STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMMOND-WHITING CARE CENTER	1000 114TH ST WHITING, IN 46394

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00413363 and IN00414236. Complaint IN00413363 - No deficiencies related to the allegations are cited. Complaint IN00414236 - Federal/State deficiencies related to the allegations are cited at F557, F559, F842, and F908. Unrelated deficiencies are cited. Survey dates: August 8 and 9, 2023 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 12 Medicaid: 44 Other: 7 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/14/23.	F 0000		
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with			

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

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	respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity, related to not assisting residents who required assistance with meal intake in a timely manner, for 2 of 8 residents during 1 of 1 meals observed. (Residents C and D) Finding includes: During an observation of the lunch meal on 8/8/23 from 11:40 a.m. through 12:33 p.m. the following was observed: The meals were served to the Resident C and D at 11:40 a.m. At 11:45 a.m., Resident C had her eyes closed and an uncovered tray of food was sitting in front of her. Resident D's meal was uncovered and sitting in front of her, she fed herself one bite of chocolate pudding. At 11:56 a.m., CNA 2 woke Resident C and asked her if she was going to eat. At that time, she was holding a spoon in her hand, though not feeding herself. Resident D has not taken any further bites of her meal. At 11:58 a.m., Resident C continued to hold her spoon and was not feeding herself and Resident D continued to not feed herself. There were five staff members in the dining room and two of the staff were assisting other residents with their	F 0557	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. F 557- Respect, Dignity/Right to Have Personal Property What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident C: No negative outcomes noted. 2. Resident D: No negative outcomes noted. 3. All residents in the	08/31/2023

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	meals. At 12:10 p.m., Residents C and D were still not eating. QMA 3 left the resident she was assisting, went to Resident C and D's table and woke Resident C up and she took one bite of food. QMA 3 also woke Resident D and handed her the healthshake and she gave herself a drink of the shake. At 12:14 p.m., QMA 3 encouraged Resident C to eat and she fed herself one bite then stopped feeding herself. Resident D continued to not eat or drink any more for the meal. At 12:15 p.m., QMA 3 stood and gave Resident D a bite of ice cream, she then sat down at the table and assisted both Residents C and D with their meals. At 12:22 p.m., Resident D indicated she was done eating. She consumed 100% of the ice cream, a sip of the health shake and two bites of the chocolate pudding. At 12:33 p.m., with the assistance of QMA 3, Resident C consumed 100% of the health shake, 50% of her mashed potatoes, 75% of the zucchini, 25% of the ground meat and 50% of the pudding. Resident C's record was reviewed on 8/8/23 at 3:01 p.m. The diagnoses included, but were not limited to, Parkinson's disease and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 7/5/23, indicated a severely impaired cognitive status, required limited assistance of one for eating, and had no significant weight gain or loss.		assisted dining room immediately received assistance with their meal. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents that require assistance with meals have the potential to be affected. 2. Additional staff have been assigned to the dining room during the meal period to assist with meal intake in a timely What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All nursing receive education related to the feeding process for long term care including timeliness of meals by date of compliance. 2. All newly hired nursing receive education related to the feeding process for long term care including timeliness of meals prior to providing resident care. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee to monitor the timeliness of meal intake for one meal per day (at different) 5x/week for 4 weeks, then 3x/week for 4 , then 1x/week for 4 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months	

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	Resident D's record was reviewed on 8/8/23 at 3:41 p.m. The diagnoses included, but were not limited to, dementia. An Annual MDS assessment, dated 5/13/23, indicated a severely impaired cognitive status, required supervision of one staff for eating, and had no significant weight gain or loss. This Federal tag relates to Complaint IN00414236. 3.1-3(t)		and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/31/23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.¿¿	
F 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure residents and/or their Responsible Party were notified in writing of an intrafacility transfer, the reason for the transfer, and the approval of the transfer/room transferring to, for 3 of 3 residents reviewed for discharge/transfer. (Residents B, E, and F)	F 0559	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond whiting Care Center maintains that the alleged deficiencies do not	08/31/2023

