

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 12/23/2013
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00141134.</p> <p>Survey dates: December 16, 17, 18, 19, 20 and 23, 2013.</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Survey Team: Jason Mench, RN, TC Ginger McNamee, RN Shelley Reed, RN (16, 17, 18 and 19) Angela Selleck, RN (16, 17, 18, and 23)</p> <p>Census bed type: SNF: 1 SNF/NF: 53 Total: 54</p> <p>Census payor type: Medicare: 4 Medicaid: 42 Other: 8 Total: 54</p> <p>These deficiencies also reflect state</p>	F000000	<p>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>	
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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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	findings in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure nursing staff were aware of a resident's fluid restrictions for 1 of 1 dialysis residents reviewed. (Resident #17)</p> <p>Findings include:</p> <p>Resident #17's clinical record was reviewed on 12/20/13 at 9:19 a.m.</p> <p>The resident's diagnoses included, but were not limited to, diabetes, chronic kidney disease end stage, neuropathy, morbid obesity, hypertension, chronic obstructive pulmonary disease, chronic pain, and chronic urinary tract infections.</p> <p>The resident had a recapitulation of Physician's Orders for November, 2013, signed by the physician. The orders were not dated when signed. The orders indicated the resident was on a 2000 milliliter fluid restriction.</p>	F000309	F 3091.Resident #17 chart was reviewed. Physician was notified to clarify the proper fluid restriction amount for this resident.The Registered Dietician has divided the proper amount of fluid for dietary and Nursing.The staff was re-educated, and the fluids received by resident 17 will be monitored and documented on the medical record.2.Any resident who acquires an order for fluid restriction, chart will be monitored and fluids per the dietician will be documented on the medical record.3.The facility's policy for Fluid Restrictions was reviewed and no changes are indicated at this time. The nursing staff has been re-educated related to the documentation with a special focus on monitoring fluid intake of any individual with a restriction. The DON and/or her designee will monitor all residents with fluid restrictions on scheduled work days as follows: Daily for 2 weeks, 3 xs weekly for 2 weeks once weekly for 4 weeks, and monthly thereafter. Should concerns be found, re-education will be completed immediately.	01/10/2014	

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	<p>The resident's 10/11/13, quarterly Minimum Data Set assessment indicated Resident #17's Brief Interview for Mental Status score was 15 and indicated the resident had no cognitive impairment.</p> <p>Resident's care plan meeting was on 10/31/13. The resident had a problem of "The resident suffers from [sic] end stage renal disease and receives hemodialysis, thus has the potential for complications associated [sic] with dialysis. Such as fluid volume excess..." Interventions included, but were not limited to, Encourage resident to follow all dietary and fluid restrictions. Monitor intakes and outputs.</p> <p>During an interview with the RN Consultant on 12/20/13 at 12:50 p.m., she indicated dietary divides the fluids and tells nursing how much water they were allowed to use for passing medications. She reviewed Resident's clinical record at that time and indicated the record lacked an indication of how the fluids for the resident were to be divided between dietary and nursing. She indicated she would check with the Director of Nursing to see if there was any further information.</p>		(see attachment #1)4.Results of these reviews and any corrective actions taken will be discussed at the facility's monthly QA meetings and the plan revised, if indicated.5.1/10/2014	

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	<p>During an interview with LPN #2 on 12/20/13 at 12:55 p.m., she indicated Resident #17 was not on a fluid restriction.</p> <p>During an interview with the Dietary Manager on 12/20/13 at 1:37 p.m., she indicated she had recently updated Resident #17's fluid preferences. She indicated the resident had requested less fluids be given with her meals because she keeps soft drinks in her room and likes to drink them during the day.</p> <p>During an interview with the Dietary Manager on 12/20/13 at 2:06 p.m., she indicated she had not discussed the resident's fluid restrictions with Nursing staff.</p> <p>During the exit conference on 12/23/13 at 9:30 a.m., no additional information was provided.</p> <p>3.1-37(a)</p>				

