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	09/25/2023

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 19, 20, 21, 22, and 25, 2023. Facility number: 000137 Provider number: 155232 AIM number: 100266140 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 1 Medicaid: 29 Other: 4 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 29, 2023.	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 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Sanders	HFA	10/13/2023

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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	§483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation, interview, and record review, the facility failed to ensure the results report from the last annual Indiana Department of Health (IDOH) survey were posted at an accessible height and in a readily accessible location for 2 of 2 residents interviewed in a group setting (Residents 4 and 5). This deficient practice had the potential to impact 34 of 34 residents/or representatives for those residents who resided in the facility. Findings include: During an observation on 9/20/23 at 9:28 a.m., a sign was posted in the lobby which indicated the last annual IDOH survey report was posted in the activity room. During an observation on 9/20/23 at 9:29 a.m., a sign identifying the activity room could not be located. Following directions received, the activity area was located on the B Hall.	F 0577	1 & 2. There were no residents, including Residents 4 & 5, affected by this alleged deficient practice. The results report from the last annual Indiana Department of Health (IDOH) survey are now posted at an accessible height and in a readily accessible location. A sign has been hung to indicate the location of the Survey results. 3. The facility's policy for Residents Rights was reviewed. All staff have been re-educated on the policy with a special focus on posting survey results in a place readily accessible to residents and family members and to post a notice of availability of such report in areas of the facility that are prominent and accessible to the public. A monitoring tool has been	09/26/2023

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	During an observation on 9/20/23 at 9:33 a.m., the last annual IDOH survey report was observed in a wall mounted box hanging approximately 5 feet from the ground, inside the activity room. The box had no labeling to indicate the binder was the survey report. By standing upright, and looking down on the spine of the binder, the label could be read. During a resident group interview on 9/21/23 at 3:04 p.m., 2 of 2 awake residents (Residents 4 & 5) indicated they would not be able to obtain and review the last annual IDOH survey results without assistance because they could not reach the report where it was posted. During an observation on 9/25/23 at 9:19 a.m., a direction sign, located at the end of the hall leading to the dining room and therapy area, indicated the activity room was located on this hall. There was no activity area located on this hallway, as the activity room was observed in the B Hall. During on interview on 9/25/23 at 9:21 a.m., the Administrator indicated the directions signs located at the end of each hallway had not been changed since her arrival in 2020. During an observation and interview in the activity room on 9/25/23 at 10:30 a.m., the Activity Director and Administrator indicated an individual would need to stand to reach the annual IDOH survey report binder. Review of a current, undated, facility policy titled, " Resident Rights", provided by the Administrator during the 9/19/23 entrance conference and located in a survey preparedness binder, indicated the following:		implemented. 4. The Administrator or designee will be responsible to complete the monitoring tool to ensure survey results are readily available. Monitoring will occur monthly on an ongoing basis during Resident Council meetings via questioning of the residents regarding the survey binder. Should a concern be found, immediate corrective action will occur. The results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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	"...The resident has the right to...Examine the results of the most recent survey of the facility conducted by Federal or State survey on and any plan of correction in effect with respect to the facility; and the facility must-- Post in a place readily accessible to residents, and family members...the results if the most recent survey of the facility...Post notice of availability of such report in areas of the facility that are prominent and accessible to the public...." 3.1-3(b)(1)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure a resident's code status was correctly listed and readily available in the resident's electronic medical record (EMR) for 1 of 16 residents reviewed for advance directives (Resident 83). Finding includes: Resident 83's record was reviewed on 9/20/23 at 3:49 p.m. Diagnoses included left and right femur fractures, chronic obstructive pulmonary disease, abnormal electrocardiogram, acute respiratory failure with hypoxia, and chronic atrial fibrillation. Her physician's orders included code status DNR (do not resuscitate) initiated on 9/17/23. A Code Status/Advance Directives form indicated the resident did not want to have CPR (cardiopulmonary resuscitation) performed as a life-saving measure. The form, signed by the	F 0578	1 & 2. There were no residents, including Resident 83, negatively affected by this alleged deficient practice. Resident 83's code status is correctly listed and readily available in the resident's electronic medical record. All other residents have been reviewed and their code status is correctly listed and readily available in their EMR. 3. The facility's policy for Advance Directives has been reviewed and no changes are indicated at this time. All Nursing Staff have been re-educated on this policy with a special focus on ensuring the code status is listed and readily available in the resident's EMR. A monitoring tool has been implemented.	09/26/2023

