

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 28, 29, 30 and November 2, 4, and 5, 2015</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 3 Medicaid: 51 Other: 6 Total: 60</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on November 12, 2015.</p>	F 0000		
F 0164	483.10(e), 483.75(l)(4)			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
SS=D Bldg. 00	<p>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure resident privacy was maintained while receiving perineal care for one of one residents observed (Resident #1).</p> <p>Findings include:</p> <p>During a transfer observation of Resident</p>	F 0164	<p>F 164</p> <p>1.Residents #1 and #37 were not affected. C.N.A.'s #2 and #3 were re-educated onprivacy issues including but not limited to pulling privacy curtains duringcare.</p> <p>2.All Residents receiving care could be affected.Staff were re-educated on the right to personal privacy during care,</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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 0248 SS=D Bldg. 00	<p>#1 on 11/02/2015 at 10:56 a.m., CNA (Certified Nursing Assistant) #2 indicated she was about to transfer Resident #1 to his wheel chair. CNA #2 indicated that first she had to change the brief of Resident #1 and that CNA #3 was going to help her. She then removed her gloves and placed them in the trash can. 2 of 2 privacy curtains remained open (pushed back against the wall) throughout the procedure. Resident #37 was observed to be asleep in the window bed throughout the procedure.</p> <p>During an interview with CNA #4 on 11/05/2015 at 11:49 a.m., she indicated that the CNAs were to always provide privacy when providing personal care to a resident and that she always closed the residents' door and pulled their curtain to maintain that privacy.</p> <p>3.1-3(p)(4)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and</p>	F 0248	<p>includingbut not limited to pulling privacy curtains during care. 3.The facility's policy on initial steps has beenreviewed and no changes are indicated at this time. Staff was re-educated on the policy with aspecial focus on providing privacy by pulling privacy curtains. A QA form hasbeen implemented. 4.The DON or her designee will monitor careprovided to 3 residents on scheduled work days as follows: 3x/week x 1 monththen weekly thereafter to ensure personal privacy is provided(Attachment #1). Should concernsbe noted, immediate corrective action will be taken. The findings of the monitoring and any corrective actions will bereviewed in the facility's QA meetings on an ongoing basis for a minimum of sixmonths and revision made to the plan, if warranted 5.12-5-15</p> <p>F 248 1.Resident #1 and #37 did not</p>	12/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>record review, the facility failed to provide activities to promote cognitive stimulation for 2 of 3 residents reviewed for activity needs (Resident #37 and Resident #1).</p> <p>Findings include:</p> <p>1. Resident #1 diagnoses included but were not limited to "...Cerebral Palsy with mental retardation, agitation..."</p> <p>During an observation of Resident #1 on 10/28/2015 at 2:00 p.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #1 on 10/29/2015 at 9:42 a.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #1 on 10/29/2015 at 1:15 p.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #1 on 10/29/2015 at 2:49 p.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #1 on 10/30/2015 at 8:12 a.m., he was observed to be dressed, sitting in his wheel chair in his room.</p> <p>During an observation of Resident #1 on</p>		<p>experience anynegative outcomes. The facility'sactivity program has been reviewed and revised as indicated to includeactivities that promote cognitive stimulation. Residents #1 and #37's care plans were reviewed and revised to includeactivities that promote cognitive stimulation.</p> <p>2.All residents have the potential to be affected. The activity care plans for all residents werereviewed and revised if necessary to ensure proper activities are beingprovided to promote cognitive stimulation.</p> <p>3.The activity director was re-educated onindividualized resident activity programs and providing activities that promotecognitive stimulation. A QA monitoringform has been implemented.</p> <p>4.The Activity Director or designee will completea QA monitoring tool to ensure activities are being provided to promotecognitive stimulation. Monitoring willbe completed as follows: 5 residentswill be reviewed on scheduled work days 3 times weekly for two weeks, one timeweekly for two weeks, once monthly for two months then quarterly thereafter(Attachment # 2). Shoulda concern be noted, immediate corrective action will occur. Results of this monitoring and any correctiveactions will be discussed during the facility's QA meetings on an ongoing basisfor</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>10/30/2015 at 9:53 a.m., he was observed to be laying in his bed. The resident was dressed at this time and had his eyes open looking at the ceiling.</p> <p>During an observation of Resident #1 on 11/02/2015 at 7:22 a.m., he was observed to be sitting in his wheel chair in his room. The television was observed to be on while the resident was looking at the doorway.</p> <p>During an observation of Resident #1 on 11/04/2015 at 8:18 a.m., he was sitting in his wheel chair, dressed in green shirt and gray sweat pants, with no socks. The TV was on in his room. Resident #1 was looking to the left toward the wall.</p> <p>During an observation of Resident #1 on 11/04/2015 at 2:56 p.m., he was observed laying in bed with his eyes open, looking at the ceiling. The TV was observed to be on in the room.</p> <p>During an observation of Resident #1 on 11/05/2015 at 8:28 a.m., he was observed to be laying in bed with his eyes open, staring at the ceiling.</p> <p>The medical record was reviewed on 11/02/2015 7:11 a.m. The "activity quarterly review", dated 4/2/15 signed by the Activity Director, indicated the</p>		a minimum of 6 months and the plan adjusted if indicated. 5.12-5-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>resident was to receive one to one activities three times per week.