

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2015
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NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/23/15</p> <p>Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140</p> <p>At this Life Safety Code survey, Twin City Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 75 and had a census of 55 at the time of this survey.</p> <p>Quality Review completed 12/01/15 -</p>	K 0000	<p>K 000 Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged o the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state and federal laws. Please accept this Plan of Correction as our credible allegation of compliance.</p>	

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.

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K 0027 SS=B Bldg. 01	<p>DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 6 smoke barrier doors were providing a fire resistance of at least 20 minutes. This deficient practice could affects up to 38 residents in 4 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 11/23/15 between 11:20 a.m. and 1:00 p.m., the following sets of smoke barrier doors had labels that were painted over and the fire rating could not be determined:</p> <ol style="list-style-type: none"> The smoke barrier door to "A" hall The smoke barrier door to "B" hall The smoke barrier door to "C" hall <p>Based on interview at the time of observation, the Maintenance Supervisor</p>	K 0027	<p>K027 Corrective action for residents affected: No residents were affected by this alleged negative practice. Smoke barrier doors have labels that were painted over and fire rating could not be determined. Labels have been cleaned and fire rating can now be read. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Smoke barrier doors have labels that were painted over and fire rating could not be determined. Labels have been cleaned and fire rating can now be read. (Attachment 3)</p> <p>Measures to ensure that the practice does not recur: Monthly checks will be completed per Maintenance Director or designee to ensure labels are able to be read and fire rating legible. This corrective action will be monitored by: Maintenance Supervisor or</p>	12/23/2015

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K 0050 SS=F Bldg. 01	<p>acknowledged the labels were painted and stated the paint will be removed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly</p>	K 0050	<p>designee will complete monthly checks to ensure fire rating labels are present and able to be read. Maintenance Director or designee will immediately notify the Administrator of any negative findings during checks and immediate corrections will be completed. Fire rating label monthly checks will be forwarded and reviewed during facilities quarterly Quality Assurance meeting for continued compliance, with monitoring being ongoing. Completed: 12/23/2015</p> <p>K050 Corrective action for residents affected: No residents were affected by this alleged negative practice. Fire drills will be held quarterly on each shift under unexpected conditions. The staff is familiar with procedures and is aware that drills are part of established routine. Other residents having potential to be affected and corrective action: No residents were affected by this</p>	12/23/2015			

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K 0051 SS=B Bldg. 01	<p>Fire Drill Record" with the Maintenance Supervisor on 11/23/15 at 09:30 a.m., there was no record of a first shift fire drill for the third quarter of 2015, and there was no record of a second shift fire drill for the fourth quarter of 2014 . Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify the drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation.</p>		<p>alleged negative practice. Fire drills will be held quarterly on each shift under unexpected conditions. Measures to ensure that the practice does not recur:The fire drills report will be reviewed by the Administrator each month to ensure they are completed quarterly on each shift under unexpected conditions. Any negative findings will result in staff re-education and/or disciplinary action and will be corrected immediately. This corrective action will be monitored by: Fire drills will be held quarterly on each shift under unexpected conditions. The fire drills report will be reviewed by the Administrator each month and reports will be forwarded to the facilities quarterly Quality Assurance committee for continued compliance, monitor will be ongoing.Completed 12/23/15</p>	

