PRINTED: 12/15/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPL	
		155423			10/25	72022
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD 14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCT		DATE
1 0000						
Bldg. 00						
	This visit was for a	Recertification and State	F 0000	This plan of correction is prepa	ared	
	1	This visit included the		and executed because the		
	_	omplaints IN00386810,		provisions of state and federal	law	
	IN00388294, IN00	389608, and IN00392720.		require it and not because		
	Complaint IN0038	6810 - Substantiated.		Hammond-Whiting Care Center agrees with the allegations and		
	•	iencies related to the		citations listed. Hammond-Whi		
	allegations are cited			Care Center maintains that the	•	
				alleged deficiencies do not		
	Complaint IN0038	8294 - Substantiated.		jeopardize the health and safe	ty of	
	Federal/State defici	iencies related to the		the residents nor is if of such		
	allegations are cited	d at F677, F686, and F757.		character to limit our capabilition to render adequate care. Please		
	Complaint IN00389	9608 - Substantiated.		accept this plan of correction a		
	Federal/State defici	iencies related to the		our credible allegation of		
	allegations are cited	d at F677 and F693.		compliance that the alleged deficiencies have or will be con	rrect	
	Complaint IN00392	2720 - Substantiated.		by the date indicated to remain		
	Federal/State defici	iencies related to the		compliance with state and fede	eral	
	allegations are cited	d at F686, F755, and F921.		regulations, the facility has tak or will take the actions set forth		
	Survey dates: Octo	ober 19, 20, 21, 24, and 25, 2022		this plan of correction. We respectfully request a desk rev		
	Facility number: 0	00365		100pooliumy roquost a dosk rev	10 VV.	
	Provider number:					
	AIM number: 1002	287460				
	Census Bed Type:					
	SNF/NF: 57					
	Total: 57					
	Census Payor Type	: :				
	Medicare: 8					
	Medicaid: 44					
	Other: 5		I	I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Total: 57

(X6) DATE

TITLE

Verna Meacham **Executive Director** 12/02/2022

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: H71G11 Facility ID: 000365 If continuation sheet Page 1 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		155423	B. W	ING		10/25	/2022	
	PROVIDER OR SUPPLIER		•	1000 11	ADDRESS, CITY, STATE, ZIP COD 4TH ST IG, IN 46394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	These deficiencies raccordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.						
	Quality review completed on 11/1/22.							
F 0550 SS=D Bldg. 00	existence, self-det communication wi and services insid including those sp §483.10(a)(1) A faresident with respendent in a environment that penhancement of h recognizing each	xercise of Rights ent Rights. a right to a dignified termination, and th and access to persons e and outside the facility, ecified in this section. acility must treat each ect and dignity and care for						
	access to quality of diagnosis, severity source. A facility maintain identical regarding transfer provision of services	of condition, or payment						
	her rights as a res	se of Rights. he right to exercise his or ident of the facility and as nt of the United States.						
	the resident can e	facility must ensure that xercise his or her rights te. coercion, discrimination.						

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 2 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING. IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and F 0550 This plan of correction is prepared 12/03/2022 interview, the facility failed to ensure each and executed because the resident's dignity was maintained related to a provisions of state and federal law foley catheter bag not being covered with a require it and not because dignity bag and residents wearing hospital gowns Hammond-Whiting Care Center throughout the day while in bed for 3 of 5 agrees with the allegations and residents reviewed for dignity. (Residents F, 6, citations listed. Hammond-Whiting and 29) Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of Findings include: the residents nor is it of such 1. On 10/19/22 at 12:09 p.m., 1:25 p.m., and 2:40 character to limit our capabilities p.m., Resident F was observed in his room in bed. to render adequate care. Please The resident's foley catheter drainage bag was accept this plan of correction as hanging from the bed frame and urine was visible our credible allegation of at that time. The drainage bag was not covered compliance that the alleged with a dignity bag and the door to the resident's deficiencies have or will be correct room was open. The drainage bag was visible by the date indicated to remain in from the hallway. compliance with state and federal regulations, the facility has taken On 10/20/22 at 1:23 p.m. and 3:37 p.m., the resident or will take the actions set forth in was again observed in his room in bed. The foley this plan of correction. We catheter drainage bag was hanging from the bed respectfully request a desk review. frame and not covered with a dignity bag. The F 550- Resident Rights door to the resident's room was partially open and What Corrective Action will be the drainage bag was visible from the hallway. accomplished for those residents found to have been affected by this The Record for Resident F was reviewed on deficient practice: 10/20/22 at 1:30 p.m. Diagnoses included, but 1. Resident F had no negative were not limited to, Parkinson's disease, adult outcomes. Resident F's foley failure to thrive, protein calorie malnutrition, and catheter drainage bag was

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

neurogenic bladder.

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

immediately covered with a dignity

Page 3 of 64

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING. IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Admission Minimum Data Set (MDS) 2. Resident number 6 and 29 had assessment, dated 10/18/22, indicated the MDS no negative outcomes. Both was in progress. The resident was moderately residents were immediately impaired for daily decision making and had an assisted into clothes. indwelling catheter. How other residents having the potential to be affected by the Interview with the Director of Nursing on 10/21/22 same deficient practice will be at 12:40 p.m., indicated the resident was admitted identified and what corrective from the hospital with the foley catheter and the action will be taken: drainage bag should be changed or a dignity bag 1. An in house audit will be added to the resident's bed. 2. On 10/19/22 11:10 completed by activities and SSD a.m., 12:00 p.m., and 1:15 p.m., Resident 6 was and/or designee for current observed lying in bed. At those times she was residents to update their personal dressed in a hospital gown. preferences. If unable to make decision POA and/or family will be On 10/20/22 at 8:45 a.m., and 1:10 p.m., the resident contacted to give information. was observed lying in bed. At those times she 2. Preferences will be updated and was dressed in a hospital gown. put on care plans and kardex by date of compliance. On 10/21/22 at 7:55 a.m., 8:16 a.m., and 9:30 a.m., 3. An in house audit will be the resident was observed lying in bed. At those completed by DON/designee for times she was dressed in a hospital gown. current residents that have a catheter to ensure a dignity bag is On 10/24/22 at 8:50 a.m., 10:47 a.m., and 12:33 p.m., the resident was observed lying in bed. At those What measures and what times she was dressed in a hospital gown. systemic changes will be made to ensure that the deficient practice The record for Resident 6 was reviewed on doesn't recur: 10/21/22 at 9:33 a.m. The resident was admitted to 1. SSD and Activities will be

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

the facility on 2/11/22. Diagnoses included, but

were not limited to, stroke with hemiplegia, heart

failure, type 2 diabetes, major depressive disorder,

and expressive language disorder.

The Quarterly Minimum Data Set (MDS)

assessment, dated 7/8/22, indicated the resident

assist with a 2 person physical assist for bed

was not cognitively intact. She needed extensive

mobility and transfers and extensive assist with a

H71G11 Event ID:

Facility ID: 000365

If continuation sheet

educated by ED and/or designee

on updating preferences at least

quarterly with care plans and prn

as indicated. Education to include if resident unable to make

preference decision then POA

and/or family to be contacted for

be responsible for updating care

plan and kardex with changes.

preference. SSD and activities will

Page 4 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			14TH ST		
наммо	ND-WHITING CAR	E CENTER			NG, IN 46394		
TIAWWO		L GENTER		VVIIIII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		assist for eating, dressing, and			Education will be completed by	ру	
		The resident had a limitation in			date of compliance.		
	-	one side for both upper and			2. DON/designee will provide		
		She received a mechanically			education to nursing staff to		
		erapeutic diet and had 1 stage 3			ensure residents with a cathe	ter	
	pressure ulcer.				have a dignity bag in place.		
					Education will be completed to	ру	
		2/20/22, indicated the resident			date of compliance.		
	preferred to sleep i	n gowns.			How the corrective action will		
		7.1 10/01/00 10 17			monitored to ensure the defic		
	Interview with LPN 1 on 10/24/22 12:15 p.m.,				practice will not recur, i.e., wh		
	indicated the resident preferred to wear a hospital				quality assurance program wi	ill be	
	_	however, that information was			put in place:		
	not documented in the clinical record.				1. ED and/or designee will au		
	T	D: 1/04/00			charts weekly x 8 weeks, then		
		Director of Nursing on 1/24/22			charts weekly x 8 weeks, then	n 2	
	_	cated the resident's preferences			charts weekly x 8 weeks to		
	should be followed	l.			ensure resident preferences a		
	2 0 10/10/22 -4	10.24 12.59 12.20			updated. Results will be present		
		10:24 a.m., 12:58 a.m., and 3:20			to QAPI x 6 months and QAP		
		was observed lying in bed			determine the need for furthe	ſ	
	hospital gown.	mes, she was wearing a			audits.	4_	
	nospitai gowii.				2. DON/designee will comple observations 5 x/week for 6	ıe	
	On 10/20/22 at 8.4	0 a.m., 9:25 a.m., and 1:09 p.m.,			months to ensure resident		
		oserved lying in bed. At those			preferences are being honore	2d	
		ring a hospital gown.			Results will be presented to 0		
	times she was wear	ring a nospital gown.			x 6 months and QAPI will	ארתו ו	
	On 10/21/22 at 10-	20 a.m., and 1:30 p.m., the			determine the need for furthe	r	
		ved lying in bed. At those			audits.		
		ring a hospital gown.			3. The results of these review	s will	
		C 1 6			be discussed at the monthly		
	On 10/24/22 at 8:5	0 a.m., and 10:50 a.m., the			facility Quality Assurance		
		ved lying in bed. At those			Committee meeting monthly f	for a	
		ring a hospital gown.			total of 3 months and then		
		- , -			quarterly thereafter once		
	The record for Res	ident 29 was reviewed on			compliance is at 100%.		
		a.m. Diagnoses included, but			Frequency and duration of re	views	
		, dementia without behaviors,			will be increased as needed,		
		anxiety disorder, psychosis,			compliance is below 100%.		

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

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

		ER/SUPPLIER/CLIA TION NUMBER	A. BUILDING B. WING	00	COMPLETED 10/25/2022
	PROVIDER OR SUPPLIER ND-WHITING CARE CENTER		1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTI	PRECEDED BY FULL FYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	peg tube (a tube inserted directle for nutrition) and major depress. The Quarterly Minimum Data Sassessment, dated 8/10/22, individual assessment, dated 8/10/22, individual assessment, dated 8/10/22, individual assist with 2 passist for decision making. needed extensive assist with 2 passist for bed mobility and transassist with a 1 person physical at A Care Plan, updated 8/7/22, in resident preferred gowns and paremoved daily. The intervention were not limited to, help the resund selection of clothing or governered. Interview with the Director of Nat 1:30 P.M., indicated she was resident got out of bed and preferred dressed in street clothes. 3.1-3(t)	Set (MDS) cated the resident was severely The resident berson physical effers and extensive assist for dressing. dicated the ajamas to be as included, but ident with removal was as she Sursing on 10/24/22 unaware the		Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of F §483.10(f)(10)(iii) Accounting (A) The facility must establish system that assures a full an separate accounting, accord accepted accounting principl resident's personal funds ent facility on the resident's beha (B) The system must preclud commingling of resident fund funds or with the funds of any than another resident. (C)The individual financial re available to the resident through	y and Records. In and maintain a Id complete and Ing to generally es, of each rusted to the Ilf. e any s with facility y person other			

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 6 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25	/2022
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
	UD MUUTING GADI	COENTED			14TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
	statements and up	oon request.					
		view and interview, the facility	F 0:	568	This plan of correction is prepared	ared	12/03/2022
		rterly statements were			and executed because the		
	provided for 1 of 1 residents reviewed for personal				provisions of state and federal	law	
	funds. (Resident 28	-			require it and not because		
	,				Hammond-Whiting Care Cent	er	
	Finding includes:				agrees with the allegations an		
					citations listed. Hammond-Wh		
	Interview with Resi	dent 28 on 10/19/22 at 10:42			Care Center maintains that the	•	
		did not receive quarterly			alleged deficiencies do not		
		esident funds account.			jeopardize the health and safe	etv of	
					the residents nor is it of such	.,	
	The personal funds review was completed with				character to limit our capabiliti	es	
	the Business Office Manager (BOM) on 10/25/22				to render adequate care. Plea		
	at 1:06 p.m.	g (= -1.5) -1111			accept this plan of correction a		
	F				our credible allegation of		
	The BOM indicated	I the facility handled Resident			compliance that the alleged		
		icated statements were			deficiencies have or will be co	rrect	
		to the residents or their			by the date indicated to remain		
	Responsible Party.				compliance with state and fed		
					regulations, the facility has tak		
	Phone interview wi	th the Corporate Business			or will take the actions set fort		
		e, indicated statements were			this plan of correction. We		
	-	nd copies of the statements			respectfully request a desk rev	/iew	
		er. She also indicated Social			F 568- Accounting and Record		
		go over the statement with the			Personal Funds		
		er sign the statement if she			What Corrective Action will be		
	was able.	8			accomplished for those reside		
					found to have been affected b		
	A statement for the	resident was dated 4/1/22 -			deficient practice:	<i>y</i>	
		nent had not been signed by			Resident 28 had no negativ	e	
		re was no documentation in			outcomes. Resident 28 was	-	
		progress notes indicating the			immediately issued a quarterly	,	
	_	ed a copy of her statement or			statement.	,	
	was told her balance				How other residents having th	e	
	as tota not outdie				potential to be affected by the		
	Interview with the r	resident on 10/25/22 at 1:25			same deficient practice will be		
	p.m., indicated sometimes they would tell her how				identified and what corrective		
	_	r account. She could not			action will be taken:		
		ime they did and she had not			1. An in house audit will be		
	remember the last th	inc ancy and and one had not	- 1		i. An in nouse addit will be		I

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

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 10/25	
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP CO 14TH ST NG, IN 46394)D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PPROPRIATE	(X5) COMPLETION DATE
	Interview with the 10/25/22 at 1:45 p.s she would have Soo			completed by ED/design current residents to ensine residents and/or responsion parties have received a statement. What measures and which systemic changes will be ensure that the deficient doesn't recur: 1. BOM will be educated and/or designee on province in the process of the practice will not recur, it is quality assurance progriput in place: 1. ED and/or designee on province will not recur, it is quality assurance progriput in place: 1. ED and/or designee on statement binder quarted ensure resident statement signed that they were requarterly. Results will be presented to QAPI x 6 rand QAPI will determine for further audits. 2. The results of these repetitions of the process of th	nee for sure all asible quarterly at the made to at practice and to ained. In the man will be a deficient arm will be will audit early to ents are exceived a months are the need areviews will anthly for a men are an of reviews eded, if 0%.	

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet

Page 8 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155423 B. WING 10/25/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction. F 0677 483.24(a)(2) SS=D ADL Care Provided for Dependent Residents Bldg. 00 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and F 0677 This plan of correction is prepared 12/03/2022 interview, the facility failed to ensure dependent and executed because the residents were provided assistance with activities provisions of state and federal law of daily living (ADL's) related to assistance with require it and not because personal hygiene, oral care, nail care and shaving Hammond-Whiting Care Center for 3 of 5 residents reviewed for ADL's. agrees with the allegations and (Residents E, H and J) citations listed. Hammond-Whiting Care Center maintains that the Findings include: alleged deficiencies do not jeopardize the health and safety of 1. On 10/19/22 at 9:22 a.m., 10:27 a.m., 12:08 p.m., the residents nor is it of such 1:25 p.m., and 2:45 p.m., Resident E was observed character to limit our capabilities in bed lying on his right side. At those times, to render adequate care. Please there was a rolled wash cloth inside the resident's accept this plan of correction as left hand. There was a large amount of dried our credible allegation of mucous on his lips and he had a large amount of compliance that the alleged overgrown facial hair. The resident's hair was deficiencies have or will be correct greasy. by the date indicated to remain in compliance with state and federal On 10/20/22 at 8:42 a.m., and 1:10 p.m., the regulations, the facility has taken resident was observed lying in bed on the right or will take the actions set forth in side. At those times, there was a rolled wash this plan of correction. We cloth inside the resident's left hand. There was a respectfully request a desk review. large amount of dried mucous on his lips and he F 677- ADL Care Provided for had a large amount of over grown facial hair. The Dependent Residents

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

resident's hair was greasy.

