would expect there to be documentation of the bruise on Resident #14's left hand. She also indicated there was no documentation that she could find of the bruise. Furthermore, she indicated it was important to assess and monitor bruises			

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	for worsening, swelling and pain or discomfort. During an interview with the DON on 7/22/16 at 9:25 A.M., she indicated the bruise to top of Resident #14's left hand was just discovered on 7/21/16 by staff. Resident #14's clinical record review began on 7/21/16 at 10:51 A.M. Resident #14's current diagnoses included, but were not limited to, anemia, end stage renal disease, chronic atrial fibrillation and dementia. Resident #14 had a current, 5/25/16, annual, Minimum Data Set (MDS) assessment which indicated she was moderately cognitively impaired and required extensive assistance from staff for transfers, mobility, dressing, toileting and personal hygiene. Review of a document titled, "[Name of Hospital] Phlebotomist Draw List", dated 6/27/16, and provided by the DON on 7/21/16 at 11:40 A.M., indicated Resident #14 had blood drawn from her left hand on 6/27/16. Review of a "Progress Note", dated 7/21/16 at 10:56 P.M., included the following: "...Center of bruise is more red/purple and faint in appearance ...No			

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	causation noted by staff." Review of a document titled, "FOLLOW-UP INVESTIGATION FOR INJURY OF UNKNOWN ETIOLOGY", dated 7/21/16, and provided by the DON on 7/22/16 at 9:25 A.M., included the following: "...Resident frequently leaves hand hanging from Broda Chair. Spouse and Hospice nurse state they have observed resident hit bed side table at times..." 3.1-37(a)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were securely stored for 2 of 5 soiled utility rooms. This practice had the potential to affect 42 of 53 residents. Findings include: During the initial tour of the facility, beginning on 7/19/16 at 9:24 a.m., a storage cabinet, located in the unlocked	F 0323	1.F-323 It is, and always has been the intent ofTimbercrest for residents to have an environment that is free and remains freeof accidents, as possible. Immediatecorrective action taken to ensure that Timbercrest resident's environment wasfree of accidents is as follows: chemical was removed and closet/cabinet waslocked. Director of Housekeeping andLaundry added missing Safety Data Sheet. 2.An audit of all housekeeping storage areas andutility rooms	08/25/2016

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

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	100 Hall soiled utility room, was observed with the key in the lock. The cabinet was found to be unlocked and contained, but was not limited to, a gallon of bleach, a spray bottle labeled as QUAT (a disinfectant), a spray bottle labeled as T.E.T. solution (a disinfectant cleaner), a 16 ounce bottle of rubbing alcohol, and a tub of disinfectant wipes. A sign taped to the cabinet indicated the doors were to be kept locked at all times. On 7/19/16 at 9:27 a.m., CNA #30 indicated the cabinets were to be kept locked at all times. She turned the key to lock it, and hung the key on the side of the cabinet, indicating it was to be stored there when not in use. Additionally, during the initial tour of the facility, in the unlocked soiled laundry room near the 400 Hall, a storage cabinet was observed to be unlocked. The cabinet contained, but was not limited to, a spray bottle labeled as T.E.T. and a bottle of T.E.T. concentrate. On 7/21/16 at 7:43 a.m., in the unlocked soiled laundry room near the 400 Hall, a storage cabinet was observed to be open. The cabinet contained, but was not limited to, a bottle of T.E.T. concentrate, a spray bottle labeled as T.E.T., and a spray bottle of odor neutralizer.		was conducted. All chemicals that were found to be unsecured weresecured away from residents. Director ofHousekeeping and Laundry added missing Safety Data Sheet. 3.Timbercrest removed the cabinet from the closetto ensure chemicals were not stored in an area that was kept unlocked.Housekeeping staff will be educated on proper chemical storage and Safety DataSheets. Reminder notes will be provided to all nursing staff that chemicalstorage areas indicating areas/cabinets are to be locked at all times. 4.The Director of Housekeeping will audit janitorialand utility areas weekly. Audit results will be reported through Timbercrest'sQAPI process, monthly, until 95% compliance is maintained for 3 consecutivemonths and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review/ paper compliance for plan of correction submitted for F323.	