</p> <p>A review of the one to one activity record on 11/2/2015 at 3:02 p.m., indicated Resident #1 would accept one to one visits three times weekly. Interests included were "watching television (Sponge Bob) animal planet, going outside, and music." The following activities were listed at Resident #1's one to one activities for the time frame of 8/3/2015- 10/30/2015. The one to one activities included but were not limited to "...fed him a snack, lotioned him, cleaned nails, washed face and hands, changed his shirt, fed him lunch...."</p> <p>2. A review of the activity calendars for 10/28/2015-11/5/2015 indicated the following activities:</p> <p>On 10/28 the activities were 10:30 a.m. - Wii, 1:30 p.m. - Bingo, 3:00 p.m. - monthly birthday/ Halloween party, 7:00 p.m. - ice cream social.</p> <p>On 10/29 the activities were 10:00 a.m. - ball toss, 1:00 p.m. - bag candy, 2:00 p.m. - popcorn social, 4:00 p.m. - game-monopoly.</p> <p>On 10/30 the activities were 11:00 a.m. - exercise, 1:00 p.m. - bingo, 2:30 p.m. -</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>bag candy, 4:00 p.m. - social hour.</p> <p>On 11/2 the activities were 10:00 a.m. - ball toss, 1:00 p.m. - popcorn, 2:00 p.m. - bingo, 3:00 p.m. - social hour.</p> <p>On 11/3 the activities were 11:00 a.m. - exercise, 1:00 p.m. - good ol days, 3:00 p.m. - catholic mass, 6:30 p.m. - Chaplin visit.</p> <p>On 11/4 the activities were 9:30 a.m. - Bible study, 10:00 a.m. - ball toss, 2:00 p.m. - bingo, 7:00 p.m. - ice cream social.</p> <p>On 11/5 the activities were 10:00 a.m. - Wii, 11:00 a.m. - exercise, 1:00 p.m. - popcorn social, 3:00 p.m. - game time.</p> <p>3. Resident #37 diagnosis included but were not limited to "dementia, depression, leukemia, osteoarthritis, COPD...." with current physician's orders for a pureed diet.</p> <p>Resident #37 had a current, quarterly, 9/26/15, Minimum Data Set (MDS) assessment, which indicated the resident was severely cognitively impaired.</p> <p>During an observation of Resident #37 on 10/28/2015 at 2:00 p.m., he was observed to be asleep in bed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>During an observation of Resident #37 on 10/29/2015 at 9:43 a.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #37 on 10/29/2015 at 1:13: p.m., he was observed to be laying in bed with eyes open looking at the ceiling.</p> <p>During an observation of Resident #37 on 10/30/2015 at 9:53 a.m., he was observed to be laying in bed asleep.</p> <p>During an observation of Resident #37 on 10/30/2015 at 1:05 p.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #37 on 11/04/2015 at 2:56 p.m., he was observed to be asleep in bed.</p> <p>During an observation of Resident #37 on 11/05/2015 at 8:30 a.m., he was observed to be asleep in his bed.</p> <p>During an observation of Resident #37 on 11/05/2015 at 10:14 a.m., he was asleep in bed.</p> <p>A review of the Interdisciplinary care plan conference, dated 10/15/15, indicated the following: 1. "Area Reviewed: Behavior and emotional</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>status.....Comments include resident enjoys naps, passively engages in some activities...."</p> <p>2. "Area reviewed communication and sensory status addressed (including devices / techniques used or refused, alternative interventions offered. Comments include Spanish, knows some English, speaks very little...."</p> <p>A review of the activity care plan, with last review date of 7/16/2015, indicated the resident was unable to plan their own activity pursuits due to : dementia, depression, and chronic leukemia. Resident enjoyed lounge activities, people watching, church, and walks outside (weather permitting). Interventions included: "seek residents past interests from resident, family, and friends, promote activities that are enjoyable to resident, observe for responses that may define pleasure and or lack of interest in activity, assist resident to and from activities of interest such as church, lounge activities, special events, outside walks, reassure resident throughout the activity of interest by gestures, give positive verbal reinforcements as needed but be realistic." The goal listed was that Resident #37 would "show pleasure" during 4 large group activities each week thru next review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>The care plan worksheet for Depression Diagnosis with no symptoms indicated the problem as resident has a diagnosis of depression but was symptom free at this time last dated 10/9/2015. The care plan indicated the interventions were to "encourage activities of choice such as: watch television, spend time out doors, parties, talking and conversing with others and 1:1 as needed."</p> <p>A paper titled Problem communication, last review date of 10/9/2015, indicated the resident spoke poor English.</p> <p>During an interview with the Activities Director, on 11/05/2015 at 11:13 a.m., she indicated she had multiple activities for one to one visits and that she had one game to play with the residents who were cognitively impaired called "Hot Potato". She indicated that she did one to one activities with Resident # 1 and that Resident #37 sometimes participated in group activities when offered. She also indicated that the activity called "popcorn" was an activity that included her making popcorn and the resident's eating the popcorn. She also indicated that Resident #37 probably should be moved back to one to one activities because of a decline in his cognition.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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 0279 SS=D Bldg. 00	<p>A review of the group activity log for Resident #37, provided by the activity director on 11/05/2015 11:13 a.m., indicated the following examples of large group activities which were offered for September and October "...bingo, Chaplin visit, popcorn, trivia, church and social hour...."</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to</p>	F 0279	<p>F 279 1.Resident #1 did not experience any negativeoutcome</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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			