Event ID:

H71G11

Facility ID: 000365

What Corrective Action will be accomplished for those residents

If continuation sheet

Page 9 of 64

12/15/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 10/20/22 at 1:36 p.m., CNA 1 and Agency CNA found to have been affected by this 1 were observed providing incontinence care for deficient practice: the resident as well as repositioning him. He was 1. Resident E was shaven, given a observed lying on his right side with a large full bed bath per his preference, amount of dried mucous to his lips. There was had his hair washed, given oral also a large amount of facial hair observed on his care, and rolled wash cloth to left face. Neither CNA provided oral care or shaved hand replaced immediately. the resident. 2. Resident H and J were shaven and had fingernails cut On 10/21/22 at 7:52 a.m., and 9:31 a.m., the resident immediately. was observed lying in bed on the right side. At How other residents having the those times, there was a rolled wash cloth inside potential to be affected by the the resident's left hand. There was a large amount same deficient practice will be of dried mucous on his lips and he had a large identified and what corrective amount of over grown facial hair. The resident's action will be taken: hair was greasy. 1. An in house audit will be completed by nursing On 10/21/22 at 9:56 a.m., CNA 2 was observed management on residents for the preparing to provide morning care for the resident. POC charting to ensure completed She placed a warm wash cloth on the resident's per policy. Any issues identified lips to remove the dried mucous. The mucous did will be addressed and follow up not come off right away. The CNA then cleaned will be completed. his left ear with a wash cloth. She removed a large What measures and what amount of black wax from inside his ear. She was systemic changes will be made to asked to remove the wash cloth from the ensure that the deficient practice resident's left hand. At the time of removal of the doesn't recur: wash cloth, a large amount of orange/yellow dried 1. Education will be provided to debris was observed on the wash cloth. The licensed nurses and aides r/t resident's hand was dry and the skin was flaking completion of POC/PCC off. There was an odor from the resident's hand. documentation related to ADL care including shower/bed bath, At 10:15 a.m., the Director of Nursing (DON) and oral care, and nail care. Shower LPN 1 entered the room. The LPN brought in sheet to be completed and turned toothettes and cleaned the resident's mouth. The into nurse each shift. MD and DON instructed the CNA to do a complete bed POA and/or family to be notified of bath for the resident. refusal. Nursing to notify SSD of refusal(s). SSD to ensure care The record for Resident E was reviewed on plan is updated to reflect 10/20/22 at 1:18 p.m. Diagnoses included, but refusal(s). This will be completed were not limited to, multiple sclerosis, seizures, by DON/Designee by date of

H71G11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE pressure ulcer left heel, quadriplegia, compliance. schizophrenia, abnormal posture, falls, muscle 2. Any new nursing staff will wasting, contractures, neuromuscular bladder, receive this education during bipolar disorder, peg tube (a tube inserted directly orientation as well. into the stomach for nutrition), major depressive How the corrective action will be disorder, dysphagia, and moderate intellectual monitored to ensure the deficient disabilities. practice will not recur. i.e., what quality assurance program will be The Annual Minimum Data Set (MDS) put in place: assessment, dated 9/14/22, indicated the resident 1. DON/Designee will review was not cognitively intact and needed extensive shower sheets daily 5 times assist with a 2 person physical assist for bed weekly to ensure compliance. The mobility, transfers, and personal hygiene. The shower sheets must be compared resident was totally dependent on staff for to the POC charting to ensure bathing and had range of motion impairment to they match. Audits will be both sides for both upper and lower extremities. presented to QAPI x 6 months The resident had 1 unstageable pressure ulcer. and QAPI will determine the need for further audits. A Care Plan, updated 9/14/22, indicated the 2. DON/Designee will complete resident preferred have short facial hair and short observations 5 x/week for 6 hair. months to ensure ADLs are being completed as documented. A Care Plan, updated 9/14/22, indicated the 3. The results of these reviews will resident had an ADL self-care performance deficit. be discussed at the monthly facility Quality Assurance Interview with the Director of Nursing on 10/24/22 Committee meeting monthly for a at 2:00 p.m., indicated the resident should have total of 3 months and then been provided with morning and evening care quarterly thereafter once every day, including oral care The resident compliance is at 100%. should have been bathed from head to toe if Frequency and duration of reviews provided a complete bed bath.2. On 10/20/22 at will be increased as needed, if 1:46 p.m., Resident H was observed with facial hair compliance is below 100%. and long fingernails. Compliance date: 12/3/22. The Administrator at On 10/21/22 at 8:34 a.m., the resident was Hammond-Whiting Care Center is observed sitting in a wheelchair near the nurses' responsible in ensuring station. His facial hair was still visible, but his compliance in this Plan of fingernails had been trimmed. An interview with Correction. LPN 1 and QMA 2 at that time, indicated that

sometimes bathing and nail care may depend on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			4TH ST		
IOMMAH	ND-WHITING CAR	E CENTER			G, IN 46394		
(X4) ID	CLIMMADA	CTATEMENT OF DEFICIENCIE		ID			(7/5)
PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	Y OR LSC IDENTIFYING INFORMATION TAG			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
mo		, as he could be aggressive at	+	1710			DATE
	times.	, as he could be aggressive at					
	,es.						
	The record for Resi	dent H was reviewed on					
	10/20/22 at 2:00 p.i	m. Diagnoses included, but					
	were not limited to,	, non-Alzheimer's dementia,					
	syncope (fainting),	history of falls, and general					
	muscle weakness.						
		Minimum Data Set)					
		3/9/22, indicated the resident					
		intact and needed extensive ith personal hygiene.					
	1-2 person assist wi	im personai nygiene.					
	A Care Plan, dated 12/2/21, indicated the resident						
		with ADL's (Activities of					
	_	ed to dementia and muscular					
		ches included, but were not					
		e assistance by 1-2 staff with					
	bathing/showering	as a safety precaution for					
	behaviors and trans	fers, and check nail length and					
	trim and clean on b	ath day.					
		1/10/00 1 11 1 1					
		1/12/22, indicated the					
	_	es were to have short nails					
		Approaches included offering s of when he would like his					
		when he would bathe/shower.					
	nans trimined and v	when he would bathe/shower.					
	Interview with the	Assistant Director of Nursing					
		p.m., indicated personal					
		lone as needed, and not					
	necessarily waiting						
	3. On 10/19/22 at	10:30 a.m., Resident J was					
	observed near the n						
		esident had a growth of facial					
	hair and long finger	rnails.					
		24 a.m., the resident was again					

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 12 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155423	B. WING		10/25/2022	
	PROVIDER OR SUPPLIEF		1000 1	ADDRESS, CITY, STATE, ZIP COD 114TH ST NG, IN 46394	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIDED OF AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE	
	_	his wheelchair near the nurses'				
		ed unshaven and his				
	fingernails remaine	d long and dirty.				
	On 10/21/22 at 8:09	a.m., the resident was				
		the dining room for breakfast.				
		long fingernails were visible.				
		CNA 3 at that time, indicated				
		d assistance with bathing				
	when he allowed it,	depending on his mood. He				
	1 ~	cian to shave him, but has				
	_	ff to do if the beautician had				
		few days. He doesn't always				
		is nails and cannot be swayed				
	by attempts to re-di	rect.				
	The record for Resi	dent J was reviewed on				
		n. Diagnoses included, but				
	_	Parkinson's, diabetes mellitus,				
	non-Alzheimer's de	mentia, anxiety, depression,				
	and glaucoma.					
	The Questerly Mini	mum Data Set (MDS)				
		/23/22, indicated the resident				
		irment and required extensive				
		nore persons for personal				
	hygiene.	ter persona for personal				
		1/12/22 and revised 6/8/22,				
		nt preferred short fingernails				
		r. Approaches included				
	_	when he would like to bathe,				
	shave, and get his n	ails trimmed.				
	Interview with the A	Assistant Director of Nursing				
		p.m., indicated personal				
		lone as needed, and not				
	necessarily waiting					
	This Federal tag rel	ates to Complaints IN00388294				

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 13 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		155423	B. WIN	IG		10/25/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWDERS BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0679 SS=D Bldg. 00	§483.24(c) Activities §483.24(c)(1) The on the comprehen plan and the preferongoing program to choice of activities group and individual independent activities of and surand psychosocial encouraging both interaction in the compact of the presidents for 2 of 2 mactivities were in planes activities. (Resident Findings include: 1. On 10/19/22 11: Resident 6 was observation a Spanish resident spoke Englor radio on near the On 10/20/22 at 8:45 was observed lying times her roommate.	facility must provide, based sive assessment and care rences of each resident, and to support residents in their is, both facility-sponsored and activities and sities, designed to meet the apport the physical, mental, well-being of each resident, independence and community. In record review, and trained to ensure ongoing acce for cognitively dependent residents reviewed for the family of th	F 06'	79	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whow Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleas accept this plan of correction a cour credible allegation of compliance that the alleged deficiencies have or will be cour by the date indicated to remain compliance with state and feder regulations, the facility has take or will take the actions set fortile.	law er d iting e ety of es se as rrect n in eral eral	12/03/2022

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 14 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155423	B. WI	NG		10/25/2	2022
		<u> </u>	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			14TH ST		
		CENTER					
HAIVIIVIUI	ND-WHITING CARE	EUENIER		VVIIIIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	On 10/21/22 at 8:16	a.m., and 9:30 a.m., the resident			this plan of correction. We		
	was observed lying	in bed and awake. At those			respectfully request a desk rev	view.	
	times her roommate	e's television was turned on a			F 679- Activities Meet		
	Spanish speaking cl	hannel. There was no			Interest/Needs Each Resident	<u> </u>	
	television or radio on near the resident.				What Corrective Action will I	be	
					accomplished for those		
	On 10/24/22 at 8:50 a.m., 10:47 a.m., and 12:33 p.m.,				residents found to have been	n	
	the resident was ob	served lying in bed and awake.			affected by this deficient		
	At those times there	e was no television or radio			practice:		
	turned on.				1. Resident 6 had no		
					negative outcomes. Resident's	s	
	The record for Resi	dent 6 was reviewed on			television was turned on to an		
	10/21/22 at 9:33 a.m. The resident was admitted to				English speaking channel.		
	the facility on 2/11/	22. Diagnoses included, but			2. Resident 29 had no)	
	were not limited to,	stroke with hemiplegia, heart			negative outcomes. Resident's	s	
	failure, type 2 diabe	etes, major depressive disorder,			television was turned on to a		
	and expressive lang	uage disorder.			Spanish speaking channel.		
					How other residents having	the	
	The Quarterly Mini	mum Data Set (MDS)			potential to be affected by th	e	
	assessment, dated 7	/8/22, indicated the resident			same deficient practice will l	be	
	was not cognitively	intact. She needed extensive			identified and what correctiv	re	
		on physical assist for bed			action will be taken:		
	1	ers and extensive assist with a			1. An in house audit w	/ill	
		ssist for eating, dressing, and			be completed to ensure ongoing	ng	
		The resident had a limitation in			activities are in place for		
	~	one side for both upper and			cognitively dependent residen	ts.	
		She received a mechanically			Any issues identified will be		
	altered diet and the	rapeutic diet and had 1 stage 3			addressed and follow up will b	e	
	pressure ulcer.				completed. Audits will be		
					completed by date of compliar	nce.	
		2/20/22, indicated the resident			What measures and what		
		vity involvement related to her			systemic changes will be ma	ide	
	_	ipate. The interventions			to ensure that the deficient		
		not limited to, the resident			practice doesn't recur:		
	_	ving radio stations: jazz music			1. Education to all stat		
	_	ous and the Hallmark channels			r/t ongoing activities for cognit	ively	
		resident's preferred activities			dependent residents will be		
	1	vision, spending time with			completed by date of compliar	nce.	
	family, and reading	the bible.			Any new staff will		
					receive this education during		

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STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION DENTIFICATION NUMBER 155423 NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER UNITED SUMMARY STATEMENT OF DEFICIENCIE TAG AR ACITY AND ACTION YOUNG THE PRECIPED BY PALL TAG AR ACITY AND ACTION YOUNG STATEMENT OF DEFICIENCIE TAG AR ACITY AND ACTION YOUNG STATEMENT OF DEFICIENCIE TAG AR ACITY AND ACTION YOUNG STATEMENT OF DEFICIENCIE TAG AR ACITY AND ACTION YOUNG STATEMENT OF DEFICIENCIE TAG AR ACITY AND ACTION YOUNG STATEMENT OF DEFICIENCY Experiment of the Privacy Curtain was put the resident was observed bying in bed awake. At those times, there was no faction reteivision war on an English's peaking however, the privacy curtain was putted and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:30 p.m., the resident was observed bying in bed awake. At those times, there was no fradio or television turned on. The resident's roommate's television was on an English's peaking homanel, however, the privacy curtain was putted and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:30 p.m., the resident was observed bying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was on an English speaking hamanel, however, the privacy curtain was putted and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:30 p.m., the resident was observed bying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was on an English speaking hamanel, however, the privacy curtain was putted and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the resident was observed bying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was not an English speaking hamanel, however, the privacy curtain was putted and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the resident was observed b	CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394 Upper CALL DEPTENCY MIST HE PRECEDED BY FULL TAG An Activity Assessment, dated 2713/22, indicated felevision, religion, and the radio were very important. Interview with the Director of Nursing on 10/24/22 12:28 p.m. indicated she had fried to turn on the felevision but the resident has not wanted it on, however, there was no documentation of any refusals in the climical record. Interview with the Activity Director on 10/25/22 at 9-40 a.m., indicated the resident does receive 1 to 1 visits two times a week. The resident would sometimes let staff turn on the felevision, but then other days she does not want it on, however, there was no documentation of those refusals and changes in activities preferences in the clinical record. 2. On 10/19/22 10:24 a.m., 12:58 p.m., and 3:20 p.m., Resident 29 was observed lying in bed awake. At those times, there was no radio or felevision turned on. The resident's roommate's television was on an English speaking channel, however, the privacy currain was pulled and she could not see the television. On 10/20/22 at 8-40 a.m., 9:25 a.m., and 1:90 p.m., the resident was observed lying in bed awake. At those times, there was no radio or felevision turned on. The resident sommated stelevision was on an English speaking channel, however, the privacy currain was pulled and she could not see the television. On 10/21/22 at 8-40 a.m., 9:25 a.m., and 1:90 p.m., the resident was observed lying in bed awake. At those times, there was no radio or felevision turned on. The resident's roommate's television was on an English speaking channel, however, the privacy currain was pulled and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the resident was observed lying in bed awake. At those times, there was no radio or felevision turned on. The resident's roommate's television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the resident was ob	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLER HAMMOND-WHITING CARE CENTER (X4 JD SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYMEN DEFORMATION TAG INTERPRETATION TAG REGULATORY OR LARGE CORRECTION AND ALL STATEMENT OF THE PRETATION TAG INTERPRETATION TAG INTERPRETATI	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
HAMMOND-WHITING CARE CENTER (RAI) D SLIMMARY STATEMENT OF DEPCIENCE (REACH DEPCIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Activity Assessment, dated 21/33/22, indicated television, religion, and the radio were very important. Interview with the Director of Nursing on 10/24/22 12/28 p.m. indicated she had tried to turn on the television but the resident has not wanted it on, however, there was no documentation of any refusals in the clinical record. Interview with the Activity Director on 10/25/22 at 9:40 a.m., indicated the resident does receive 1 to 1 visits two times a week. The resident would sometimes let staff turn on the television, but then other days she does not want it on, however, there was no aclourementation of fhose refusals and changes in activities preferences in the clinical record. 2. On 10/19/22 10/24 a.m., 12/58 p.m., and 3/20 p.m., Resident 29 was beserved lying in bed awake. At those times, there was no radio or television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. The residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the			155423	B. W	NG		10/25	/2022
HAMMOND-WHITING CARE CENTER (RAI) D SLIMMARY STATEMENT OF DEPCIENCE (REACH DEPCIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Activity Assessment, dated 21/33/22, indicated television, religion, and the radio were very important. Interview with the Director of Nursing on 10/24/22 12/28 p.m. indicated she had tried to turn on the television but the resident has not wanted it on, however, there was no documentation of any refusals in the clinical record. Interview with the Activity Director on 10/25/22 at 9:40 a.m., indicated the resident does receive 1 to 1 visits two times a week. The resident would sometimes let staff turn on the television, but then other days she does not want it on, however, there was no aclourementation of fhose refusals and changes in activities preferences in the clinical record. 2. On 10/19/22 10/24 a.m., 12/58 p.m., and 3/20 p.m., Resident 29 was beserved lying in bed awake. At those times, there was no radio or television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. The residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the residents roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the					STREET	ADDRESS CITY STATE ZIP COD		
HAMMOND-WHITING CARE CENTER	NAME OF I	PROVIDER OR SUPPLIER	t					
REEX TAG REGULATORY OR LSC IDENTIFYING INFORMATION An Activity Assessment, dated 2/13/22, indicated television, religion, and the radio were very important. Interview with the Director of Nursing on 10/24/22 12/28 p.m. indicated she had tried to turn on the television but the resident has not wanted it on, however, there was no documentation of any refusals in the clinical record. Interview with the Activity Director on 10/25/22 at 9-40 a.m., indicated the resident does recive 1 to 1 visits two times a week. The resident would sometimes let staff turn on the television, but then other days she does not want it on, however, there was no activities preferences in the clinical record. 2. On 10/19/22 10/24 a.m., 12/258 p.m., and 3/20 p.m., Resident 29 was observed lying in bed awake. At those times, there was no radio or television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. The resident primarily spoke Spanish. On 10/20/22 at 8:40 a.m., 9-25 a.m., and 1:09 p.m., the resident was observed lying in bed awake. At those times, there was no radio or television turned on. The resident primarily spoke Spanish. On 10/20/22 at 8:40 a.m., 9-25 a.m., and 1:09 p.m., the resident was observed bying in bed awake. At those times, there was no radio or television turned on. The resident primarily spoke Spanish. On 10/20/22 at 8:40 a.m., 9-25 a.m., and 1:09 p.m., the privacy curtain was pulled and she could not see the television. The resident primarily spoke Spanish. On 10/20/22 at 8:40 a.m., 9-25 a.m., and 1:09 p.m., the privacy curtain was pulled and she could not see the television. On 10/20/22 at 10/20 a.m., and 1:30 p.m., the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10/20 a.m., and 1:30 p.m., the	HAMMOI	ND-WHITING CARE	E CENTER					
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observe cognitively dependent residents 5 x/week for 6 months to ensure ongoing activity is provided. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. On 10/19/22 10:24 a.m., 12:58 p.m., and 3:20 p.m., Resident 29 was observed lying in bed awake. At those times, there was no radio or television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:30 p.m., the resident's roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:09 p.m., the resident was observed lying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:09 p.m., the resident was observed lying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:09 p.m., the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the		television but the re	sident has not wanted it on,			program will be put in place:		
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determine the need for further audits. 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 is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is below 100%. Compliance is the clevision at the privacy curtain was pulled and she could not see the television. Uniform the resident's roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the		9:40 a.m., indicated	the resident does receive 1 to 1			provided. Audits will be preser	nted	
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privacy curtain was pulled and she could not see the television. The resident primarily spoke Spanish. On 10/20/22 at 8:40 a.m., 9:25 a.m., and 1:09 p.m., the resident was observed lying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the		was on an English s	speaking channel, however, the			_		
the television. The resident primarily spoke Spanish. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction. Correction. The resident primarily spoke Spanish. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction. Correction.		1						
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privacy curtain was pulled and she could not see the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the		was on an English s	speaking channel, however, the					
the television. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the								
			-					
		On 10/21/22 at 10:2	20 a.m., and 1:30 p.m., the					
			-					