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Review of a MSDS (Material Safety Data Sheet) document, dated 3/11/1996, and provided by the DON on 7/21/16 at 10:46 a.m., indicated T.E.T. solution could cause severe eye burns and severe skin burns on contact, as well as burns to the mouth, throat, and stomach if ingested.

Review of a MSDS (Material Safety Data Sheet) document, dated 9/6/13, and provided by the DON on 7/21/16 at 10:46 a.m., indicated Bright Air Odor Eliminator could cause irritation to skin, eyes, throat, and lungs. It further indicated the chemical could be harmful if swallowed.

Review of a MSDS (Material Safety Data Sheet) document, dated 7/25/1990, and provided by the DON on 7/21/16 at 10:46 a.m., indicated QUAT 256 Disinfectant indicated ingestion of the chemical required immediate medical management.

Review of a policy, titled "RESIDENT RISK AND ENVIRONMENTAL HAZARDS," revised April 2015 and provided by the DON on 7/21/16 at 10:46 a.m., indicated the following:

"...1.b. For a material to pose a safety hazard to a resident, it must be toxic,

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	caustic, or allergenic; accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access... ...1.c. Examples of materials that may pose a hazard to a resident include (but are not limited to): i. Chemicals used by the facility staff in the course of their duties (e.g. housekeeping chemicals)... ...3. Employees will monitor all areas for securing of environmental hazards as appropriate...." 3.1-45(a)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to			

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	treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure residents did not receive psychotropic medications without indication for use for 1 of 5 residents reviewed for unnecessary medications (Resident #2). Furthermore, the facility failed to ensure gradual dose reductions for psychotropic medications were attempted or a letter of contraindication was completed for 2 of 5 residents reviewed for unnecessary medications (Residents #11 and #50). Findings include: 1. On 7/21/16 at 9:10 a.m., a resident was overheard to be yelling to leave him alone. The resident indicated he was hungry and wanted to eat. A staff member was overheard to abruptly tell the resident to not to talk to her like that and that he had already eaten. Upon observation, QMA #32 and LPN #34 were standing in the common room in front of Resident #2 while he was seated in his Broda chair. Resident #2 indicated again that he had not eaten anything.	F 0329	1.F 329 It is, and always has been the intent ofTimbercrest that resident's drug regimen is free from unnecessary drugs.Immediate corrective action to ensure residents were free from unnecessarydrugs is as follows: a medication review was conducted on residents 2, 11, and50 and physician reported on medication usage. 2.An audit of all residents receiving psychotropicmedication to ensure documentation showing gradual dose reduction was active orin case of contraindications that pharmacists and physician rational forcontraindication, was conducted. There were no other irregularities found inaudit of residents receiving psychotropic medications. 3.Along with our pharmacy provider, consultantpharmacist and physician, Timbercrest has developed dual systems for trackingmedication usage to include frequency; duration; diagnosis; date of most recentreview and recommendation; and date that an updated review needs to becompleted. 4.Director of Residential Care	08/25/2016

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	On 7/21/16 at 9:27 a.m., Resident #2 was sitting quietly in his Broda chair near the nurse's station. On 7/25/16 from 11:05 a.m. to 11:10 a.m., Resident #2 was observed sitting in his Broda chair in his room, yelling that he wanted someone to take him out of his room. Five staff members were observed at the nurses' station during this time. At 11:10 a.m., LPN #35 was observed to enter Resident #2's room and propel him near the nurse's station. The resident indicated to LPN #35 that he did not need anything further. Review of Resident #2's clinical record began on 7/19/16 at 2:26 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, age-related debility, chronic kidney disease, single episode of major depression, and diabetes. Resident #2 had current physician's orders for, but not limited to, Zoloft (an antidepressant) 50 mg daily, Seroquel (an anti-psychotic) 25 mg three times a day, and Ativan 1 mg three times a day as needed for anxiety. Resident #2 had a quarterly MDS (Minimum Data Set) assessment, dated 6/29/16, which indicated he was		will auditdocumentation for Timbercrest internal system once a month. Audit results willbe reported through Timbercrest's QAPI process, monthly, until 95% compliance for3 consecutive months and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review / paper compliance for plan of correction submitted for F329.	

