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	01/19/2017

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 the Investigation of Complaint IN00219238. Complaint IN00219238 - Substantiated. Federal/State deficiency related to the allegation is cited at F323. Survey date: January 19, 2017 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census bed type: SNF/NF: 56 Residential: 129 Total: 185 Census payor type: Medicare: 5 Medicaid: 10 Other: 41 Total: 56 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 35984 on	F 0000	1.F-323 It is, and always has been the intent of Timbercrest for residents to have an environment that is free and remains free of accidents, as possible, and residents are provided adequate supervision. Immediate corrective action taken to ensure that Timbercrest is providing adequate supervision was resident's care plan was reviewed, updated and resident was placed on 15 minute checks. 2.All residents within Timbercrest's specialize care unit for dementia were reviewed for wandering behavior and at potential elopement risks. Care plans were updated for those determined to be at risks. Also, residents identified as at risk for elopement, were placed on 15 minute checks. 3.Timbercrest consulted with peers and the fire marshal regarding potential corrective actions. Timbercrest has set all doors going to the exterior of the building to remain locked unless: there is a loss of power, a fire alarm, staff unlock via key pad or key. Staff will be provided keys for exterior doors that do not have a key pad. A1 Door was here to adjust doors to remain locked, as described above on Friday, January 27th and Tuesday, January 31st. Keys were made	

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

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	January 23, 2017.		and provided to staff on Tuesday, January 31st. Staff are to transfer keys during the shift to shift report. Also, an extra key is kept behind the nurse's station and added with the medication cart keys. The doors will also open with a building master key, provided to each nurse, maintenance, and members of Administration. 4.The Director of Maintenance or designee will audit at random times on all three shifts, to ensure doors remain locked. The Director of Maintenance or designee will perform random audit weekly that the doors open via one of the following methods: key pad, key, fire alarm, loss of power for 3 months and then quarterly. Audit results will be reported through Timbercrest's QAPI process, monthly, and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 1/31/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for F323.	
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and			

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	(2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on interview and record review, the facility failed to ensure a resident, who was at risk for elopement, received the supervision to prevent elopement from the facility. (Resident B) Findings include: During record review, on 1/19/17 at 9:03 a.m., the clinical record indicated Resident B was admitted to the facility on 10/31/16. Diagnoses included, but were not limited to, debility, dementia with Lewy bodies, hallucinations, major	F 0323	1.F-323 It is, and always has been the intent of Timbercrest for residents to have an environment that is free and remains free of accidents, as possible, and residents are provided adequate supervision. Immediate corrective action taken to ensure that Timbercrest is providing adequate supervision was resident's care plan was reviewed, updated and resident was placed on 15 minute checks. 2.All residents within Timbercrest's specialize care unit for dementia were reviewed for wandering behavior and at	01/31/2017

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	depression and hypertension. The Minimum Data Set (MDS) admission assessment, dated 11/7/16, indicated Resident B was severely cognitively impaired. Resident B was able to ambulate independently with an unsteady gait. Resident B resided in the lock unit. During review of an elopement assessment, dated 10/31/16 at 4:47 p.m., Resident B was noted to wander aimlessly and independently. She was also noted to have poor decision making skills and was at risk for elopement. A progress note, dated 11/4/16 at 3:40 a.m., indicated Resident B opened the door, sounding the alarm. An elopement assessment, dated 11/7/16 at 1:54 p.m., indicated Resident B was noted to have been standing near exit doors and was deemed an elopement risk. No other interventions were put into place. A progress note, dated 1/9/17 at 6:51 a.m., indicated Resident B was sitting in a recliner in the lounge, near the nurses' station. The alarm sounded and staff responded to the alarm. Resident B was not in the area, but her walker was found. Staff yelled into the courtyard for Resident B, but she did not respond.		potential elopement risks. Care plans were updated for those determined to be at risks. Also, residents identified as at risk for elopement, were placed on 15 minute checks. 3.Timbercrest consulted with peers and the fire marshal regarding potential corrective actions. Timbercrest has set all doors going to the exterior of the building to remain locked unless: there is a loss of power, a fire alarm, staff unlock via key pad or key. Staff will be provided keys for exterior doors that do not have a key pad. A1 Door was here to adjust doors to remain locked, as described above on Friday, January 27th and Tuesday, January 31st. Keys were made and provided to staff on Tuesday, January 31st. Staff are to transfer keys during the shift to shift report. Also, an extra key is kept behind the nurse's station and added with the medication cart keys. The doors will also open with a building master key, provided to each nurse, maintenance, and members of Administration. 4.The Director of Maintenance or designee will audit at random times on all three shifts, to ensure doors remain locked. The Director of Maintenance or designee will perform random audit weekly that the doors open via one of the following methods: key pad, key, fire alarm, loss of power for 3 months and then	

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	Resident B was found knocking at the activity room door across the grassy area from the lock unit door. Resident B was wearing a two piece pajama set and socks. Resident B was placed on 15 minute checks. No injuries were noted and the physician and family were notified. Resident B remained within the chain link fence area. A progress note by the Social Service Director, dated 1/9/17 at 9:53 a.m., indicated Resident B was asked specifically about going outside. Resident B stated "had no socks on and it was cold." She indicated she was told to go outside, but could not identify the voice. She indicated she knew she should not have gone outside as it was very cold. Review of the weather from 1/8/17 through 1/9/17, the high temperature was approximately 33 degrees Fahrenheit and the low temperature was approximately 9 degrees Fahrenheit. A care plan, dated 1/9/17, indicated Resident B was at risk for elopement due to elopement. Interventions included 15 minute checks. During an interview, on 1/19/17 at 9:54 a.m., the Director of Nursing, indicated		quarterly. Audit results will be reported through Timbercrest's QAPI process, monthly, and then quarterly thereafter for a period of 1 year. 5.Compliance Date: 1/31/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for F323.	

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	she had a total of 2 residents who wore a Wanderguard band. She indicated the two resided in the general health care area. She indicated the locked unit did not have any Wanderguard sensors, only the exit doors on the main entrance and into the residential area. She indicated the 100 and 200 hall exit doors had a keypad, as well as, the activity room door. She indicated when Resident B exited the facility, the alarm did sound and staff responded. She indicated it was dark outside and they were not able to see Resident B. She indicated she had a nurse and CNA on duty at the time of the elopement. Both staff members were in rooms assisting other residents when Resident B exited the facility. During an interview, on 1/19/17 at 10:14 a.m., CNA #1 indicated she clocked in on 1/9/17 and was walking towards the locked unit as the staff were walking Resident B down the hall, back into the locked unit. She indicated Resident B was wearing socks and pajamas. During an interview, on 1/19/17 at 11:31 a.m., the Maintenance Director indicated the area between the activity room door and the locked unit, had a chain linked fence around it with gates at both end.			

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	The facility policy, dated 4/2015 and titled, "RESIDENT RISK AND ENVIRONMENTAL HAZARDS" was provided by the Assistant Director of Nursing on 1/19/17 at 2:40 p.m., indicated the following: "Policy: The resident environment remains as free from accident hazards as is possible. Each resident receives adequate supervision and assistance devices to prevent accidents" ...2. Identify residents at risk for environmental hazards.... 3. Employees will monitor all areas for securing of environmental hazards as appropriate...." This Federal tag relates to Complaint IN00219238. 3.1-45(a)(2)			