those times, there was no radio or television turned on. The resident's roommate's television

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			I4TH ST		
HAMMOI	ND-WHITING CAR	E CENTER		1	IG, IN 46394		
	Г			<u> </u>	, 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION speaking channel, however, the	+	TAG	DE TOLERO		DATE
	_	s pulled and she could not see					
	the television.						
	On 10/24/22 at 8:50 a.m., and 10:50 a.m., the						
		ved lying in bed awake. At					
		vas no radio or television					
		dent's roommate's television					
	was on an English s	speaking channel, however, the					
	privacy curtain was	s pulled and she could not see					
	the television.						
	The record for Resident 29 was reviewed on						
		.m. Diagnoses included, but					
		, dementia without behaviors,					
		anxiety disorder, psychosis,					
		serted directly into the stomach najor depressive disorder.					
	101 Hutifuloii) and iii	lajor depressive disorder.					
	The Ouarterly Mini	imum Data Set (MDS)					
		3/10/22, indicated the resident					
		intact and was severely					
	impaired for decision	on making. The resident					
	needed extensive as	ssist with 2 person physical					
	assist for bed mobil	lity and transfers and extensive					
	assist with a 1 perso	on physical assist for dressing.					
		10/40/00					
	_	ed 8/10/22, indicated the					
		make simple needs/wishes					
		The resident would be					
		ed with sensory interaction,					
	· '	civities. The interventions					
		not limited to, encourage the watch spiritual programs on					
	television when ava						
		levision channels for possible					
	selection of persona						
	solection of persona	ar moreon.					
	The resident had re-	ceived 1 to 1 room visits two					
	times a week by act	tivity staff for the months of					

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 17 of 64

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD	IPLE CONSTRUCTION DING <u>00</u>	(X3) DATE	
		155423	B. WING		10/25	/2022
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STAT 000 114TH ST VHITING, IN 46394	E, ZIP COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		EFIX (EACH CORRECTIVE . CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE 1 TO THE APPROPRIATE IENCY)	(X5) COMPLETION
TAG	9/2022 and 10/2022	R LSC IDENTIFYING INFORMATION 2.	Tz	AG DEFICE	IENCY	DATE
F 0684 SS=D Bldg. 00	Interview with the 29:40 a.m., indicated spoke only Spanish visits 2 times a wee chair, they did take 1 other staff membed difficult to ensure it some type of stimular while they were aw should have been on while she was in her as a standard of the staff and the residents. It comprehensive as facility must ensure treatment and car professional standard comprehensive part of the residents. Based on observation interview, the facility were completed as were assessed and reviewed for skin carelated). The facility monitoring and treatelevated blood presents.	Activity Director on 10/25/22 at a she was aware the resident. She did receive 1 to 1 room ask and when she was up in the her to activities. She only had are to help out, therefore, it was the dependent residents had lation going on in their rooms take. The television or radio in a Spanish speaking channel are room. In a fundamental principle that ment and care provided to Based on the assessment of a resident, the re that residents receive in accordance with dards of practice, the erson-centered care plan,	F 0684	and executed be provisions of sta require it and no Hammond-Whiti agrees with the	ite and federal law of because ing Care Center allegations and Hammond-Whiting intains that the	12/03/2022
	G) Findings include:			jeopardize the h the residents no character to limit		

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 18 of 64

12/15/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to render adequate care. Please 1. On 10/19/22 at 10:19 a.m., Resident F was accept this plan of correction as observed with a gauze dressing to his left shin. our credible allegation of compliance that the alleged On 10/21/22 at 8:56 a.m., the resident was deficiencies have or will be correct observed in his room in bed. The dressing to the by the date indicated to remain in resident's left shin was dated 10/19/22. compliance with state and federal regulations, the facility has taken The Record for Resident F was reviewed on or will take the actions set forth in 10/20/22 at 1:30 p.m. Diagnoses included, but this plan of correction. We were not limited to, Parkinson's disease, adult respectfully request a desk review. failure to thrive, protein calorie malnutrition, and neurogenic bladder. F 684- Quality of Care What Corrective Action will be The Admission Minimum Data Set (MDS) accomplished for those assessment, dated 10/18/22, indicated the MDS residents found to have been was in progress. The resident was moderately affected by this deficient impaired for daily decision making. practice: Resident F had 1. A Care Plan, dated 10/11/22, indicated the resident dressing to left shin changed and had a break in skin integrity to the coccyx, lower signed out per order. MD and left leg, and lower left leg lateral. Interventions family were notified. Resident F included, but were not limited to, treatment as had no negative outcomes. ordered. Resident B no longer resides at facility. A Physician's Order, dated 10/18/22, indicated to 3. Resident G cleanse the left lower leg with normal saline, pat immediately had a skin dry, and cover abrasion with antibiotic ointment assessment and treatment orders one time a day for 7 days. were obtained. Resident G had no negative outcomes. The October 2022 Treatment Administration How other residents having the

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Record (TAR), indicated the treatment had not

The Wound Observation Tool, dated 10/18/22.

indicated the resident was admitted with the left

Interview with the Director of Nursing on 10/21/22

lower leg abrasion and the area measured 1

centimeter (cm) x 1 cm.

been signed out as being completed on 10/20/22.

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

potential to be affected by the

same deficient practice will be identified and what corrective

completed with head to toe skin

assessments to ensure any skin

In house audit

action will be taken:

issues are identified and

addressed by nursing

Page 19 of 64

STATEMENT OF DETICINENTS AND PLAN OF CORRECTION INSTITICATION NUMBER 155423 NAME OF ROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER SUMMARY STATIMENT OF DEPICIENCIE (LOCI) DEPICENCY MLST III PRICEIDED BY TILL TAG IL 1243 pm., indicated the resident's treament was to be completed daily. 2. The closed record for Resident Was reviewed on 1024/22 at 85.2 a.m. The resident was often to the facility on 7/8/22 and discharged to the hospital on 7/5/22. Diagnoses included, but were not limited to, and stage remal disease, dependence on rend dialysis, type 2 disheles, anemia, atrial fibrillation, chronic systemic heart failure, and hypertinjudents. The Admission Minimum Data (MDS) assessment, dated 7/8/22, indicated the resident was cognitively intact. The resident was a limited useful was cognitively intact. The resident was a limited useful was comitively intact failure, and propendate was cognitively intact. The resident was a limited useful was comitively intact failure, and hypertinjudents. A Care Plan, dated 7/22/22, indicated the resident was cognitively intact flater, and hypertinjudents. A Care Plan, dated 7/22/22, indicated the resident was cognitively intact flater, and hypertinjudents of the proposal proposa	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			OVAN DATE CHRAVEY		
Invariable Inv				r í			l ′	
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The Admission Minimum Data (MDS) assessment, dated 7/15/22, indicated the resident was cognitively intact. The resident had no ral problems, weighed was 249 pounds with no right fibrillation, congestive heart disease. The approaches were to obtain vital signs and notify the Physician's Orders, dated 7/12/22, indicated the resident had no related to the resident was not becompliance. The promote of significant abnormalities. A Care Plan, dated 7/22/22, indicated the resident had altered cardiovascular status related to atrial fibrillation, congestive heart disease. The approaches were to obtain vital signs and notify the Physician of significant abnormalities. A Care Plan, dated 7/22/22, indicated the resident had altered cardiovascular status related to atrial fibrillation, congestive heart failure, and hypertensive heart disease. The approaches were to obtain vital signs and notify the Physician of significant abnormalities. Physician's Orders, dated 7/8/22, indicated the following: Losartan 50 milligrams (mg) daily for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 100 mg three times a day for high blood pressure. Bydralazine HCI 10	NAME OF P	PROVIDER OR SUPPLIER						
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employees will receive education

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155423	B. WING		10/25/2022	
	PROVIDER OR SUPPLIEI		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
	T			1	(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION DATE	
TAG	blood pressure.	CLSC IDENTIFTING INFORMATION	IAG	prior to working.	DATE	
	_	two times a day for high blood		How the corrective action w	ill	
	pressure.			be monitored to ensure the	""	
		200 mg every 12 hours for high		deficient practice will not re	cur	
	blood pressure.	too mg every 12 hours for mgn		i.e., what quality assurance	cui,	
	blood pressure.			program will be put in place	,.	
	The resident's blood pressures were documented			1. DON/Designee will		
	as follows:			review 24/72 hour report 5 tim		
				weekly to ensure treatment or		
	7/10/22 at 7:43 p.m	a., 185/105		are obtained and in place for		
7/13/22 at 8:23 a.m., 167/100			skin issues, and care plan is	,		
7/13/22 at 8:23 a.m., 176/100			updated x 6 months. Audits w	vill be		
	7/17/22 at 8:51 a.m., 176/111			presented to QAPI x 6 months		
	7/25/22 at 8:50 a.m	and 9:01 a.m., 157/141		and QAPI will determine need		
				further audits. Competencies	will	
	Nurses' Notes, date	d 7/25/22 at 8:35 p.m.,		be completed by date of		
	indicated the reside	ent was admitted to the		compliance on aides and nurs	ses	
	hospital.			for the appropriate protocol fo	or skin	
				assessments and accurate fo	llow	
		mentation in the clinical record		through and documentation b	у	
	regarding what was	done, if anything, regarding		Nursing Management.		
	the high blood pres	sures.		2. DON/Designee will	I	
				review 24/72 hour report 5 tim		
		Director of Nursing (DON) on		weekly to ensure orders for B	P	
		m., indicated the resident was		medications contain		
	admitted to the hos	pital from dialysis on 7/25/22.		monitoring/parameters x 6		
		D 03.7 4.0 (0.7 (0.0) 4.0 0.0		months. Audits will be presen		
		DON on 10/25/22 at 10:20 a.m.,		to QAPI x 6 months and QAP		
	_	vas done regarding the high		determine need for further au		
	1 ^	cause there were no Physician		3. The results of thes		
	_	for monitoring the blood		reviews will be discussed at the		
		lent's blood pressure was not ange. The resident was sent to		monthly facility Quality Assura		
		gh blood pressure recorded		Committee meeting monthly f	UI d	
		g. 3. On 10/19/22 at 2:00 p.m.,		total of 3 months and then		
		served on her way to bingo in		quarterly thereafter once		
		cabs and redness were noted to		compliance is at 100%.	viows	
	the right lower shir			Frequency and duration of reviews		
	ine right lower silli	L.		will be increased as needed, compliance is below 100%.	"	
	I		I	Compliance is Delow 100 /0.	I	

On 10/21/22 at 12:35 p.m., the resident was

Compliance date: 12/3/22. The

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

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY LETED 5/2022	
	PROVIDER OR SUPPLIER ND-WHITING CARI		1000 1	ADDRESS, CITY, STATE, ZIP C 14TH ST NG, IN 46394	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
IAU	observed seated at a The right lower leg and scabs. On 10/24/22 at 9:52 observed in the hall wheelchair. The right dry, flaky skin and The record for Resi 10/19/22 at 3:00 p.1 were not limited to, (DM), non-Alzhein pressure ulcer. The Annual Minim assessment, dated 7 required extensive and transfers. A Care Plan, dated indicated the reside skin integrity relate weakness, and incoincluded, but were ordered and weekly There was no order resident's right lower assessment of the a On 10/24/22 at 10:4 assessment, dated 1 the right lower leg 1 literview with the 4 (ADON) on 10/24/24/24.	a table in the dining room. remained red with flaky skin 2 a.m., the resident was tway near her room in her ght ankle was visibly red with scabs. dent G was reviewed on m. Diagnoses included, but heart failure, diabetes mellitus her's dementia, and left heel um Data Set (MDS) //20/22, indicated the resident assistance with bed mobility 10/4/22 and revised 10/5/22, nt was at risk for a break in d to diabetes mellitus, muscle ntinence. Interventions not limited to, treatment as y skin checks. for any treatment to the er leg. There was also no	IAG	Administrator at Hammond-Whiting Car responsible in ensuring compliance in this Plan Correction.	g	DATE

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet

Page 22 of 64

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	NG		10/25/	2022
	PROVIDER OR SUPPLIER		•	1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	This Federal tag rela	ates to Complaint IN00386810.					
	3.1-37(a)						
F 0686 SS=E Bldg. 00	1686 483.25(b)(1)(i)(ii) S=E Treatment/Svcs to Prevent/Heal Pressure		F 00		This plan of correction is prepa	prod	12/03/2022
			1 00	980	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		12/03/2022
					alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleas accept this plan of correction a our credible allegation of compliance that the alleged deficiencies have or will be colby the date indicated to remain	es se as	

