

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 11/05/2012
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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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K0000	<p>A Life Safety Code Recertification and State Licensure Survey and a Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/05/12</p> <p>Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140</p> <p>Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist</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, spaces open to the corridors and</p>	K0000	<p>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 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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	<p>battery operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 51 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 12 resident rooms in the 100 hallway corridor of the facility were provided with positive latching hardware. This deficient practice had the potential to affect residents in one smoke compartment evacuated through the 100 hall corridor in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 11/05/12 with the Maintenance Supervisor during the tour from 9:00 a.m. to 11:03 a.m., the doors to resident rooms 108 and 110 lacked a positive latching mechanism and did not latch into the frame. Based on interview at the time of observation, the</p>	K0018	<p>K 018 Corrective action for residents affected: No residents were affected by this alleged negative practice. The doors in question were adjusted so that they close properly. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. All resident room doors were checked for positive latching hardware and were found to be working properly. Measures to ensure that the practice does not recur: Maintenance will check all doors monthly to ensure positive latching hardware. This corrective action will be monitored by: Maintenance director will keep a monthly log for door checks to ensure positive latching hardware. Any concerns will be reported to the</p>	11/21/2012	

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	Maintenance Supervisor acknowledged the doors to resident rooms 108 and 110 were not provided with positive latching hardware. 3.1-19(b)		Administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance. Completed 11/21/12		

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K0039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice had the potential to affect residents in the 100 hall corridor in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 11/05/12 with the Maintenance Supervisor during the tour from 9:00 a.m. to 11:03 a.m., there was a patient lift, medication cart, weight scale, and one wheel chair on both sides of the 100 hall corridor, decreasing the corridor width to less than forty eight inches. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0039	<p>K039 Corrective action for residents affected: No residents were affected by this alleged negative practice. All equipment was immediately moved to one side of the 100 hall corridor so that there was a 4 foot clear path. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. All equipment was moved on all other halls so that there was a 4 foot clear path. Measures to ensure that this practice does not recur: All staff were in serviced on 11-21-12 by the Administrator on the need to keep all equipment on one side of the hall so that we could provide a 4 foot clear path. This corrective action will be monitored by: Administrator will monitor hallways/corridors on normal scheduled days and document findings. Any areas of concern will be immediately corrected and will result in re-education and/or disciplinary action. Monitoring will be ongoing for continued compliance. Completed 11/21/12</p>	11/21/2012	

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 6 of 6 sprinklers in the activity room which had an excessive amount of foreign substance and spider webs. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice had the potential to affect 30 residents who could use the activity room.</p> <p>Findings include:</p> <p>Based on observation on 11/05/12 with the Maintenance Supervisor during the tour from 9:00 a.m. to 11:03 a.m., all six sprinklers in the activity room had an excessive amount of foreign substance and spider webs on them. At the time of observation the Maintenance Supervisor acknowledged there was an excessive amount of foreign substance and spider</p>	K0062	<p>K062 Corrective action for residents affected: No residents were affected by this alleged negative practice. All sprinkler heads in activity room were blown off and are free of foreign substance and spider webs. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. All sprinkler heads in the activity room were blown off and are free of foreign substance and spider webs. Measures to ensure that this practice does not recur: Maintenance director will monitor sprinkler heads throughout building monthly and will clean as needed. This corrective action will be monitored by: Maintenance director will monitor sprinkler heads monthly and log findings. Any concerns will be reported to the Administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance. Completed 11/21/12</p>	11/21/2012			

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	webs on the sprinkler heads. 3.1-19(b)			

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K0066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect any staff utilizing the designated smoking area adjacent to the activity room during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation on 11/05/12 with the Maintenance Supervisor during the</p>	K0066	<p>K 066 Corrective action for residents affected: No residents were affected by this alleged negative practice. The resident smoking area has had all seventeen cigarette butts picked up. Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. The resident smoking area has had all seventeen cigarette butts picked up. Measures to ensure that the practice does not recur: All nursing staff were in-serviced by the Administrator on 11-21-12 in</p>	11/21/2012	

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	<p>tour from 9:00 a.m. to 11:03 a.m., the smoking area adjacent to the activity room had seventeen cigarette butts scattered about the staff bench seat area, and throughout the grass area. Based on interview on 11/05/12 concurrent with the observations, the Maintenance Supervisor acknowledged the facility's employees disposed of cigarette butts on the ground and throughout the grass area instead of using the approved long neck vessel which was provided.</p> <p>3.1-19(b)</p>		<p>regards to using the approved long neck vessel for butts, and keeping the area clean and neat from cigarette butts. This corrective action will be monitored by: Housekeeping supervisor or designee will monitor daily on normal scheduled days the resident smoking area grounds to ensure no cigarette butts are on the ground and that they are disposed of properly. The housekeeping supervisor will keep a daily (normal scheduled days) log of observations of the area. Areas of concern will be reported to the Administrator and will be immediately corrected and will result in re-education and or disciplinary action. Monitoring will be ongoing for continued compliance. Completed 11/21/12</p>		