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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	10/25/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00386810, IN00388294, IN00389608, and IN00392720. Complaint IN00386810 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00388294 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F686, and F757. Complaint IN00389608 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F693. Complaint IN00392720 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F755, and F921. Survey dates: October 19, 20, 21, 24, and 25, 2022 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 8 Medicaid: 44 Other: 5 Total: 57	F 0000	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 if 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.	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/1/22.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination,			

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	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 interview, the facility failed to ensure each resident's dignity was maintained related to a foley catheter bag not being covered with a dignity bag and residents wearing hospital gowns throughout the day while in bed for 3 of 5 residents reviewed for dignity. (Residents F, 6, and 29) Findings include: 1. On 10/19/22 at 12:09 p.m., 1:25 p.m., and 2:40 p.m., Resident F was observed in his room in bed. The resident's foley catheter drainage bag was hanging from the bed frame and urine was visible at that time. The drainage bag was not covered with a dignity bag and the door to the resident's room was open. The drainage bag was visible from the hallway. On 10/20/22 at 1:23 p.m. and 3:37 p.m., the resident was again observed in his room in bed. The foley catheter drainage bag was hanging from the bed frame and not covered with a dignity bag. The door to the resident's room was partially open and the drainage bag was visible from the hallway. The Record for Resident F was reviewed on 10/20/22 at 1:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, adult failure to thrive, protein calorie malnutrition, and neurogenic bladder.	F 0550	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 550- Resident Rights What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident F had no negative outcomes. Resident F's foley catheter drainage bag was immediately covered with a dignity	12/03/2022

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The Admission Minimum Data Set (MDS) assessment, dated 10/18/22, indicated the MDS was in progress. The resident was moderately impaired for daily decision making and had an indwelling catheter.

Interview with the Director of Nursing on 10/21/22 at 12:40 p.m., indicated the resident was admitted from the hospital with the foley catheter and the drainage bag should be changed or a dignity bag added to the resident's bed. 2. On 10/19/22 11:10 a.m., 12:00 p.m., and 1:15 p.m., Resident 6 was observed lying in bed. At those times she was dressed in a hospital gown.

On 10/20/22 at 8:45 a.m., and 1:10 p.m., the resident was observed lying in bed. At those times she was dressed in a hospital gown.

On 10/21/22 at 7:55 a.m., 8:16 a.m., and 9:30 a.m., the resident was observed lying in bed. At those times she was dressed in a hospital gown.

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 times she was dressed in a hospital gown.

The record for Resident 6 was reviewed on 10/21/22 at 9:33 a.m. The resident was admitted to 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 was not cognitively intact. She needed extensive assist with a 2 person physical assist for bed mobility and transfers and extensive assist with a

bag.
2. Resident number 6 and 29 had no negative outcomes. Both residents were immediately assisted into clothes.
How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:
1. An in house audit will be completed by activities and SSD and/or designee for current residents to update their personal preferences. If unable to make decision POA and/or family will be contacted to give information.
2. Preferences will be updated and put on care plans and kardex by date of compliance.
3. An in house audit will be completed by DON/designee for current residents that have a catheter to ensure a dignity bag is in place.
What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:
1. SSD and Activities will be 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 preference. SSD and activities will be responsible for updating care plan and kardex with changes.

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	1 person physical assist for eating, dressing, and personal hygiene. The resident had a limitation in range of motion on one side for both upper and lower extremities. She received a mechanically altered diet and therapeutic diet and had 1 stage 3 pressure ulcer. A Care Plan, dated 2/20/22, indicated the resident preferred to sleep in gowns. Interview with LPN 1 on 10/24/22 12:15 p.m., indicated the resident preferred to wear a hospital gown all the time, however, that information was not documented in the clinical record. Interview with the Director of Nursing on 1/24/22 at 12:28 p.m., indicated the resident's preferences should be followed. 3. On 10/19/22 at 10:24 a.m., 12:58 a.m., and 3:20 p.m., Resident 29 was observed lying in bed awake. At those times, she was wearing a hospital gown. 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. At those times she was wearing a hospital gown. On 10/21/22 at 10:20 a.m., and 1:30 p.m., the resident was observed lying in bed. At those times she was wearing a hospital gown. On 10/24/22 at 8:50 a.m., and 10:50 a.m., the resident was observed lying in bed. At those times she was wearing a hospital gown. The record for Resident 29 was reviewed on 10/24/22 at 10:55 a.m. Diagnoses included, but were not limited to, dementia without behaviors, dysphagia, stroke, anxiety disorder, psychosis,		Education will be completed by date of compliance. 2. DON/designee will provide education to nursing staff to ensure residents with a catheter have a dignity bag in place. Education will be completed by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. ED and/or designee will audit 5 charts weekly x 8 weeks, then 3 charts weekly x 8 weeks, then 2 charts weekly x 8 weeks to ensure resident preferences are updated. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. DON/designee will complete observations 5 x/week for 6 months to ensure resident preferences are being honored. . Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	peg tube (a tube inserted directly into the stomach for nutrition) and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/10/22, indicated the resident was not cognitively intact and was severely impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility and transfers and extensive assist with a 1 person physical assist for dressing. A Care Plan, updated 8/7/22, indicated the resident preferred gowns and pajamas to be removed daily. The interventions included, but were not limited to, help the resident with removal and selection of clothing or gowns as she preferred. Interview with the Director of Nursing on 10/24/22 at 1:30 P.M., indicated she was unaware the resident got out of bed and preferred to be dressed in street clothes. 3.1-3(t)		Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly			