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	<p>Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation, the facility failed to ensure 2 of 2 manual fire alarm boxes in "C" hall were mounted at the correct height. NFPA 72, 1999 Edition of the National Fire Alarm Code at 2-8.1 states each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 3 1/2 feet (42 inches) and not more than 4 1/2 feet (54 inches) above floor level. This deficient practice could affect approximately 17 residents on "C" hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor and Administrator on 11/23/15 between 11:00 a.m. to 11:10 a.m. , The manual fire alarm pull stations located by the exit door and by the smoke doors on "C" hall were mounted 61 inches from the floor. Based on interview</p>	K 0051	<p>K051 Corrective action for residents affected: No residents were affected by this alleged negative practice. Manual fire alarm boxes shall be no less than 3 10/2 feet (4 inches) and not more than 4 1/2 (54 inches) above floor level. All manual fire alarm boxes have been relocated to required height. (Attachment 1). Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Manual fire alarm boxes shall be no less than 3 10/2 feet (4 inches) and not more than 4 1/2 (54 inches) above floor level. All manual fire alarm boxes have been relocated to required height. (Attachment 1). Measures to ensure that the practice does not recur: Manual fire alarm boxes shall be no less than 3 10/2 feet (4 inches) and not more than 4 1/2 (54 inches) above floor level. All manual fire alarm boxes have been relocated to required height. (Attachment 1). Inspection by Maintenance</p>	12/23/2015			

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K 0130 SS=E Bldg. 01	<p>at the time of observation, the Maintenance Supervisor confirmed the height of the pull stations.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be</p>	K 0130	<p>Supervisor was conducted upon completion of repair of fire alarm box locations and will be completed monthly to ensure continued compliance. This corrective action will be monitored by: Maintenance Supervisor or designee will complete monthly fire alarm box inspections and will forward completed inspection reports to the facilities Quarterly Quality Assurance meeting to ensure continued compliance, monitoring will be ongoing. Completed: 12/23/2015</p> <p>K130 Corrective action for residents affected: No residents were affected by this alleged negative practice Rolling fire door protecting the opening from the kitchen to the main dining room was out of compliance with annual inspection. Inspection has been completed and will be completed annually. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Rolling fire door protecting the opening from the kitchen to the main dining room was out of compliance with annual inspection. Inspection has been completed and will be completed annually. (At)tachment 2 Measures to ensure that the practice does not recur:</p>	12/23/2015	

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K 0143 SS=D Bldg. 01	<p>maintained and shall be made available to the authority having jurisdiction. This deficient practice could up to 35 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 11/23/15 at 12:15 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on record review with the Maintenance Supervisor at 10:12 a.m., the roll down door inspection by Elwood Fire showed the last inspection was conducted on 03/19/14. Based on interview at the time of records review, the Maintenance Supervisor was unable to provide any other documentation for review to show the rolling fire door was inspected in the last year.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated,</p>		<p>Maintenance Supervisor or designee will ensure that annual inspection is completed on the above mentioned fire door. This corrective action will be monitored by: Maintenance Supervisor or designee will forward annual inspection report to the facilities Quarterly Quality Assurance committee for review for continued compliance, monitoring will be ongoing. Completed: 12/23/2015</p>				

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	<p>sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice was not in a resident care area but could affect 1 staff in the oxygen transferring/storage room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor and Administrator on 11/25/14 at 10:59 a.m., there was no mechanical ventilation in the oxygen transferring/storage room which contained at least five large stationary containers of liquid oxygen. The transferring/storage room was attached to the outside of the building and contained two natural air vents totaling 82 square inches. Based on interview at the time of observation, the Maintenance Supervisor confirmed there was not a mechanical vent in the oxygen room.</p>	K 0143	<p>K143 Corrective action for residents affected: No residents were affected by this alleged negative. No mechanical ventilation in the oxygen transferring/storage room with contained at least five large stationary containers of liquid oxygen. The transferring/storage room was attached to the outside of the building and contained two natural air vents totaling 82 sq inches. Mechanical ventilation has been installed in oxygen transferring/storage room. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Mechanical ventilation has been installed in oxygen transferring/storage room.</p> <p>Measures to ensure that the practice does not recur: Mechanical ventilation will be monitored per preventive maintenance policy to ensure it is in place and properly working.</p> <p>This corrective action will be monitored by: Maintenance Supervisor or designee will forward preventative maintenance inspections to the facilities</p>	12/23/2015	

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	3.1-19(b)		Quarterly Quality Assurance commitee for continued compliance, monitoring will be ongoing. Completed by: 12/23/2015		