

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 08/12/2014
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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 the Investigation of Complaint #IN00153088.</p> <p>Complaint #IN00153088 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies were cited at F441 and F225.</p> <p>Survey dates: August 11 and 12, 2014.</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Survey team: Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 0 Medicaid: 51 Other: 2 Total: 53</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings</p>	F000000	<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 law. 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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F000225 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be</p>				

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	<p>reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure timely criminal history checks were completed for 2 of 6 employee files reviewed for appropriate pre-hiring screening (CNAs # 8 and #12).</p> <p>Findings include:</p> <p>On 8/11/14, at 4:00 p.m., 6 employee files were reviewed for appropriate pre-hiring screening, related to the abuse prohibition protocol. 2 of the 6 employee files reviewed, for CNA #8 and CNA #12, did not have evidence of timely criminal history screening.</p> <p>Review of the employee file for CNA #8 indicated the CNA, who was a minor, was hired on 5/23/14. An employee release of information statement was dated 5/15/14 and signed by the CNA. There were no results in the employee file regarding a criminal history check being completed.</p> <p>The employee file for CNA #12 was</p>	F000225	<p>F225</p> <ol style="list-style-type: none"> C.N.A.'s #8 and #12 were removed from the schedule immediately pending the return and review of the Juvenile Criminal History checks. All current employee records audited to assure Criminal History checks were completed and reviewed for appropriate pre-hiring screening. In order to ensure ongoing compliance with the completion of the Criminal Background checks, The Administrator and/or designee will audit all potential hire/rehire employee files to assure all Criminal history checks are completed and reviewed prior to hiring. Should concerns be noted during pre-hire screenings, immediate corrective action shall be taken. The Administrator and/or designee will report the findings of these audits and any corrective actions to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted. 9-11-14 	09/11/2014			

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	<p>reviewed, and indicated the CNA, who was a minor, was hired on 5/23/14. There was a Request for Juvenile Criminal History Information, dated 5/23/14, and signed by CNA #12, but there were no results from the criminal history request.</p> <p>The Administrator was interviewed, on 8/12/14, at 11:20 a.m., and indicated since the CNAs were both minors, their parents had to make the request to the state for the criminal history checks to be completed. She indicated she did not know if the parents of CNA #8 and #12 had requested that the criminal history checks be completed.</p> <p>The Regional Director of Operations was interviewed, on 8/12/14, at 12:30 p.m., and indicated the procedure for criminal checks for minors was for the minor to go to the local police station with the parent, get finger printed, the police then provided the parent with an application which only the parent could send to the Indiana State Police. She indicated the results were then sent to the parents from the Indiana State Police, and the parents would provide the documentation to the facility. She indicated this process could take a long time.</p> <p>The Administrator provided a policy, Employee Release of Information</p>						

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F000441 SS=D	<p>Statement(undated), on 8/12/14 at 12:55 p.m., which she indicated was the policy used for criminal checks for minors. The policy was reviewed on 8/12/14, at 12:55 p.m., and indicated, "I hereby authorize the release of any information related to arrests, convictions, and imprisonments available from any police records or law enforcement sources."</p> <p>3.1-28(b)(1)(A) 3.1-28(b)(1)(B) 3.1-28(b)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 2 of 3 CNAs (CNA #1 and #9), observed during incontinence/toileting care, washed their hands after removing gloves when providing incontinence care. This affected 2 of 3 residents observed for incontinence/toileting care (Residents #E and #D).</p> <p>Findings include:</p> <p>CNA #1 was observed providing incontinence care to Resident E, on 8/11/14, at 10:14 a.m.</p> <p>The resident was noted to have an indwelling catheter, with a brief. However, the catheter was leaking and</p>	F000441	<p>F441</p> <p>1. Residents' #E and # D were not affected. C.N.A.'s #1 and #9 were re-educated on proper hand washing technique, including but not limited to specific times in which hands must be washed.</p> <p>2. As all residents' have the potential to be affected, all staff was re-educated on proper hand washing technique, with return demonstration, including but not limited to specific times in which hands must be washed.</p> <p>3. In an effort to ensure ongoing compliance with proper hand washing specifically times for hand washing in a manner to prevent infection, the DON and/or designee will monitor resident care at varied times on varied shifts 5x/week x 1</p>	09/11/2014

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	<p>the brief, as well as the resident's pants and shirt were wet. CNA #1 removed the wet clothes and brief, cleansed the resident, applied a new brief, pants, and shirt, then removed her gloves. The CNA then took a plastic bag, put on another pair of gloves and placed the brief in one plastic bag, and soiled clothing items in another. She then removed her gloves, and without washing her hands took the plastic bags out to the nursing station, placed her left hand on the counter at the nurse's station for a brief time, then proceeded to walk to the soiled utility room.</p> <p>CNA #9 was observed assisting Resident #D to the bathroom in the resident's room, on 8/11/14, at 2:27 p.m. She assisted the resident to the bathroom, removed his brief, which she indicated was wet, placed the brief in a plastic bag, then removed her gloves. Without washing her hands, she left the resident's room with the plastic bag in her hand, went into the soiled utility room, quickly came back out, then went to the linen cart in the hall, removed some washcloths from the cart, and went back into the resident's room.</p> <p>The Director of Nursing was interviewed, on 8/12/14, at 11:25 a.m., and indicated staff should wash their hands before and</p>		<p>month then weekly thereafter to assure proper procedure. Should concerns be observed, corrective actions will be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report the findings of the observations and any corrective actions taken to the QA committee monthly x 3 months, then quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 9-11-14</p>	

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	<p>after removal of gloves, and before leaving the resident's room.</p> <p>The Administrator provided 2 policies, one for Handwashing Procedure and one for Use of Gloves (both were undated), on 8/12/14, at 11:30 a.m. Review of the policies at 11:35 a.m., on 8/12/14 indicated the following: The Handwashing Procedure policy indicated: "Specific times hands must be washed: 1. Before and after direct resident contact."</p> <p>The Use of Gloves policy indicated: Gloves were worn to reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite could transmit these microorganisms to another resident. Also, gloves should not be used as a substitute for hand-washing. The Use of Gloves policy indicated gloves should be removed and hands washed when the activity was completed, when the integrity of the glove was in doubt, and between residents.</p> <p>3.1-18(a)</p>			