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	moderately cognitively impaired and required extensive assist for ADLs and locomotion. The assessment further indicated the resident had no delusions or behavioral symptoms. Review of depression screenings for Resident #2, dated 3/29/16 and 6/29/16, indicated the resident did not show depressive signs or symptoms. Review of progress notes, dated 4/22/16, indicated Resident #2 had received 14 doses of Ativan in 13 days for yelling out and anxiety. A new order was received from the physician to increase the Seroquel 25 mg from twice daily to three times daily for behaviors. Review of progress notes, dated 5/5/16, indicated Resident #2 had received Ativan 23 times the month prior for anxiety, despite receiving Seroquel 25 mg three times daily. Review of a dietary progress note, dated 5/23/16, indicated Resident #2 had lost seven pounds since 4/25/16. Review of a Social Services note, dated 6/23/16, indicated Resident #2 was receiving Seroquel and Ativan due to being aggressive toward staff. The note further indicated the resident had been			

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	more pleasant to staff and was less agitated since the dose of Seroquel was increased. Review of an Interdisciplinary Team quarterly review note, dated 7/6/16, indicated a review of the black box warning for Seroquel was reviewed with the resident's POA (power of attorney). The note further indicated the POA did not want a gradual dose reduction of the Seroquel since Resident #2 had been on the medication for a long time. Review of a Behavior Summary note, dated 7/8/16, indicated Resident #2's identified behaviors were threatening to hit and kick staff, threatening to hit other residents in the past, trying to get out of his chair when anxious, and yelling "help me, help me" and "hello, hello" repeatedly. Additional identified behaviors included being demanding in the dining room, demanding refills of hot chocolate, and not giving staff time to respond to him before yelling or cursing at staff who are trying to help him. On 7/21/16 at 2:35 p.m., CNA #36 indicated Resident #2 usually just wanted someone to spend time with him when he was yelling out. CNA #37 indicated Resident #2 forgot to use his call light a lot and usually just wanted to talk to			

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	someone. On 7/25/16 at 10:06 a.m., the Social Services Director (SSD) indicated Resident #2's behaviors were attempting to get up by himself and hitting staff during care. She further indicated Resident #2 required the use of an anti-psychotic due to yelling and agitation and being aggressive toward staff. She indicated Resident #2 would become agitated during the night if he had to use the restroom. She indicated the resident had remained on an anti-depressant since his admission because he had high depression screening scores in the past. She indicated Resident #2's behaviors were monitored by his Ativan usage on the medication administration record and when the nurses documented in the progress notes. She was not able to indicate how Resident #2's yelling out was harmful to the resident or other residents. On 7/25/16 at 11:12 a.m., LPN #35 indicated Resident #2 usually had increased agitation between 8 p.m. and 10 p.m. LPN #35 indicated Resident #2 was usually aware of what was going on and would yell a lot after being laid down in bed. LPN #35 indicated Resident #2 would not need anything at times, but could usually be calmed by being			

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	toileted, watching sports, or getting back up out of bed. 2. On 7/20/2016 at 9:18 a.m., Resident #11 was laying in bed with her eyes open. On 7/25/2016 at 10:49 a.m., Resident #11 was laying in bed with her eyes open. Resident #11's clinical record was reviewed on 7/20/2016 at 10:12 a.m. Resident #11 had current diagnoses which included, but were not limited to, hypertension, Alzheimer's disease and Vascular dementia. Resident #11 had a, 4/20/2016, quarterly, Minimum Data Set (MDS) assessment which indicated she was severely cognitively impaired and mildly depressed. Resident #11 had a current physician order for Buspirone (antianxiety medication) twice daily which originated on 3/8/2015, Cymbalta (antidepressant) 60 mg once per day which originated on 3/8/2015 and Remeron (antidepressant) 15 mg, once daily which originated on 3/8/2015. During an interview with the SSD on 7/22/2016 at 2:09 p.m., she indicated they had not done a Gradual Dose Reduction (GDR) on Resident #11 because of a change in status (began hospice services) in January. SSD			

