STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 00 B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TWIN CITY HEALTH CARE	627 E NORTH H STREET GAS CITY, IN 46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 11, 12, 13, 16, and 17, 2024 Facility number: 000137 Provider number: 155232 AIM number: 100266140 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 5 Medicaid: 30 Other: 10 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 20, 2024.	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on 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 law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure medications given by gastrostomy tube (G-tube) were administered according to physician's orders and facility policy for 1 of 7 residents observed for medication administration, resulting in an 8.89 % medication error rate. (Resident 31) Finding includes:	F 0759	1. Resident 31 did not receive any negative outcomes related to this alleged deficient practice. Resident 31 is receiving medications per physician's orders and facility policy. LPN 4 and RN 6 have been re-educated on medication administration via g-tube with a special focus on	09/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Sanders	HFA	10/02/2024

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	During an observation, on 9/13/24 at 10:19 a.m., LPN 4 removed the stopper from Resident 31's G-tube, flushed the G-tube with 30 ml (milliliters) of water, and administered multiple medications one at a time via G-tube. The medications included escitalopram (antidepressant) 20 mg tablet crushed mixed with 20 ml water, multivitamin crushed mixed with 20 ml water, linezolid (antibiotic) 600 mg crushed and mixed with 20 ml water, and docusate sodium (50 mg/5 ml) 10 ml. Auscultation of an air bolus and a check for residual stomach contents was not performed prior to the medication administration. During an interview, immediately following the medication administration, LPN 4 indicated the resident took all medications via G-tube. Placement for the G-tube should have been checked prior to the administration of medications, which included an air bolus and a check for residual stomach contents. She had not completed a placement check. Resident 31's record was reviewed on 9/13/24 at 10:38 a.m. Diagnoses included dysphagia, nausea, and vomiting. Physician's orders included docusate sodium (stool softener) liquid 50 mg/5 ml - 10 ml orally twice a day (7/11/24), escitalopram (antidepressant) 20 mg orally daily (7/24/24), multivitamin orally daily (8/15/24), linezolid (antibiotic) 600 mg orally twice a day (8/30/24), Administer 10 ml air bolus via G-tube prior to administration of medications or feeding, and auscultate abdomen to confirm air movement and appropriate placement of feeding tube every shift. (2/9/24), Assess bowel sounds in all quadrants before and after medication administration, and hold if absent and notify medical provider for further instructions every shift. (2/9/24), and		giving medications, checking placement, and checking residual per physician's orders and facility policy. 2. Any resident receiving medications via g-tube have the potential to be affected and are receiving medications per physician's orders and facility policy. Nurses and QMAs have been educated on medication administration via g-tube with a special focus on giving medications, checking placement, and checking residual per physician's orders and facility policy. 3. The facility's policies for Medication Administration and Tube Feedings (Naso-gastric or Gastrostomy) have been reviewed and no changes are indicated at this time. The QMAs and nurses, including LPN 4 and RN 6, have been re-educated on medication administration via g-tube with a special focus on giving medications, checking placement, and checking residual per physician's orders and facility policy. A monitoring form has been implemented. 4. The DON or designee will be responsible for completing the monitoring form to ensure g-tube medications are given per physician's orders and facility	

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	Check residual (stomach contents) before medication administration, including enteral nutrition. If less than 120 ml obtained, re-instill residual via feeding tube. If greater than 120 ml obtained, do not proceed and notify medical provider for further instructions every shift (2/9/24). During an interview, on 9/16/24 at 4:20 p.m., RN 6 indicated Resident 31 received all of his medications per G-tube. Resident 31 had attempted to take medications orally for about two days, but he did not like taking medications orally, and the medications were again administered per G-tube. To administer medications per G-tube, she listened to bowel sounds before and after medication administration. During an interview, on 9/17/24 at 2:00 p.m., the DON indicated prior to medication administration per G-tube, placement should be checked per facility policy. Resident 31 was to receive his medications per G-tube. He had wanted to take his medications orally and get rid of his G-tube. His medications had gone back and forth between oral and G-tube routes with some medicines taken orally and others taken via G-tube. An interdisciplinary care plan meeting with the resident representative was held on 9/13/24. The resident's medication administration was discussed and it was decided that G-tube medication administration was preferred. After the medical provider's consent, the DON had updated the medication orders on 9/17/24 to administer all medications via G-tube as some had been listed per oral route. A current facility policy, revised 4/2017 and provided by the Administrator on 9/17/24 at 3:17 p.m., titled "Medication Administration,"		policy. Two residents receiving g-tube medications will be monitored. Monitoring will be completed on scheduled work days, at alternating times as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be identified, immediate corrective action will occur. The results of this monitoring and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months. The frequency of this monitoring will be increased or decreased according to the findings.	

