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	08/15/2023

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 the Investigation of Complaint IN00414782. Complaint IN00414782 - Federal/state deficiencies related to the allegations are cited at F602 and F609. Survey dates: August 14 and 15, 2023. Facility number: 000137 Provider number: 155232 AIM number: 100266140 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicaid: 32 Other: 4 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 21, 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 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jessica Sanders | HFA | 08/28/2023

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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	resident's medical symptoms. Based on interview and record review, the facility failed to ensure narcotic medication was free from diversion for 1 of 3 residents reviewed for misappropriation of resident property (Resident B). Findings include: Resident B's clinical record was reviewed on 8/14/23 at 2:47 p.m. Diagnoses included encounter for palliative care, anxiety disorder, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and chronic pulmonary edema. His current medications included morphine concentrate 0.25 ml (milliliter) every two hours as needed for shortness of breath or pain. Review of a Consolidated Delivery Sheet indicated, on 9/23/22 at 11:15 p.m., the pharmacy delivered a 30 ml bottle of morphine sulfate 100 mg/5 ml and it was signed for by a nurse at the facility. Review of the resident's MARs (Medication Administration Records) indicated the following: In September 2022, he was not administered morphine for the entire month. In October 2022, he was administered morphine 0.25 ml on 10/31/22. In November 2022, he was not administered morphine for the entire month. In December 2022, he was administered 0.25 mls of morphine, on 12/3/22 at 11:43 p.m., 12/8/22 at 4:21	F 0602	1. Resident B is no longer a resident of the facility. Narcotics are being counted by the Nurses/QMAs at shift change. Along with Narcotic counting at shift change, the Nurses/QMAs must also count Narcotic cards/bottles and the number of Narcotic sheets to ensure they match. The ADON and/or the DON are spot checking the Narcotics to verify the count is correct and the number of Narcotic cards/bottles match the Narcotic sign out sheets for each resident with an order for Narcotics. 2. All residents with orders for Narcotics have been reviewed. Narcotics are being counted by the Nurses/QMAs at shift change. Along with Narcotic counting at shift change, the Nurses/QMAs must also count Narcotic cards/bottles and the number of Narcotic sheets to ensure they match. The ADON and/or the DON are spot checking the Narcotics to verify the count is correct and the number of Narcotic cards/bottles match the Narcotic sign out sheets for each resident with an order for Narcotics. 3. The facility's policy for Abuse Prohibition and Reporting and Investigation has been reviewed and no changes are indicated. The facility's staff has been educated	08/16/2023

