

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Twin City Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 627 E North H Street Gas City, IN 46933	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45122</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications given by gastrostomy tube (G-tube) were administered according to physician's orders and facility policy for 1 of 7 residents observed for medication administration, resulting in an 8.89 % medication error rate. (Resident 31)</p> <p>Finding includes:</p> <p>During an observation, on 9/13/24 at 10:19 a.m., LPN 4 removed the stopper from Resident 31's G-tube, flushed the G-tube with 30 ml (milliliters) of water, and administered multiple medications one at a time via G-tube. The medications included escitalopram (antidepressant) 20 mg tablet crushed mixed with 20 ml water, multivitamin crushed mixed with 20 ml water, linezolid (antibiotic) 600 mg crushed and mixed with 20 ml water, and docusate sodium (50 mg/5 ml) 10 ml. Auscultation of an air bolus and a check for residual stomach contents was not performed prior to the medication administration.</p> <p>During an interview, immediately following the medication administration, LPN 4 indicated the resident took all medications via G-tube. Placement for the G-tube should have been checked prior to the administration of medications, which included an air bolus and a check for residual stomach contents. She had not completed a placement check.</p> <p>Resident 31's record was reviewed on 9/13/24 at 10:38 a.m. Diagnoses included dysphagia, nausea, and vomiting. Physician's orders included docusate sodium (stool softener) liquid 50 mg/5 ml - 10 ml orally twice a day (7/11/24), escitalopram (antidepressant) 20 mg orally daily (7/24/24), multivitamin orally daily (8/15/24), linezolid (antibiotic) 600 mg orally twice a day (8/30/24), Administer 10 ml air bolus via G-tube prior to administration of medications or feeding, and auscultate abdomen to confirm air movement and appropriate placement of feeding tube every shift. (2/9/24), Assess bowel sounds in all quadrants before and after medication administration, and hold if absent and notify medical provider for further instructions every shift. (2/9/24), and Check residual (stomach contents) before medication administration, including enteral nutrition. If less than 120 ml obtained, re-instill residual via feeding tube. If greater than 120 ml obtained, do not proceed and notify medical provider for further instructions every shift (2/9/24).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/16/24 at 4:20 p.m., RN 6 indicated Resident 31 received all of his medications per G-tube. Resident 31 had attempted to take medications orally for about two days, but he did not like taking medications orally, and the medications were again administered per G-tube. To administer medications per G-tube, she listened to bowel sounds before and after medication administration.</p> <p>During an interview, on 9/17/24 at 2:00 p.m., the DON indicated prior to medication administration per G-tube, placement should be checked per facility policy. Resident 31 was to receive his medications per G-tube. He had wanted to take his medications orally and get rid of his G-tube. His medications had gone back and forth between oral and G-tube routes with some medicines taken orally and others taken via G-tube. An interdisciplinary care plan meeting with the resident representative was held on 9/13/24. The resident's medication administration was discussed and it was decided that G-tube medication administration was preferred. After the medical provider's consent, the DON had updated the medication orders on 9/17/24 to administer all medications via G-tube as some had been listed per oral route.</p> <p>A current facility policy, revised 4/2017 and provided by the Administrator on 9/17/24 at 3:17 p.m., titled Medication Administration, indicated .Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders . Medications are administered to residents only as prescribed . Always observe the six rights of giving each medication . right route</p> <p>A current facility policy, dated 10/2014, provided by the Administrator on 9/17/24 at 3:17 p.m., titled Tube Feedings (Naso-gastric or Gastrostomy Tubes) indicated .Medication Administration via Gastrostomy Tube: . Check placement by auscultating the resident's abdomen about 3 inches below the sternum with the stethoscope, gently insert 10 cc [cubic centimeters] of air into the tube. You should hear the bubble entering the stomach. If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric content implies that the tube is patent and in the stomach. If no gastric content appears, the tube may be against the lining of the stomach or the tube may be obstructed. If you meet resistance as you aspirate for stomach content, stop the procedure. After you establish the tube is patent and in the correct position . Administer each medication</p> <p>3.1-48(c)(1)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49411</p> <p>Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 by not wearing appropriate personal protective equipment (PPE) in areas requiring transmission-based precautions (TBP) during random observations on the 100 and 200 halls.</p> <p>Findings include:</p> <p>During a random observation, on 9/11/24 at 11:29 a.m., Housekeeper 3 was seen entering and exiting room [ROOM NUMBER] while wearing gloves and a surgical mask. Signage on the door indicated the residents were in TBP and a gown, gloves, face shield and mask were required before entering the residents' room.</p> <p>During an interview, at the time of observation, Housekeeper 3 indicated she didn't need to wear a face shield, as she wore glasses. She only needed to wear gloves and a surgical mask.</p> <p>During a random observation, on 9/12/24 at 2:08 p.m., Housekeeper 3 entered a positive COVID-19 resident's room while wearing a gown and gloves. Signage on the door indicated the resident was on TBP and everyone must wear a gown, gloves, mask and face shield upon entering the room.</p> <p>During an interview, on 9/13/24 at 10:19 a.m., LPN 4 indicated she just needed to wear a gown, gloves, surgical mask, and a face shield when entering. She didn't need to wear an N95 (respirator) mask.</p> <p>During a random observation, on 9/13/24 at 11:28 a.m., CNA 5 entered Resident 31's room wearing a gown, gloves, surgical mask, and a face shield.</p> <p>During an interview, at the time of observation, CNA 5 indicated they could wear surgical masks upon entering a TBP resident's room.</p> <p>During an interview, on 9/13/24 at 1:31 p.m., the DON indicated signage for any resident on contact or droplet isolation was taped to the door. Staff should be wearing N95 masks if they entered an isolation room. The facility had plenty of PPE available. The facility had just had an in-service regarding infection control when the first resident tested positive for COVID-19. There were teachable moments completed as she walked through the facility. The facility was aware that they were having a problem with infection control. Housekeeper 3 completed a return demonstration for donning and doffing of PPE.</p> <p>Review of Resident 31's clinical record was completed on 9/16/24 at 10:38 a.m. Review of a progress note indicated he was positive for COVID-19 with symptoms of cough and nasal congestion. Current orders included strict droplet, single room isolation maintained, all services in the room due to positive COVID-19.</p> <p>A facility policy, dated 10/2015, provided by the Administrator on 9/17/24 at 3:13 p.m., titled Isolation (Transmission- Based Precautions) Guidelines, indicated the following: .5. All personnel must follow transmission- based precautions, as indicated</p> <p>(continued on next page)</p>

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