	<p>develop a care plan related to transfers for 1 of 15 residents reviewed for care plans (Resident #1).</p> <p>Findings include:</p> <p>Resident #1 diagnosis included but were not limited to: Cerebral Palsy with mental retardation, and agitation.</p> <p>During a transfer observation of Resident #1 on 11/02/2015 at 10:56 a.m., CNA (Certified Nursing Assistant) #2 indicated she was about to transfer Resident #1 to his wheel chair. CNA #2 indicated that first she had to change the brief of Resident #1 and that CNA #3 was going to help her. the CNA's approached the bed, perineal care was performed. CNA #2 then stepped away from the bed while CNA #3 was observed to lean over Resident #1 placing her right arm under his head and her left arm under his knees and lifting him off of the bed. She then turned around holding the resident and placed him in his wheel chair.</p> <p>During an interview with CNA #6, on 11/05/2015 at 8:30 a.m., she indicated that 5 people on the hall used the Hoyer lift for transfers. She indicated that Resident #1 was a one person assist, and that to transfer him, she cradled him like a baby.</p>		<p>related to the alleged deficient practice. Resident #1's care plan for transfers has been completed. Physical Therapy is evaluating the resident to ensure the safest transfer. Resident # 1's care plan will be updated as indicated.</p> <p>2. All residents transfer care plans were reviewed and revised if necessary.</p> <p>3. The facility's policy for care plan development has been reviewed and no changes are indicated at this time. The staff were re-educated on care plan development and proper transfers for individual resident needs. A QA monitoring tool has been implemented.</p> <p>4. The DON and or her designee will review 5 resident care plans on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter to ensure transfer care plans are present and accurate (Attachment #3). Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p> <p>5. 12-5-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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 0282 SS=D Bldg. 00	<p>During an interview with the DON, on 11/05/2015 at 8:40 a.m., she indicated they did not need a physician order for use of the Hoyer lift. She further indicated that the Hoyer lift was for use on non weight bearing residents The DON indicated that because Resident #1 thrashes around that the Hoyer lift should not be used for him. The DON then indicated Resident #1 was a two person assist for transfer. She indicated one staff member should not be picking up any resident by themselves because doing so could hurt either the resident or the staff member. She indicated she did not know that any resident, including Resident #1, was being transferred by one staff member. The DON indicated there was no care plan for transfers for Resident #1.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>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 interview and record review, the facility failed to implement</p>	F 0282	F282 1.Resident #54 did not	12/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>individualized interventions for behaviors for 1 of 5 residents reviewed for unnecessary medications (Res. #54).</p> <p>Findings include:</p> <p>Review of Resident #54's clinical record began on 10/28/15 at 2:56 p.m. Diagnoses included, but were not limited to, dementia with behaviors, dementia with psychosis, alcohol dependence, anxiety, and seizures.</p> <p>Resident #54 had a current, quarterly, 7/6/15, Minimum Data Set (MDS) assessment, which indicated the resident was severely cognitively impaired.</p> <p>Resident #54 had a current care plan problem of anxious moments and negative statements due to dementia and alcoholism. Interventions included, but were not limited to, providing activities of interest, veteran's club, diversional conversation, and talking about his time in the military.</p> <p>During an interview, on 11/2/15 at 9:17 a.m., CNA # 2 and CNA #13 indicated they were not sure what behaviors were being monitored for different residents. They indicated they were to monitor for anything "out of the ordinary" and report it on a behavior memo. They further</p>		<p>experience any negativeoutcomes related to the alleged deficient practice. Resident #54's record was reviewed. Plan ofcare was updated with individualized interventions for behaviors. C.N.A.'s #2and #13, RN's # 9 and 11, and LPN #12 were re-educated concerningindividualized interventions for Resident #54 behaviors.</p> <p>2.All residents with behavioral issues have thepotential to be affected. Record reviewwas completed for residents with behaviors, individual interventions werereviewed and revised if necessary.</p> <p>3.The facility's policy on behavior management hasbeen reviewed and no changes are indicated at this time. Staff has been re-educated on the policy witha special focus on individualized plans for residents with behaviors. A QA monitoring tool has been implemented.</p> <p>4.The Social Service Director and or her designeewill monitor resident behavior memos daily on scheduled work days to ensureindividualized interventions are revised as necessary(Attachment #4). Should a concern be found, immediatecorrective action will occur. Results ofthe monitoring and any corrective actions will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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 0311 SS=D Bldg. 00	<p>indicated there were not specific interventions for each resident, they just tried different things until something worked.</p> <p>During an interview, on 11/2/15 at 9:43 a.m., RN #9 indicated staff was to look for resident behavior that was "out of the ordinary" and report it on a behavior memo. She indicated the same interventions were used for all residents and were listed on the memos.</p> <p>During an interview, on 11/5/15 at 1:30 p.m., RN #11 and LPN #12 indicated resident behaviors were identified by being familiar with the residents, and communicated amongst staff verbally. RN #11 indicated a behavior memo was used when a resident was not "socially appropriate" or the action was not "normal." They indicated interventions were listed on the memos.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on interview and record review,</p>	F 0311	discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated. 5.12-5-15			12/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>the facility failed to provide access to assistive devices to promote mobility for 1 of 3 residents reviewed for accidents. (Resident #44)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #44 was reviewed on 11/4/15 at 10:41 a.m. Diagnoses for the resident included, but were not limited to, heart disease, anemia, vascular dementia, systemic heart disease, anxiety, shortness of breath, chronic pain, depression, cerebrovascular accident with dysarthria and gait abnormality.