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	indicated the "time frame" for a GDR was reset with the status change and did not need to GDR at this time. 3. The clinical record of Resident #50 was reviewed on 7/22/16 at 8:57 a.m. Diagnoses for the resident included but were not limited to, dementia with behavioral disturbance - hallucinations and delusions, psychotic disorder with hallucinations due to known physiological condition - Alzheimer's dementia, anxiety disorder and Alzheimer's disease. Resident #50's had a quarterly Minimum Data Set (MDS) assessment, dated 6/29/16, which indicated she was severely cognitively impaired. Resident #50 had a current physician order for Lexapro (an anti-depressant medication) 10 milligrams one tablet by mouth once a day with a start date of 3/6/15 for anxiety and Risperdal (an antipsychotic medication) 0.25 milligrams half tablet (0.125mg) by mouth twice a day with a start date of 7/7/2016 for Dementia with behavioral disturbance-hallucinations and delusions. A review of "Psychoactive & Sedative/Hypnotic Utilization By Resident For Records Updated Between 7/1/2016 And 7/13/2016" provided by the			

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	Director of Nursing on 7/22/16 at 2:00 p.m., indicated the physician's order for Lexapro 10 milligrams by mouth once a day for Resident #50 was contraindicated on 1/22/2016 for a gradual dose reduction. During an interview with the Social Service Director on 7/22/16 at 4:28 p.m., the Social Service Director indicated she was unable to locate a letter of contraindication for a gradual dose reduction (GDR) for the antidepressant Lexapro for Resident #50. During an interview with the Social Service Director on 7/25/16 at 10:07 a.m., she indicated there was no letter of contraindication for a GDR for the antidepressant Lexapro. She indicated the physician did not want the medication adjusted because they had been adjusting the antipsychotic medication. A progress note from Resident #50's physician was not completed until 7/24/16 after it was brought to the social service director's attention for the need of clinical rationale for no attempt at a gradual dose reduction on the antidepressant. Review of a policy, titled "PSYCHOACTIVE MEDICATIONS			

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	OTHER THAN ANTIPSYCHOTICS AND SEDATIVE/HYPNOTICS", revised April 2015 and provided by the Social Service Worker on 7/25/16 at 10:45 a.m., indicated the following: "POLICY: Psychoactive medications, other than antipsychotics and sedative/hypnotics, will only be used for indication by prescribing physician. To indicate guidelines to be followed when psychoactive medications other than antipsychotics and sedative/hypnotic meds are ordered and administered. RESPONSIBILITY: Licensed Nurses, Social Services, Pharmacist PROCEDURE: 1. Agents usually classified as "antidepressants" are prescribed for conditions other than depression including anxiety disorders... ...2. Duration should be in accordance with pertinent literature, including clinical practice guidelines			

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	3. Prior to discontinuation, many antidepressants may need a gradual dose reduction or tapering to avoid a withdrawal syndrome... 4. If used to manage behavior, stabilize mood, or treat a psychiatric disorder: a. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR [gradual dose reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. b. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: i. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and ii. The physician has documented the clinical rationale for why and [sic]			

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	additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. No further information was provided by exit on 7/26/16 at 3:20 p.m. 3.1-48(a)(3) 3.1-48(a)(4)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with			

