STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING -- B. WING	09/26/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/26/24 Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140 At this Emergency Preparedness survey, Twin City Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 75 certified beds. At the time of the survey, the census was 43. Quality Review completed on 09/30/24	E 0000	Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or corrections set forth on this statement of deficiencies. The plan of correction is prepared and submitted because of the requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/26/24 Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140 At this Life Safety Code survey, Twin City Health Care was found not in compliance with	K 0000	Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or corrections set forth on this statement of deficiencies. The plan of correction is prepared and submitted because of the requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This 1975 one story facility with a 1990 addition 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 and areas open to the corridors. The facility was partially protected with type II EES 330 Kw propane generator. The facility has a capacity of 75 and had a census of 43 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached garage and shed providing facility services including storage of mowers, maintenance equipment and were not sprinklered. Quality Review completed on 09/30/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General (#1.) Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions. (#2.) Based on observation and interview, the facility failed to ensure 1 of 1 egress doors from the sprinkler room met the clear width according to LSC 7.2.1.2.3.2, which states door openings in means of egress shall be not less than 32 in. (810 mm) in clear width. The deficient practices could affect 30 residents in two smoke compartments.	K 0211	1 There were no residents affected by this alleged deficient practice. However, up to 30 residents had the potential to be affected. 2 a. The isolation cart has been removed from service. There has been facility wide re-education provided on the delivery of stock, and it being delivered to the storage room, and not hallway. Facility wide education	10/10/2024

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	Findings include: (#1.) Based on observation with the Maintenance Director and the Administrator on 09/26/24 at 8:45 a.m. and again at 10:30 a.m., the E-hall exit corridor contained a skid full of supplies and a PPE cart not on wheels taking up to four feet of corridor width. Based on an interview at the time of observations, the Maintenance Director agreed in the E-hall exit corridor there was a skid of supplies taking up 4 feet of the corridor, PPE cart in the hall not on wheels, and the items were removed. (#2.) Based on observation with the Maintenance Director at 10:55 a.m., the sprinkler riser room door would only half open due to an air compressor blocking the door from fully opening. This condition reduces the clear width of 32 inches by half. Based on an interview at the time of observation, the Maintenance Director agreed the sprinkler riser room door would not fully open to the required width of 32 inches because of the placement of the air compressor. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		on PPE carts requiring wheels, and dollies built in-case the wheels break off of isolation carts. b. The Air compressor for the sprinkler system was re-located in the electrical room, and the door now opens completely. 3 The facility's preventative maintenance program has been reviewed with no required changes at this time. The maintenance director has been re-educated regarding the means of egress is continuously maintained free of all obstructions to full use in case of emergency. 4 The Administrator or designee will be responsible to check all means of egress to ensure staff compliance. This will be done daily for the first month on scheduled working days and then weekly thereafter. Should a concern be found immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed at the monthly QA meetings on an ongoing basis for a minimum of 6 months and the frequency of the audits will be increased or decreased according to the findings. 5 The above corrective action will be completed on or after 10/10/2024	

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K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 main exit door had exit and directional signs that are displayed in accordance with LSC 7.10 with continuous illumination. This deficient practice could affect 30 residents. Findings include: Based on observation with the Maintenance Director on 09/26/24 at 11:44 a.m., to the main exit from the lobby/dining area and C-hall had an exit door through a waiting entrance area leading to the outside. The main exit door did have an exit sign above the door but was not visible from the lobby and C-hall and there were no directional exit signs leading to the main exit. Based on an interview at the time of the observations, the Maintenance Director agreed the main exit door was not visible from the lobby and there were no directional exit signs leading to the main exit. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0293	1 There were no residents affected by this alleged deficient practice. However, up to 30 residents have the potential to be affected. 2 There has been a directional exit sign installed in the lobby leading to the main exit. 3 The facility's preventative maintenance program has been reviewed with no required changes at this time. A facility tour was conducted ensuring all exit lights are visible, and that the line of exit travel is obvious. The Maintenance Director has been re-educated on exit signage and that the line of exit travel has to be obvious. 4 The Maintenance director or designee will be responsible to visually inspect all exit lights to ensure they are displayed, illuminating and the line of exit travel is obvious. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed at the monthly QA meetings on an ongoing basis for a minimum of 6 months and the frequency of the audits will be increased or decreased according to the findings. 5 The above corrective action	10/23/2024

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			will be completed on or before 10/10/2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 14 electrical splices for exit signs were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 09/26/24 at 11:54 a.m., above the ceiling tiles by the C-hall smoke door there were two electrical wires spiced into an exit sign that were not contained inside a junction box. Based on an interview at the time of the observation, the Maintenance Director acknowledged there were electrical splices that were not protected with a junction box. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0511	1 There were no residents affected by this alleged deficient practice. However, up to 20 residents had the potential to be affected. 2 Above the ceiling tiles by the C hall smoke door the two electric wires spliced into and exit sign are now contained inside a junction box. 3 The Facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated that splices shall be made in a junction box. 4 The Maintenance director or designee will be responsible to visually inspect all exit signs to ensure all splices are contained in a junction box. This will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed at the monthly QA meetings on an ongoing basis for a minimum of 6 months and the frequency of the audits will be increased or decreased according to the findings.	10/10/2024

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			5 The above corrective action will be completed on or before 10/10/2024	
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 8 of 43 resident rooms in the facility from the use of liquid oxygen cylinders stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 Liters (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits to be self-closing or automatic closing. This deficient practice affects at least 10 residents. Findings include: Based on observations with the Administrator and Maintenance Director on 09/26/24 between 11:15 a.m., to 1:00 p.m. there were eight resident rooms (108, 128, 207, 213, 214, 215, 217, and 218) that contained an upright liquid oxygen stationary container on wheels that were not separated from the remainder of the facility by a complete fire barrier. Each resident room door had a fire rating of 45 minutes but were not self-closing or	K 0930	No POC required.	10/10/2024

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	automatic closing. Based on interview at the time of observation, the Maintenance Director agreed there were liquid oxygen containers in eight resident sleeping rooms within the patient care area and the resident room doors were not self-closing or automatic closing. The Administrator provided the count of liquid oxygen containers in resident rooms and stated the reason liquid oxygen tanks are used is because the residents in the eight rooms are on doctor's orders for high flow oxygen. Additionally, the Administrator indicated the Respiratory Therapy office keeps track of residents using liquid oxygen and their room locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			