

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 04/21/2014
--	---	--	---

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
K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/26/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/21/14</p> <p>Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this PSR survey, Twin City Health Care was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 2 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, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 54 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were</p>	K010000		

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 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
--	---	--	---

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
K010066 SS=A	<p>sprinklered except a maintenance garage including the maintenance office, and two additional sheds used for the storage of maintenance supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following: 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 observation and interview, the facility failed to ensure 15 of 15 cigarette</p>	K010066	<p>K066 Corrective action for residents affected: No residents were affected by this alleged negative practice. Signage has been posted within</p>	04/29/2014

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 04/21/2014
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>butts were deposited into a noncombustible container at the kitchen exit. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/21/14 at 2:00 p.m., there were 15 cigarette butts on the ground at the kitchen exit near the generator. The Maintenance Director acknowledged there were cigarette butts on the ground at the kitchen exit.</p> <p>This deficiency was cited on 02/26/14. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		<p>building reminding to staff to use the cigarette noncombustible containers after smoking. Maintenance cleaned all grounds, cigarette butts were disposed of in proper noncombustible containers on 4/22/2014.</p> <p>Other resident having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Maintenance cleaned all grounds and cigarette butts were disposed of in proper noncombustible containers on 4/22/2014. Staff re-educated to importance of using noncombustible containers when putting out cigarettes.</p> <p>Measure to ensure that the practice does not recur: Maintenance Director was re-educated on monitoring of cigarette butts to ensure all areas of grounds are monitored instead of isolated areas. Maintenance Director/designee will monitor by walking entire parameter of building on scheduled work days, 2 x's daily to ensure proper disposal of cigarette butts and that none are on grounds.</p> <p>This corrective action will be monitored by: Maintenance Director/designee and Administrator will monitor daily on normal scheduled days to ensure proper disposal of cigarette butts and that none are on the grounds. Any concerns will be reported to the</p>		

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 04/21/2014
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	
K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 3 of the past 3 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K010144	<p>administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance. Completed : 4-29-2014</p> <p>K144 Corrective action for residents affected: No resident affected by this alleged negative practice. Correct formula established and currently being used on "Emergency Generator-Monthly Test Log". Maintenance Director re-educated by Corporate Life Safety to proper formula.</p> <p>Other residents having potential to be affected and corrective action: No residents were affected by this alleged negative practice. Maintenance Director re-educated to correct way of using formula on "Emergency Generator-Monthly Test Log".</p> <p>Measure to ensure that the practice does not recur: Safecare was scheduled to do Low Bank Test (attachment A), maintenance director/designee to do load test 2x's per week x 2 weeks, then weekly for 4 weeks, then monthly as required. Log will be reviewed by administrator weekly x six weeks, then monthly thereafter.</p> <p>This corrective action will be monitored by: Maintenance Director and the Administrator will</p>	05/01/2014	

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 04/21/2014
--	---	--	---

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>Based on record review of the "Emergency Generator - Monthly Test Log" with the Maintenance Director on 04/21/14 at 1:45 a.m., the generator test log showed a monthly load test for the past three months. The log revealed the generator did not reached thirty percent of the EPS nameplate rating for two of the last three months. Based on an interview with the Maintenance Director at the time of record review, he was unaware the generator would require an annual load bank test and he wasn't sure he was using the amp meter correctly.</p> <p>This deficiency was cited on 02/26/14. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		<p>monitor documentation of load generator load test on weekly basis x 6 weeks then monthly thereafter. Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance.</p> <p>Completed May 1,2014</p>	