

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 04/16/2015
--	---	--	---

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 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170407.</p> <p>Complaint IN00170407- Substantiated. Federal/state deficiencies related to the allegations are cited at F314.</p> <p>Unrelated deficiency is cited at F441.</p> <p>Survey date: April 16, 2015.</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 6 Medicaid: 48 Other: 2 Total: 56</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F 000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	
F 314	483.25(c)			

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 04/16/2015
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=E Bldg. 00	<p>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with pressure areas received ordered skin treatments in accordance with their plan of care for 3 of 3 residents reviewed (Residents # B, C and D). The facility also failed to provide weekly skin assessments for 1 of 3 residents reviewed for pressure ulcers (Resident B).</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident B was reviewed on 4/16/15 at 10:07 a.m. Diagnoses for the resident included, but were not limited to, decreased mobility, anxiety, pain, chronic obstructive pulmonary disease and thyroid disorder.</p> <p>The Admission/Re-admission Resident Assessment, dated 1/12/15, indicated a 1.4 cm x 1.0 cm open area on the right buttocks. Also noted was a 1.0 cm x 0.8</p>	F 314	<p>F314 1. Resident B no longer resides at facility. Resident C and D treatment records reviewed. Any areas of concerns with treatments were addressed immediately. LPN #1 was re-educated concerning documentation of treatments including but not limited to: circles around initials on the TAR indicating unable to complete treatment, Proper documentation of treatment given, proper infection control during dressing change. Nurses were re-educated concerning documentation of treatments including but not limited to: circles around initials on the TAR indicating unable to complete treatment, Proper documentation of treatment given, proper infection control during dressing change. 2. All resident treatment records were reviewed; any areas of concern were addressed immediately. Nurses were re-educated concerning documentation of treatments</p>	05/16/2015	

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 04/16/2015
--	---	---	---

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>cm open area above the bend of the right knee. There was noted excoriation on the buttocks and in the abdominal folds.</p> <p>The Braden scale indicated, on 1/12/15, Resident B scored an 18, indicating mild risk for developing a pressure ulcer. On 1/19/15, the Braden score was a 15, also indicating mild risk for developing a pressure ulcer.</p> <p>A Physician's Order, dated 1/14/15, indicated Vasolex (topical ointment to promote wound healing), "apply to coccyx and red areas twice daily."</p> <p>Review of the Treatment Administration Record (TAR), provided by the Corporate Nurse Consultant on 4/16/15 at 4:04 p.m., Vasolex was done only one time on 4/16, 4/17 and 4/22/15. The medication was not done at all on 4/23/15.</p> <p>Resident B's Health Care Plan, initiated on 1/16/15 and updated on 1/23/15, indicated, "The resident has a non-blanchable reddened area (stage 1) location: coccyx...." The interventions indicated, "...Provide treatment as ordered...Assess area at least weekly...."</p> <p>During an interview on 4/16/15 at 4:59 p.m., the Corporate Nurse Consultant</p>		<p>including but not limited to: circles around initials on the TAR indicating unable to complete treatment, Proper documentation of treatment given, proper infection control during dressing change. Residents with dressing were assessed to assure dressings intact and treatments were completed as ordered, with no issues identified. 3. The Skin Management Program was reviewed with no changes made. Nurses were re-educated concerning documentation of treatments including but not limited to: circles around initials on the TAR indicating unable to complete treatment, Proper documentation of treatment given, proper infection control during dressing change, with return demonstration. The DON and or designee will monitor treatment records of all residents with current dressings, as well as any resident with new orders for dressings and 1 dressing change will be monitored 5x /week x 4weeks, then weekly x 4 weeks then monthly thereafter, to assure compliance with dressing changes as per order as well as proper documentation of dressing changes and proper infection control during dressing change. 4. The DON and or designee will report the findings of these audits and any corrective action taken to the QA committee monthly x 3 months, then quarterly thereafter ongoing. Revisions will be made</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 04/16/2015
--	---	--	---