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	Findings include: 1. Resident B's record was reviewed on 8/8/23 at 11:12 a.m. The diagnoses included, but were not limited to, end stage renal disease with dialysis, stroke, and vascular dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 7/26/23, indicated an intact cognitive status. There were intrafacility transfers on 7/24/23, 7/31/23, and 8/1/23. A Social Service Progress Note, dated 7/24/23 at 3 p.m., indicated the resident's daughter was notified of the room change. The daughter informed Social Service the resident had never had a roommate and might have a problem with the roommate. There was no documentation of why the resident was moved or if the resident and/or family waived the right to be moved. There was also no documentation why the resident was moved or if the resident and/or family waived the right to be moved on 7/31/23 and 8/1/23. During an interview on 8/9/23 at 8:50 a.m., LPN 1 indicated the resident was temporarily moved due to roommate concerns on 7/31/23 and she had notified the resident's sister. 2. Resident E's record was reviewed on 8/8/23 at 4:47 p.m. The diagnoses included, but were not limited to, end stage renal disease. A Quarterly MDS assessment, dated 6/19/23,		jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. F 559- Choose/Be Notified of Room/Roommate Change What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident B: No negative outcomes noted. 2. Resident E: No negative outcomes noted 3. Resident F: No negative outcomes noted How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents requesting/receiving an room move have the potential to be affected. 2. All residents/responsible party that are requesting/receiving an room move will receive the appropriate notification in writing including the reason for the transfer and the approval of the transfer. What measures and what systemic changes will be made to ensure	

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	indicated a severely impaired cognitive status. Intrafacility transfers occurred on 6/14/23, 7/31/23, and 8/3/23. There was no documentation why the resident was transferred, family/resident notification of the transfer, and if the resident/family waived the right to be transferred. 3. Resident F's record was reviewed on 8/8/23 at 4:42 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 7/11/23, indicated an intact cognitive status. Intrafacility transfers occurred on 6/8/23 and 7/27/23. There was no documentation why the resident was transferred, family/resident notification of the transfer, and if the resident/family waived the right to be transferred. During an interview on 8/8/23 at 2:20 p.m., the Social Service Director indicated no written notices for the intrafacility transfers had been completed. She had been calling the families or talking to the residents, though had not documented the conversations. A facility policy for resident room location, dated 8/18/22 and received from the Corporate Regional Nurse as current, indicated when a resident was being moved, the resident, family and/or representative must be notified in writing of why the move was required. The resident was to be provided the opportunity to see the new location, meet the new roommate, and ask questions about		that the deficient practice doesn't recur: 1. All nursing staff and SSD to receive education related to the proper process resident room relocation, including the documentation required and the rights the resident has in that process by date of compliance. 2. All newly hired nursing staff and/or SSD will receive this education prior to providing resident care. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Social Services/ Designee will audit all room moves for documentation, written notice, and approval 5x/week for 4 weeks, then 3x/week for 4 , then 1x/week for 4 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/31/23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.¿¿	

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	the move. This Federal tag relates to Complaint IN00414236. 3.1-12(a)(15) 3.1-12(a)(16)			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation 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 resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure a resident was free from physical abuse, related to a resident to resident altercation which resulted in Resident J being injured with bilateral non-displaced nasal bone fractures and a hematoma to the face for 1 of 1 resident to resident altercations reviewed. (Residents J and K) Finding includes: An Indiana Department of Health (IDOH) state reported incident indicated on 6/23/23 at approximately 7:36 p.m., Resident J and Resident	F 0600	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of	09/01/2023