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 23 of 64

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155423	B. W	ING		10/25/	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
	ND WILLITING OAD	CENTED			14TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	neurogenic bladder.				compliance with state and fed	eral	
					regulations, the facility has tak	(en	
The Admission Minimum Data Set (MDS)				or will take the actions set fort	h in		
	assessment, dated 1	0/18/22, indicated the MDS			this plan of correction. We		
	was in progress. Th	e resident was moderately			respectfully request a desk rev	view.	
	impaired for daily of	lecision making.			F 686- Treatment/Services to		
					prevent/heal pressure ulcer		
	A Care Plan, dated	10/11/22, indicated the resident			What Corrective Action will be		
	had a pressure ulcer	to his coccyx and he had the			accomplished for those reside	nts	
	potential for pressu	re ulcer development related to			found to have been affected b	y this	
	immobility. Interve	entions included, but were not			deficient practice:		
	limited to, administ	er treatments as ordered.			1. Resident F had dressing to	right	
					upper back changed immedia	tely.	
	A Physician's Order, dated 10/18/22, indicated the				Resident F had no negative		
	right posterior lowe	r thoracic area was to be			outcomes.		
	cleansed with norm	al saline, pat dry, then apply			2. Resident C and D no longe	r	
	Xeroform and cove	r with a dry dressing every			resides at facility.		
	night shift for wour	nd care and as needed (prn).			3. Resident E had skin		
					assessment completed with N	ID	
		Treatment Administration			notified and treatment orders		
		cated the treatment had not			obtained. Resident E had no		
	been signed out as l	peing completed on 10/20/22.			negative outcomes.		
					How other residents having th	е	
		ssessment, dated 10/18/22,			potential to be affected by the		
		nt was at high risk for			same deficient practice will be		
	developing pressure	e ulcers.			identified and what corrective		
					action will be taken:		
		ration Tool, dated 10/18/22,			In house audit completed w		
		nt had an unstageable			head to toe skin assessments	to	
	_	s right posterior lower thoracic			ensure any skin issues are		
	area that measured	2 centimeters (cm) x 1.5 cm.			identified and addressed by		
					nursing management by date	of	
		Director of Nursing on 10/21/22			compliance. Any new orders		
	_	ated the resident's treatment			received put on TX and/or me	d	
	was to be completed	d daily.			sheet, care plan and kardex		
					updated. Any issues identified	will	
	2. The Closed Record for Resident D was				be addressed.		
		22 at 10:17 a.m. Diagnoses			What measures and what		
		not limited to, aspiration			systemic changes will be mad		
	pneumonia, history	of stroke, and congestive			ensure that the deficient pract	ice	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25/	2022
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			14TH ST		
I HAMMON	ND-WHITING CARE	E CENTER			NG, IN 46394		
					T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		esident was admitted to the			doesn't recur:		
	facility on 9/30/22.				Education will be completed		
	A PM - 11 - 1 - 0 - 1 - 1 - 1 - 1 - 1 - 0 - 1 - 1				licensed and certified nursing	staff	
A Physician's Order, dated 9/30/22, indicated wound care was to evaluate and treat.				to ensure any skin issue or			
	wound care was to	evaluate and treat.			abnormal finding needs report		
	37 137 . 1 .	1.10/1/20 10.00			and documented in the clinica		
		d 10/1/22 at 12:20 a.m.,			record, MD and Responsible	-	
		nt was noted with skin			need notified and care plan ar		
	_	acral area and wound care was			Kardex to be updated to reflect		
	to treat and evaluate	€.			new orders and/or include any	new	
	T D 1 C 1	1 . 10/20/22			interventions by Nursing		
The Braden Scale assessment, dated 9/30/22,					management by date of		
indicated the resident was a high risk for				compliance. New licensed or			
	developing pressure	e ulcers.			certified nursing employees w	III	
	TI W 101	T. 1.110/20/22			receive this education prior to		
		ration Tool, dated 9/30/22,			working.		
		nt was noted with an open			2. Education will be completed	1 10	
		and wound care was to treat			licensed nursing staff staff		
		area was identified as a Stage 3			regarding the following:		
	_	measured 4 centimeters (cm) x			i. Notification of physician upo		
		slough was present with a			identification of new pressure	uicer	
		f sanguineous (bloody			for treatment		
	- '	and had an odor and the			ii. Notification of responsible p	-	
	resident had pain re	rated to the wound.			and or resident regarding new	iy	
	The medidant had no	treatment order for the			identified pressure ulcers and		
	wound.	treatment order for the			treatment		
	wound.				iii. Documentation of newly		
	Interview with the	Nurse Consultant on 10/25/22			identified pressure ulcers to		
		ated a treatment order for the			include site, description, measurement, notification of		
		ld have been obtained on				ı	
	-	0/19/22 at 9:22 a.m., 10:27 a.m.,			responsible party/resident and	1	
		m., and 2:45 p.m., Resident E			physician and treatment plan/orders.		
		d lying on his right side. At			pian/orders. I iv. Bath sheets are documented	nd.	
		d was lying directly on a					
		ear was not offloaded.			with each bath and any identif		
	pinow and the right	car was not officaded.			wounds documented and report to the licensed nurse.	n t e u	
	On 10/20/22 at 9.42	2 a.m., and 1:10 p.m., the				or	
					v. Weekly skin assessments for	JI	
		red lying in bed on the right			each in house resident are		
	side. At those times	s, his head was lying directly			completed on the due date		

PRINTED: 12/15/2022

	T OF HEALTH AND HUI R MEDICARE & MEDIC					IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	
		155423	B. WING		10/25	
NAME OF	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
		C CENTED		14TH ST		
ПАІИІИО	ND-WHITING CARI	ECENTER	٧٧٦١١١١	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	on a pillow and the	right ear was not offloaded.		vi. Communication with the D	• • • •	
				and/or wound nurse with any		
		6 p.m., CNA 1 and Agency CNA		newly identified pressure ulce		
		to check for incontinence and		How the corrective action will		
	_	ent. The resident was placed		monitored to ensure the defic		
	_	th a pillow under his head. The		practice will not recur, i.e., when the contract of the contra		
		floaded. CNA 1 removed the		quality assurance program w	ill be	
	_	n his feet and there was a		put in place:		
		on the left heel and dark		1. DON/Designee will review		
		bottom of his right foot with		hour report 5 times weekly to)	
the remnants of betadine (an orange solution used			ensure treatment orders are			
	for wound care) on	the scab.		obtained and in place for any		
	T			issues and care plan is upda		
		CNA 1 at that time, indicated		6 months. DON/Designee wil		
		verely contracted in his legs		review TAR 5 times weekly to		
		as only able to be repositioned		ensure treatments are compl		
	on the right side.			as ordered x 6 months. Audit		
	On 10/21/22 at 7:57	2 a.m., and 9:31 a.m., the resident		be presented to QAPI x 6 mg		
		in bed on the right side. At		and QAPI will determine need further audits.	u ioi	
		id was lying directly on a		2. DON/Wound Nurse will		
		t ear was not offloaded.		complete observations 5 x/w	aak	
	pinow und the right	car was not officiated.		for 6 months to ensure wound		
	On 10/21/22 at 9:56	6 a.m., CNA 2 was observed		is being completed as	a care	
		e morning care for the resident.		documented.		
		8		3. The results of these review	vs will	
	Interview with CNA	A 1 at that time, indicated she		be discussed at the monthly		
		5:30 a.m. and had not turned or		facility Quality Assurance		
		sident since she had been		Committee meeting monthly	for a	
	there.			total of 3 months and then		
				quarterly thereafter once		
	Interview with the	Director of Nursing on 10/21/22		compliance is at 100%.		
		ated the ear was to be offloaded		Frequency and duration of re	views	
	to prevent the press	sure ulcers.		will be increased as needed,		
	_			compliance is below 100%.		
	On 10/25/22 at 8:45	5 a.m., LPN 2 provided wound		Compliance date: 12/3/22. The	ne	
		e ulcers There was a dark		Administrator at		

scabbed area to the bottom of the resident's right foot, a yellow necrotic area to the left heel and

black necrotic deep tissue injury to the left plantar

Hammond-Whiting Care Center is

responsible in ensuring compliance in this Plan of

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155423	B. WING		10/25/2022
		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	t		114TH ST	
I IOMMAH	ND-WHITING CARE	E CENTER		ING, IN 46394	
					1
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE COM LETTON
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		open. All of the open areas		Correction.	
	were measured as follows: right plantar foot 1.5				
	centimeters (cm) by 1 cm, left heel 2 cm by 4 cm,				
	and left plantar heel 1 cm by 2 cm.				
	The record for Dagi	dant E was ravioused on			
	The record for Resident E was reviewed on 10/20/22 at 1:18 p.m. Diagnoses included, but				
	-	multiple sclerosis, seizures,			
	pressure ulcer left h	-			
	-	ormal posture, falls, muscle			
	-	es, neuromuscular bladder,			
	_ ·	g tube (a tube inserted directly			
		r nutrition), major depressive			
		, and moderate intellectual			
	disabilities.	,			
	The Annual Minim	um Data Set (MDS)			
		/14/22, indicated the resident			
	was not cognitively	intact and needed extensive			
	assist with a 2 perso	on physical assist for bed			
	mobility, transfers,	and personal hygiene. The			
	resident was totally	dependent on staff for			
	bathing and had ran	ge of motion impairment to			
	both sides for both	upper and lower extremities.			
	The resident had 1 i	unstageable pressure ulcer.			
	-	ed on 10/14/22, indicated the			
		for a break in skin integrity.			
	~ ~	re for nursing staff to do			
	-	ensure proper positioning and			
	to provide treatmen	ts as ordered.			
	A Comp D1 4-4 1	6/10/22 indicated 41: 1			
		6/10/22, indicated the resident			
	had an abrasion to t	ne right ear.			
	Physician's Orders	dated 9/4/22, indicated to			
	offload right ear eve				
	officad fight car eve	ory sinit.			
	Physician's Orders	dated 10/20/22, indicated left			
	-	e with normal saline pat dry			
	noor plantar, eleans	norman same par ary			

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 27 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 25/2022	
	PROVIDER OR SUPPLIEI		1000 1	ADDRESS, CITY, STATE, ZIP (14TH ST NG, IN 46394	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	dry dressing daily. normal saline pat d	daily. Cover right ear with a Left medial heel: cleanse with ry and apply calcium alginate nd then wrap with kerlix daily.				
	indicated the reside blistered area to the A measurement on measured 2.5 cm by monitor until resolve ulcer was 100% dry cm by 1.0 cm. The betadine." On 9/20 the same with the spressure ulcer measureatment was "cha 10/11/22 the measuremained the same 100% black. On 10 ulcer measured 1 cm black. The treatme	re Ulcer Tracking Report nt was readmitted with a right plantar foot on 9/2/22. 9/6/22 indicated the blister y 1 cm and the treatment was to yed. On 9/13/22 the pressure y and black and measured 1.5 treatment was "change to //22 the measurements remained ame treatment. On 9/27/22, the sured 1.5 cm by 1.0 cm and the nage to skin prep." On 10/4 and rements and treatment and the pressure ulcer was still 0/18/22 the right plantar foot m by 1 cm and was 100% dry nt remained the same. sician's Orders for the Betadine upplied to the right plantar foot				
	indicated the reside pressure ulcer on 9/cm and was a dark treatment was "Nur saline and apply sk pressure ulcer measure ulcer measure and unstageable treatment remained 10/11/22 the measuremained the same pressure sore measuremassure sore measuremass	re Ulcer Tracking Report int acquired a left plantar heel 20/22 that measured 2 cm by 3 purple fluid filled blister. The using to cleanse with normal in prep daily." On 9/27/22 the ured 1 cm by 2 cm and was black intact eschar. The the same. On 10/4 and rements and treatment as on 9/27/22. On 10/18/22 the ured 1 cm by 1 cm and was still The treatment of skin prep				

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 28 of 64

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

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. Wl	ING		10/25	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IATH ST		
HAMMO	ND-WHITING CARE	- CENTER			IG, IN 46394		
	1						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	daily was the same.						
	Thomas vyos ma Dhyvai	sions Orders for the string man					
		cian's Orders for the skin prep to the left plantar heel pressure					
	ulcer until 10/20/22						
	uicei uittii 10/20/22						
	There were no treat	ment orders on the Treatment					
	Record or on the Medication Record for the						
		ep to the right plantar foot and					
		for the month of 9/2022 and up					
	until 10/20/22 for th	•					
	Interview with LPN	I 2 on 10/25/22 at 9:00 a.m.,					
	indicated she worke	ed part time at the facility and					
	only came in on Tu	esdays to provide wound care					
	and measure all the	wounds. The regular shift					
	nurses were to com	plete the treatments on a daily					
	basis. A treatment	was in place for the right					
	plantar foot and the	left plantar heel, however, a					
	Physician's Order w	vas never obtained and nothing					
		onto the treatment record. An					
	order was obtained	for the left plantar heel on					
	10/20/22.						
		Director of Nursing on 10/25/22					
		ated the resident was to be					
	_	oned at least every 2 hours.					
		ments obtained for the					
	-	he right plantar foot and left					
	plantar heel.						
	Interview with the	Nurse Consultant on 10/25/22					
		ated the treatments for right					
		t heel pressure ulcers were					
		eal record, but they were on the					
		ressure Ulcer Tracking Report.					
	Senior Street	Tuoning report					
	4. The closed recor	rd for Resident C was reviewed					
		a.m. The resident was admitted					
		charged home on 7/30/22.					

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 29 of 64

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			4TH ST		
HAMMOI	ND-WHITING CAR	E CENTER			IG, IN 46394		
	1		1		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE!		DATE
	"	l, but were not limited to, atrial					
		sease, polyneuropathy, low					
	back pain, insomnia	a, and high blood pressure.					
	The Admission Mi	nimum Data Set (MDS)					
	The Admission Minimum Data Set (MDS) assessment, dated 7/19/22, indicated the resident						
		act. In the last 7 days, the					
		antidepressant medication 7					
		lant medication 6 times, an					
	_	on 5 times, a diuretic medication					
		oid medication 6 times.					
	o times and an opioid medication o times.						
	A Care Plan, dated 7/12/22, indicated the resident						
	had an unstageable pressure ulcer to the left heel.						
	_	re to provide treatments as					
	ordered.						
	Physician's Orders,	dated 7/19/22, indicated					
	cleanse left heel wi	th normal saline, pat dry, then					
	apply manuka hone	y and cover with dry dressing					
	every night shift.						
		ninistration Record for the					
		ndicated the left heel treatment					
	1	as being completed on 7/19,					
	7/20, 7/23, and 7/26	5/22.					
		ion Tool, dated 7/12/22,					
		nt was admitted to the facility					
	_	on the left heel. The area was					
		c tissue that measured 5.5					
		6 cm. On 7/19/22 the pressure					
		cm by 6 cm and had					
	1 -	oted. The treatment was					
		e. On 7/26/22 the pressure					
	uicer measured 2 cr	m by 2 cm and was improving.					
	Interview with the	Nurse Consultant on 10/25/22					
		ated the left heel pressure ulcer					
		-					
	i cannent was not s	igned out as being completed	- 1				I

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 30 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	COMPLETED	
155423		B. W.	B. WING 10/25/			/2022		
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			14TH ST			
НАММОН	ND-WHITING CARE	= CENTER			IG, IN 46394			
1 17 (IVIIVIOI	10-11111110 07111			VVI II I II I				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	on the above mention	oned days.						
	This Federal tag rel and IN00392720.	ates to Complaints IN00388294						
	3.1-40(a)(2)							
F 0688 SS=D Bldg. 00	§483.25(c) Mobiliti §483.25(c)(1) The resident who enter range of motion do reduction in range resident's clinical of that a reduction in unavoidable; and §483.25(c)(2) A remotion receives a services to increase prevent further de §483.25(c)(3) A rereceives appropria	e facility must ensure that a rs the facility without limited oes not experience e of motion unless the condition demonstrates a range of motion is esident with limited range of ppropriate treatment and se range of motion and/or to crease in range of motion. esident with limited mobility ate services, equipment, and						
	with the maximum	ntain or improve mobility n practicable independence						
	unless a reduction							
	demonstrably una			600			10/02/2022	
		on, record review, and ty failed to ensure residents	F 00	588	This plan of correction is prepared by and averaged because the	ared	12/03/2022	
	· ·	ty failed to ensure residents e of motion had splints and/or			and executed because the	Llow		
	_	ices applied as ordered by the			provisions of state and federal require it and not because	ıidW		
		residents reviewed for limited			Hammond-Whiting Care Cent	er		
	_	OM). (Residents 6, E and 23)			agrees with the allegations an citations listed. Hammond-Wh	d		
	Findings include:				Care Center maintains that the alleged deficiencies do not	-		
	1. On 10/19/22 11	:10 a.m., 12:00 p.m., and 1:15			jeopardize the health and safe	etv of		
		as observed lying in bed. At			the residents nor is it of such	· - <i>y</i> ·		