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>indicated she did not find any additional Skin Assessment sheets. She also indicated the Medication Administration Record (MAR) or TAR did not have any date specified for weekly skin inspections. She indicated no skin assessment was completed prior to discharge. No Initial Pressure Ulcer Assessment was provided.</p> <p>Resident B was in the facility 14 days total.</p> <p>2. The clinical record of Resident C was reviewed on 4/16/15 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, chronic ischemic heart disease, diabetes mellitus, depressive disorder and hypertension.</p> <p>The Braden scale indicated, on 12/18/14 and 2/19/15, Resident C was at mild risk for developing a pressure ulcer.</p> <p>A Physician's Order, dated 3/18/15, indicated to "cleanse area to buttocks with normal saline. Apply wet collagen, cover with Optifoam & secure with (cont) tape one daily."</p> <p>Review of the TAR for March, provided by the Corporate Nurse Consultant on 4/16/15 at 3:50 p.m., indicated the treatment was not done on 3/28 or</p>		to the plan(i.e., frequency of monitoring increased if non-compliance observed or decreased if increased compliance observed), if warranted 5. 5-16-2015	

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 04/16/2015
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>3/30/15. Review of the TAR for April, no signature was noted as treatment being done on 4/3, 4/4, 4/5, 4/8, 4/9, 4/10, 4/13 or 4/14/15. On 4/6, 4/7 and 4/11/15, initials were noted with a circle around the dates.</p> <p>During an interview on 4/16/15 at 10:45 a.m., LPN #1 indicated she would do her wound treatments after lunch. While reviewing the TAR with LPN #1, she indicated the circles around her initials indicated she was unable to complete the treatment for those days. She indicated the blank squares were dates she did not work.</p> <p>Resident C's Health Care Plan, initiated on 8/20/14 and updated on 3/12/15, indicated, "The resident has a pressure ulcer Location(s): L [left] outer heel vascular R [right] buttock pressure...." The interventions indicated, "Treatment as ordered. Monitor per Skin Management Program and SWAT protocol"</p> <p>Review of the Initial Pressure Ulcer Assessment, dated 3/11/15, a pressure wound on the right buttocks was noted. The wound measured 2.9 cm x 0.8 cm < [less than] 0.1 cm. The wound developed after admission and was a stage 2. On 3/19/15, the wound measured 2.0 cm x</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 04/16/2015
--	---	--	---

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>0.5 cm < 0.1 cm. On 3/26/15, the wound measured 1.5 cm x 1.0 cm < 0.1 cm. On 4/3/15, the wound measured 0.5 cm x 0.2 cm x < 0.1 cm. On 4/10/15, the wound measured 1.0 cm x 0.2 cm x < 0.5 cm.</p> <p>During wound care observation on 4/16/15 at 2:45 p.m., Resident C was observed in bed in a supine position. LPN #1 donned disposable gloves then left the room to get the measuring tape. Without changing gloves or washing her hands, LPN #1 returned and assisted Resident C onto his side with help from CNA #2. LPN #1 unfastened the resident's brief. The wound was open to air and LPN #1 indicated he did not have any dressing covering the wound. LPN #1 measured the wound to be 4.5 cm x 3.0 cm. She measured the reddened area from side to side on the coccyx. An open area was noted in the middle of the red area.</p> <p>Without changing her gloves or washing her hands, LPN #1 applied normal saline and patted the skin dry. She applied normal saline to the collagen dressing and applied over the wound. The collagen was then covered with Optifoam and secured with tape.</p> <p>Without washing her hands, LPN #1 left the room with her gloves on and trash in</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 04/16/2015
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>hand.</p> <p>On 4/16/15 at 4:20 p.m., the DON indicated she re-measured Resident C's wound. The coccyx wound measured 0.4 cm x 0.4 cm. She indicated the nurse measured incorrectly and measured the reddened area and not the open area.</p> <p>3. The clinical record of Resident D was reviewed on 4/16/15 at 11:05 a.m. Diagnoses for the resident included, but were not limited to, schizophrenia, hydrocele, coronary artery disease and vitiligo.</p> <p>The Braden scale indicated, on 1/16/15, Resident D scored an 22, indicating a low risk for developing a pressure ulcer.</p> <p>Review of the Initial Pressure Ulcer Assessment, dated 4/12/15, indicated a pressure wound on the coccyx was noted. The wound measured 1.8 cm x 1.3 cm < [less than] 0.5 cm. The wound developed after admission and was a stage 2.</p> <p>A Physician's Order, dated 4/12/15, indicated to "cleanse o/a [open area] to coccyx c [with] normal saline-pat dry-apply wet collagen-cover c [with] Optifoam daily."</p> <p>Review of the Treatment Administration</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 04/16/2015
--	---	--	---