</p> <p>A review of the "INCIDENT & ACCIDENT REPORT AND INVESTIGATION", dated 10/7/15 at 4:45 a.m. and completed by LPN #20, was provided by the Director of Nursing (DON) on 11/4/15 at 3:20 p.m. It indicated Resident #44 had a fall and "stated she was backing up to bed and missed...THE IMMEDIATE ACTION OR KEEP SAFE INTERVENTION IMPLEMENTED TO PREVENT ANY RECURRENCE: removed walker...." The report was signed by both the Administrator and the DON.</p> <p>A review of the "INCIDENT & ACCIDENT REPORT AND</p>		<p>1. Resident #44 currently has the walker in her room to use at her discretion. The fall for Resident # 44 which occurred on 10/7/15 and 10/23/15 have been reviewed to determine the root cause and care plan interventions were implemented in an attempt to prevent injury related to falls. LPN #20 was re-educated on the safety of resident and the need for access to the walker as a mobility device to maintain functional mobility for transfers.</p> <p>2. All residents who experience falls have the potential to be affected. Review of residents with assistive mobility devices for transfers was conducted to ensure access was provided for safe and functional mobility.</p> <p>3. The facility's fall management policy has been reviewed and no changes are indicated at this time. Staff was re-educated on the policy with a special focus on the use of assistive devices. A QA monitoring tool has been implemented.</p> <p>4. The DON and or designee will review the incident & accident investigation reports to ensure proper interventions are implemented and mobility devices remain accessible to the residents. These reviews will be done on a daily basis on scheduled work days (Attachment #5). Should a concern be noted, immediate corrective action will occur. Results of the monitoring and any corrective actions will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>INVESTIGATION", dated 10/23/15 at 10:45 a.m. and completed by LPN #20, was provided by the Director of Nursing (DON) on 11/4/15 at 3:20 p.m. It indicated Resident #44 had a fall without injuries and "Resident fell in room while trying to walk to closet, stated [she] just lost her balance and fell...THE IMMEDIATE ACTION OR KEEP SAFE INTERVENTION IMPLEMENTED TO PREVENT ANY RECURRENCE: removed walker from resident room and explained she needs to use call light for assistance..." The report was signed by both the Administrator and the DON.</p> <p>A review of the current physician orders indicated the following: "...UP WITH ASSIST OF WALKER...AMBULATE WEIGHT BEARING AS TOLERATED WITH WALKER..."</p> <p>A review of Resident #44's current health care plan indicated the following:</p> <p>"...The resident has multiple risk factors for falls, such as: ...impaired balance... impaired vision ...hx [history] of falls..." Interventions included "...*Ensure that resident is using assistive devices as indicated...Re-educate res [resident] to use assistive device as indicated..."</p> <p>A review of the Minimum Data Set</p>		discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated. 5.12-5-15		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>quarterly assessment was dated 9/4/15. The assessment indicated Resident #44 was cognitively intact and used a walker as a mobility device. It further indicated Resident #44 was an extensive assist with one person physical assist for transfers and was a limited assist with one person physical assist to walk in room.</p> <p>During a telephone interview on 11/5/15 at 11:48 a.m., LPN #20 indicated after Resident #44 had a fall on 10/23/15, she had removed the resident's walker from her room, but left her wheelchair. LPN #20 further indicated she did not want the resident walking in her room, since she just had a fall. LPN #20 indicated she had not received the direction to remove the walker, but had made the decision on her own.</p> <p>During an interview on 11/5/15 at 11:53 a.m., the Director of Nursing indicated the walker/assistive device should not have been removed from Resident #44's room, even if the resident had a fall. The DON further indicated Resident #44 had both a walker and a wheelchair used for assistive devices.</p> <p>During an interview with PTA (Physical Therapy Assistant) #22 on 11/5/15 at 1:32 p.m., she indicated Resident #44 used a front wheel walker for assistance</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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 0323 SS=D Bldg. 00	<p>with ambulation and to transfer in her room. She indicated the resident, at start of physical therapy on 8/29/15, was walking 40 feet with a rolling walker. PTA #22 further indicated, when the resident was discharged from therapy on 10/9/15; she was walking 175 feet with a rolling walker and stand by assist. She indicated the resident still needed 25% cues do to safety awareness. PTA #22 indicated Resident #44's long term goal with ambulation was 200 feet with a front wheel walker and supervision, but the resident did not reach that goal.</p> <p>No further information was provided by exit on 11/5/15. 3.1-38(c)</p> <p>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 and interview, the facility failed to ensure common resident areas were free from hazards regarding unsecured, accessible sharps containers and medication disposal. This practice had the potential to affect 28 of 60</p>	F 0323	<p>F323 1 & 2. No residents were affected by this alleged deficient practice but all confused residents have the potential to be affected. The key was removed from the locked key slot of the locked cabinet in the B hall shower room.</p>	12/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>residents with a diagnosis of dementia residing in the facility.</p> <p>Findings include:</p> <p>1. On 10/28/15 at 9:04 a.m., the cabinet in the B Hall shower room was observed with the key, attached to the wall with a stretchable, plastic cord, sitting in the lock, and the cabinet doors open. The cabinet contained 2 hair dryers, a bottle of hair conditioner, a gait belt, 2 boxes of gloves, and a partially full 12 quart sharps container with razors inside. The sharps container was not secured to the cabinet.