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	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timbercrest Church of the Brethren Home	2201 East St North Manchester, IN 46962

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49411 Based on interview and record review, the facility failed to follow an Indiana Physician Order for Scope of Treatment (POST) form indicating do not attempt resuscitation/DNR for a resident that received cardiopulmonary resuscitation (CPR) for 1 of 3 residents reviewed for Advanced Directives. (Resident 61) Findings include: Resident 61's clinical record was reviewed on [DATE] at 11:49 a.m. Diagnoses included unspecified systolic (congestive) heart failure, obstructive sleep apnea, dysphagia, oropharyngeal phase, and other pneumonia, unspecified organism. Current orders indicated the resident was a full code, pending POST form completion, dated [DATE]. An Indiana Physician Order for Scope of Treatment (POST) form dated [DATE], and signed [DATE], indicated in section A that Resident 61 requested a do not attempt resuscitation (DNR) if he had no pulse and was not breathing. A progress note, dated [DATE] at 3:30 a.m., indicated resident had no pulse, was not breathing, and had no chest rising. Code status was verified by staff as a full code. CPR was initiated and 911 emergency services were called. A progress note, dated [DATE] at 3:38 a.m., indicated the resident's representative was notified that staff started chest compressions. Once EMS arrived, they administered medications, but the emergency medical technician (EMT) spoke with the resident representative, who indicated Resident 61 would not want chest compressions if he didn't have a heartbeat. Since there was no heartbeat, the decision was made to stop medications and ventilation. During an interview, on [DATE] at 12:19 p.m., the DON and Social Services indicated it wasn't a clear cut and dry DNR. The resident wanted to be a DNR, but with full interventions. The resident voiced that if he was found with no heartbeat and not breathing, he did not want CPR performed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 1:46 p.m., the DON indicated there was a note stating the resident still had respirations, but they were unable to provide those documents. She didn't know why his code status was not updated. Once a POST form was completed and in the chart, the order should be updated. Staff members verify a resident's code in the banner of their face sheet within the electronic clinical record. A printed resident face sheet, provided by the DON on [DATE] at 2:15 p.m., indicated Resident 61's status was DNR, but had a note attached stating full interventions. The alerts indicated full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs. During an interview, on [DATE] at 2:37 p.m., RN 11 indicated she found a resident's code status on the face sheet under the tab continuance of care. During an interview, on [DATE] at 2:38 p.m., RN 12 indicated she looked at the banner for a resident's code status. A current policy titled Advanced Directive Policy, provided by the ADON on [DATE] at 2:48 p.m., indicated the following: .Changes to the residents choices for advanced directives will be documented, included in the residents plan of care, state specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48384 Based on observation, record review, and interview, the facility failed to allow a resident with the ability to make their own decisions to formulate an advance directive. (Resident 50) Findings include: On 9/26/24 at 8:55 a.m., Resident 50's clinical record was reviewed. Diagnoses included essential hypertension, heart failure, acute kidney failure, and Type 2 diabetes mellitus. A Minimum Data Set (MDS) assessment, dated 6/30/24, did not include a BIMS (Brief Interview for Mental Status) assessment to evaluate cognition. On 6/27/24, Resident 50's family member signed a Do Not Resuscitate (DNR) form. A progress note, on 6/27/24 at 8:47 p.m., indicated Resident 50 was alert and oriented. A POST form (a physician's order for scope of treatment based on the resident's medical conditions and preferences),dated 7/5/24, indicated the resident had a DNR code status. During an interview with the Admissions Coordinator (AC) on 9/27/24 at 9:45 a.m., she indicated the resident's family member had completed the admission paperwork. At the time of admission, Resident 50 had come from the hospital and was tired. Each admission was different, dependent upon her assessment of a person's ability to sign advance directives at that time. When she visited residents at the hospital, before they were admitted to the facility, she would also assess family dynamics to