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	K were roommates and an altercation occurred between the two of them in their room. Resident J was found to have bruising and bleeding from the face and Resident K was observed kicking Resident J as he exited the room to seek help. Resident J had been transferred to the Emergency Room and returned with diagnoses of nondisplaced bilateral nasal bone fractures, right periorbital soft tissue swelling and edema. There was facial bruising and swelling. A Police Report, dated 6/23/23 at 7:47 p.m., indicated Resident K was interviewed and informed the Officer Resident J had fallen asleep while watching TV and was awoken when Resident K turned the TV off. Resident J asked Resident K if he could turn the TV back on and was refused. Resident J grabbed his remote and turned the TV on. Resident K then physically attacked Resident J. Resident K admitted to striking Resident J numerous times in the face with a closed fist. Resident J was then interviewed and reported the same information, and indicated he wanted to press charges against Resident K. The Officer then interviewed staff at the facility, who informed him this was not the first altercation for Resident K, and Resident J had requested a room change earlier in the day due to fearing for his safety. Resident J was interviewed on 8/9/23 at 1:54 p.m. and indicated he had just been lying in bed. Both TV's in the room were on, he had dozed off, and Resident K turned his TV off. When he woke up, he told Resident K he wanted his TV on and when he attempted to turn his TV back on, it turned off Resident K's TV and then Resident K started "beating on my face." He had been Resident K's roommate before and had been transferred to another room due to a prior verbal altercation. He		compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. ="" span="">and we respectfully request an IDR to review the findings for F600. **F 600 Free from Abuse and Neglect** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident K: No longer resides at facility 2. Resident J: Was immediately transported to the ER via EMS. 3. The Executive Director was immediately notified of the reported altercation by licensed nursing staff on 6/23/23. 4. The Executive Director contacted the Hammond Police Department to report the altercation on 6/23/23. 5. Resident K was released to the custody of the Hammond Police Department on 6/23/23. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All residents have the potential	

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	had asked to be moved back into this room due to the window view and his belongings were still in the room. He had talked with the Social Service Director on 6/23/23 before the altercation occurred and requested a room change due to Resident K's aggression. He had not been fearful at the time. Resident J's record was reviewed on 8/9/23 at 11:13 a.m. The diagnoses included, but were not limited to, stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 8/4/23, indicated a moderately impaired cognitive status and had no behaviors. A Nurse's Progress Note, dated 6/3/23 at 11:56 a.m. indicated an intrafacility transfer to another room. There was no documentation why the intrafacility transfer occurred. A Nurse's Progress Note, dated 6/8/23 at 2:27 p.m., indicated he was moved back to his original room per his request. A Social Service Progress Note, dated 6/23/23 at 4:41 p.m., indicated the resident came to her office and requested a room change. He indicated the night before his roommate had verbal aggression with the staff. The roommate had not been aggressive toward him. He requested either his roommate be transferred out of the room or he would transfer to a room and requested a bed by the window. Social Service indicated she would need to locate a room for the possible transfer and would follow up to the request. A Nurse's Progress Note, dated 6/23/23 at 8:36 p.m., indicated screaming from the resident's room.		to be affected. 2. An abuse audit was completed for all residents residing on the same unit with no new findings reported or identified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Associates in all disciplines provided with education by the Executive Director on abuse prevention and management on at time of incident and again by date of compliance. Associates will receive education before their next worked shift. 2. Room change requests will be acted on promptly up to and including the emergency discharge and/or transfer of a resident when there is a perceived threat to resident health or safety. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. ED/Designee will audit all room change requests for signs of potential for abuse x 6 months. 2. ED/Designee will conduct 3 interviews with resident/responsible party or staff members to ensure all potential safety concerns related to abuse have been reported 5x/week x 6 months. 3. SSD/Designee will complete an abuse audit with all residents that	

