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	03/14/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49411 Based on interview and record review, the facility failed to follow physician orders to call the physician for low blood pressure readings for 1 of 3 residents reviewed at risk for falls. (Resident B) Findings include: Resident B's clinical record was reviewed on 3/13/24 at 10:35 a.m. Diagnoses included hypertension, amnesia (memory loss), unsteadiness on feet, muscle weakness, and other lack of coordination. Current physician orders included calling the physician when the resident's blood pressure was below 80/50 and with signs/symptoms of hypotension (low blood pressure). A progress note, dated 2/18/24 at 5:50 p.m., indicated the resident had a low blood pressure of 71/53 with symptoms including shortness of breath and lethargy (lack of energy/ motivation). He was reclined to 30 degrees in his recliner. The resident representative was notified and was to be called if he experienced further symptoms. A note was sent to the physician. A progress note, dated 2/24/24 at 10:33 a.m., indicated the resident had a low blood pressure of 77/47 with symptoms of shortness of breath. He was encouraged to drink fluids to help increase his blood pressure. A note was sent to the physician. During an interview, on 3/14/24 at 11:45 a.m., LPN 5 indicated resident had parameters if his blood pressure was 80/50 or below to notify the physician. She didn't think she called the physician regarding his last low blood pressure reading. During an interview, on 3/14/24 at 11:51 a.m., RN 4 indicated there was a physician order to notify the physician if his blood pressure was below 80/50. If his symptoms don't improve with interventions, she would call the physician. If he improved without showing signs of symptoms, she would send a note to the physician through inner office mail. During an interview, on 3/14/24 at 2:07 p.m., the ADON indicated she would expect the nurses to call the physician regarding a low blood pressure unless the physician has said not to call them. Some physicians are notified Monday through Friday through inner office mail. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/24 at 2:56 p.m., the DON indicated that pushing fluids and elevating feet were a nursing intervention for low blood pressure. Since resident B's blood pressure improved with interventions, it wasn't emergent to call the physician. Review of a current policy, dated 5/14/19, provided by the ADON on 3/14/24 at 2:09 p.m., titled Guidelines for Physician Notification, indicated the following: .Purpose: To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for the need of provision of appropriate intervention for care This citation relates to complaint IN00424450. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45122 Based on observation, interview, and record review the facility failed to provide supervision and implement personalized interventions to prevent falls for 1 of 3 residents reviewed for falls (Resident C). Findings include: During an observation, on 3/13/24 at 3:07 p.m., Resident C sat in a recliner in her room. She wore stockings, with her shoes laying beside her feet. During an observation, on 3/14/24 at 11:41 a.m., the resident was assisted out of her room in a wheelchair. The resident's clinical record was reviewed on 3/13/24 at 11:30 a.m. Diagnoses included heart failure, hypertension (high blood pressure), repeated falls, pain, disorientation, syncope (fainting) and collapse, difficulty in walking, generalized muscle weakness, history of falling, unsteadiness on feet, and fatigue. Current physician orders included diltiazem (for blood pressure) 240 mg extended release daily started 9/28/23, tramadol (opiate for pain) 50 mg three times a day started 12/29/23, and oxygen at 2-5 liters per minute per nasal cannula for dyspnea (difficulty breathing) started 11/27/23. A significant change Minimum Data Set (MDS) assessment on 12/6/23 indicated the resident was moderately cognitively impaired. She required substantial to maximal assistance with putting on and taking off footwear. She required partial to moderate assistance with walking. A quarterly MDS assessment on 3/6/24 indicated the resident was severely cognitively impaired. She required partial to moderate assistance with putting on and taking off footwear and walking. An activities of daily living (ADLs) functional status/rehabilitation potential care plan, initiated on 8/18/22 and last revised on 2/25/24, indicated the resident was limited in ability to doing her own ADLs related to left sided weakness. Her goal was to be able to do her own ADLs with set up assistance through the next review on 3/30/24. Current interventions included walking: walks with walker, gait belt, and one assist but is noncompliant (5/18/23). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current fall care plan, initiated on 8/5/22 and last revised on 3/6/24, for falls indicated the resident was at risk for falling. Her goal was to remain free from injury through the next review (3/30/24). Current interventions included purposeful routine rounding 4P's - 1. Pain 2. Personal needs (bathroom) 3. Personal items (everything within easy reach - call light, water, phone, tissue, remote) (8/5/22), keep personal items and frequently used items within reach (11/1/22), frequent checks (12/6/23), leave door open to see resident, she may not be compliant with this as she likes the door to be closed (12/25/23), place excess oxygen tubing in oxygen tubing bag to void a trip hazard (1/10/24), encourage resident to be in supervised area with meaningful activities if without companion between 12 noon and 8 p.m. or whenever awake and restless (2/7/24), reeducate staff to make sure that frequently used items like TV remote control are within reach (2/14/24), clean and keep resident's dentures and its storage within her reach (2/20/24), and