determine if the resident could sign the advance directives. On 9/25/24, at 10:24 a.m., Resident 50's clinical record indicated a BIMS score of 14, which indicated she was cognitively intact and capable of making reasonable and consistent decisions. During an interview with the Administrator on 9/30/24 at 2:42 p.m., she indicated the resident would have been competent enough to sign the Advance Directive at admission. A current facility policy, titled Advance Directive Policy, with a revision date of 6/23/23, was provided by the Director of Nursing (DON) on 9/25/24 at 2:48 p.m. The policy indicated the following: It is the policy of (the facility) to establish, implement and maintain written policies and procedures for advance directives. The resident has the right and the facility will assist the resident to formulate an advance directive .a) Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive .c) .The facility will identify the primary decision maker (e.g., assess the resident's decision-making capacity) 3.1-4 (f)(1)(A)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48384 Based on observation and interview, the facility failed to ensure medications stored in the medication carts were labeled with resident identifiers and directions for 2 of 3 medication carts reviewed. (Hall 100 Medication Cart and Hall 400 Medication Cart). Findings include: During an observation of the Hall 100 medication cart on 9/26/24 at 3:30 p.m., accompanied by QMA 6, the bottom drawer contained an unlabeled bottle of Vanadium Complex (a supplement used to support blood glucose levels), an unlabeled bottle of Stasis Liver Detox (a liver supplement), and an unlabeled bottle of Thytrophin PMG (a thyroid supplement). QMA 6 indicated all supplements belonged to one resident and each should have a label with resident identifiers. During an observation of the Hall 400 medication cart on 9/26/24 at 3:42 p.m., accompanied by QMA 8, an unlabeled bottle of acetaminophen 500 mg tablets and an unlabeled bottle of Juice Plus Fruit & Vegetable Blend supplement were in the cart. QMA 8 indicated both should be labeled. During an interview with RN 9 on 9/26/24 at 3:57 p.m., she indicated all bottles and containers in the medication carts should have a label containing the name of the resident, their date of birth, instructions for use, and the name of a provider. On 9/26/24, at 4:00 p.m., the Assistant Director of Nursing (ADON) indicated medications in the medication carts should have a resident name, physician name, an open date, and directions for use on the bottle. The DON provided a current facility policy, titled Storage and Expiration Dating of Medications and Biologicals on 9/27/24 at 12:34. This policy did not contain information regarding labeling of medications. 3.1-25(j)(k)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49411 Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 by not wearing appropriate personal protective equipment (PPE) in areas requiring transmission-based precautions (TBP) during random observations on the 300 Hall. Findings include: During a random observation, on 9/24/24 at 10:59 a.m., CNA 14 entered room [ROOM NUMBER] while wearing gloves, an N95 mask placed over a surgical mask, and a gown. No face shield and/or eye protection was worn before entering the resident's room. Signage on the door indicated the resident was in transmission-based precautions, and required a gown, gloves, N95 mask and a face shield/goggles before entering the room. During a random observation, on 9/24/24 at 11:05 a.m., CNA 14 was wearing a gown, gloves, and an N95 mask overtop of a surgical mask while entering room [ROOM NUMBER]. During an interview, on 9/24/24 at 12:12 p.m., CNA 14 indicated she only wore gloves, a gown, and placed an N95 mask over a surgical mask. No face shield/ goggles were worn before entering the resident's room. During a random observation, on 9/26/24 at 9:11 a.m., CNA 3 entered room [ROOM NUMBER] while wearing gloves, a gown, goggles, and an N95 mask over a surgical mask. During an interview, on 9/26/24 at 9:15 a.m., CNA 3 indicated she wore a gown, gloves, face shield and placed an N95 mask overtop a surgical mask before entering the resident's room. During an interview, on 9/26/24 at 11:44 a.m., the ADON indicated staff should not be wearing both a surgical mask and N95 before entering a resident's room who was on transmission-based precautions. A current facility policy titled COVID-19 PREVENTION AND RESPONSE and REPORTING, provided in the entrance survey binder on 9/25/24 at 10:45 a.m., indicated the following: .16. HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filers or higher, gown, gloves, and eye protection 3.1-18(a)