PRINTED: 11/01/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEPRICENTS AND PLANS OF CORRECTION INSTRUCTION NUMBER 155232 NAME OF PROVIDER OR SUPPLIER TOWN CITY HEALTH CARE SUMMARY STATEMENT OF DEPRICENCE (EACH DEPRESENT MUST BE PRECEDED BY FULL TAG REGULATORY OR ISC IDENTIFY IND INFORMATION ECOSOME BIdg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 010/10/23 At this Emergency Preparedness survey, Twin City Health Care was found in acompliance with Emergency Preparedness Requirements for Medicare and Medicare with Emergency Preparedness Requirements for Medicare and Medicare | CENTERS FOR | R MEDICARE & MEDIC | AID SERVICES | | | OM | B NO. 0938-039 |
|--|--|--|---|-----------------|--|-------------------------|----------------|
| NAME OF PROVIDER OR SUPPLIER TOWN CITY HEALTH CARE (NS) ID SIMMARY STATEMENT OF DIFFICIENCE TAG SIZE NORTH H STREET GRACITY, IN 46933 (AS CITY, IN 46933 (AS CITY AS CITY A | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE C | CONSTRUCTION | (X3) DATE SURVEY | |
| NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEPICIENCIE (CACH DIFFICUNCY MIST HE PRECEDID BY PULL). TAG REGULATORY OR LSC IDENTIFYING INFORMATION E 0000 BIdg. — An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/10/23 Facility Number: 000137 Provider Number: 152322 AIM Number: 100266140 At this Emergency Preparedness survey, Twin City Health Care was found in accordance with 42 CFR 483.90(a). Bidg. 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: 10/10/23 K 0000 K 0000 K 0000 K 0000 K 0000 Submission of the plan of correction set forth on this statement of deficiencies. The plan of correction is our redible allegation of compliance. K 0000 K 0000 K 0000 K 0000 K 0000 K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of correction as our redible allegation of compliance. K 0000 Submission of the plan of correction as our redible allegation of compliance. | AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING | | COMPLETED | |
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| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION E 0000 Bidg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 2 CFR 483.73. Survey Date: 010/10/23 At this Emergency Preparedness survey, Twin City Health Care was found in accordance with 2 CFR 483.79. K 0000 Bidg. 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: 10/10/23 K 0000 Submission of the plan of correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction accept this plan of correction as our credible allegation of compliance. K 0000 Bidg. 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: 10/10/23 Facility Number: 000137 Provider Number: 152522 AIM Number: 100266140 At this Life Safety Code survey, Twin City Health Care was found not in compliance with Requirements for Participation in | | | <u>l</u> | 627 E | NORTH H STREET | | |
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| E 0000 Bidg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 010/10/23 Facility Number: 000137 Provider Number: 152322 AlM Number: 100266140 At this Emergency Preparedness survey, Twin City Health Care was found on to morpliance with 42 CFR 483.90(a). Bidg. 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). K 0000 Bidg. 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). K 0000 Bidg. 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). K 0000 Bidg. 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). A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 A Life Safety Code Recertification and State Licensure Survey are completed on 10/13/23 A Life Safety Code Survey, Twin City Health Care was found not in compliance with Requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. | | | | | CROSS-REFERENCED TO THE APPROPRIA | .TE | |
| Bidg. — An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. K 2 CFR 483.73. K 2 CFR 483.73. E 0000 Submission of the plan of correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction set forth on this statement of deficiencies. The plan of correction is prepared and submitted because of the requirement under state and federal taw. Please accept this plan of correction of correction of correction is prepared and submitted because of the requirement under state and federal taw. Please accept this plan of correction accordance with 42 CFR 483.73. The facility has a capacity of 75 and had a census of 39 at the time of this survey. Quality Review completed on 10/13/23 K 0000 Bidg. 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: 10/10/23 E 0000 Submission of the plan of correction is prepared and submitted because of the requirement under state and federal taw. Please accept this plan of correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or correction is prepared and submitted because of the requirement under state and federal taw. Please accept this plan of correction is prepared and submitted because of the requirement under state and federal taw. Please accept this plan of correction as our credible allegation of compliance. | | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCE | | DATE |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE | blug. U1 | Licensure Survey w Department of Head 483.90(a). Survey Date: 10/10 Facility Number: 00 Provider Number: 1002 At this Life Safety of Care was found not | vas conducted by the Indiana Ith in accordance with 42 CFR 0/23 00137 155232 266140 Code survey, Twin City Health in compliance with | K 0000 | correction does not constitute admission or an agreement by provider of the truth or facts alleged or correction set forth this statement of deficiencies. plan of correction is prepared submitted because of the requirement under state and federal law. Please accept this plan of correction as our credi | the on The and | |
| | LABORATOR | Y DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S S | SIGNATURE | TITLE | | (X6) DATE |