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the facility was free of a medication error rate greater than 5 percent for 2 of 29 medications observed affecting 1 of 13 residents resulting in a medication rate of 6.89% affecting 1 of 13 residents observed during medication pass. (Resident # 49)</p> <p>Findings include:</p> <p>1. During medication administration observation on 12/18/13 at 11:10 a.m. with RN #1, Resident #49 was given a Haldol (a medication used to treat antipsychotic behavior) 5 mg, 1 tablet via oral route. Resident #49 was then given Naproxen (a medication used to treat pain) 500 mg, 1 tablet via oral route.</p> <p>During medication reconciliation, the current Medication Administration Record (MAR) indicated Resident #49 should have been given Haldol three times daily (TID) at 7 a.m., 1 p.m. and 7 p.m. The current MAR indicated the Naproxen 500 mg should have</p>	F000332	F 3321.Resident # 49 did not experience any negative outcomes. Medication passes have been observed for this resident and medications have been administered timely, accurately, and per MD orders. RN # 1 has been re-educated on medication pass, with focus on timely administration.2.All other residents have the potential to be affected. The licensed nursing staff have been re-educated on medication administration with a focus on timeliness of medications, and the 5 rights of medication pass.3.The facility's policy and procedure for medication pass has been reviewed and no changes are indicated at this time. Licensed nursing staff have been re-educated on medication pass with a focus on administering medications timely.(See attachment #2) A medication administration observation/audit has been implemented.The DON and/or her designee will be responsible to ensure medications are passes appropriately by observing medication pass on three nurses per day, altering shifts, on scheduled work days as follows. (See Attachment #4) Daily for 2	01/10/2014	

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	<p>been given TID at 6 a.m., 2 p.m. and 10 p.m. Both medications were given more than 90 minutes prior to the stated ordered time.</p> <p>During an interview on 12/18/13 at 11:20 a.m., RN #1 indicated staff had 1 hour prior and 1 hour post the stated medication time to administer medications.</p> <p>Review of a current undated facility policy, titled "Administration of Drugs", which was provided by the Corporate Nurse on 12/19/13 at 11:40 a.m., indicated the following:</p> <p>"Procedures</p> <p>1. Only licensed medical, nursing, or other lawfully authorized staff...</p> <p>8. Medications, except those ordered before or after meals, must be administered within one hour before or after the time specified on the MAR. Orders for administration before or after meals must be administered one half hour before or after the ingestion of food."</p> <p>3.1-48(c)(1)</p>		<p>weeks, 2x weekly for 2 weeks, once weekly for 4 weeks then monthly thereafter. Should any concerns be identified, re-education will be completed immediately.4.Results of these reviews and any corrective actions taken will be discussed at the facility's monthly QA meetings and the plan revised, if indicated.5.1/10/2014</p>		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the baking pans were clean and dry when stored and ceiling vents were clean for 2 of 2 kitchen observations. This deficient practice had the potential to affect 54 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>An observation of the kitchen was made on 12/16/13 at 9:27 a.m., with the Dietary Manager present. There were two large muffin pans on the rack of the three basin sink. The pans were discolored from silver to a brown.</p> <p>The kitchen was observed on 12/19/13 at 9:46 a.m., with the Dietary Manager and the Registered Dietician present. There was one large cookie sheet in the middle of a stack of 15 cookie sheets that had water run off of it when the Dietary Manager picked it up. There were</p>	F000371	F 3711. No residents were affected by the alleged negative practice. The facility has purchased new muffin pans. The cookie sheets were cleaned and stored dry. The metal cart was cleaned and staff is currently using a plastic cart for trays. The ceiling vents were cleaned and repainted. 2. All residents have the potential to be affected. The facility has purchased new muffin pans. The cookie sheets were cleaned and stored dry. The metal cart was cleaned and staff is currently using a plastic cart for trays. The ceiling vents were cleaned and repainted. 3. Dietary staff was re-educated on the importance kitchen sanitation, including but not limited to, putting away clean and dry pans along with cleaning of carts and ceiling vents (see attachment #3). The Dietary Manager or designee will complete sanitation rounds daily (on scheduled work days) for 4 weeks then twice weekly for 4 weeks then weekly for 2 months then monthly to ensure ongoing compliance. Should concerns be noted, immediate corrective action and	01/10/2014	