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	Resident J was observed exiting the room with blood on his face and bleeding from the mouth, nose, and right eye. Resident K was behind the resident and kicked his buttocks. The Emergency Management System and Police were notified. An order was received from the Physician for a transfer to the Emergency Room. The family, Administrator, and Director of Nursing was notified. The resident indicated he had been sleeping and his roommate had turned off his TV, when he asked why he turned off his TV, Resident K began to beat him in the face. The Hospital Emergency Room Notes, dated 6/23/23 at 8:44 p.m., indicated the resident had been assaulted by his roommate. There was facial swelling present. A CT of the facial bones, indicated bilateral nondisplaced nasal bone fractures were present and a large soft tissue hematoma along the right side of the face, which extended from the inferior orbital region to the mandible. There were numerous small soft tissue hematomas. A laceration of the chin was observed. During an interview on 8/9/23 at 1:48 p.m., the Social Service Director indicated he came to her office and said his roommate had been verbally aggressive with the staff and he wanted a new roommate. He requested a bed by a window. He had informed her he was not fearful. She informed him she was the Week-End Manager and would work on the room transfer on the week-end. (6/23/23 was a Friday). She had not spoken to the roommate because he was out of the building with his family. Resident K's record was reviewed on 8/9/23 at 11:40 p.m. The diagnoses included, but were not limited to, dementia.		have received a room change daily x 72 hours for 6 months. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. ="" span="">
Compliance date: 9/1/23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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A Quarterly MDS assessment, dated 5/3/23, indicated an intact cognitive status and no behaviors.

A Care Plan, dated 5/4/23, indicated a potential for physical aggression. The interventions included, contributing sensory deficits would be assessed and addressed and when agitated, intervene before he escalates. He was to be guided away from the source of the distress, if he was aggressive, staff were to walk away calmly and approach at a later time.

A Care Plan, dated 5/4/23, indicated a potential to be verbally aggressive. The interventions include his coping skills and support system would be assessed, he would be assessed for understating of the situation and given time to express feelings, if he becomes agitated, guide away from the source and reapproach.

The Point of Care Behavior Tracking, from 5/26/23 to 6/23/23, indicated behaviors of physical aggression, cursing, anger at others, screaming at others, and threatening others occurred on the evening shift on 6/1/23 and 6/3/23.

The Nurses' Progress Notes indicated the following:

On 5/2/23 at 9:59 p.m., he displayed behaviors toward staff and his roommate. He was cussing at the staff and his roommate and was physically approaching the staff in an aggressive manner. The behaviors were reported to the Shift Manager.

On 6/3/23 at 12:10 p.m., verbal aggression towards the roommate. Several attempts of redirection were

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(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
	unsuccessful. He continued to yell at the staff and his roommate. The roommate was transferred to another room. The Physician and Assistant Director of Nursing were made aware. Attempted to notify family and the voicemail was full. On 6/23/23 at 8:59 p.m., was physically aggressive toward roommate and battered the roommate in the face and kicked him in the buttocks. He stated the roommate had hit him first. He became verbally aggressive toward the Nurse when she entered the room. Police were notified. The Physician was notified of the aggression and removal from the facility. Three attempts were made to contact the family. There was no answer and no answering machine. The Supervisor notified the Administrator and Director of Nursing. A facility abuse policy, dated 10/4/22 and revised 7/18/23, received from the Regional Corporate Nurse as current, indicated the facility would ensure that all residents were protected from physical and psychosocial harm. The resident had the right to be free from abuse. 3.1-27(a)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.			

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	155423	A. BUILDING 00 B. WING	08/09/2023

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	§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a resident's record was complete and accurate, related to a resident's behavior which resulted in an intrafacility transfer, for 2 of 9 resident records reviewed. (Residents B and G) Finding includes: Resident B's record was reviewed on 8/8/23 at 11:12 a.m. The diagnoses included, but were not limited to, end stage renal disease with dialysis, stroke, and vascular dementia. An intrafacility transfer to another room occurred on 7/31/23. There was no documentation for the reason of the room transfer. During an interview on 8/8/23 at 2:20 p.m., the Social Service Director indicated on 7/31/23, the resident was transferred to another room by the nurse during the night. She was informed the transfer occurred due to his roommate (Resident	F 0842	p="" paraid="1545799419" paraeid="{5f71c5f3-31f2-42fe-b970-d83ee457ec27}{217}">This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions	08/31/2023