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 (TAR) for April,2015 provided by the DON on 4/16/15 at 4:20 p.m., indicated the treatment was not done on 4/13 and 4/14/15.</p> <p>Resident D's Health Care Plan, initiated on 4/12/15, indicated, "The resident has an open area. Location: coccyx...." The interventions indicated, "...Provide treatment as ordered...Weekly head to toe skin assessments...."</p> <p>During wound care observation on 4/16/15 at 3:00 p.m., Resident D was assisted to stand at the side of the bed. LPN #1 donned disposable gloves then left to get a washcloth with her gloves on. Without washing her hands, LPN #1 returned to the room and donned 1 new glove, but left to get measuring tape before applying the other glove. LPN #1 returned and donned a second glove then assisted Resident D to lower his pants. The wound was not covered with any Optifoam or tape. LPN #1 applied normal saline to the collagen to soften and remove it. LPN #1 removed the old collagen and disposed of her gloves. The DON was assisting the resident to stand.</p> <p>Without washing her hands, LPN #1 donned new gloves. She wet the new collagen with normal saline and applied it to the wound. Optifoam was then placed</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 04/16/2015
--	---	--	---

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 441	<p>onto tape and applied over the collagen. LPN #1 left the room without washing her hands.</p> <p>During an interview on 4/16/15 at 3:00 p.m., the DON and Corporate Nurse indicated the previous Assistant Director of Nursing (ADON) was responsible for monitoring for pressure wounds. The DON indicated the ADON was not keeping up with the tasks.</p> <p>Review of a current facility policy, dated 10/2013, and titled "Skin Management Program", which was provided by the Corporate Nurse Consultant on 4/16/15 at 4:04 p.m., indicated the following:</p> <p>"...A comprehensive head to toe assessment...at least weekly and thereafter....A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring....Interventions will be implemented according the individual resident's risk factors...."</p> <p>This federal tag relates to Complaint IN00170407.</p> <p>3.1-40(a)(2)</p>			
	483.65			

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 04/16/2015
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>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 accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to assure</p>	F 441	F 441 1. Residents C and D were not affected. LPN # 1	05/16/2015	

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 04/16/2015
--	---	--	---

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 staff followed infection control procedures regarding barrier use, hand washing and glove use during wound care for 1 of 1 staff observed concerning 2 of 2 residents observed during wound care. (LPN #1; Residents # C and D)</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 4/16/15 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, chronic ischemic heart disease, diabetes mellitus, depressive disorder and hypertension.</p> <p>The Braden scale indicated, on 12/18/14 and 2/19/15, Resident C scored an 15, indicating mild risk for developing a pressure ulcer.</p> <p>A Physician's Order, dated 3/18/15, indicated to "cleanse area to buttocks with normal saline. Apply wet collagen, cover with Optifoam & secure with (cont) tape one daily."</p> <p>Resident C's Health Care Plan, initiated on 8/20/14 and updated on 3/12/15, indicated, "The resident has a pressure ulcer Location(s): L [left] outer heel vascular R [right] buttock pressure...." The interventions indicated, "Treatment as ordered. Monitor per Skin</p>		<p>was re-educated on proper infection control during dressing change.</p> <p>2. Nurses were re-educated on proper infection control with dressing changes. Return demonstration completed.</p> <p>3. The DON and or designee will monitor 1 dressing change 5 xs / week x 4 weeks, weekly x 4 weeks and monthly thereafter, to assure proper infection control during dressing changes.</p> <p>4. The DON and/or designee will report the findings of the monitoring and any corrective actions taken to the QA committee monthly x 3 months, then quarterly thereafter ongoing. Revisions to the plan, if warranted.</p> <p>5. 5-16-2015</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 04/16/2015
--	---	--	---

