Jessica Sanders

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

10/10/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155232		ILDING	ONSTRUCTION	(X3) DATE COMPL 09/26 /	ETED	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 627 E NORTH H STREET GAS CITY, IN 46933					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000 Bldg			E 00	000	Submission of this Plan of			
	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		E 00)OO	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. plan of correction is prepared submitted because of the requirements under state and	The and		
	City Health Care wa Emergency Prepared Medicare and Medic and Suppliers, 42 C	Preparedness survey, Twin as found in compliance with dness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of			federal law. Please accept this plan of correction as our credil allegation of compliance.			
	the survey, the cens	us was 43.						
K 0000								
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 00	000	Submission of this Plan of correction does not constitute admission or an agreement by provider of the truth or facts	the		
	Survey Date: 09/26 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C Care was found not	0137 55232 66140 Code survey, Twin City Health			alleged or corrections set forth this statement of deficiencies. plan of correction is prepared a submitted because of the requirements under state and federal law. Please accept this plan of correction as our credil allegation of compliance.	The and		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	E	TITLE		(X6) DATE	

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B53L21 Facility ID: 000137 If continuation sheet Page 1 of 7

HFA

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155232	A. BUILDING B. WING	<u>01 </u>	COMPLETED 09/26/2024		
		155252	<u> </u>		09/20/2024		
NAME OF P	ROVIDER OR SUPPLIER	1		r address, city, state, zip cod NORTH H STREET			
TWIN CITY HEALTH CARE				CITY, IN 46933			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Requirements for Pa	articipation in , 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the					
		etion Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	-	facility with a 1990 addition					
	was determined to b						
		as fully sprinklered. The arm system with smoke					
	•	ridors and areas open to the					
		ity was partially protected with					
		v propane generator. The facility					
		and had a census of 43 at the					
	time of this survey.						
	All areas where resi	idents have customary access					
	were sprinklered. T	he facility had a detached					
		oviding facility services					
		f mowers, maintenance					
	equipment and were	e not sprinklered.					
	Quality Review con	npleted on 09/30/24					
K 0211	NFPA 101						
SS=E Bldg. 01	Means of Egress -	- General					
	` ′	ervation and interview, the	K 0211	1 There were no residents	10/10/2024		
	-	sure 1 of 5 corridor means of		affected by this alleged deficie	ent		
	_	nuously maintained free of		practice. However, up to 30			
	obstructions.			residents had the potential to	be		
	` ′	ervation and interview, the		affected.			
	-	sure 1 of 1 egress doors from		2 a. The isolation cart ha			
	-	net the clear width according which states door openings in			nere		
		all be not less than 32 in. (810		has been facility wide re- education provided on the del	ivery		
	mm) in clear width.	*		of stock, and it being delivered	- I		
	· ·	ces could affect 30 residents in		the storage room, and not			
	two smoke compart			hallway. Facility wide educati	on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B53L21

Facility ID: 000137

If continuation sheet Page 2 of 7

Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2024 155232 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 627 E NORTH H STREET TWIN CITY HEALTH CARE GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on PPE carts requiring wheels, Findings include: and dollies built in-case the wheels break off of isolation carts. (#1.) Based on observation with the Maintenance b. The Air compressor for Director and the Administrator on 09/26/24 at 8:45 the sprinkler system was a.m. and again at 10:30 a.m., the E-hall exit corridor re-located in the electrical room, contained a skid full of supplies and a PPE cart and the door now opens not on wheels taking up to four feet of corridor completely. width. Based on an interview at the time of observations, the Maintenance Director agreed in The facility's preventative the E-hall exit corridor there was a skid of supplies maintenance program has been taking up 4 feet of the corridor, PPE cart in the hall reviewed with no required changes not on wheels, and the items were removed. at this time. The maintenance (#2.) Based on observation with the Maintenance director has been re-educated Director at 10:55 a.m., the sprinkler riser room door regarding the means of egress is would only half open due to an air compressor continuously maintained free of all blocking the door from fully opening. This obstructions to full use in case of condition reduces the clear width of 32 inches by emergency. half. Based on an interview at the time of The Administrator or observation, the Maintenance Director agreed the designee will be responsible to sprinkler riser room door would not fully open to check all means of egress to the required width of 32 inches because of the ensure staff compliance. This will placement of the air compressor. be done daily for the first month on scheduled working days and then The findings were reviewed with the weekly thereafter. Should a Administrator and Maintenance Director during concern be found immediate the exit conference. corrective action will occur. Results of these reviews and any 3.1-19(b) 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. The above corrective action will be completed on or after 10/10/2024

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B53L21 Facility ID: 000137 If continuation sheet