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	resident on 9/16/23, was in the paper chart. The face sheet in the EMR lacked her code status. The "Continuity of Care" record in the EMR indicated, under the Advance Directives section, "No Advance Directives are on file for this resident." During an interview, on 9/22/23 at 1:24 p.m., RN 4 indicated if the resident's code status was a DNR, then it would be listed on the resident's face sheet in the EMR. During an interview, on 9/25/23 at 12:52 p.m., LPN 5 indicated to find a resident's code status she would get the resident's paper chart as that was the fastest method for her. The code status should also be listed on the face sheet in the EMR. During an interview, on 9/25/23 at 2:18 p.m., the DON indicated the EMR face sheet should have the code status of a resident as the staff might utilize this record to determine code status. If a resident did not have advance directives, then CPR would be performed. She was uncertain why the Resident 83's code status was missing from the face sheet or why the Continuity of Care record indicated she did not have advance directives. During the interview, she checked recently admitted residents and determined a few others were missing the listing of code status on their face sheets. She was uncertain, but believed the previous office manager had entered the code status for the new residents. The new office manager was probably not aware of that duty. A current facility policy, dated 1/2015, provided by the Administrator on 9/25/23 at 3:17 p.m., titled		4. The DON or designee will be responsible for completing the monitoring tool to ensure the code status is listed and readily available in the resident's EMR. This monitoring will occur on scheduled work days looking at all new residents admitted for the past week and 5 other residents. This monitoring will occur one time weekly for four weeks then monthly thereafter on an ongoing basis. Should a concern be found, immediate corrective action will occur. The results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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	"Advance Directives," indicated " ...Nursing personnel shall be notified of the presence of an Advance Directive on the clinical record and shall be instructed about the procedures to be followed to assure the resident's expressed wishes are honored ...." 3.1-4(f)(5)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the			

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	alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency for 1 of 1 resident-to-resident altercations reviewed for abuse (Resident 9 and 26). Finding includes: During an interview, on 9/20/23 at 9:35 a.m., Resident 9 indicated another resident had hit her several months ago. She no longer went near the other resident because of the altercation. Resident 9's clinical record was reviewed on 9/20/23 at 3:40 p.m. Her diagnoses included paranoid schizophrenia, bipolar disease, major depressive disorder, recurrent, anxiety disorder, and pseudobulbar affect. An 8/8/23 quarterly Minimum Data Set (MDS) assessment indicated she was cognitively intact and had exhibited no behaviors during the assessment period. She utilized a walker and a wheelchair for mobility and was independent with locomotion off and on the nursing unit. A care plan for false allegations against staff, initiated 11/15/22 and last revised on 8/23/23, indicated the resident had a history of making false allegations against staff regarding care or lack of care, abuse, and neglect. On 5/3/23, false allegations against other residents was added. The goal was for the resident to voice concerns to staff, and staff will investigate as indicated per policy through next review. Interventions included to encourage resident to notify staff of concerns, to interview resident regarding concerns to gain detailed knowledge of neglect/abuse, and to follow the facility abuse	F 0609	The alleged incident involving Resident 9 & 26 has been reviewed by IDOH. The Administrator has been re-educated on reporting allegations of abuse to the appropriate agencies including IDOH prior to or in conjunction with investigating any such allegations. All residents have been reviewed for alleged abuse allegations with no concerns noted. The Administrator has been re-educated on reporting allegations of abuse to the appropriate agencies including IDOH prior to or in conjunction with investigating any such allegations. The facility's policy for Abuse Prohibition, Reporting, and Investigation has been reviewed and no changes are indicated at this time. The Administrator has been re-educated on this policy with a special focus on reporting allegations prior to or in conjunction with investigating the allegation. A monitoring tool has been implemented. The Administrator or designee will be responsible to complete the monitoring tool to ensure all	09/26/2023