gait belt with one assist during transfers and ambulation (walking) (2/22/24). Fall risk assessments completed on 12/6/23 and 3/6/24 indicated the resident was a high risk for falls A progress note, dated 12/4/23 at 10:38 p.m., indicated the resident was found on the floor. She was lying on her back with her head supported by a QMA on duty. The resident indicated she was trying to get clothes from her dresser to change. A falls care plan intervention, started 12/4/23, indicated the resident was to be provided with assistance with clothing change between 8 p.m. and 9 p.m. The intervention was discontinued on 12/5/23. A progress note, dated 1/2/24 at 9:55 a.m., indicated the resident was found on the floor in her room near her recliner. The falls care plan lacked a new intervention for the 1/2/24 fall. A progress note, dated 1/3/24 at 12:27 p.m., indicated the resident was found sitting on her bottom in her room calling for help. The resident indicated her legs felt weak, and she collapsed to the floor. A falls care plan intervention, started 1/3/24, indicated make sure TV remote turns on both TV and mediacom box so that resident does not have to get up and push ok on mediacom box. The intervention was discontinued on 1/4/24. A progress note, dated 1/8/24 at 1:50 p.m., indicated the resident was found lying on her back alongside her bed in her room. Resident indicated she had gotten her crackers and cream-filled sponge cakes out of her closet, walked back to her recliner, lost her balance on the way, and fell . A fall care plan intervention, started 1/8/24, indicated keep resident's snack supply up within easy reach of the resident. The intervention was discontinued on 1/9/24. A progress note, dated 1/15/24 at 10:26 p.m., indicated the resident was found on the floor. She indicated she was trying to go to the bathroom but lost her balance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall care plan intervention, started 1/15/24, indicated the resident usually went to the toilet early in the evening. Toileting assistance was to be provided between 6 p.m. and 8 p.m. The intervention was discontinued on 1/16/24. A progress note, dated 2/2/24 at 3:40 p.m., indicated the resident was found lying on her back on the floor in her room. The resident indicated she had walked to the restroom, lost her balance, and fell backward. A fall care plan intervention, started 2/2/24, indicated the resident should be offered assistance to the restroom between 3 p.m. and 4 p.m. The intervention was discontinued 2/3/24. A progress note, dated 2/19/24 at 6:31 p.m., indicated the resident was walking down the hall at 4:55 p.m. accompanied by a certified nurse aide (CNA). She started to reach something on her right side and fell over. She fell on her right side hitting her head on the wall. An ADLs care plan intervention, started on 5/18/23, indicated the resident walked with walker, gait belt, and one assist but was noncompliant. A fall care plan intervention, started on 2/22/24, indicated the resident required a gait belt and assistance of one staff member for ambulation and transfers. A progress note, dated 3/6/24 at 2:30 p.m., indicated the resident was found on the floor in a sitting position shouting for help. Her feet were bare. An abrasion was found to her upper left back and measured 1 cm by 1. 5 cm. She indicated she had to use the restroom and did not have time to use her call button. A fall care plan intervention, started on 3/7/24, indicated the resident usually ambulated all the way to the bathroom by herself when unattended. A bedside commode was to be provided and offered to the resident for toileting use to minimize fall risk from long distance ambulation. The intervention was discontinued on 3/8/24 Review of the progress notes indicated the resident fell 17 times from 12/4/23 through 3/6/24. During an interview, on 3/13/24 at 11:06 a.m., CNA 7 indicated the facility had a quick reference guide for fall preventions for all residents by the charting kiosk. Fall interventions could also be found on the electronic medical record. During an interview, on 3/14/24 at 12:26 p.m., RN 8 indicated when devising interventions for the residents, they would look at what was causing the falls. Resident C, specifically, would require long term goals and interventions due to her multiple falls. During an interview, on 3/14/24 at 2:08 p.m., the ADON indicated the nurse on shift for the fall would put in place a new intervention a fall. The intervention was generally long term, or a new one would be put in its place if it was discontinued. She was uncertain why interventions were being discontinued after one day. The nurse would have had to put in an end date. During an interview, on 3/14/24 at 2:23 p.m., CNA 9 indicated she utilized the care plan with the interventions for fall prevention on the computer software. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/24 at 2:30 p.m., QMA 10 indicated he utilized the electronic medical record (EMR) to find the interventions for falls to be used for the residents. During an interview, on 3/14/24 at 2:41 p.m., RN 11 indicated she had a paper which provided instructions on updating care plans after a fall. An intervention was added with a fall and stayed active until the condition or problem resolved. The intervention should be continued as long as necessary. During an interview, on 3/14/24 at 3:05 p.m., the DON was uncertain why Resident C's interventions for falls would have been discontinued after one day. During an interview, on 3/14/24 at 3:07 p.m., the ADON indicated fall care plan interventions should not have been discontinued unless the problem was resolved. Review of a current, undated facility policy, titled Falls, Prevention and Follow up, provided by the DON on 3/13/24 at 2:47 p.m., indicated .It is the goal of the nursing staff to prevent as many falls as possible This citation relates to complaint IN00424450. 3.1-45(a)(2)