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	p.m., 12/11/22 at 2:29 a.m., 12/13/22 at 2:30 p.m., and 12/21/22 at 7:22 p.m. In January 2023, he was not administered morphine for the entire month. In February 2023, he was not administered morphine for the entire month. In March 2023, he was administered 0.25 mls of morphine, on 3/1/23 at 7:38 p.m., 3/15/23 at 3:35 p.m., and 3/23/23 at 12:11 p.m. In April 2023, he was administered 0.25 mls of morphine, on 4/11/23 at 7:48 a.m. and at 9:53 p.m. In May 2023, he was administered 0.25 mls of morphine on 5/1/23 at 10:15 a.m. In June 2023, he was administered 0.25 mls of morphine on 6/14/23 at 9:45 a.m. In July 2023, he was administered 0.25 mls of morphine on 7/12/23 at 5:36 p.m. Review of a Consolidated Delivery Sheet indicated, on 7/11/23 at 10:35 p.m., the pharmacy delivered a 30 ml bottle of morphine sulfate 100 mg/5 ml and it was signed for by a nurse at the facility. During a narcotic count of the D hall medication cart with LPN 12, on 8/14/23 at 11:42 a.m., Resident B had one unopened and sealed 30 ml bottle of morphine. Review of the facility's investigation of a suspicion of diversion of Resident B's morphine was provided by the Administrator on 8/15/23 at 10:49 a.m., and indicated the following:		on the policy with a special focus on Misappropriation of Resident Property. A monitoring tool has been initiated. 4.The DON and/or Designee will be responsible for completing this monitoring tool to ensure Narcotic counts are correct and the number of Narcotic cards/bottles match the Narcotic sign out sheets to prevent Misappropriation of Resident Property. The monitoring tool will be completed on scheduled work days daily for four weeks, weekly for four weeks, and then monthly thereafter. 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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	A handwritten statement by LPN 15 indicated she remembered, on 7/20/23, there were two bottles of Roxanol (morphine) for Resident B. When she came to work, on Monday 7/24/23, during the narcotic count, she noticed there was only one bottle of Roxanol. She immediately called the DON. A handwritten statement by QMA 18 indicated on 7/21/23 at 2:00 p.m., when she counted with QMA 4, there were two boxes each containing a bottle of morphine, one opened and one unopened. At 6:00 p.m. the count was normal. There were still two bottles/boxes of morphine. A handwritten statement by QMA 4 indicated on Monday 7/24/23, when she counted with RN 8, she realized Resident B had one box of morphine missing. She was going to mention something to the DON about it not being in there, she just was going to make sure it wasn't discontinued, but she got busy and spaced it. At 6:00 p.m., when she was giving LPN 15 report and counted narcotics, LPN 15 also mentioned something about Resident B having two boxes of the morphine. She told LPN 15 she knew it and she was meaning to talk to the DON about it, but got busy and spaced it. LPN 15 also found it very odd, so she called the DON and the DON had them look in the medication room and a couple offices. They didn't find any trace of the morphine or the narcotic count sheet document. During an interview with the Administrator, on 8/14/23 at 1:03 p.m., she indicated she received a call, not an allegation, from QMA 4 about Resident B's bottle of morphine. There was thought to be two bottles of morphine but only one was in the narcotic drawer. It was			

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	investigated, they looked for the bottle, and couldn't find where he ever had two bottles. Education was provided to the staff and she came up with a form to count both cards and bottles. During an interview with QMA 4, on 8/14/23 at 2:09 p.m., she thought there were two bottles of morphine but she wasn't 100% sure. She reported it to management. When she did a narcotic count in the morning with RN 8, there was only one bottle but thought there had been two bottles. When she counted with LPN 15 in the evening, LPN 15 also thought there had been two bottles. QMA 4 remembered there was 18.75 mls left in his bottle because she was the last one that gave him morphine. During an interview with LPN 15, on 8/15/23 at 10:13 a.m., she indicated the last day she worked was 7/20/23 and there were two bottles of morphine for Resident B. During shift change, on 7/24/23 at 6:00 p.m., she did a narcotic count with QMA 4 and there was only one bottle of morphine in the drawer. QMA 4 indicated to her that there was only one bottle during narcotic count that morning. They were unable to find the narcotic count sheet or a disposition sheet so they called the DON. During a follow up interview with QMA 4 on 8/15/23 10:31 a.m., with the ADON present, she indicated the last day she had worked was 7/21/23 and thought there had been two bottles. The DON had them look in all medication carts and in the medication room. She distinctly remembered there were 18.75 ml left in the one bottle of morphine, because that was the count for quite some time. During an interview with the Administrator on 8/15/23 at 10:49 a.m., with the ADON present, she			

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	indicated they reviewed camera footage, checked the shred box, the trash, and the whole facility. They did drug screening, counted all the narcotics and took statements. They thought maybe, there were not two bottles. They called the pharmacy to find out who requested the morphine to be filled on 7/11/23 but they couldn't tell her. They couldn't find the narcotic sheet for the missing morphine. She did not complete a police report or report it to the Indiana Department of Health. They could not prove there was a missing bottle, or conclude there was a second bottle. A 1/2015, current facility policy, titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION," provided by the Administrator on 8/15/23 at 8:43 a.m., indicated the following: "POLICY: This facility shall prohibit and prevent...misappropriation of resident property...Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...2. The facility shall ensure that all alleged violations, including...misappropriation of resident property...are reported immediately to the administrator of the facility...." This Federal tag relates to complaint IN00414782. 3.1-28(a) 3.1-28(c)			
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:			