</p> <p>On 11/4/15 at 7:55 a.m., the cabinet in the B Hall shower room was observed with the key, attached to the wall with a stretchable, plastic cord, sitting in the lock, and the right sided door open. The cabinet contained 2 hair dryers, a bottle of hair conditioner, a gait belt, 2 boxes of gloves, and a partially full 12 quart sharps container with razors inside. The sharps container was not secured to the cabinet.</p> <p>During an interview, on 11/4/15 at 8:03 a.m., CNA #4 indicated the cabinet was supposed to remain locked due to the sharps container being stored in it.</p>		<p>The key to the soiled utility room was removed from the locked key slot of the door. RN #9 was re-educated in the proper disposal of dropped medication.</p> <p>3. All Staff have been re-educated on the safety of resident environment including, but not limited to, common resident areas free from hazards regarding keys left in locked doors allowing unsecured accessible sharps containers and proper disposal of dropped medications. A QA monitoring tool has been implemented.</p> <p>4. The Administrator and/or her designee will monitor common areas to assure locked doors remain locked and without keys being left in door locks, and medications, if dropped, are disposed of properly. The monitoring will be completed on scheduled workdays as follows: daily for one month then weekly thereafter (Attachment #6). Should concerns be noted, immediate corrective actions will be taken. Results of the monitoring and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p> <p>5. 12-5-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>2. On 10/28/2015 at 9:13 a.m., a key was observed to be in the key slot of the door handle of soiled utility room easily accessible. Inside the room were 5 red biohazard bags that were full and sitting on the floor, one full sharps container sitting on top of a biohazard bag. 3 staff members were observed going inside and came out leaving the key in the door. During an interview with Hostess #6 on 10/28/2015 at 9:20 a.m., she indicated the soiled utility room key is to be hung on the wall across the hall.</p> <p>3. On 11/2/15 at 7:42 a.m., RN #9 was observed handing a medication cup of pills to Resident #15. As Resident #15 raised the medication cup to her mouth, a pill fell from the container and onto the floor next to the resident's left foot. RN #9 indicated to the resident that she would be right back with another pill. RN #9 left the dining room, and the pill remained on the floor.</p> <p>At 8:02 a.m., RN #9 entered the dining room and administered medications to another resident. The pill remained on the floor near the resident's left foot.</p> <p>At 8:03 a.m., the surveyor pointed out the pill to RN #9, who then removed the pill from the floor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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 0329 SS=D Bldg. 00	<p>3.1-45(a)(1)</p> <p>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.</p> <p>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 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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications and dosage increases without indication for 2 of 5 residents reviewed for unnecessary medications (Res. #57 and #54). The facility also failed to implement a behavior management</p>	F 0329	<p>F 329</p> <p>1.The records for Residents #54 and #57 werereviewed and the Behavioral Health Clinician was notified for reduction ordiscontinuation of unnecessary medications without indication of use. Resident#54's care plan was updated with individualized interventions for behaviors.</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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			
	<p>program to monitor for behaviors and utilize non-pharmacological interventions for 1 of 5 residents reviewed for unnecessary medications (Res. #54).</p> <p>Findings Include:</p> <p>1. Review of Resident # 57's clinical record began on 10/28/15 at 2:35 p.m. Diagnoses included, but were not limited to, dementia, delusions, decreased appetite, chronic obstructive pulmonary disease, and arthritis.</p> <p>Resident #57's current physician's orders included the following psychotropic medications: Remeron 7.5 mg (an anti-depressant) daily and Seroquel 25 mg (an anti-psychotic) daily at bedtime.</p> <p>Resident #57 had a current, quarterly, 9/22/15, Minimum Data Set (MDS) assessment, which indicated Resident #57 was cognitively intact, did not have behaviors, and did not have delusions or hallucinations.</p> <p>Review of Resident #57's clinical record indicated an order was received on 10/26/2014 for Seroquel 25 mg twice daily for dementia with confusion. The order was received from the resident's primary care nurse practitioner.</p>		<p>QMA#1, SSD, DON, C.N.A. 's # 34, 2, 13, RN's #9, 11, and LPN #12 were re-educated on individualized interventions, behavior monitoring, and use of non-pharmacological interventions to ensure residents are free from unnecessary medications.</p> <p>2. All residents receiving psychoactive medications have had their records reviewed to ensure proper documentation to indicate the use of, or increase in the medication, as well as ensuring proper individualized interventions for behaviors.</p> <p>3. The facility's policies for unnecessary medications and behavior management have been reviewed and no changes are indicated at this time. Staff has been re-educated on individualized interventions, behavior monitoring, and use of non-pharmacological interventions to ensure residents are free from unnecessary medications. A QA monitoring tool has been implemented.</p> <p>4. The DON and or her designee will monitor all new or increase in any psychoactive medication 5 times weekly on scheduled workdays to ensure proper indication for use (Attachment 4). The Social Service Director or designee will monitor resident behavior memos daily on scheduled work days to ensure individualized interventions are revised as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>There was no other information in the clinical record as to why the medication was started.</p> <p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 10/20/14 and signed by the psychiatric nurse practitioner, indicated Resident #57's initial exam demonstrated the resident was confused with poor short term memory, but was not delusional and had a stable mood. The note indicated an order for Seroquel 25 mg twice daily for dementia with delusions.