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	155740	A. BUILDING 00 B. WING	07/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure linens were transported in a sanitary manner for 4 of 5 halls in the facility. These practices had the potential to effect 41 of 53 residents residing in the facility. Findings include: During a random observation on 7/21/16 at 9:17 A.M., there were two uncovered linen carts in the 100 hallway. Laundry Aide #14 and Laundry Aide #15 carried hanging and folded clothes into rooms 102, 101 and 113. During an interview with Laundry Aide #14 on 7/21/16 at 9:21 A.M., she indicated laundry was covered on the carts when brought up from the laundry room then uncovered once they delivered to each hall. She further indicated they always transport laundry in that manner	F 0441	1.F 441 It is, and always has been the intent ofTimbercrest that its practice for linen delivery (including equipment used),meet the standards to control and prevent the spread of infections. Immediatecorrective action: Sheets used to cover carts were modified to ensure coverageof all linens and clothing. 2.All laundry delivery carts were inspected forpotential areas which may allow micro-organisms to reach clothing or lines. Areasidentified were scheduled for modification to prevent access bymicro-organisms. 3.Timbercrest purchased and installed 4 covers forlaundry delivery carts that will appropriate cover clothing and linens. A sheetof non-porous fiberglass board was installed on all carts with openings thatmight cause an indirect exposure. Laundry staff was in-serviced on the LinenPolicy and Preventing the Potential Spread of Infections by linens.	08/25/2016

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	"we've done it this way forever". During a random observation on 7/21/16 at 9:26 A.M., there was a linen cart with hanging clothes and folded clothes unattended in the 300 hall. The folded clothes sat on a slatted shelf approximately six inches from the floor. The hanging clothes were covered by a sheet but the sheet did not cover the ends of the cart. During an interview with Laundry Aide #16 on 7/21/16 at 9:28 A.M., she indicated that she did not know of any specific rules related to the covering of clothing when transporting laundry. During a random observation on 7/25/16 at 1:14 P.M., there were uncovered linen carts observed on the 100, 200, 300 and 400 halls. During an interview with the Laundry Supervisor on 7/22/16 at 10:22 A.M., she indicated laundry personnel were trained to cover the carts with sheets while laundry was transported from the laundry room and when they delivered each cart to the halls, they were to take the sheets off. She also indicated she was not aware of any specific laundry policy related to covering of clothing when transporting laundry because she had only been the		4.Director of Housekeeping and Laundry will audit linendelivery and delivery equipment weekly. Audit results will be reported throughTimbercrest's QAPI process, monthly, until 95% compliance for 3 consecutivemonths and then quarterly thereafter for a period of 1 year. 5.Compliance Date: August 15, 2016. ComplianceDate: 8/25/2016. Timbercrest requests desk review / paper compliance for planof correction submitted for F441.	

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	supervisor for 6 years. She further indicated there would be a risk for clean laundry to be contaminated in the halls if they were uncovered because "a resident could walk up and touch the clothes". Furthermore, the Laundry Supervisor indicated that the folded laundry on the bottom shelves that were slatted or have holes could be a risk of contamination as well since there was no barrier between the floor and the clothing. Review of a facility policy, "Linen Handling - Nursing", undated, and provided by the Director of Nursing on 7/25/16 at 9:45 A.M., included the following: "...Purpose: To ensure proper handling of soiled and clean linen and personal laundry to prevent the spread of micro-organisms... Policy: It is the policy of [Name of Facility] to handle linens correctly and in compliance with mandated regulations to prevent contamination and spread of infection. Standards: 1. Clean linen shall be stored in such a manner to prevent contamination. Linens shall be maintained in the linen room or in enclosed or covered carts..." 3.1-19(g)(1) 3.1-19(g)(2) 3.1-19(g)(3)			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 134 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Timbercrest requests desk review/paper compliance for stated deficiencies.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. This Residential Rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure an evaluation of resident's individual needs on a semi-annual basis for 1 of 7 residents reviewed for completion of assessments. (Resident G) Findings include:	R 0214	1.R 214 It is, and always has been the intent ofTimbercrest that residents living within our residential living area, receiveevaluations prior to admission, at least semi-annually thereafter, upon anon-acute change in residents condition, and as requested by either theresident or Timbercrest staff. Assessments were completed for residents G andH. 2.An audit of assessments for all residentialresidents was	08/25/2016