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	G) had come over to his side of the room and had been standing over him when he was in bed. Resident G's record was reviewed on 8/9/23 at 9:58 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. The Nurse's Progress Note, dated 7/31/23 at 2:10 p.m. indicated he had been combative towards staff the first part of the shift and had calmed down as the shift went on. There was no documentation in the record of the resident being observed standing over his roommate while the roommate was in bed or getting into the roommate's items. During an interview on 8/9/23 at 8:50 p.m., LPN 1 indicated on 7/31/23 around 10:30 p.m., she observed Resident G standing over Resident B, who was in bed, and she had made the decision to temporarily move Resident B for his safety. She had not documented the incident, it was at the end of her shift. This Federal tag relates to Complaint IN00414236. 3.1-50(a)(1) 3.1-50(a)(2)		set forth in this plan of correction. We respectfully request a desk review. F 842 – Resident Records – Identifiable Information What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. No negative outcomes noted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents with an intrafacility transfer related to a resident's behavior have the potential to be affected. 2. Audit of all intrafacility transfers for the prior 30 days to be completed to ensure appropriate behavior management documentation is present to be completed by date of compliance. ¿ What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All nursing staff and SSD to receive education r/t behavior management prior to date of compliance. All newly hired nursing staff and SSD receive this education prior to working. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. SSD/Designee to audit 24/72-hour report to ensure all current residents with an intrafacility transfer r/t behavioral	

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			issues have appropriate documentation present 5x/week x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/31/23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.¿¿	
F 0908 SS=E Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on record review and interview, the facility failed to ensure resident care equipment was in safe operating condition, related to glucometers (blood sugar testing machine) not calibrated for 1 of 2 units where 8 residents received glucometer testing. (North Unit) (Residents L, M, N, P, Q, R, S, and T) Finding includes: The Glucometer Calibration/Control Binder for the North Unit was reviewed on 8/8/23 at 3 p.m. There were eight residents who received glucometer testing listed in the binder.	F 0908	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of	08/31/2023

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	Resident L was admitted into the facility on 7/21/23. Resident M was admitted into the facility on 5/23/23. Resident N was admitted into the facility on 8/4/23. Resident P was admitted into the facility on 4/10/23. Resident Q was admitted into the facility on 3/15/23. Resident R was admitted into the facility on 3/19/23. Resident S was admitted into the facility on 7/14/23. Resident T was admitted into the facility on 6/23/23. There was no calibration/control checks on the glucometers in the month of July. The first documentation of the calibration/control testing was completed on 8/8/23. During an interview on 8/8/23 at 2 p.m., LPN 5 indicated each resident had their own glucometer and the calibration/control test was done nightly. The blood glucose quality control check policy, dated 9/22/22, and received from the Regional Corporate Nurse as current, indicated the glucometer was to have the control check completed when using the meter for the first time, when a new vial of test strips are opened, if the meter or test strips do not function properly, if the resident's symptoms were inconsistent with the blood glucose result and if the meter was dropped or damaged. The facility policy was based on the manufacturer's directions.		compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. F 908- Essential Equipment, Safe Operating Condition What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice 1. No negative outcomes noted. 2. All glucometers immediately had test performed to ensure correct calibration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. All residents using a glucometer monitor have the potential to be 2. Audits to be completed to ensure the glucometer monitors' calibration record in accordance with the manufacturer's instructions with date of calibration included is complete. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education to be provided to all Nursing staff regarding the calibration schedule of glucometer monitors by date of 2. Education provided to all nursing staff on the proper process for calibration of	

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	A Professional Resource web-site, www.in.gov/dhs/files/BloodGlucose-Guidance.pdf , reviewed on 8/10/23 at 11:46 a.m., indicated blood glucometers must be routinely tested to ensure they are properly calibrated and returning accurate results. The manufacturer's directions were to be followed. This Federal tag relates to Complaint IN00414236. 3.1-19(bb)		the glucometer monitors by date of compliance. Monitors are to be calibrated for a resident per the Manufacturer's instructions: Control check must be completed upon first use, when a new vials of test strips are opened, if the meter or test strips do not function properly, if the resident's symptoms are inconsistent with the blood glucose result and if the meter was dropped or damaged. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee to review glucometer control check log 5x/week for 4 weeks, then 3x/week for 4 , then 1x/week for 4 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/31/23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.¿¿	