</p> <p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 11/17/14, indicated Resident #57 remained confused, was not delusional and mood was unchanged. Seroquel was continued for the diagnosis of dementia with delusions.</p> <p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 2/23/15, indicated Resident #57 stated her appetite was okay, but was having some difficulty eating, as she had her teeth pulled the month prior. An order was written for Remeron 7.5 mg at bedtime for appetite.</p> <p>Review of a dietary assessment, dated 3/26/15, indicated the resident's weight</p>		<p>necessary. Should concerns be noted, immediate corrective action will be taken. Results of the monitoring and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p> <p>5.12-5-15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>had been steadily increasing since admission to the facility in August 2014. The resident's admission weight was 82 pounds, and had increased to 100 pounds by December 2014. The note further indicated the resident was consuming adequate calories and meal intake was stable.</p> <p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 8/17/15, indicated a dosage reduction of Seroquel had taken place on 1/26/15 and further dose reduction was contraindicated, as it was necessary to maintain the resident's cognition. The note further indicated the resident continued without behaviors or delusions.</p> <p>A pharmacist recommendation, dated 7/9/15, indicated Remeron was discontinued due to no longer being needed.</p> <p>An order, dated 7/22/15, was received to restart Remeron 7.5 mg daily for decreased appetite.</p> <p>During an interview, on 11/2/15 at 11:10 a.m., the psychiatric Nurse Practitioner indicated she was not sure why the Seroquel had been started, nor could she speak to why the resident was diagnosed as being delusional.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>During an interview, on 11/4/15 at 9:58 a.m., QMA #1 indicated she was not aware of Resident #56 ever having delusional thoughts and the resident freely came to the dining room for meals without complaints.</p> <p>During an interview, on 11/4/15 at 11:34 a.m., with the Social Services Director (SSD) and the Director of Nursing (DON), they indicated they did not know why the Seroquel had been started or continued. The DON further indicated there was no supporting documentation in the medical record for restarting the Remeron.</p> <p>During an interview, on 11/5/15 at 12:31 p.m., CNA #4 indicated she was not aware of Resident #57 having a history of delusional thoughts.</p> <p>2. Review of Resident #54's clinical record began on 10/28/15 at 2:56 p.m. Diagnoses included, but were not limited to, dementia with behaviors, dementia with psychosis, alcohol dependence, anxiety, and seizures.</p> <p>Resident #54's current medications included the following psychotropic medications: Zyprexa 10 mg (an anti-psychotic) at bedtime, Zoloft 75 mg</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>(an anti-depressant), and Buspar 10 mg (an anti-anxiety) three times a day.</p> <p>Resident #54 had a current, quarterly, 7/6/15, Minimum Data Set (MDS) assessment, which indicated the resident was severely cognitively impaired.</p> <p>Resident #54 was observed sleeping in his bed on 10/29/15 at 9:08 a.m.</p> <p>Resident #54 was observed sleeping in a chair in the main lobby on 11/2/15 at 9:47 a.m., while surrounded by other residents and the television on.</p> <p>Resident #54 was observed sleeping in his bed on 11/4/15 at 9:40 a.m.</p> <p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 3/16/15, and signed by the psychiatric nurse practitioner, indicated the resident had been agitated, pacing, aggressive, and rude. Resident #54 was started on Zoloft for agitation and delusions, and the note indicated Buspar would be decreased if Zoloft was effective.</p> <p>There was no indication in the clinical record of the resident being agitated or delusional.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>Review of a "...Behavioral Medicine Evaluation & Management Note...", dated 4/27/15, indicated Buspar was increased on this date from 10 mg twice daily to 10 mg three times daily due to the resident being irritable.</p> <p>A medication order, dated 10/17/15, received from the psychiatric nurse practitioner, indicated an increase in the dosage of Zyprexa from 5 mg to 10 mg at bedtime. There was no indication in the clinical record as to why the dosage was increased.</p> <p>A "Mood and Behavior Communication Memo", dated 6/2/15, indicated Resident #54 had been up wandering the facility in the middle of the night, wondering what to do. There were no other memos provided by the facility for the review period.</p> <p>Review of "Mood and Behavior Monthly Flow Record" documents for May 2015 through October 2015, indicated the following:</p> <p>a. 1 episode of being an elopement risk on 5/13/15.</p> <p>b. 1 episode of being anxious/restless on 5/7/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>c. 1 episode of being socially inappropriate on 5/7/15.</p> <p>d. 1 episode of rejecting care on 5/9/15.</p> <p>There were no documented moods or behaviors for June through October, 2015 on the flow sheet.</p> <p>During an interview, on 11/2/15 at 9:17 a.m., CNA # 2 and CNA #13 indicated they were not sure what behaviors were being monitored for different residents. They indicated they were to monitor for anything "out of the ordinary" and report it on a behavior memo. They further indicated there were not specific interventions for each resident, they just tried different things until something worked.</p> <p>During an interview, on 11/2/15 at 9:43 a.m., RN #9 indicated staff was to look for resident behavior that was "out of the ordinary" and report it on a behavior memo. She indicated the same interventions were used for all residents and were listed on the memos.</p> <p>During an interview, on 11/5/15 at 1:30 p.m., RN #11 and LPN #12 indicated resident behaviors were identified by being familiar with the residents, and communicated amongst staff verbally.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>RN #11 indicated a behavior memo was used when a resident was not "socially appropriate" or the action was not "normal." They indicated interventions were listed on the memos.