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION K 0293 NFPA 101 REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX PREFIX COMPLET	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155232		(X2) MULTIPLE A. BUILDING B. WING	e construction 5 01	(X3) DATE SURVEY COMPLETED 09/26/2024			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION K 0293 NFPA 101 REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX PREFIX COMPLET			2	627 E NORTH H STREET				
	PREFIX TAG	(EACH DEFICIEN REGULATORY OR	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON UBE CO IPRIATE	(X5) MPLETION DATE	
	SS=E	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 through a waiting entrance area leading to the outside. The main exit door through a waiting entrance area leading to 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. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 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 a directional exit signage and that the line of exit travel is obvious. The Maintenance director or designee will be responsible to visually inspect all exit lights to ensure they are falloqued, illuminating and the line of exit travel is obvious. This waitinenance program. Should a concern be found immediate corrective action will occur. Results of these reviews and any corrective action will occur. Results of these reviews and any corrective action will be dincursed action of the findings. 5 The above corrective action	Bldg. 01	failed to ensure 1 of directional signs that with LSC 7.10 with deficient practice of Findings include: Based on observation Director on 09/26/2 from the lobby/dinit door through a wait the outside. The masign above the door lobby and C-hall an signs leading to the interview at the tim Maintenance Direct was not visible from directional exit sign. The finding was reveand Maintenance Director conference.	on with the Maintenance of the Maintenance are and C-hall had an exit sing entrance area leading to the with was not visible from the ad there were no directional exit main exit. Based on an e of the observations, the tor agreed the main exit door in the lobby and there were no disclarated and there were no directional exit main exit. Based on an e of the observations, the tor agreed the main exit door in the lobby and there were no disclarated to the main exit.	K 0293	affected by this alleged def practice. However, up to 30 residents have the potential affected. 2 There has been a directional exit sign installe lobby leading to the main et 3. The facility's prevental maintenance program has reviewed with no required at this time. A facility tour wonducted ensuring all exit are visible, and that the line travel is obvious. The Main Director has been re-educate exit signage and that the line exit travel has to be obvious. The Maintenance directly designee will be responsibly visually inspect all exit lightensure they are displayed, illuminating and the line of travel is obvious. This will be on a monthly basis through facility's preventative maintenance program. Should a concern found immediate corrective will occur. Results of these reviews and any corrective will be discussed at the model of the program of the audits increased or decreased act to the findings.	ficient O al to be ed in the exit. ative been changes was t lights e of exit attenance ated on ne of as. ector or le to ts to exit be done n the tenance n be e action e actions onthly ag basis s and e will be ecording	0/23/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155232	ì í	LDING	ONSTRUCTION 01	COMPL	X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIE			627 E N	ADDRESS, CITY, STATE, ZIP COD NORTH H STREET ITY, IN 46933			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ATE	(X5) COMPLETION DATE	
mo	REGUENTORT	RESCIBENTIATING INFORMATION		1710	will be completed on or before 10/10/2024	Э	DAIL	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	d Electric						
Blag. UT	failed to ensure 1 of signs were made in requires electrical with NFPA 70, Na 322.56 (A) states is junction boxes. The affect 20 residents Findings include: Based on observat Director on 09/26/ceiling tiles by the two electrical wire were not contained on an interview at Maintenance Directlectrical splices the junction box.	ion and interview, the facility of 14 electrical splices for exit in a junction box. LSC 9.1.2 wiring and equipment to comply stional Electrical Code. Article splices shall be made in listed in deficient practice could in one smoke compartment. ion with the Maintenance 24 at 11:54 a.m., above the C-hall smoke door there were is spiced into an exit sign that it inside a junction box. Based the time of the observation, the externaction acknowledged there were not protected with a eviewed with the Administrator Director during the exit	K 05	11	1 There were no resident affected by this alleged deficie practice. However, up to 20 residents had the potential to affected. 2 Above the ceiling tiles be the C hall smoke door the two electric wires spliced into and sign are now contained inside junction box. 3 The Facility's preventati maintenance program has be reviewed with no required characteristics shall be made in a junch box. 4 The Maintenance directed designee will be responsible to visually inspect all exit signs to ensure all splices are contained a junction box. This will be do on a monthly basis through the facility's preventative maintenance program. Should a concern be found immediate corrective activities and any corrective activities and activities	ent be by continued and that the continued and that the continued and the continued	10/10/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155232		A. BU	A. BUILDING <u>01</u> B. WING		COMPLETED 09/26/2024	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP COD 627 E NORTH H STREET GAS CITY, IN 46933					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					5 The above corrective act will be completed on or before 10/10/2024		
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - I	Liguid Oxygen Equipment					
	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:		K 0930		No POC required.		10/10/2024
	and Maintenance Di 11:15 a.m., to 1:00 p rooms (108, 128, 20 that contained an up container on wheels	ons with the Administrator irector on 09/26/24 between p.m. there were eight resident 17, 213, 214, 215, 217, and 218) oright liquid oxygen stationary that were not separated from					
	barrier. Each reside	e facility by a complete fire ent room door had a fire rating ere not self-closing or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B53L21

Facility ID: 000137

If continuation sheet

Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155232		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2024	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			62	27 E N	DDRESS, CITY, STATE, ZIP COD ORTH H STREET TY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	of observation, the there were liquid ox resident sleeping ro area and the resident self-closing or autor Administrator provict containers in resident reason liquid oxyge the residents in the orders for high flow Administrator indic office keeps track of and their room local.	ided the count of liquid oxygen introoms and stated the in tanks are used is because eight rooms are on doctor's oxygen. Additionally, the ated the Respiratory Therapy if residents using liquid oxygen					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B53L21 Facility ID: 000137 If continuation sheet Page 7 of 7