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 31 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE those times her right hand was clenched in the character to limit our capabilities shape of a fist. There was no anticontracture to render adequate care. Please device in the hand. accept this plan of correction as our credible allegation of On 10/20/22 at 8:45 a.m., and 1:10 p.m., the resident compliance that the alleged was observed lying in bed. At those times her deficiencies have or will be correct right hand was clenched in the shape of a fist. by the date indicated to remain in There was no anticontracture device in the hand. compliance with state and federal regulations, the facility has taken On 10/21/22 at 7:55 a.m., 8:16 a.m., and 9:30 a.m., or will take the actions set forth in the resident was observed lying in bed. At those this plan of correction. We times her right hand was clenched in the shape of respectfully request a desk review. a fist. There was no anticontracture device in the hand. **F 688 –** Increase/Prevent Decrease in ROM/Mobility On 10/24/22 at 8:50 a.m., 10:47 a.m., and 12:33 p.m., What Corrective Action will be the resident was observed lying in bed. At those accomplished for those times her right hand was clenched in the shape of residents found to have been a fist. There was no anticontracture device in the affected by this deficient hand. practice: Resident 6 had right 1. The record for Resident 6 was reviewed on hand splint applied immediately. 10/21/22 at 9:33 a.m. The resident was admitted to Resident 6 had no negative the facility on 2/11/22. Diagnoses included, but outcomes. were not limited to, stroke with hemiplegia, heart 2. Resident E had left failure, type 2 diabetes, major depressive disorder, hand washed and new rolled and expressive language disorder. washcloth placed inside so that it covered the entire hand so there The Quarterly Minimum Data Set (MDS) was no skin to skin contact. assessment, dated 7/8/22, indicated the resident Resident E had no negative was not cognitively intact. She needed extensive outcomes. assist with a 2 person physical assist for bed Resident 23 had green mobility and transfers and extensive assist with a carrot applied to left hand. 1 person physical assist for eating, dressing, and Resident 23 had no negative personal hygiene. The resident had a limitation in outcomes. range of motion on one side for both upper and How other residents having the lower extremities. potential to be affected by the same deficient practice will be A Care Plan, dated 3/16/22, indicated the resident identified and what corrective

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

had hemiplegia due to a stroke affecting the

Event ID:

H71G11

Facility ID: 000365

action will be taken:

If continuation sheet

Page 32 of 64

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
		155423	B. WING			10/25/2022	
				CTPEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					14TH ST		
HAMMOND-WHITING CARE CENTER					NG, IN 46394		
	1				T	Т	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	dominant side (righ	it side).			1. In house audit		
	Dhygisis als O 1	data d 0/2/22 : 1: 1			completed with all residents r		
	1 -	dated 8/3/22, indicated to don			to have a contracture to ensu		
	_	splint daily. The resident was			anti-contracture device is in p	iace	
	_	and rolled splint as tolerated.			as ordered by nursing		
		ve the splint for hand hygiene n and check skin for			management by date of	ified	
	redness/irritation.	II ANG CHECK SKIII IOF			compliance. Any issues ident	iiiea	
	reuness/irritation.				will be addressed. What measures and what		
	The Treatment Ada	ninistration Record (TAR) and				200	
		ministration (MAR) for the			systemic changes will be m to ensure that the deficient	aue	
	months of 9/2022 a				practice doesn't recur:		
		he right hand splint being			1. Education will be		
	donned and doffed				completed to licensed and		
	domica and domed	aurry.			certified nursing staff to ensur	re	
	Interview with I PN	V 1 on 10/24/22 12:15 p.m.,			any resident with a contractur		
		naware the resident had a			has appropriate anti-contractu		
		ced a washcloth in her right			device in place as ordered by		
	hand earlier that me				of compliance. New licensed		
		<i>⊙</i> .			certified nursing employees w		
	Interview with the	Director of Nursing on 10/24/22			receive this education prior to		
		ted there was no documentation			working.		
	-	R of donning or doffing the			How the corrective action w	rill	
	splint.				be monitored to ensure the		
					deficient practice will not re	cur,	
	2. On 10/19/22 at 9	9:22 a.m., 10:27 a.m., 12:08 p.m.,			i.e., what quality assurance		
	1:25 p.m., and 2:45	p.m., Resident E was observed			program will be put in place	:	
	in bed lying on his	right side. There was a rolled			DON/Designee wil	ı	
	wash cloth inside th	ne resident's left hand. The			review MAR/TAR 5 times wee	ekly	
	wash cloth was only	y 1/4 of the way inside of the			to ensure anti-contracture de	vices	
	hand.				are in place for any resident v	vith a	
					contracture x 6 months.		
		2 a.m., 1:10 p.m., and 1:36 p.m.,			Management will observe		
		served lying in bed on the			residents with contractures 5		
	_	e times, there was a rolled wash			times weekly to ensure		
		dent's left hand. The wash			anti-contracture devices are i		
	cloth was only 1/4	of the way inside the hand.			place as ordered. Audits will b		
					presented to QAPI x 6 month		
		2 a.m., and 9:31 a.m., the resident			and QAPI will determine need	d for	
	I was observed lying	in bed on the right side. At			further audits		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>00</u>		COMPLETED	
		155423	B. WING		10/25/2022	
		<u> </u>	STRF	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	3		0 114TH ST		
HAMMON	ND-WHITING CAR	E CENTER		ITING, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	· ·	vas a rolled wash cloth inside		2. The results of thes		
		and. The wash cloth was only		reviews will be discussed at t	=	
	1/4 of the way insid	le the hand.		monthly facility Quality Assur		
	On 10/21/22 at 0.54	Come CNA 2 was absented		Committee meeting monthly t	or a	
		6 a.m., CNA 2 was observed e morning care for the resident.		total of 3 months and then		
		emove the wash cloth from the		quarterly thereafter once compliance is at 100%.		
		At the time of removal of the		Frequency and duration of re	views	
		amount of orange/yellow dried		will be increased as needed,		
	_	d on the wash cloth. The		compliance is below 100%.		
		dry and the skin was flaking		Compliance date: 12/3/22. The	ne	
		odor from the resident's hand.		Administrator at		
	The CNA cleaned t	he resident's hand and new		Hammond-Whiting Care Cen	ter is	
	rolled wash cloth w	vas placed inside the that		responsible in ensuring		
	covered the entire h	nand so there was no skin to		compliance in this Plan of		
	skin contact.			Correction.		
		dent E was reviewed on				
	-	m. Diagnoses included, but				
		, multiple sclerosis, seizures,				
	pressure ulcer left h	ormal posture, falls, muscle				
	-	es, neuromuscular bladder,				
	_	eg tube (a tube inserted directly				
		r nutrition), major depressive				
		, and moderate intellectual				
	disabilities.	, and moderate monocitum				
	The Annual Minim	um Data Set (MDS)				
		0/14/22, indicated the resident				
		intact and needed extensive				
		on physical assist for bed				
	mobility, transfers,	and personal hygiene. The				
	-	dependent on staff for				
	-	nge of motion impairment to				
	both sides for both	upper and lower extremities.				
	There was no Care	Plan for contractures or a				
	limited range of mo					
			1			

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 34 of 64

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM		COMPL	COMPLETED	
155423		155423	B. WING 10/25/202			/2022	
				CTREET	DDDFGG CITY GTATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
HAMMOND-WHITING CARE CENTER					4TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Interview with Dire	ector of Nursing on 10/24/22 at					
	2:00 p.m., indicated	I the resident was screened by					
	therapy and they in	dicated a rolled washcloth in					
	the resident's hand	was fine. The rolled wash					
	cloth needed to be a	all the way in the hand.					
	3. On 10/19/22 at 1	10:00 a.m., Resident 23 was					
	observed in bed, lyi	ing on his back, asleep. His left					
	-	in a fist and he had no					
	anticontracture devi	ice in place.					
		•					
	On 10/19/22 at 12:0	00 p.m., the resident was					
		d, lying on his back, asleep.					
		lenched in a fist and he had no					
	anticontracture devi	ice in place.					
		•					
	On 10/20/22 at 1:22 p.m., the resident was						
	observed near the nurses' station reclined in a geri						
		l was clenched in a fist and he					
	had no anticontracture device in place.						
		-					
	On 10/21/22 at 9:58	3 a.m., QMA 1 uncovered the					
	resident's arms to v	isualize for any bruising. No					
	bruises were seen, b	out his left hand was swollen					
	and clenched. QM	A 1 indicated the resident kept					
		ed in a fist. There was no					
	anticontracture device in place.						
	On 10/24/22 at 9:30	a.m., the resident was					
	observed in bed, lyi	ing on his back, there was no					
	anticontracture devi	ice in his left hand.					
	The record for Resi	dent 23 was reviewed on					
	10/19/22 at 11:00 a	.m. Diagnoses included, but					
	were not limited to,	diabetes mellitus,					
		mentia, psychotic disorder,					
	and seizure disorde						
	The Quarterly Mini	mum Data Set (MDS)					
		7/27/22 indicated the resident					
	· ·	paired and required extensive					
		•	1				I

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 35 of 64

PRINTED: 12/15/2022

DEPARTMENT OF HEALTH AND HUM	EDICARE & MEDICAID SERVICES OMB NO. 0938-039 FOR DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155423 B. WING 10/25/2022			
CENTERS FOR MEDICARE & MEDIC.	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED
	155423	B. WI	NG	10/25/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
			1000 114TH ST	
HAMMOND-WHITING CARE CENTER			WHITING, IN 46394	

HAMMOND-WHITING CARE CENTER		WHITING, IN 46394			
(X4) ID PREFIX	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	
TAG	1-2 person assistance with transfers and mobility. The resident had no impairment in range of motion to the upper extremity and impairment on both sides of the lower extremities. A Care Plan, dated 11/6/19 and revised in October 2022, indicated the resident had a contracture of the left hand and to provide skin care (daily) to keep the hand clean and prevent skin breakdown. The October 2022 Physician's Order Summary (POS), indicated the resident was to wear a finger extender (green carrot) for up to 4 hours per day. There were no progress notes or documentation in the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) for August, September, or October 2022 related to the green carrot being applied. Interview with PTA (Physical Therapy Assistant) 1 on 10/25/22 at 9:14 a.m., indicated Occupational Therapy (OT) provided the carrot. If it was lost, nursing should notify Physical Therapy (PT) or OT to get a new one. Interview with RN 1 on 10/25/22 at 9:18 a.m., indicated she would need to check if the order was still current. A new order stating the same treatment was obtained by RN 1 at that time. 3.1-42(a)(2)	IAG	DETERMINETY	DATE	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a				

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 36 of 64

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155423	B. WI	NG		10/25	/2022
	PROVIDER OR SUPPLIER		•	1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	resident's compre facility must ensur	hensive assessment, the re that a resident-					
	§483.25(g)(1) Mai parameters of nut usual body weight range and electrol resident's clinical that this is not pospreferences indical that this is not pospreferences indical that this is not pospreferences indical §483.25(g)(2) Is of to maintain proper §483.25(g)(3) Is of when there is a nuthealth care provided Based on observation interview, the facility equipment were proconsumption was multistory of weight for risk for 1 of 2 residence (Resident 6) Finding includes: On 10/19/22 11:10 Ilying in bed. At the clenched in the shap The resident was tractorial to the right hand. The right hand. The public right hand the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident. The noted or a compartner would be a support of the resident of the	intains acceptable ritional status, such as tor desirable body weight lyte balance, unless the condition demonstrates saible or resident atte otherwise; Iffered sufficient fluid intake r hydration and health; Iffered a therapeutic diet let rorders a therapeutic diet. It is a side of the resident with a less and/or were a nutritional ents reviewed for nutrition. If a.m., Resident 6 was observed at time, her right hand was pe of a fist and contracted. It is a poon. She was observed with the spoon and the lap spoon. She was observed with the spoon and the lap over as she could not use the were no staff in the room to here was no built up utensils ment plate for food.	F 06	92	This plan of correction is prep and executed because the provisions of state and federa require it and not because of Hammond-Whiting Care Cent agrees with the allegations an citations listed. Hammond-Wh Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabiliti to render adequate care. Plea accept this plan of correction our credible allegation of compliance that alleged deficiencies have or will be corrected by the date indicate remain in compliance with sta and federal regulations, the fahas taken or will take the action	er ad aiting e ety of ies as d to te acility ons	12/03/2022
		5 p.m., the resident was bed. Her lunch was in front of			set forth in this plan of correct We respectfully request a des		

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 37 of 64

PRINTED: 12/15/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her which consisted of broth and jello. All the food was in separate containers. The resident F692-Nutrition/Hydration Status was not able to hold any of the bowls with her Maintenance right hand and was using plastic utensils to eat What Corrective Action will be the food. There was no adaptive equipment accomplished for those observed. No staff were in the room helping the residents found to be affected resident. by this deficient practice: Residents 6 had no negative On 10/20/22 at 1:10 p.m. the resident was observed outcomes. MD was notified and in bed eating lunch. Again she was served a clear order was received to discontinue liquid diet in separate containers with plastic use of adaptive silverware related utensils. No staff were in the room helping the to resident refusal of use. resident. How other residents having the potential to be affected by the On 10/21/22 at 8:16 a.m., the resident was same deficient practice will be observed in bed eating breakfast. There were no identified and what corrective built up silverware and all the food was in action will be taken: separate containers. In house audit of all residents with adaptive equipment On 10/24/22 at 12:33 p.m., the resident was completed to ensure meal observed in bed eating lunch. A regular consumption is documented in mechanically altered diet was served on a plate. POC/PCC by date of compliance. She was eating with her left hand with a plastic In house audit of all residents spoon. The food was not placed in a with adaptive equipment compartment plate nor did she have the adaptive completed to ensure adaptive utensils. equipment is available during meals. The record for Resident 6 was reviewed on 10/21/22 at 9:33 a.m. The resident was admitted to What measures and what the facility on 2/11/22. Diagnoses included, but systemic changes will be made were not limited to, stroke with hemiplegia, heart to ensure that the deficient failure, type 2 diabetes, major depressive disorder, practice does not recur: and expressive language disorder. Consumption report will be audited to ensure documentation The Quarterly Minimum Data Set (MDS) of consumption for all residents

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

assessment, dated 7/8/22, indicated the resident

assist with a 2 person physical assist for bed

was not cognitively intact. She needed extensive

mobility and transfers and extensive assist with a

1 person physical assist for eating, dressing, and

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

with adaptive equipment.

date of compliance.