</p> <p>During an interview, on 11/4/15 at 11:25 a.m., the Social Services Director (SSD), indicated the resident's Zyprexa had been increased on 10/17/15 following an incidence of the resident making an inappropriate sexual remark to his roommate in the middle of the night on 10/11/15. She indicated it had not been placed in the clinical record, and had only occurred one time.</p> <p>Review of a policy titled, "Mood And Behavior Program", dated 11/2013, and provided by the SSD on 11/2/15 at 2:45 p.m., indicated the Mood and Behavior Communication Memo would be completed by any staff member upon witnessing a mood or behavior. It further indicated the interdisciplinary team would use the monitoring to identify the following: "...Trends/patterns in shifts on which mood/behaviors identified...Efficacy of attempted interventions...Efficacy of current careplan and/or need for revision...."</p> <p>There was no other supporting documentation offered by the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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 0441 SS=E Bldg. 00	<p>prior to the end of the survey.</p> <p>3.1-37(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure that employees followed the infection control and handwashing policy having the potential to affect 60 residents living at the facility. (CNA # 3, CNA # 2, & Hostess 10)</p> <p>B. In addition, the facility failed to store the ice scoops in a way to prevent the spread of infection.</p> <p>Findings include:</p> <p>A. During a transfer observation of Resident #1 on 11/02/2015 at 10:56 a.m., CNA (Certified Nursing Assistant) #2 indicated she was about to transfer Resident #1 to his wheel chair. CNA #2 indicated that first she had to change the brief of Resident #1 and that CNA #3 was going to help her. CNA #3 was observed to wash her hands for 8 seconds and then donned gloves. CNA #2 washed her hands and then donned gloves. the CNA's approached the bed, CNA #2 removed Resident #1's pants and soiled brief. She then used 3 wet wash cloths to clean the penis and scrotum of Resident #1. She then placed the wash</p>	F 0441	<p>F 441</p> <p>1. Resident #1 was not affected by this alleged deficient practice. C.N.A.'s #2 and #3 were re-educated on infection control including but not limited to hand washing and use of gloves during resident care. Hostess # 10 was re-educated on the proper storage of ice scoops.</p> <p>2. All residents have the potential to be affected. All staff has been re-educated on infection control including but not limited to hand washing, glove use during resident care, and proper storage of ice scoops to prevent the spread of infection.</p> <p>3. The facility's policy on infection control has been reviewed and no changes are indicated at this time. All staff has been re-educated on infection control including but not limited to hand washing, glove use during resident care, and proper storage of ice scoops to prevent the spread of infection. A QA monitoring tool has been implemented.</p> <p>4. The DON and or her designee will monitor resident care 3 times per week x 1 month (Attachment #8), weekly for 1 month, then monthly thereafter to ensure proper hand washing and glove</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933			
(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			
	<p>cloths into a clear plastic bag that CNA #3 was holding. CNA #2 picked up the clean brief while wearing the same gloves and placed it on the resident. She then assisted CNA #3 to pull up the pants of the resident. CNA #2 stepped away from the bed while CNA #3 was observed to lean over Resident #1 placing her right arm under his head and her left arm under his knees and lifting him off of the bed. She then turned around holding the resident and placed him in his wheel chair. CNA #2 then buckled the seat belt of resident #1 with the dirty gloves on her hands. CNA #2 then removed her gloves and placed them in the trash can and washed her hands.</p> <p>A review of the Infection Control policy provided by the Assistant Director of Nursing (ADON) titled "General Instructions for Resident Care" on 11/4/2015 indicated "...4. Disposable gloves, sterile and non sterile, should be removed and discarded after contact with each resident, fluid item or surface...."</p> <p>A review of the Handwashing Policy provided by the ADON on 11/4/2015 indicated "...Situations that require hand hygiene include, but were not limited to:...before and after resident contact...before and after assisting a resident with personal care...after</p>		<p>usage during care. The Dietary Supervisor will monitor the ice scoops in the dining room 5 times per week x 1 month, weekly x 1 month, then monthly thereafter to ensure proper storage of ice scoops (Attachment #9). Should concerns be noted, immediate corrective action will be taken. Results of the monitoring and any corrective actions will be discussed during the facility's QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated. 5.12-5-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>handling soiled or used linens, dressings, bedpans, catheters and urinals....Rub hands together vigorously, as follows for at least 20 seconds...."</p> <p>B. In the main dining room on 10/28/2015 at 9:23 a.m., one large metal ice scoop was observed on top of a smaller plastic ice scoop in the holder on the wall.</p> <p>During an interview with Hostess #10 on 11/04/2015 at 10:43 a.m., she indicated the the ice machines in the main dining room were used for ice pass in the kitchen. Hostess #10 used the metal ice scoop to get ice from the machine, placed the ice into her cooler, and then placed the metal ice scoop in the holder on the wall on top of the handle of the plastic ice scoop.</p> <p>During an interview with the DON on 11/05/2015 at 9:06 a.m., she indicated they have two ice scoops because there are two ice machines and that both ice scoops are regularly used.</p> <p>3.1-18(j) 3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure resident rooms and common areas were clean, in good repair and odor free for 5 of 27 resident rooms Rooms # 201, 120, 125, 106, and 107; Hall A, the Main Dining room, and the 200 hallway activity/conference room,.