

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155740</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIMBERCREST CHURCH OF THE BROTHERS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 EAST ST</b> <b>NORTH MANCHESTER, IN 46962</b>	
(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
{E 000}	Initial Comments	{E 000}		
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/15/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 12/10/24</p> <p>Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140</p> <p>At this PSR survey, Timbercrest Church of The Brethren Home was found 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.</p> <p>This one-story facility was determined to be of Type V (111) construction and the basement was determined to be of Type II (222). The facility was fully sprinklered, has a fire alarm system with hard wired smoke detection in the corridors, and areas open to the corridor. 16 resident rooms in the 300-hall and 400-hall with the exception of rooms 305, 306, and 406 were wired for power but were not connected to the fire alarm system. 30 battery operated smoke detectors were installed in the resident rooms on the 200-hall, 300hall, rooms 305, 306, and 406. The facility has a capacity of 65 and had a census of 57 at</p>	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

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FORM APPROVED  
OMB NO. 0938-0391

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{K 000}	Continued From page 1 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 12/11/24	{K 000}		