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>Management Program and SWAT protocol"</p> <p>During wound care observation on 4/16/15 at 2:45 p.m., Resident C was observed in bed in a supine position. LPN #1 donned disposable gloves then left the room to get the measuring tape. Without changing gloves or washing her hands, LPN #1 returned and assisted Resident C onto his side with help from CNA #2. LPN #1 unfastened the resident's brief. The wound was open to air and LPN #1 indicated he did not have any dressing covering the wound. LPN #1 measured the wound to be 4.5 cm x 3.0 cm. She measured the reddened area from side to side on the coccyx. An open area was noted in the middle of the red area.</p> <p>Without changing her gloves or washing her hands, LPN #1 applied normal saline and patted the skin dry. She applied normal saline to the collagen dressing and applied over the wound. The collagen was then covered with Optifoam and secured with tape.</p> <p>Without washing her hands, LPN #1 left the room with her gloves on and trash in hand.</p> <p>2. The clinical record of Resident D was</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 04/16/2015
--	---	--	---

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>reviewed on 4/16/15 at 11:05 a.m. Diagnoses for the resident included, but were not limited to, schizophrenia, hydrocele, coronary artery disease and vitiligo.</p> <p>The Braden scale indicated, on 1/16/15, Resident D scored an 22, indicating less than a mild risk for developing a pressure ulcer.</p> <p>Review of the Initial Pressure Ulcer Assessment, dated 4/12/15, a pressure wound on the coccyx was noted. The wound measured 1.8 cm x 1.3 cm < [less than] 0.5 cm. The wound developed after admission and was a stage 2.</p> <p>A Physician's Order, dated 4/12/15, indicated to "cleanse o/a [open area] to coccyx c [with] normal saline-pat dry-apply wet collagen-cover c [with] Optifoam daily."</p> <p>Resident D's Health Care Plan, initiated on 4/12/15, indicated, "The resident has an open area. Location: coccyx...." The interventions indicated, "...Provide treatment as ordered...Weekly head to toe skin assessments...."</p> <p>During wound care observation on 4/16/15 at 3:00 p.m., Resident D was assisted to stand at the side of the 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 04/16/2015
--	---	--	---

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>LPN #1 donned disposable gloves then left to get a washcloth with her gloves on. Without washing her hands, LPN #1 returned to the room and donned 1 new glove, but left to get measuring tape before applying the other glove. LPN #1 returned and donned second glove then assisted Resident D to lower his pants. The wound was not covered with any Optifoam or tape. LPN #1 applied normal saline to the collagen to soften and remove. LPN #1 removed the old collagen and disposed of her gloves. The DON was assisting the resident to stand.</p> <p>Without washing her hands, LPN #1 donned new gloves. She wet the new collagen with normal saline and applied to the wound. Optifoam was then placed onto tape and applied over the collagen. LPN #1 left the room without washing her hands.</p> <p>During an interview on 4/16/15 at 3:50 p.m., the DON indicated she was aware LPN #1 did not follow the handwashing policy during wound care for Resident D.</p> <p>Review of a current facility policy, dated 10/2014 and titled "Handwashing/Hand Hygiene", which was provided by the Director of Nursing (DON) on 4/16/15 at 4:50 p.m., indicated the following:</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 04/16/2015
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>"PURPOSE: ...Situations that require hand hygiene include, but are not limited to:...Before and after direct resident contact...Before and after performing any invasive procedure...Before and after changing dressing...After removing gloves...."</p> <p>This federal tag relates to Complaint IN00170407.</p> <p>3.1-18(l)</p>				