</p> <p>Findings include:</p> <p>1. During the initial tour the following observations were made:</p> <p>Hall A on 10/28/2015 at 9:05 a.m., had a strong odor of urine throughout the entire hallway. During an interview with Resident #69 on 10/29/2015 at 9:04 a.m., he indicated the hall way smelled bad and he had to close the door to keep the smell out. He had purchased air freshener spray to aide in covering the smell.</p> <p>In the main dining room on 10/28/2015 at 9:23 a.m., rough wood on trim was observed on the wall near vending machines in the main dining room.</p>	F 0465	<p>F 465</p> <p>1.No residents were affected by the allegeddeficient practice. Hall A was deep cleaned and urine odor was removed. Thorough wood on the trim near vending machines was corrected. There were nodishes noted on the ice machine in the dining room, the ice machine was cleanedand disinfected. The bathroom door in the activity room/conference room at theend of the 200 hall was replaced. The wallpaper behind the residents' bed inroom 201 was repaired. The bathroom in room 120 was deep cleaned to remove theurine odor, the brown toilet water and the dirt on the floor. The wallpaper wasrepaired to the wall in the bathroom. The closet doors in room 125 were repaired as well as the hole in thewall next to the closet. Room 106 was deep cleaned to remove the urine odor.The bathroom in the man cave was deep cleaned and the wash cloth was removed,the stained chair from the activity room was disposed of.</p> <p>2.All residents have the potential to be affected.All resident rooms and common areas were checked to ensure urine odors are eliminated,wood trim is not rough, there are no</p>	12/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>In the main dining room on 10/28/2015 at 9:23 a.m., a white bowl was observed to be sitting on top of the small ice machine with dried yellow and black substance in the bottom.</p> <p>In the activity room/conference room at the end of the 200 hallway on 10/28/2015 at 9:42 a.m., there was a hole observed in the bathroom door.</p> <p>2. The following observations of resident rooms were made during the following dates and times during the Stage I survey:</p> <p>Room 201 on 10/28/2015 at 2:14 p.m., the wall paper behind the resident's bed was observed to be torn.</p> <p>Room 120 on 10/29/2015 at 8:47 a.m., the bathroom had a strong odor of urine, the toilet water was brown. Dirt was observed on the bathroom floor and torn wall paper was observed on the bathroom wall.</p> <p>Room 125 on 10/29/2015 at 9:10 a.m., the left closet door was observed to be off the hinges of both ends of the door and leaning on the frame of the closet, the right closet door was off on one of two ends. There was a hole in wall next to the closet.</p>		<p>dirty dishes on ice machines or otherequipment, there are no holes in doors, torn wallpaper is repaired, toiletbowls are clean, there is no dirt on bathroom floors, closet doors are hung andintact, holes in walls are repaired, dirty linens are disposed of properly, andstained or soiled furniture is cleaned and or disposed of.</p> <p>3. Staff has been educated on providing a clean,odor-free, environment that is in good repair. A QA monitoring tool has been implemented.</p> <p>4. The Administrator or designee will monitorresident rooms and common areas on a daily basis on scheduled days of work to ensure urine odors are eliminated(Attachment #10), wood trim is notrough, there are no dirty dishes on ice machines or other equipment, there areno holes in doors, torn wallpaper is repaired(Attachment #11), toilet bowls are clean, there isno dirt on bathroom floors, closet doors are hung and intact, holes in wallsare repaired, dirty linens are disposed of properly, and stained or soiledfurniture is cleaned and or disposed o(Attachment #12)f. Should concerns be noted, immediate correctiveaction will be taken. Results of the monitoring and any corrective actions willbe discussed during the facility's QA meetings on an ongoing basis for aminimum of 6 months and the plan adjusted if indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
-----------------------------------------------------------	-------------------------------------------------------------------------------

(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
	<p>During the resident interview in room 106 on 10/29/2015 at 1:43 p.m., there was a strong urine like odor present in the room and a strong stale urine like odor present in the bathroom.</p> <p>During the environmental tour with the Maintenance Manager on 11/4/2015 at 10:58 a.m., when approaching room 106, he indicated that there was a strong urine like odor coming from that room. He indicated that he has replaced the floor around the toilet and that the resident's of that room continue to urinate on the floor. He also indicated there was no vent fan in that bathroom and that would possibly help the smell.</p> <p>During an interview with a resident residing in room 107 on 11/04/2015, he indicated that there was a strong urine odor in the hall way. He indicated that he did not know where it was coming from but that he thought it was another resident's room.</p> <p>5. During a random observation on 11/04/2015 at 10:30 a.m., there was a strong urine like odor in the bathroom of the "Man Cave" room with a wash cloth observed to be hanging in the bathroom for 4 days of the survey. 11/05/2015 11:04:16 a.m., the chair from the man cave that was urinated in was observed</p>		5.12-5-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933		
(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	
	<p>sitting in activity room with a large dark spot on the seat. The chair was not marked in any way to notify residents not to sit in it.</p> <p>6. During an interview with the Maintenance Manager on 11/4/2015 at 10:45 a.m., he indicated that all staff members had access to the repair request forms and that when filled out the staff member placed the form on his clip board and he reviewed them each day.</p> <p>During an interview with the house keeping manager on 11/04/2015 at 12:12 p.m., he indicated that each room is deep cleaned one time per month. A review of the deep cleaning calendar he provided indicated that room 106 was last deep cleaned on 10/6/2015.</p> <p>During an interview with Housekeeper #8 on 11/04/2015 at 12:30 p.m., he indicated that the bathrooms in each resident room of the facility were cleaned each day.</p> <p>3.1-19(f)</p>				