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	indicated "...Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders ... Medications are administered to residents only as prescribed ... Always observe the six rights of giving each medication ... right route ...." A current facility policy, dated 10/2014, provided by the Administrator on 9/17/24 at 3:17 p.m., titled "Tube Feedings (Naso-gastric or Gastrostomy Tubes)" indicated " ...Medication Administration via Gastrostomy Tube: ...Check placement by auscultating the resident's abdomen about 3 inches below the sternum with the stethoscope, gently insert 10 cc [cubic centimeters] of air into the tube. You should hear the bubble entering the stomach. If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric content implies that the tube is patent and in the stomach. If no gastric content appears, the tube may be against the lining of the stomach or the tube may be obstructed. If you meet resistance as you aspirate for stomach content, stop the procedure. After you establish the tube is patent and in the correct position ... Administer each medication ...." 3.1-48(c)(1)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 by not wearing appropriate personal protective equipment (PPE) in areas requiring transmission-based precautions (TBP) during random observations on the 100 and 200 halls.	F 0880	1 & 2. There were no residents affected by this alleged deficient practice but all residents in have the potential to be affected. Housekeeper 3, LPN 4, and CNA 5 have been re-educated on isolation procedures including	09/19/2024

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	Findings include: During a random observation, on 9/11/24 at 11:29 a.m., Housekeeper 3 was seen entering and exiting Room 123 while wearing gloves and a surgical mask. Signage on the door indicated the residents were in TBP and a gown, gloves, face shield and mask were required before entering the residents' room. During an interview, at the time of observation, Housekeeper 3 indicated she didn't need to wear a face shield, as she wore glasses. She only needed to wear gloves and a surgical mask. During a random observation, on 9/12/24 at 2:08 p.m., Housekeeper 3 entered a positive COVID-19 resident's room while wearing a gown and gloves. Signage on the door indicated the resident was on TBP and everyone must wear a gown, gloves, mask and face shield upon entering the room. During an interview, on 9/13/24 at 10:19 a.m., LPN 4 indicated she just needed to wear a gown, gloves, surgical mask, and a face shield when entering. She didn't need to wear an N95 (respirator) mask. During a random observation, on 9/13/24 at 11:28 a.m., CNA 5 entered Resident 31's room wearing a gown, gloves, surgical mask, and a face shield. During an interview, at the time of observation, CNA 5 indicated they could wear surgical masks upon entering a TBP resident's room. During an interview, on 9/13/24 at 1:31 p.m., the DON indicated signage for any resident on contact or droplet isolation was taped to the door.		wearing a gown, gloves, face shield, and N95 mask when entering a Covid positive room. 3. The facility's policy on Isolation/TBP has been reviewed and no changes are indicated at this time. All staff has been re-educated on isolation procedures including wearing a gown, gloves, face shield, and N95 mask when entering a Covid positive room. A monitoring form has been implemented. 4. The Administrator or designee will be responsible for completing the monitoring form to ensure TBP is being used appropriately. Two staff members will be monitored daily on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be identified, immediate corrective action will occur. The results of this monitoring and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months. The frequency of this monitoring will be increased or decreased according to the findings.	

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	Staff should be wearing N95 masks if they entered an isolation room. The facility had plenty of PPE available. The facility had just had an in-service regarding infection control when the first resident tested positive for COVID-19. There were teachable moments completed as she walked through the facility. The facility was aware that they were having a problem with infection control. Housekeeper 3 completed a return demonstration for donning and doffing of PPE. Review of Resident 31's clinical record was completed on 9/16/24 at 10:38 a.m. Review of a progress note indicated he was positive for COVID-19 with symptoms of cough and nasal congestion. Current orders included strict droplet, single room isolation maintained, all services in the room due to positive COVID-19. A facility policy, dated 10/2015, provided by the Administrator on 9/17/24 at 3:13 p.m., titled "Isolation (Transmission- Based Precautions) Guidelines," indicated the following: "...5. All personnel must follow transmission- based precautions, as indicated...." 3.1-18(a)(2)			