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	<p>two large muffin pans with a heavy brown burned on coating. The Registered Dietician indicated it was caused by the staff overspraying the pans with non-stick spray prior to use and it becoming baked on. The metal three tier cart used to serve hall trays had cob webs and dust by the wheels. The Dietary Manager indicated the tiers of the cart were wiped down after use. The two overhead vents in the kitchen were black in the corners from dust and had dust hanging from them. Both the Dietary Manager and Registered Dietician indicated they did not know who was responsible for cleaning the vents in the kitchen.</p> <p>3.1-21(i)(3)</p>		<p>re-education shall be performed.4. The findings of the above audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action revised, if indicated.</p>		

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure suppositories, bottles of medications and vials of medications</p>	F000431	F 4311.No residents experienced negative outcomes. All expired medications were disposed upon discovery.2.Audit was conducted to identify any other outdated or	01/10/2014			

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	<p>were properly disposed of following expiration dates for 1 of 1 refrigerators and 1 of 3 treatment carts observed. (200 Hall cart and main refrigerator)</p> <p>Findings include:</p> <p>On 12/19/13 at 9:00 a.m., while observing medication storage, the treatment cart on the 200 Hall contained a bottle of Lactulose (a medication used to treat constipation) 10mg/15ml which expired 9/13. The cart also contained a bottle of Mapap (a medication used to treat pain) 160mg/5ml which expired 6/13.</p> <p>The refrigerator behind the nurses' station contained a vial of Aplisol (tuberculin PPD) which was opened on 11/5/13 and expired on 12/5/13. The refrigerator also contained the following expired suppositories; 25 Acephen (a suppository for pain relief) expired 11/13, 5 Bisacodyl (a suppository for constipation) expired 5/13, 7 Bisacodyl which expired 10/13 and 3 Bisacodyl which expired 11/13.</p> <p>During an interview on 12/19/13 at 9:45 a.m., the Corporate Nurse indicated the facility should have removed the expired medications since they were due for their annual</p>		<p>undated medications with corrective action taken as warranted. All residents have the potential to be affected, thus, licensed nursing staff have been re-educated on medication disposal. 3.The facility's policy and procedure for storage of medications was reviewed and no changes are indicated at this time. Licensed nursing staff have been re-educated on medication disposal with a special focus on outdated meds in medication room refrigerator and medication carts. The DON and/or designee will be responsible to ensure medications are disposed of appropriately by observing medication carts and medication room refrigerator, as well as treatment carts and medication room storage for outdated medications on scheduled work days as follows: Daily for 2 weeks, 2x weekly for 2 weeks, once weekly for 4 weeks then monthly thereafter. Should any concerns be identified, re-education will be completed immediately.4.Results of these reviews and any corrective actions taken will be discussed at the facility's monthly QA meetings and the plan revised, if indicated.5.1/10/2014</p>		

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	<p>survey. The expired medications were given to the Corporate Nurse for disposal.</p> <p>Review of a current undated facility policy, titled "Storing Drugs", which was provided by the Corporate Nurse on 12/19/13 at 11:40 a.m., indicated the following:</p> <p>"Procedures</p> <p>1. The pharmacy supplier must dispense drugs in containers...</p> <p>12. Any outdated, contaminated, or deteriorated drugs, or those in containers which are cracked, soiled, or without secure closures must be removed from stock and destroyed according to procedures for drug destructions."</p> <p>3.1-25(o)</p>						