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	1. The clinical record of Resident G was reviewed on 7/26/16 at 10:19 a.m. Diagnoses for the resident included but were not limited to, congestive heart failure, edema, pneumonia, chronic obstructive pulmonary disease, cough, hypertension and diabetes. A review of Resident G's clinical record indicated the last semi-annual evaluation was completed in April 2015. During an interview with the Director of Nursing on 7/26/16 at 2:30 p.m., she indicated the last semi-annual evaluation or service plan was completed in April 2015. The Director of Nursing indicated Resident G was located on the healthcare side of the facility for the October 2015 service plan and semi-annual evaluation. She further indicated Resident G was discharged from healthcare on 10/21/15 and transferred back to Residential. The Director of Nursing further indicated there should have been a service plan and semi-annual evaluation for Resident G in April 2016. During an interview with the Director of Nursing on 7/26/16 at 2:50 p.m., she indicated there should have been a service plan and semi-annual evaluation for October 2015, in addition to the April		conducted. There was an assessment completed for resident's mostrecent assessment being conducted more than six months ago. 3.In addition to the process used by nursing,additional system was developed Residential Care to track due dates forsemiannual assessments. Any missed oroverdue assessments will be forward to the Director of Nursing and AssociateAdministrator. 4.Director of Residential Care will auditdocumentation for assessment due dates once a month. Audi results will bereported through Timbercrest's QAPI process, monthly, until 95% compliance for3 consecutive months and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review / paper compliance for plan of correction submitted for R 214.	

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	2016 service plan and semi-annual evaluation. No further information was provided upon exit on 7/26/16 at 3:20 p.m.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. This Residential Rule was not met as evidenced by:	R 0217	1.R 217 It is, and always has been the intent ofTimbercrest that residents living within our	08/25/2016

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	Based on observation, record review, and interview, the facility failed to identify and document services to be provided by the facility for 2 of 7 residents reviewed for completion of service plans. (Resident G and H) Findings include: 1. The clinical record of Resident G was reviewed on 7/26/16 at 10:19 a.m. Diagnoses for the resident included but were not limited to, congestive heart failure, edema, pneumonia, chronic obstructive pulmonary disease, cough, hypertension and diabetes. A review of Resident G's clinical record indicated the last service plan was completed 4/23/15. During an interview with the Director of Nursing on 7/26/16 at 2:30 p.m., she indicated the last semi-annual evaluation or service plan was completed in April 2015. The Director of Nursing indicated Resident G was located on the healthcare side of the facility for the October 2015 service plan and semi-annual evaluation. She further indicated Resident G was discharged from healthcare on 10/21/15 and transferred back to Residential. The Director of Nursing further indicated		residential living area, to havethe services we provided updates after each assessment. Each service to include:scope; frequency; need; and preference. Any area of service and plan that was identified as missing for residentG was updated to reflect the residents need and what was to be provided byTimbercrest. 2.An audit of service plans for all residentialresidents was conducted. Any area of service and plan that was missing documentationwas updates to reflect the residents need and what was to be provided byTimbercrest. 3.In addition to the process used by nursing,additional system was developed Residential Care to track due dates forsemiannual assessments. Any missed oroverdue service plan will be forward to the Director of Nursing and AssociateAdministrator. 4.Director of Residential Care will audit documentationfor assessment due dates once a month. Audi results will be reported throughTimbercrest's QAPI process, monthly, until 95% compliance for 3 consecutivemonths and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 8/25/2016. Timbercrest requestsdesk review / paper compliance for plan of correction submitted for R 217.	

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	there should have been a service plan and semi-annual evaluation for Resident G in April 2016. During an interview with the Director of Nursing on 7/26/16 at 2:50 p.m., she indicated there should have been a service plan and semi-annual evaluation for October 2015, in addition to the April 2016 service plan and semi-annual evaluation. 2. The clinical record of Resident H was reviewed on 7/26/16 at 10:30 a.m. Diagnoses for the resident included but were not limited to, hypertension, gout, edema, urgency urination and congestive obstructive pulmonary disease. A review of Resident H's clinical record indicated no service plan was completed. During an interview with the Director of Nursing on 7/26/16 at 2:30 p.m., she indicated there was no service plan completed for Resident H. The Director of Nursing further indicated the service plan should have been completed on the day the resident admitted on 5/23/16. No further information was provided upon exit on 7/26/16 at 3:20 p.m.			