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	policy and procedure. During an interview, on 9/21/23 at 10:28 a.m., the Administrator provided an investigation into an allegation of abuse by Resident 9, and indicated she had not reported the allegation to the State Agency because the allegation was false. The investigation of the resident altercation on 5/3/23 was reviewed on 9/21/23 at 10:34 a.m. The resident had alleged that Resident 26 had hit her because she (Resident 9) had stopped in front of her (Resident 26). The area Resident 26 hit (her arm) was sore. Resident 26 indicated she had asked Resident 9 to move, she did not so she tapped Resident 9 on the arm to get her attention and talked louder. Another resident witnessed the event and corroborated Resident 26's version. Review of the camera footage of the event by the Social Service Director and the Administrator corroborated Resident 26's statement. They concluded there was no abuse, and the allegation was false. Resident 26's clinical record was reviewed on 9/21/23 at 2:31 p.m. Her diagnoses included unspecified intellectual disabilities, psychotic disorder with delusions due to known physiological condition, unspecified psychosis not due to a substance or known physiological condition, vascular dementia, anxiety disorder, major depressive disorder, recurrent, mood disorder due to known physiological condition, visual hallucinations, violent behavior, and delusional disorders. A 4/21/23 annual MDS assessment indicated the resident was cognitively intact and had not exhibited behaviors during the assessment period. She utilized a walker and a wheelchair for mobility		allegations of abuse are reported. Interviewing five residents and completing the monitoring tool will occur on scheduled work days as follows: Daily x 2 weeks, weekly x 2 weeks, monthly x 2 months then quarterly thereafter on an ongoing basis. Should a concern be found, immediate corrective action will occur. The results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	

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	and was independent with locomotion off and on the nursing unit. During an interview, on 9/25/23 at 2:26 p.m., the Director of Nursing (DON) indicated all allegations of abuse were investigated. The allegations were reported to the Administrator. The Administrator determined whether they were to be reported to the State Agency. During an interview, on 9/25/23 at 2:38 p.m., the Administrator indicated she had investigated the incident within a few minutes of the allegation. She had statements from Resident 26 and another resident who indicated Resident 9 was lightly tapped on the arm to get her attention. She viewed the camera recording and confirmed their statements. Since the allegation was a false allegation, she did not report the incident. A current facility policy, titled "Abuse Prohibition, Reporting, and Investigation", dated 1/2015, and provided during the entrance conference on 9/19/23 by the Administrator, indicated " ...If resident abuse or suspicion of abuse, is reported ...The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies as applicable: State Department of Health ...The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report with the State Department of Health. Said reporting of alleged violations shall be conducted immediately but not later than two (2) hours if the alleged violation involves abuse or results in serious bodily injury; and not later than twenty-four (24) hours if the alleged violation involved neglect exploitation, mistreatment, or misappropriation of resident property and does			