related to documentation of

consumption to be completed by

Education provided to all staff

Page 38 of 64

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155423	B. WING		10/25/2022	
	PROVIDER OR SUPPLIER		1000 1°	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
1110		The resident had a limitation in	1110	Education provided to all		
		one side for both upper and		related to use of adaptive	Stan	
	_	She received a mechanically		equipment to be completed by		
		rapeutic diet and had 1 stage 3		date of compliance.		
	pressure ulcer.	rapeutic diet and nad 1 stage 3		How the corrective action will	,,	
	pressure dicer.			be monitored to ensure the	"	
	A Core Plan dated	10/4/22, indicated the resident				
	· ·	eight loss of 17.1% in the last		deficient practice will not		
	_	_		recure, i.e. what quality	4	
	assistance with mea	roaches were to provide		assurance program will be po	ut	
	assistance with mea	as as needed.		in place:	.:01	
		1.170 1 (///22.170		1. The management team w	I	
	The resident weighed 170 pounds on 6/6/22, 169			observe random meal times to		
	pounds on 7/5, 164 pounds on 8/22, 150 pounds on 9/26 and 151 pounds on 10/18/22.			ensure adaptive equipment is	in	
	on 9/26 and 151 po	unds on 10/18/22.		place x 6 months.	Pr.	
	DI COLOR	1 . 110/10/20 : 1: . 16 !!		2. The DON/Designee will a	udit	
	1 -	dated 10/18/22, indicated full		consumption report to ensure		
		texture, thin consistency		documentation of meal intakes		
	_	s, jello, apple or cranberry juice		times a week for 4 weeks, then 4		
		ntil 10/23/22. Provide a regular		times a week x 4 weeks, then		
		altered texture, thin consistency		times a week x 4 weeks, then	2	
	for after completion	of her liquid diet.		times a week x 4 weeks, then		
				weekly x 4 weeks.		
	1 -	dated 7/11/22, indicated the		The results of these revie		
		e a compartmental plate with		will be discussed at the month	ly	
		to increase independence in		facility Quality Assurance		
	self feeding.			Committee meeting monthly for	or a	
				total of 3 months and then		
		dated 7/19/22, indicated the		quarterly thereafter once		
		e a left angular built up utensil		compliance is at 100%.		
	during all meals, ne			Frequency and duration of rev	iews	
	independence in sel	If feeding.		will be increased as needed, if		
				compliance is below 100%.		
		ian's (RD) Progress Note,		Compliance date: 12/3/22 The	•	
		26 a.m., indicated the resident		Administrator at		
	_	eight loss over the last months.		Hammond-Whiting Care Cente	er is	
		ed a mechanically altered diet.		responsible in ensuring		
	Continue to monito	r oral intake as tolerated.		compliance in this Plan of		
				Correction.		
	The meal consumpt	tion logs indicated there was				
		of any meals on 9/27 and				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		A. BUI B. WIN	LDING	00	COMPL 10/25/	ETED	
	PROVIDER OR SUPPLIER			1000 11	DDRESS, CITY, STATE, ZIP COD 4TH ST G, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	breakfast and dinne documentation of di Interview with LPN indicated the residen						
	Interview with the I indicated the reside utensils and compar	_					
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and	stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a nensive assessment, the					
	to eat enough alor fed by enteral met	_					
	means receives the and services to re- eating skills and to enteral feeding industrial aspiration pneumo	esident who is fed by enteral the appropriate treatment store, if possible, oral to prevent complications of cluding but not limited to onia, diarrhea, vomiting, bolic abnormalities, and ulcers.					

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 40 of 64

PRINTED: 12/15/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155423	B. WI	NG		10/25	/2022	
NAME OF I			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEI	(14TH ST			
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	This plan of correction is prepared		DATE	
		on, record review, and	F 06	593	ared	12/03/2022		
		ity failed to ensure a resident			and executed because the			
	_	t on enteral tube feedings			provisions of state and federal	law		
	_	nutrition after readmission and was raised while the feedings			require it and not because	o.r		
		of 1 residents reviewed for			Hammond-Whiting Care Center agrees with the allegations an			
	tube feeding. (Resi				citations listed. Hammond-Wh			
	tabe recaing. (ress	dent 2)			Care Center maintains that the	•		
	Finding includes:				alleged deficiencies do not			
					jeopardize the health and safe	ty of		
	On 10/20/22 at 1:36 p.m., the room door for				the residents nor is it of such	,		
	Resident E was clo	sed. At that time, upon			character to limit our capabiliti	es		
	entering the room,	there were 2 CNAs standing on			to render adequate care. Plea	se		
	each side of the bed	l preparing to reposition and	accept this plan of correction as					
		ce care for the resident. The			our credible allegation of			
		s completely flat and the			compliance that the alleged			
		g was infusing at 60 cubic			deficiencies have or will be co			
		r hour. CNA 1 and Agency			by the date indicated to remain			
		o turn and reposition the			compliance with state and fed			
		change the incontinent brief all			regulations, the facility has tak			
		of the bed was flat the tube			or will take the actions set fort	h in		
	feeding was infusin	ıg.			this plan of correction. We			
	Interview with CN	A 1 at that time, indicated the			respectfully request a desk rev	view.		
		not on hold or turned off			F 693- Tube Feeding			
		re. The nurse usually came in			Management/Restore Eating			
		ld or turned it off while care			Skills			
	•	e was questioned as if this was			What Corrective Action will I	be		
	_	f providing care with the head			accomplished for those			
		tube feeding infusing, the CNA			residents found to have been	n		
		t. She was aware the resident			affected by this deficient			
	was not supposed to	o be lying flat in bed while the			practice:			
	tube was infusing.				1. Resident E had no			
					negative outcomes. MD and F			
		ident E was reviewed on			notified of head of bed being f			
		m. Diagnoses included, but			while tube feeding was running	g		
	were not limited to	, multiple sclerosis, seizures,			while providing ADL care.			

pressure ulcer left heel, quadriplegia,

schizophrenia, abnormal posture, falls, muscle wasting, contractures, neuromuscular bladder,

Education provided to CNA # 1 and Agency CNA # 1 immediately.

How other residents having the

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25/	2022
				CTREET	ADDRESS CITY STATE TIP COP		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD 14TH ST		
	ND-WHITING CAR	CENTER			141H 51 IG, IN 46394		
HAIVIIVIOI	ND-WHITING CAR	CENTER		VVIIIIN	NG, IIN 40394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		g tube (a tube inserted directly			potential to be affected by the	1e	
		r nutrition), major depressive			same deficient practice will	be	
	disorder, dysphagia, and moderate intellectual				identified and what corrective	⁄e	
	disabilities.				action will be taken:		
					1. Residents with tube	9	
	The Annual Minimum Data Set (MDS)				feeding have been audited to		
	l '	/14/22, indicated the resident			ensure orders are in place pe		
		intact and needed extensive			Nursing Management observe	ed	
	_	on physical assist for bed			these residents with no other		
		and personal hygiene. The			issues noted by date of		
	I	dependent on staff for			compliance.		
	_	age of motion impairment to			What measures and what		
		upper and lower extremities.			systemic changes will be ma	ade	
		unstageable pressure ulcer.			to ensure that the deficient		
		ed greater than 51% of			practice doesn't recur:		
	nutrition through er	nteral feedings.			1. Nursing Manageme		
		10/14/00 : 11			will educate licensed nursing	staff	
		ed 9/14/22, indicated the			on admission process for		
	_	tube feeding related to			residents with tube feeding pe	er	
		proaches were to ensure the			policy by date of compliance.		
		s elevated to 45 degrees during			2. Nursing Manageme	ent	
		er the tube feeding. The			will educate all licensed and		
	resident needed tub	e feedings and water flushes.			certified nursing staff on ADL	care	
	The modification	lunitted to the hearit-1			of a resident with tube feed		
		lmitted to the hospital on back to the facility on 9/2/22		running per policy by date of			
	at 6:51 p.m.	to deck to the facility on 9/2/22			compliance. 3. New licensed and		
	at 0.51 p.III.					ive	
	Physician's Orders	dated 9/2/22 indicated NPO			certified nursing staff will rece this education prior to working		
	(nothing by mouth)				How the corrective action w		
	(nonnig by mouni)	•			be monitored to ensure the		
	Physician's Orders	dated 9/4/22, indicated flush			deficient practice will not re	cur	
	l -	ec of water every 6 hours.			i.e., what quality assurance		
		of Jevity 1.5 at 60 cc per hour			program will be put in place		
		10:00 a.m. and off at 6:00 a.m.			1. DON/Designee will		
					audit all admission/readmission		
	The Medication Ad	ministration Record (MAR),			charts with tube feeding to en		
		2022, indicated the water			appropriate orders are obtained		
		out for the first time after			tube feeding x 6 months.	J 4 1/ C	
		22 at 12:00 a.m., and the enteral			2. DON/Designee will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155423	B. W	ING		10/25/	/2022
				CERTE	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
11004040	ND WILLITING OAD	CENTED			14TH ST		
HAMMO	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	15	DATE
	tube feeding was si	gned out for the first time at			make random observations 5		
	10:00 a.m. on 9/5/2	2.			x/week to ensure HOB is not f	lat	
					during ADL care for residents	with	
	Nurses' Notes, date	d 9/3/22 at 10:03 p.m., and			tube feed running x 6 months.	This	
	9/4/22 at 1:27 a.m.,	indicated there was no			will be rotated on shifts. Audits	s will	
	information or docu	mentation indicating the			be presented to QAPI x 6 mor	nths	
	enteral tube feeding	g was infusing.			then QAPI will determine the r	need	
					for further audits.		
	Interview with the I	Director of Nursing on 10/21/22			3. The results of these	.	
		ted the resident was not to be			reviews will be discussed at th	ie	
		h the enteral feeding infusing.			monthly facility Quality Assura	ince	
	The CNA should ha	ave called the nurse in to turn			Committee meeting monthly for	or a	
	off or place the tube feeding on hold during ADL				total of 3 months and then		
	care.				quarterly thereafter once		
					compliance is at 100%.		
	Interview with the l	Nurse Consultant on 10/25/22			Frequency and duration of rev	iews	
	at 11:30 a.m., indica	ated she was notified of the			will be increased as needed, it	f	
	incident regarding l	ack of documentation of the			compliance is below 100%.		
	-	s and enteral feedings when			Compliance date: 12/3/22. The	е	
		d from the hospital. There was			Administrator at		
		of the enteral feeding being			Hammond-Whiting Care Cent	er is	
		f or of any water flushes from			responsible in ensuring		
	9/2-9/4/22.				compliance in this Plan of		
					Correction.		
	This Federal tag rel	ates to Complaint IN00389608.					
	3.1-44(a)(2)						
E 0005							
F 0695	483.25(i)						
SS=D		eostomy Care and					
Bldg. 00	Suctioning						
	- ,,	atory care, including					
		e and tracheal suctioning.					
	•	ensure that a resident who					
	needs respiratory						
	-	e and tracheal suctioning,					
		eare, consistent with					
	•	lards of practice, the					
		erson-centered care plan,					
	the residents' goa	ls and preferences, and					1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155423 B. WING 10/25/2022 STREET ADDRESS, CITY, STATE, ZIP COD

NAME OF PROVIDER OR SUPPLIER 1000 114TH ST

HAMMC	OND-WHITING CARE CENTER		1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE			
	483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 2 of 3 residents reviewed for oxygen. (Residents 38 and 47) Findings include: 1. On 10/19/22 at 10:25 a.m., 12:00 p.m., 1:25 p.m., and 3:20 p.m., Resident 38 was observed in her room in bed. The resident was wearing oxygen by the way of a nasal cannula and her concentrator was set at 4 liters. On 10/20/22 at 8:45 a.m., the resident was in her room in bed. The resident was wearing oxygen per a nasal cannula and her oxygen concentrator was set at 4 liters. At 1:14 p.m., the resident remained in bed and her nasal cannula was not in her nares (nostrils). The oxygen concentrator was set at 4 liters. On 10/21/22 at 10:08 a.m., the resident was in her room in bed. The oxygen concentrator was set at 3 1/2 liters and the nasal cannula was not in the resident's nares. The record for Resident 38 was reviewed on 10/24/22 at 10:06 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), congestive heart failure, and delusional disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/2/22, indicated the resident was cognitively intact and she received oxygen while a resident of the facility. The resident did not have a Care Plan related to	F 0695	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 695- Respiratory/Tracheostomy Care and Suctioning What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident 38 and 47 had no negative outcomes. MD was notified on inaccurate liter flow. O2 sats were taken immediately with no issues noted and O2 liter flows adjusted to ordered liter flow immediately.	12/03/2022			
	her oxygen use.		How other residents having the				

PRINTED: 12/15/2022

DEPARTMENT	T OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	NG		10/25	/2022
				CERT	A DDDDGG GITTY GT ATD GOD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
114444	ND WUITING OAD	E OENTED			14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
					potential to be affected by th	ie	
	A Physician's Order, dated 9/14/22, indicated the				same deficient practice will b		
	resident was to rece	eive 2 liters of oxygen per			identified and what correctiv		
	minute continuousl	y per a nasal cannula.			action will be taken:		
					1. An Audit was		
	Interview with the	Director of Nursing on 10/21/22			completed on residents in hou	se	
	at 12:43 p.m., indic	cated the resident's oxygen			with current 02 orders to ensu		
	concentrator should	d have been set at 2 liters.			orders accurate and clinical te	am	
					observed liter flow being		
	2. On 10/19/22 at 10:23 a.m., 1:25 p.m., and 2:40				administered per order. No oth	ner	
p.m., Resident 47 was observed in her room in				issues have been identified. A			
	bed. The resident's	oxygen concentrator was set			completed by nursing		
	at 2 1/2 liters and s	he was wearing a nasal			management by date of		
	cannula.				compliance.		
					What measures and what		
	On 10/20/22 at 9:4	0 a.m., 1:14 p.m. and 3:40 p.m.,			systemic changes will be ma	nde	
	the resident was we	earing her nasal cannula and			to ensure that the deficient		
	her oxygen concent	trator was set at 2 1/2 liters.			practice doesn't recur:		
					1. DON and/or design	ee	
	The Record for Res	sident 47 was reviewed on			have educated licensed nursir	ng	
		m. Diagnoses included, but			staff and certified aides to obs	erve	
		, chronic obstructive pulmonary			liter flow on residents using 02	2 and	
	disease (COPD) an	d congestive heart failure.			ensure liter flow is accurate pe	er	
					order by date of compliance.		
		imum Data Set (MDS)			How the corrective action wi	III	
	assessment, dated 9	9/14/22, indicated the resident			be monitored to ensure the		
		paired for daily decision			deficient practice will not red	cur,	
	_	ent received oxygen while she			i.e., what quality assurance		
	was a resident of th	ne facility.			program will be put in place:	•	
					1. Don/Nursing		
	· ·	wed 9/15/22, indicated the			management will observe 5		
		n therapy related to her			residents daily Monday throug		
		Interventions included, but			Friday x 8 weeks, then 3 resid		
		, oxygen via nasal prongs/mask			daily Monday through Friday x	8	
	at 2 liters continuo	usly.			weeks, then 2 residents daily		
					Monday through Friday x 8 we	eks	

A Physician's Order, dated 5/26/22, indicated the

resident was to receive oxygen at 2 liters

continuously per nasal cannula.

H71G11

to assure compliance. Audits will

be presented to QAPI x 6 months

and then QAPI will determine the need for further audits. Any noted

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	l	COMPLETED	
		155423	B. WIN	IG		10/25/	/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) issues will be addressed immediately. 2. The results of these reviews will be discussed at th monthly facility Quality Assura Committee meeting monthly fo total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed, if compliance is below 100%.	e nce or a	(X5) COMPLETION DATE	
F 0732 SS=C Bldg. 00	Posted Nurse Staffing Information				Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.			
	(iv) Resident cens §483.35(g)(2) Pos (i) The facility mus							

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 46 of 64

12/15/2022 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a

F 0732

minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post the daily staffing sheet which indicated how many staff were working in the facility and the facility census. This had the potential to affect all 57 residents who resided within the facility.

Finding includes:

On 10/21/22 at 8:16 a.m. and 1:52 p.m., the daily staffing sheet located near the entrance door was dated 10/20/22.

On 10/24/22 at 9:02 a.m., the daily staffing sheet was dated 10/20/22.

On 10/25/22 at 8:30 a.m. and 1:30 p.m., the daily staffing sheet was dated 10/20/22.