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	§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 alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report misappropriation of a resident's property related to missing morphine to law enforcement and to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for misappropriation of property (Resident B). Findings include: During an interview with the Administrator, on 8/14/23 at 1:03 p.m., she indicated she received a call, not an allegation, from QMA 4 about Resident B's bottle of morphine, there was	F 0609	1. Resident B is no longer a resident of the facility. The Administrator has been re-educated on the facility's policy for Abuse Prohibition, Reporting and investigation with a special focus on reporting misappropriation of resident's property to law enforcement and to the Indiana Department of Health. 2. All residents receiving Narcotics have the potential to be	08/16/2023

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	thought to be two bottles of morphine but only one was in the narcotic drawer. It was investigated, they looked for the bottle and couldn't see where he had two bottles. Education was provided to the staff and she came up with a form to count cards and bottles. During an interview with QMA 4, on 8/14/23 at 2:09 p.m., she thought there were two bottles of morphine but she wasn't 100% sure, she reported it to management. She did a narcotic count in the morning with RN 8, there was only one bottle but thought there had been two bottles, when she counted with LPN 15, in the evening, LPN 15 also thought there had been two bottles. QMA 4 remembered there was 18.75 mls left in his bottle because she was the last one that gave him morphine. During an interview with LPN 15, on 8/15/23 at 10:13 a.m., she indicated the last day she worked was 7/20/23 and there were two bottles of morphine for Resident B. During shift change, on 7/24/23 at 6:00 p.m., she did a narcotic count with QMA 4 and there was only one bottle of morphine in the drawer. QMA 4 indicated to her that there was only one bottle during narcotic count that morning. They were unable to find the narcotic count sheet or a disposition sheet so they called the DON. She was drug tested and in-serviced. During a follow up interview with QMA 4 on 8/15/23 10:31 a.m., with the ADON present, she indicated the last day she had worked was 7/21/23 and thought there had been two bottles. The DON had them look in all medication carts and the medication room. She distinctly remembered there was 18.75 ml that was left in the one bottle of morphine, because that was the count for quite some time.		affected. The Administrator has been re-educated on the facility's policy for Abuse Prohibition, Reporting and investigation with a special focus on reporting misappropriation of resident's property to law enforcement and to the Indiana Department of Health. 3. The facility's policy for Abuse Prohibition, Reporting, and Investigation has been reviewed with no changes needed at this time. The Administrator has been re-educated on the facility's policy for Abuse Prohibition, Reporting and Investigation with a special focus on reporting misappropriation of resident's property to law enforcement and to the Indiana Department of Health. A monitoring tool has been implemented. 4. The Administrator or designee will complete the monitoring tool in an effort to ensure all allegations of Abuse, including Misappropriation of Resident Property are reported to the law enforcement and the Indiana Department of Health. The monitoring will occur with each allegation of Abuse on an ongoing basis for a minimum of 2 months. Should a concern be found, immediate corrective action will occur. The results of these reviews and any corrective actions will be discussed during the	

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	During an interview with the Administrator on 8/15/23 at 10:49 a.m., with the ADON present, she indicated they reviewed the camera footage, checked the shred box, the trash and the whole facility. They did drug screening, counted all the narcotics and took statements. They thought, maybe, there were not two bottles. They called the pharmacy to find out who requested the morphine to be filled on 7/11/23 but they couldn't tell her. They couldn't find the narcotic sheet for the missing morphine. She did not complete a police report or report to IDOH. They could not prove there was a missing bottle or conclude there was a second bottle. A current facility policy, dated 10/2014, titled "DRUG DIVERSION," and provided by the Administrator on 8/15/23 at 8:43 a.m., indicated the following: "POLICY: Should the facility note missing medication(s) indicative of possible drug diversion, the following steps shall be take and notifications made to applicable regulatory agency. PROCEDURE...2. Contact local law enforcement...3. Prepare an initial Reportable Incident to be forwarded to the State Department of Health (SDH)...." Cross reference F602. This Federal tag relates to complaint IN00414782. 3.1-28(c)		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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