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	not result in serious bodily injury ...." 3.1-28(e)			
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication (insulin) was administered according to professional standards for 5 of 41 residents (Residents 8, 9, 22, 11, and 19), resulting in a medication administration error rate of 12.2%. Findings include: On 9/22/23 at 6:45 am, during a medication administration observation with the DON, she administered 2 units of insulin aspart to Resident 8. She did not prime the pen needle before administration, and held the pen in the resident's left upper arm for less than 3 seconds before withdrawing the needle. During an interview, on 9/22/23 at 6:50 a.m., the DON indicated it was her practice to hold the needle in the injection site for 2 to 3 seconds. On 9/22/23 at 6:53 a.m., the DON administered 30 units of insulin detemir to Resident 9. She did not prime the needle before administration, and held the needle in place for less than 2 seconds. On 9/22/23 at 7:00 a.m., the DON administered 14 units of insulin lispro to Resident 22. She did not prime the needle before administration, and	F 0759	1 &2. All residents who receive insulin injections, including Residents 8, 9, 22, 11,and 19, did not receive any negative outcome related to this alleged deficient practice. The DON has been re-educated on the facility's policy for Insulin Injection with a special focus on priming the insulin pen and keeping the needle inserted the allotted amount of time. 3. The facility's policy for insulin injections has been reviewed with no required changes at this time. All nurses have been re-educated on the facility's policy for insulin injections with a special emphasis on priming the insulin pen and keeping the needle inserted the allotted amount of time. 4. The DON or designee will be responsible for completing the monitoring tool to ensure nurses are administering insulin according to policy. The monitoring tool will be completed on scheduled work days as follows: Review insulin	09/26/2023

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	immediately removed the needle from resident's right upper abdomen. On 9/22/23 at 7:07 a.m., the DON administered 15 units of insulin detemir to Resident 11. She did not prime the needle before administration, and held the needle in place for less than 2 seconds. On 9/22/23 at 7:15 a.m., the DON administered 19 units of insulin glargine to Resident 19. She did not prime the needle before administration, and immediately removed the needle from the resident's right upper abdomen. Resident 8's clinical record was reviewed on 9/22/23 at 8:13 a.m. They had a current diagnosis of type 2 diabetes mellitus and a physician's order for Novolog FlexPen U-100 Insulin (insulin aspart u-100) per sliding scale to be administered twice a day with breakfast and dinner. Resident 9's clinical record was reviewed on 9/22/23 at 8:30 a.m. They had a current diagnosis of type 2 diabetes mellitus and a physician's order for Levemir 30 units (insulin detemir u-100) every morning. Resident 22's clinical record was reviewed on 9/22/23 at 8:48 a.m. They had a current diagnosis of type 2 diabetes mellitus and a physician's order for Humalog KwikPen Insulin (insulin lispro) 12 units twice a day and sliding scale for coverage. Resident 11's clinical record was reviewed on 9/22/23 at 9:00 a.m. They had a current diagnosis of type 2 diabetes mellitus and a physician's order for Levemir FlexPen (insulin detemir u-100) 15 units twice a day. Resident 19's clinical record was reviewed on		administration daily for four weeks, weekly for four weeks and then monthly thereafter. Should a concern be identified, immediate corrective action will occur. The results of these findings will be reviewed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to findings.	

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	09/25/2023

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

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	9/22/23 at 9:22 a.m. They had a current diagnosis of type 2 diabetes mellitus and a physician's order for Basaglar KwikPen U-100 Insulin (insulin glargine) twice a day. A current facility policy, titled "Insulin Injections," provided by the Infection Prevention Nurse on 9/25/23 at 11:35 a.m. indicated the following: "Administering Insulin...6) Inject the insulin: Let go of the skin pinch before you inject the insulin. Push the plunger with your thumb at a moderate, steady pace until the insulin is fully injected. If using a syringe, keep the needle in the skin for 5 seconds. If using a pen, keep the needle in the skin for 10 seconds...." Review of a 2018 document titled "Insulin Pen Injections", retrieved from https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections, on 9/26/23 at 11:45 a.m., indicated the following: "...Prime the insulin pen. Priming means removing air bubbles from the needle, and ensures that the needle is open and working. The pen must be primed before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears... Insert the needle with a quick motion into the skin at a 90-degree angle. Slowly push the knob of the pen all the way in to deliver your full dose. Remember to hold the pen at the site for 6-10 seconds, and then pull the needle out...." 3.1-48(c)(1)			