Interview with the Director of Nursing on 10/24/22 at 1:30 p.m., indicated the staffing sheets should

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 is prepared

provisions of state and federal law

and executed because the

require it and not because

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 47 of 64

12/03/2022

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/25/2022		
	PROVIDER OR SUPPLIE		1000 1	ADDRESS, CITY, STATE, ZIP CO 14TH ST NG, IN 46394	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	have been updated day shift.	daily at the beginning of the		this plan of correction. V		
				F 732- Posted Nurse St Information What Corrective Action accomplished for thos residents found to hav affected by this deficie practice: 1. No residents affected. How other residents in potential to be affected same deficient practic identified and what co action will be taken: 1. No residents potential to be affected. What measures and w systemic changes will to ensure that the defin practice doesn't recur. 1. DON and/or have educated scheduli department on posted in staffing policy and proce date of compliance. How the corrective act be monitored to ensur deficient practice will in i.e., what quality assur program will be put in 1. DON and/or will audit posted staffing x/week x 8 weeks, then x 8 weeks, then 2 x/wee	n will be see re been ent were aving the ed by the e will be rrective have the hat be made cient: designee ing nurse edure by tion will re the not recur, rance place: designee eg sign 5 3 x/week	
				weeks to ensure compli Audits will be presented 6 months and then QAF	ance. I to QAPI x	

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet

Page 48 of 64

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155423	B. W	NG		10/25/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				I4TH ST		
НАММОН	ND-WHITING CARE	CENTER	WHITING, IN 46394				
11/ ((V))(V)	10-11111110 07111			***********	10, 114 40004		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					determine the need for further		
					audits. Any noted issues will b	е	
					addressed immediately.		
					The results of these		
					reviews will be discussed at th		
					monthly facility Quality Assura		
					Committee meeting monthly for	or a	
					total of 3 months and then		
					quarterly thereafter once		
					compliance is at 100%.	_	
					Frequency and duration of rev		
					will be increased as needed, if	ī	
					compliance is below 100%.		
					Compliance date: 12/3/22. The	е	
					Administrator at	:-	
					Hammond-Whiting Care Center	eris	
					responsible in ensuring		
					compliance in this Plan of Correction.		
					Correction.		
F 0755	483.45(a)(b)(1)-(3)					
SS=D	Pharmacy	,					
Bldg. 00	•	/Pharmacist/Records					
3	§483.45 Pharmac						
		provide routine and					
		and biologicals to its					
		n them under an agreement					
	· ·	.70(g). The facility may					
	_	personnel to administer					
	drugs if State law	permits, but only under the					
	_	on of a licensed nurse.					
	§483.45(a) Proced	dures. A facility must					
	provide pharmace	utical services (including					
	procedures that as	ssure the accurate					
		g, dispensing, and					
		ll drugs and biologicals) to					
	meet the needs of	each resident.					
	§483.45(b) Servic	e Consultation. The facility					

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 49 of 64

PRINTED: 12/15/2022

DEPARTMEN' CENTERS FOI		FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	PLE CONSTRUCTION (X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			PLETED	
		155423	B. WING		_	5/2022	
			STREE	ET ADDRESS, CITY, STATE, ZIP CO	OD .		
NAME OF I	PROVIDER OR SUPPLIEF	8		114TH ST			
HAMMO	ND-WHITING CARE	E CENTER	WHI ⁻	TING, IN 46394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		IOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
		otain the services of a					
	licensed pharmac	ist who-					
	8483 45(b)(1) Pro	vides consultation on all					
	. , , ,	vision of pharmacy services					
	in the facility.	violon or priarmacy convices					
	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records						
	. , , ,	nat an account of all					
	controlled drugs is						
	periodically recon						
	1 '	view and interview, the facility	F 0755	This plan of correction	is prepared	12/03/2022	
		dications were obtained timely	1 0/33	and executed because		12/03/2022	
		related to admission		provisions of state and			
		f 3 residents reviewed for		require it and not becau			
	hospitalization. (Re	esident D)		Hammond-Whiting Car			
				agrees with the allegati			
	Finding includes:			citations listed. Hammo			
				Care Center maintains	that the		
	The Closed Record	for Resident D was reviewed		alleged deficiencies do	not		
		7 a.m. Diagnoses included, but		jeopardize the health a	-		
		aspiration pneumonia, history		the residents nor is if of			
	_	estive heart failure. The		character to limit our ca	-		
		ed to the facility on 9/30/22 at		to render adequate car			
	3:20 p.m.			accept this plan of corre			
		6.11		our credible allegation			
		e following admission orders		compliance that the alle	•		
	on 9/30/22 for med	ications:		deficiencies have or wil			
	Cofinanian	1 (an antihiatia) tal-1-4 250		by the date indicated to			
		l (an antibiotic) tablet 250		compliance with state a			
		ery 12 hours for infection.		regulations, the facility			
- Doxycycline Hyclate (an antibiotic) 100 mg every			or will take the actions	set torth in	1		

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

daily.

12 hours for infection.

- Amiodarone HCl (a heart medication) 200 mg

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

respectfully request a desk review.

this plan of correction. We

Page 50 of 64

12/15/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE - Atorvastatin Calcium (a cholesterol medication) **F 755**- Pharmacy 20 mg daily at 6:00 p.m. Services/Procedures/Pharmacist/ - Carvedilol (a blood pressure medication) 25 mg Records twice a day. - Docusate Sodium (a stool softener) 100 mg daily. What Corrective Action will be - Ezetimibe (a cholesterol medication) 10 mg daily. accomplished for those - Lasix (a diuretic) 20 mg daily. residents found to have been - Hydralazine (a blood pressure medication) 50 mg affected by this deficient three times a day. practice: - Nifedipine ER (a blood pressure medication) 30 1. Resident D no longer mg daily. resides at facility. - Polysaccharide Iron Complex Capsule (an iron supplement) 150 mg daily. How other residents having the - Primidone (a seizure medication) 250 mg three potential to be affected by the times a day. same deficient practice be - Tramadol HCl (a pain medication) 50 mg every 6 identified and what corrective hours for pain. action will be taken: All new The September 2022 Medication Administration admission/readmissions have the Record (MAR), indicated the resident had no potential to be affected. medications signed out as being administered on 2. 9/30/22. admission/readmissions will be audited to ensure medications are The October 2022 MAR, indicated the resident did received in a timely manner. not receive the following medications on 10/1/22: What measures and what - Amiodarone HCl 200 mg. systemic changes will be made - Docusate Sodium 100 mg. to ensure that the deficient - Nifedipine ER 30 mg. practice doesn't recur: Education provided to

- Polysaccharide Iron Complex 150 mg.

- Primidone 250 mg not received at 6:00 a.m. and 1:00 p.m.

- Tramadol 50 mg not received at 6:00 a.m. and 12:00 p.m.

A Nurses' Note, dated 10/1/22 at 8:22 a.m., indicated medications that were available from the EDK (emergency drug kit) were crushed and given without difficulty. The medications listed above, were not in the EDK.

assurance program will be put

licensed nursing staff on

arrival from pharmacy to be

admission process r/t medication

completed by date of compliance.

How the corrective action will

be monitored to ensure the

deficient practice will not

recur, i.e., what quality

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	E SURVEY PLETED 5/2022
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP (14TH ST NG, IN 46394	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	indicated the resider the emergency room. The resident was adnot return to the fact. Interview with the I at 1:30 p.m., indication the evening shift delivered that evening the next morning, so available in the EDI	Director of Nursing on 10/24/22 ted if a resident was admitted and if the medications weren't ng, they should be delivered ome medications were also		in place: 1. DON/desig all admission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/reasion/reasion/readmission/reas	re received x 6 months. of these sed at the y Assurance nonthly for a compliance by and II be if 00%.	
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnect Each resident's dr from unnecessary drug is any drug w §483.45(d)(1) In eduplicate drug the §483.45(d)(2) For §483.45(d)(3) Withor	xcessive dose (including				

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155423	B. WI	ING		10/25	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			14TH ST		
HAMMOI	ND-WHITING CARE	ECENTER			IG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	should be reduced \$483.45(d)(6) Any reasons stated in (5) of this section. Based on record rev failed to ensure med	he presence of adverse sich indicate the dose d or discontinued; or combinations of the paragraphs (d)(1) through view, and interview, the facility dications were administered as sician for 1 of 7 residents	F 07	757	This plan of correction is prepared and executed because the provisions of state and federal		12/03/2022
		essary medications. (Resident			require it and not because Hammond-Whiting Care Centagrees with the allegations an citations listed. Hammond-Wh	er d iting	
	10/20/22 at 9:50 a.r 7/12/22 and dischar Diagnoses included fibrillation, heart di	or Resident C was reviewed on m. The resident was admitted on reged home on 7/30/22. I, but were not limited to, atrial sease, polyneuropathy, low a, and high blood pressure.			alleged deficiencies do not jeopardize the health and safe the residents nor is if of such character to limit our capabiliti to render adequate care. Plea accept this plan of correction a our credible allegation of	ety of es se	
	assessment, dated 7 was cognitively into resident received ar times, an anticoagu antibiotic medicatic 6 times and an opio A Care Plan, dated was on pain medical	nimum Data Set (MDS) //19/22, indicated the resident act. In the last 7 days, the n antidepressant medication 7 lant medication 6 times, an on 5 times, a diuretic medication aid medication 6 times. //22/22, indicated the resident ation. The approaches were to c medications as ordered by			compliance that the alleged deficiencies have or will be co by the date indicated to remain compliance with state and fed regulations, the facility has take or will take the actions set fort this plan of correction. We respectfully request a desk reference of the plan o	n in eral cen h in view. rom	
	Gabapentin (a medi and relieve pain for	dated 7/13/22, indicated ication used to prevent seizures certain conditions in the			residents found to have been affected by the deficient practice? Resident C no longer reseat facility.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	ING		10/25/	2022
		l		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			14TH ST		
НФиииОп	ND-WHITING CAR	F CENTER			NG, IN 46394		
i iAiviiviOi	-WILLING CARI	LOLIVILIX	_	VVI 11 11N	, III 70004		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	1	ne-Acetaminophen Tablet			How other residents having		
		tablet by mouth every 6 hours			potential to be affected by th		
	for pain.				same deficient practice will		
	El 7/2022 15 11				identified and what corrective	re	
		ation Administration Record			actions(s) will be taken?		
	(MAR) indicated th	-			· All residents have the		
	1 *	to be administered at 12:00			potential to be affected.		
	a.m., 0:00 a.m., 12:	00 p.m., and 6:00 p.m.			· Audits to be completed to	ם כ	
	The Coherentin	og mot glomod out og belige			determine if medication is		
		is not signed out as being 13 at 12 a.m., and 6 a.m. There			administered per physician or		
		· · · · · · · · · · · · · · · · · · ·			What measures will be put in		
	a.m. dose.	n 7/22, 7/23, and 7/30/22 for 12			place or what systemic char	_	
	a.m. dose.				will be made to ensure that t	ne	
	The Undreadens	ves not signed out as being			deficient practice does not		
	I -	was not signed out as being 13 at 6 a.m. A "7" was coded			recur? MAR to be audited on all		
		and 6 p.m. doses. A "7" was			residents to determine if		
	_	he 12 p.m. and 6 p.m. doses and				nor	
		m, dose. A "7" was coded for			medications are administered	per	
		.m. doses on 7/15/22. A "9"			physician order by date of compliance.		
		2 a.m. dose on 7/22 and			Nursing Management to		
		as coded for the 12 a.m. and 6			educate licensed nursing staff	on	
		d a "9" was coded for the 12			administration of medications		
	a.m. on 7/30/22.	a d y was coded for the 12			physician order by date of	PCI	
					compliance.		
	The legend on the h	pottom of the MAR indicated a			How the corrective action(s)	will	
		progress notes, a "9" meant			be monitored to ensure the		
		" meant other see progress			deficient practice will not rec	cur,	
	notes.				i.e., what quality assurance	´	
					program will be put into place	e?	
	Nurses' Notes, date	d 7/13/22 at 1:58 p.m.,			The Medication Admin A		
		lone, medication not available.			Report will be reviewed by		
	-				DON/designee to ensure		
					medication is administered pe	r	
	Nurses' Notes, date	d 7/14/22 at 2:10 p.m.,			physician order 5x/week x 4		
	indicated this writer	r spoke with the doctor and			weeks, then 3x/week x 4 weel	ks,	
	was informed the so	cript for the Hydrocodone			then weekly times 4 months.		
	would be sent out to	o pharmacy today.			The results of these reviews	ews	
					will be discussed at the month	ıly	
	Nurses' Notes, date	d 7/14/22 at 8:56 p.m.,			facility Quality Assurance	-	

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		l í	UILDING	nstruction 00	(X3) DATE COMPI 10/25		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	indicated Hydrocod Awaiting arrival from Nurses' Notes, dated Hydrocodone medical Nurses' Notes, dated a.m., indicated their from the doctor for Interview with the Natl 11:30 a.m., indicated their from the doctor for Interview with the Natl 11:30 a.m., indicated their from the doctor for Interview with the Natl 11:30 a.m., indicated their from the doctor for Interview with the Natl 11:30 a.m., indicated their following the Ass. 45(c)(3)(e)(1) Free from Unnecture §483.45(e) Psychology (i) Appendix (ii) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-anxiety; and (iv) Hypnotic Based on a computer sident, the facility §483.45(e)(1) Respondix for the sident, the facility §483.45(e)(1) Respondix for the sident, the facility for the sident, the facility for the sident, the facility for the sident	done medication not available. In pharmacy. dd 7/15/22 at 7:04 a.m., indicated cation not available. dd 7/29/22 at 1:44 a.m., and 5:48 resident needed a new script the Hydrocodone medication. Nurse Consultant on 10/25/22 ated the Hydrocodone and the of signed out as being ered by the Physician. ates to Complaint IN00388294. -(5) Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any train activities associated asses and behavior. These are not limited to, drugs in gories: at; nd rehensive assessment of a ty must ensure that sidents who have not used are not given these drugs are not given these drugs are not given these drugs ation is necessary to treat a		1AG	Committee meeting monthly total of 6 months until complis at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. Administrator at Hammond-Whiting Care Cerresponsible in ensuring compliance in this Plan of Correction.	for a fance	DATE

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet Page 55 of 64

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155423	B. WI	NG		10/25/	/2022
	PROVIDER OR SUPPLIEF			1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394		
TIAWWO	rid-Willing CAN	_ CENTER		VVIIIIII	16, 11 40394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	ICY MUST BE PRECEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	documented in the	R LSC IDENTIFYING INFORMATION		TAG	DE TELEKET I		DATE
		e cirricar record,					
	reductions, and be unless clinically co to discontinue the §483.45(e)(3) Respsychotropic drug unless that medic	s receive gradual dose ehavioral interventions, ontraindicated, in an effort se drugs; sidents do not receive s pursuant to a PRN order ation is necessary to treat					
		ific condition that is					
	documented in the	e clinical record; and					
	drugs are limited to provided in §483.4 physician or presonant that it is appropriate extended beyond document their rail	N orders for psychotropic to 14 days. Except as 45(e)(5), if the attending cribing practitioner believes te for the PRN order to be 14 days, he or she should tionale in the resident's ad indicate the duration for					
	. , , , ,	N orders for anti-psychotic					
	renewed unless the prescribing practite for the appropriate	to 14 days and cannot be ne attending physician or ioner evaluates the resident eness of that medication.					
	failed to ensure AIM Movement Scale - a designed to measur effects known as ta completed for 2 of unnecessary medica	view and interview, the facility MS (Abnormal Involuntary a rating scale that was e involuntary movement side rdive dyskinesia) scales were 7 residents reviewed for ations. (Residents 34 and 38)	F 07	58	This plan of correction is preparand executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Who Care Center maintains that the	law er d iting	12/03/2022
	Findings include:	esident 34 was reviewed on			alleged deficiencies do not jeopardize the health and safe	ty of	

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

Event ID:

H71G11 Facility ID: 000365

If continuation sheet

Page 56 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155423	B. W	ING		10/25	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			14TH ST		
⊔∆или∩н	ND-WHITING CARE	CENTER			IG, IN 46394		
i iAiviiviOi	-WILLING CARE	_ OLIVILIX		VVIIIIIV			_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	10/21/22 at 11:04 a.m. Diagnoses included, but				character to limit our capabiliti		
		neurocognitive disorder with			to render adequate care. Plea		
	1	ntia with agitation, psychosis,			accept this plan of correction a	as	
	and hallucinations.				our credible allegation of		
		D			compliance that the alleged		
		um Data Set (MDS)			deficiencies have or will be co		
		/23/22, indicated the resident			by the date indicated to remain		
		paired and she received an			compliance with state and fed		
	antipsychotic medic	cation on a routine basis.			regulations, the facility has tak		
	4 PM - 1 1 0 1	1 . 111/10/01 . 1 14			or will take the actions set fort	h in	
	1	r, dated 11/19/21, indicated the			this plan of correction. We		
	· ·	yprexa (an antipsychotic			respectfully request a desk rev	view.	
	order was discontin	ligrams (mg) at bedtime. The			- 	_	
	order was discontin	ued on 6/2//22.			F 758- Free from Unnecessary	<u>Y_</u>	
	A Physician's Order	r, dated 8/12/22, indicated the			Psychotropic Meds/PRN Use What Corrective Action will I	ha	
		eive Zyprexa 2.5 mg at bedtime.			accomplished for those	oe .	
	resident was to rece	ive Zypiexa 2.5 mg at bedtime.			residents found to have been	,	
	The resident had no	t had an AIMS scale			affected by this deficient	''	
		ceiving the Zyprexa.			practice:		
	completed while re-	cerving the Zyprexa.			1. Resident 34 had Al	MS	
	Interview with the 1	Nurse Consultant on 10/25/22			completed. Resident 34 had n		
		ated the resident didn't have an			negative outcomes.		
		eted. She also indicated AIMS			How other residents having	the	
	scales were to be co				potential to be affected by th		
					same deficient practice will l		
	2. The record for R	esident 38 was reviewed on			identified and what corrective		
	10/24/22 at 10:06 a	.m. Diagnoses included, but			action will be taken:		
		dementia without behavior			1. An Audit to be		
	disturbance and del	usional disorder.			completed on residents in hou	ise	
					that require an AIMS assessm		
	The Quarterly Mini	mum Data Set (MDS)			to ensure completed per polic		
	assessment, dated 9	/2/22, indicated the resident			date of compliance. Any issue	s	
		act and she received an			identified will be addressed.		
	antipsychotic medic	cation on a routine basis.			What measures and what		
					systemic changes will be ma	ade	
	A Physician's Order, dated 8/25/22, indicated the				to ensure that the deficient		
		senapine Maleate (an			practice doesn't recur:		
	antipsychotic medic	cation) 5 milligrams (mg)			1. DON and/or design	ee	
	sublingually twice a	a day	1		to educate licensed nursing et	off	I

PRINTED: 12/15/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/25/2022	
	PROVIDER OR SUPPLIER		1000	ET ADDRESS, CITY, STATE, ZIP COD 114TH ST FING, IN 46394	•
(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 CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
TAG	An AIMS scale was Interview with the 1 at 11:15 a.m., indica	Nurse Consultant on 10/25/22 ated the resident's last AIMS d on 6/25/22 and should be	TAG	on requirements of compliance. How the corrective actions to be monitored to ensure deficient practice will not i.e., what quality assurate program will be put in p. 1. DON/Nursing management will audit UI schedule to ensure compliance and then QAPI determine the need for furth audits. Any noted issues addressed immediately. 2. The results of the reviews will be discussed monthly facility Quality Assumently facility Quality Assumently thereafter once compliance is at 100%. Frequency and duration of will be increased as need compliance date: 12/3/22 Administrator at Hammond-Whiting Care of responsible in ensuring compliance in this Plan of the properties of the compliance in this Plan of the compliance in the compl	detion of the of will the of recur, nace lace: DA letion of Monday, then 3 x/week pliance. o QAPI x will rither will be these at the ssurance hly for a not of reviews led, if %. 2. The Center is
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication §483.45(f) Medica	n Error Rts 5 Prcnt or More tion Errors.		Correction.	

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

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

Page 58 of 64

12/15/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/25/2022 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The facility must ensure that its-§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and F 0759 This plan of correction is prepared 12/03/2022 interview, the facility failed to ensure a medication and executed because the error rate of less than 5% for 3 of 7 residents provisions of state and federal law observed during medication pass. Three errors require it and not because were observed during 28 opportunities for errors Hammond-Whiting Care Center during medication administration. This resulted in agrees with the allegations and a medication error rate of 10.71%. (Residents G, citations listed. Hammond-Whiting 40, and 56) Care Center maintains that the alleged deficiencies do not Findings include: jeopardize the health and safety of the residents nor is it of such 1. During an observation of medication pass on character to limit our capabilities 10/19/22 at 9:43 a.m., Agency LPN 1 administered to render adequate care. Please Glipizide (a diabetic medication) a 10 milligram accept this plan of correction as (mg) tablet to Resident G. The medication punch our credible allegation of card indicated the medication was to be given 30 compliance that the alleged minutes before meals. The resident could not deficiencies have or will be correct recall if she had eaten breakfast at that time. by the date indicated to remain in compliance with state and federal Interview with the LPN on 10/19/22 at 9:54 a.m., regulations, the facility has taken indicated the resident had already eaten her or will take the actions set forth in breakfast. She did not see the information on the this plan of correction. We punch card, however, the resident should have respectfully request a desk review. received the medication prior to eating breakfast. F 759- Free of Mediation Error 5% or More 2. During an observation of medication pass on What Corrective Action will be 10/19/22 at 10:52 a.m., LPN 3 prepared the insulin accomplished for those residents Lispro 100 unit/milliliter pen for Resident 40. She found to have been affected by this opened the insulin pen, wiped the seal with an deficient practice: alcohol swab, attached the needle, dialed the pen 1. Resident G, 40, and 56 had no to 4 units, and proceeded to administer the negative outcomes. LPN # 1, 3 medication to the resident. The LPN did not prime and QMA #1 were educated the pen before administration of the insulin. immediately. MD was notified of

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

Interview with LPN 3 on 10/19/22 at 11:05 a.m.,

indicated she did not prime the pen before

Event ID:

H71G11

Facility ID: 000365

If continuation sheet

medication errors and no new

How other residents having the

orders were received.

Page 59 of 64

STREET ADDRESS, CITY, STATE, AIP COD IDENTIFICATION NUMBER ISSA 23 NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER ID SUMMARY STATIMENT OF DESICIENCIE GEACH DEPTICANY MUST BE PRECEDED BY FULL TAG REQULATORY OR I.S. (IDENTIFYING INFORMATION) administering the medication. The facility policy titled, "Insulin Pen Administration" received on 10/20/22 at 12:1 p.m. from the Infection Preventionis, indicated "Procedure4	CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (NA ID SUMMARY STATIMENT OF DEPCIENCIE (PACH DEPCIENCY MLST BLE PRECEDED BY RELL. TAG REGILATORY OR LSC IDENTIFYING NFORMATION administering the medication. The facility policy titled, "Insulin Pen Administration" received on 10/20/22 at 121 p.m. from the Infection Preventionist, indicated "Procedure4ai. Dial 2 units by turning the dose selector clockwise." 3. During an observation of medication administration on 10/20/22 at 18:40 a.m., QMA 1 was preparing medications for Resident 56. The resident received Lokelma (a medication used to treat high polassium) 10 grams per packet. The packet was mixed with 6 ounces of water. The label on the hox indicated the medication was to be given 2 hours before or 2 hours after other medications at the same time the Lokelma was given. Interview with the QMA at that time, indicated she was not aware of the label on the box and she would have the nurse clarify the order. The Lokelma safety information was reviewed on 10/20/22 at 9:16 a.m. The information indicated, Lokelma could transiently increase gastric pH. In general, oral medications with pH-dependent solubility. Should be administered at least 2 hours before or 2 hours after Lokelma. Spacing was not needed if it had been determined the concomitant medication discussed the medication and the concomitant medication discussed the medication and the concomitant medication and the concomitant medication and the concomitant medication and the primed with 2 units print of white performed on 10/20/22 at 9:25 a.m., indicated the medication and competencies have been completed. How the corrective action will be monitored to ensure the deficient practice doesn't recour. 1. Education will be provided to all licensed nursing staff and medication added a	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
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medications would be clarified and times would be

put in place:

quality assurance program will be

PRINTED: 12/15/2022

	Γ OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MUL A. BUIL B. WING	DING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/25/2022	
	PROVIDER OR SUPPLIE			1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) 1. Don/Designee will observe residents weekly receiving insvia insulin pen x 3 months, the residents weekly x 3 months rotating shifts. 2. DON/Designee will observe random medication pass 2 tim weekly x 3 months, then 1 time weekly x 3 months, then 1 time weekly x 3 months rotating shifts will be presented to QA 6 moths then QAPI will determ the need for further audits. 3. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed, if compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring	3 ulin en 2 es e iftsPI x nine s will or a	(X5) COMPLETION DATE
F 0921 SS=E Bldg. 00	§483.90(i) Other The facility must	Sanitary/Comfortable Environ Environmental Conditions provide a safe, functional, nfortable environment for			compliance in this Plan of Correction.		

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

residents, staff and the public.

Based on observation and interview, the facility

failed to ensure the residents' environment was

clean and in good repair related to stained floor

tiles, marred walls and doors, stained privacy

curtains, and urine odors on 2 of 2 units. (The

Event ID:

H71G11

F 0921

Facility ID: 000365

If continuation sheet

This plan of correction is prepared

provisions of state and federal law

Hammond-Whiting Care Center

and executed because the

require it and not because

Page 61 of 64

12/03/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	NG		10/25/	/2022
				CED FEET	ADDRESS OF A STATE OF COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
LIANANAO		E CENTED			14TH ST		
HAMMO	ND-WHITING CARI	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	South and North U	nits)			agrees with the allegations an	d	
					citations listed. Hammond-Wh	iting	
	Finding includes:				Care Center maintains that the	9	
					alleged deficiencies do not		
	During the Environmental Tour, on 10/25/22 at				jeopardize the health and safe	ty of	
	9:58 a.m. with the I	Maintenance Supervisor, the			the residents nor is it of such		
	following was obse	erved:			character to limit our capabiliti	es	
					to render adequate care. Plea	se	
	1. South Unit				accept this plan of correction a	as	
					our credible allegation of		
	~	rine odor was noted in Room			compliance that the alleged		
		s resided in the room. Interview			deficiencies have or will be co	rrect	
		ice Supervisor at that time,			by the date indicated to remain	n in	
		en an ongoing issue and he			compliance with state and fed	eral	
	was going to chang	ge the resident's mattress.			regulations, the facility has tak	en	
					or will take the actions set fort	h in	
		s, room walls, and bathroom			this plan of correction. We		
		were scratched and marred.			respectfully request a desk rev	/iew.	
		substance on the floor next to			_		
		ow. The floor register was also			<u>F 921-</u>		
	marred. One reside	nt resided in the room.			Safe/Functional/Sanitary/Com	<u>forta</u>	
					<u>ble Environment</u>		
		0 a.m., a clear plastic cylinder			What Corrective Action will I	be	
		e back of the toilet, not			accomplished for those		
		llow wash basin was also			residents found to have been	า	
	observed on the toil	let seat.			affected by this deficient		
	0 10/05/00 + 0.5/	0			practice:		
		8 a.m., two plastic clear cylinders			1. The marred walls a	nd	
		ne glove compartment of the			door frames were repaired in		
	_	cated behind the toilet. Three			rooms 110, 112, 115, 117. The		
	residents shared the	е вашгоот.			floor tile in the bathrooms of ro		
	The analysis d	1-1 A : D 112			220 and 221 was cleaned. The		
		bed A in Room 112 was ed. Two residents resided in			Privacy curtain in room 204 wa	a S	
		cu. Two residents resided in			exchanged with a freshly		
	the room.				laundered privacy curtain. The	;	
	d. The bathroom door frame in Room 115 was				mattress in room 100 was		
		oor frame in Room 115 was ed. Four residents shared the			exchanged with a new mattress.		
	bathroom.	ed. Pour residents shared the			All wash basins, urinals, and	and	
	oaumoom.				bedpans were placed in trash		
	1		1		new were obtained and covere	au in	I

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

Event ID:

H71G11

Facility ID: 000365

35

If continuation sheet Page 62 of 64

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155423	B. WING		10/25/2022	
			CTREET	ADDRESS SITV STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD 14TH ST		
1100000		DE CENTED				
HAMMO	ND-WHITING CAR	RE CENTER	VVHIII	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	On 10/20/22 at 9:	05 a.m., two wash basins were		appropriate plastic bag with		
	observed tucked in	nside one another on the		resident's name.		
	bathroom floor. T	he wash basins were not		How other residents having	the	
	contained.			potential to be affected by the	he	
				same deficient practice will	be	
	The wash basins re	emained on the floor on		identified and what corrective	ve e	
	10/25/22 at 10:05	a.m. Four residents shared the		action will be taken:		
	bathroom.			1. Other residents ha	d	
				the potential to be affected by	this	
	e. The walls in Ro	oom 117 as well as the bathroom		deficient practice.		
	walls and door fra	me were scratched and marred.		What measures and what		
	Two residents resi	ded in the room and 4 residents		systemic changes will be me	ade	
	shared the bathroo	m.		to ensure that the deficient		
				practice doesn't recur:		
		35 a.m., two wash basins were		Environmental roui	nds	
	observed tucked in	nside one another on the		have been completed by		
	bathroom floor. T	The wash basins were not		maintenance department and	plan	
	contained.			has been put into place to add	dress	
				scratched/marred walls,		
	2. North Unit			discolored floor tiles in bathro	oms,	
				privacy curtains, stale urine o	dor	
		rtain in Room 204 was stained.		and wash basins, urinals, and		
	Two residents resi	ded in the room.		bedpans on or prior to 11/23/2	22.	
				2. The Maintenance		
		t the base of the sink in the		Director and/or designee will		
		n 220 was discolored. One		include identified areas in the		
	resident used the b	pathroom.		current preventive maintenan	ce	
	man di di			program and conduct routine		
		t the base of the sink in the		resident room rounds accordi	ng to	
		n 221 was discolored. One		the facility policy.		
	resident used the b	oathroom.		How the corrective action w	1111	
	0 10/20/22 4 0 0	22		be monitored to ensure the		
		22 a.m., two wash basins were		deficient practice will not re	cur,	
		another, a bed pan was placed		i.e., what quality assurance	_	
	_	basins and the bed pan and		program will be put in place		
		positioned on top of a gray room. The bucket was		1. Maintenance Direct	COT	
				and/or designee to conduct		
	_	floor and the items were not		resident room observations 5	X	
	contained. One re	sident used the bathroom.		weekly for next 6 months to	.	
				ensure the resident's environi	ment	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 COMPL			SURVEY ETED		
ANDILAN	or correction	155423	B. WING				10/25/2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 14TH ST			
HAMMON	ND-WHITING CARE	CENTER		WHITIN	IG, IN 46394			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	On 10/25/22 at 10:1	0 a.m., the items remained in the			is in good repair from			
	bathroom.				marred/scuffed walls, chipped	l		
					paint, gouged night stands, ar	nd		
	Interview with the M	Maintenance Supervisor at that			marred/scratched floors. Any			
		above were in need of cleaning			concerns identified will be			
	and/or repair and the	e wash basins and bed pans		addressed immediately. Audits				
	should have been st	ored properly.			will be presented to QAPI x 6			
					months then QAPI will determ	nine		
	Interview with the N	Nurse Consultant on 10/25/22			the need for further audits.			
	at 11:20 a.m., indica	ated the above items should			2. The results of these	е		
	have been contained	d and not stored on the floor.			reviews will be discussed at the	ne		
					monthly facility Quality Assura	ance		
	The facility policy t	itled, "Keeping a Resident's			Committee meeting monthly for	or a		
	Room in Order" wa	s provided by the Nurse			total of 3 months and then			
	Consultant on 10/25	5/22 at 12:59 p.m. The policy			quarterly thereafter once			
	-	nd urinals must be covered			compliance is at 100%.			
		nd each plastic bag would be			Frequency and duration of rev	views		
	marked with the res	ident's name.			will be increased as needed, i	f		
					compliance is below 100%.			
					Compliance date: 12/3/22. Th	е		
	This Federal tag rela	ates to Complaint IN00392720.			Administrator at			
					Hammond-Whiting Care Cent	er is		
	3.1-19(f)				responsible in ensuring			
					compliance in this Plan of			
					Correction.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: H71G11 Facility ID: 000365 If continuation sheet Page 64 of 64