Jessica Sanders HFA 10/27/2023

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

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 disclodays 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: VDGT21 Facility ID: 000137 If continuation sheet Page 1 of 3

PRINTED: 11/01/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155232 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/10/2023 | | |
|--|--|--|---------------------|--|---------------|--|
| 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 APPROPRIA DEFICIENCY) | BE COMPLETION | |
| | Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa | the and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. | | | | |
| | Type V (000) constructions sprinklered. The far with smoke detection open to the corridor | ty was determined to be of ruction and was fully cility has a fire alarm system on in the corridors and areas s. The facility has a capacity sus of 39 at the time of this | | | | |
| | were sprinklered. To garage and shed pro- including storage of equipment and were | | | | | |
| K 0511 SS=E Bldg. 01 | complies with NFF Code, electrical wi complies with NFF | Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. | | | | |
| | Based on observation failed to ensure 5 of interrupter (GFCI) of protection against e 2011 Edition at 210 Circuit-Interrupter I states, ground-fault | on and interview, the facility Fover 40 ground fault circuit were properly maintained for lectric shock. NFPA 70, NEC | K 0511 | 1 1. There were no resider affected by this deficient pract However, up to 10 residents he the potential to be affected. 2 2. All Receptacles within feet of sink in resident's rooms 204, 205, 208, 209, 212 rooms have been changed to GFCI. | ice. ad 6 s | |

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

Event ID:

VDGT21 Facility ID: 000137

If continuation sheet

Page 2 of 3

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

PRINTED: 11/01/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | onstruction 01 | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|--|---|-------------------------------|--------------------|
| | | 155232 | B. W | ING | | 10/10/ | 2023 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 627 E NORTH H STREET | | | | |
| TWIN CITY HEALTH CARE | | | GAS CITY, IN 46933 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | COMPLETION DATE |
| 1710 | This deficient practice could affect 10 residents in | | | 3 3. The Facility's prever | | tive | DITTE |
| | the vicinity of resident rooms 204, 205, 208, 209 | | | maintenance program | | | |
| | and 212. | | | | reviewed with no required char | | |
| | Findings includes | | | at this time. The Maintenance director has been reeducated | | | |
| | Findings include: | | | regarding GFCI receptacles | | | |
| | Based on observation with the Maintenance | | | required within 6 feet of sinks or | | or | |
| | Supervisor on 10/10/23 between 01:00 p.m.and | | | | water source. | | |
| | 01:15 p.m., when the electric receptacle located | | | 4 4. The entire buildings | | | |
| | about 4 feet from the sink of resident rooms 204, | | | receptacles have been surveyed, | | | |
| | 205, 208, 209, and 212, were tested with a GFCI | | | | and all within 6 feet of sink or water source have been identified | | |
| | tester the receptacles failed to trip and did not break the electrical circuit. Based on interview at | | | | and changed to GFCI. | ilea | |
| | the time of observation, the Maintenance | | | 5 5. The above corrective actions will be completed on or | | | |
| | Supervisor agreed the electric receptacles did not | | | | | | |
| | trip when tested. | | | | before October 27, 2023. | | |
| | These findings wer | e reviewed with the | | | | | |
| | Administrator and t | the Maintenance Supervisor | | | | | |
| | during the exit conf | ference. | | | | | |
| | 3.1-19(b) | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VDGT21 Facility ID: 000137 If continuation sheet Page 3 of 3