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	statements and upon request. Based on record review and interview, the facility failed to ensure quarterly statements were provided for 1 of 1 residents reviewed for personal funds. (Resident 28) Finding includes: Interview with Resident 28 on 10/19/22 at 10:42 a.m., indicated she did not receive quarterly statements for her resident funds account. The personal funds review was completed with the Business Office Manager (BOM) on 10/25/22 at 1:06 p.m. The BOM indicated the facility handled Resident 28's funds. She indicated statements were provided quarterly to the residents or their Responsible Party. Phone interview with the Corporate Business Manager at that time, indicated statements were sent out quarterly and copies of the statements were kept in a binder. She also indicated Social Service staff would go over the statement with the resident and have her sign the statement if she was able. A statement for the resident was dated 4/1/22 - 6/30/22. The statement had not been signed by the resident and there was no documentation in the Social Service progress notes indicating the resident had received a copy of her statement or was told her balance. Interview with the resident on 10/25/22 at 1:25 p.m., indicated sometimes they would tell her how much she had in her account. She could not remember the last time they did and she had not	F 0568	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 568- Accounting and Records of Personal Funds What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident 28 had no negative outcomes. Resident 28 was immediately issued a quarterly statement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. An in house audit will be	12/03/2022

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	been asked to sign the statements. Interview with the Business Office Manager on 10/25/22 at 1:45 p.m., indicated moving forward she would have Social Service staff make an entry and have the resident sign the statement if able. 3.1-6(g)		completed by ED/designee for current residents to ensure all residents and/or responsible parties have received a quarterly statement. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. BOM will be educated by ED and/or designee on providing resident and/or responsible parties quarterly statements and to ensure signature is obtained. Education will be completed by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. ED and/or designee will audit statement binder quarterly to ensure resident statements are signed that they were received quarterly. Results will be presented to QAPI x 6 months and QAPI will 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 date: 12/3/22. The	

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			Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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 interview, the facility failed to ensure dependent residents were provided assistance with activities of daily living (ADL's) related to assistance with personal hygiene, oral care, nail care and shaving for 3 of 5 residents reviewed for ADL's. (Residents E, H and J) Findings include: 1. On 10/19/22 at 9:22 a.m., 10:27 a.m., 12:08 p.m., 1:25 p.m., and 2:45 p.m., Resident E was observed in bed lying on his right side. At those times, there was a rolled wash cloth inside the resident's left hand. There was a large amount of dried mucous on his lips and he had a large amount of overgrown facial hair. The resident's hair was greasy. On 10/20/22 at 8:42 a.m., and 1:10 p.m., the resident was observed lying in bed on the right side. At those times, there was a rolled wash cloth inside the resident's left hand. There was a large amount of dried mucous on his lips and he had a large amount of over grown facial hair. The resident's hair was greasy.	F 0677	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 677- ADL Care Provided for Dependent Residents What Corrective Action will be accomplished for those residents	12/03/2022

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	On 10/20/22 at 1:36 p.m., CNA 1 and Agency CNA 1 were observed providing incontinence care for the resident as well as repositioning him. He was observed lying on his right side with a large amount of dried mucous to his lips. There was also a large amount of facial hair observed on his face. Neither CNA provided oral care or shaved the resident. On 10/21/22 at 7:52 a.m., and 9:31 a.m., the resident was observed lying in bed on the right side. At those times, there was a rolled wash cloth inside the resident's left hand. There was a large amount of dried mucous on his lips and he had a large amount of over grown facial hair. The resident's hair was greasy. On 10/21/22 at 9:56 a.m., CNA 2 was observed preparing to provide morning care for the resident. She placed a warm wash cloth on the resident's lips to remove the dried mucous. The mucous did not come off right away. The CNA then cleaned his left ear with a wash cloth. She removed a large amount of black wax from inside his ear. She was asked to remove the wash cloth from the resident's left hand. At the time of removal of the wash cloth, a large amount of orange/yellow dried debris was observed on the wash cloth. The resident's hand was dry and the skin was flaking off. There was an odor from the resident's hand. At 10:15 a.m., the Director of Nursing (DON) and LPN 1 entered the room. The LPN brought in toothettes and cleaned the resident's mouth. The DON instructed the CNA to do a complete bed bath for the resident. The record for Resident E was reviewed on 10/20/22 at 1:18 p.m. Diagnoses included, but were not limited to, multiple sclerosis, seizures,		found to have been affected by this deficient practice: 1. Resident E was shaven, given a full bed bath per his preference, had his hair washed, given oral care, and rolled wash cloth to left hand replaced immediately. 2. Resident H and J were shaven and had fingernails cut immediately. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. An in house audit will be completed by nursing management on residents for the POC charting to ensure completed per policy. Any issues identified will be addressed and follow up will be completed. What measures and what systemic changes will be made to ensure that the deficient practice doesn’t recur: 1. Education will be provided to licensed nurses and aides r/t completion of POC/PCC documentation related to ADL care including shower/bed bath, oral care, and nail care. Shower sheet to be completed and turned into nurse each shift. MD and POA and/or family to be notified of refusal. Nursing to notify SSD of refusal(s). SSD to ensure care plan is updated to reflect refusal(s). This will be completed by DON/Designee by date of	

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	pressure ulcer left heel, quadriplegia, schizophrenia, abnormal posture, falls, muscle wasting, contractures, neuromuscular bladder, bipolar disorder, peg tube (a tube inserted directly into the stomach for nutrition), major depressive disorder, dysphagia, and moderate intellectual disabilities. The Annual Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident was not cognitively intact and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and personal hygiene. The resident was totally dependent on staff for bathing and had range of motion impairment to both sides for both upper and lower extremities. The resident had 1 unstageable pressure ulcer. A Care Plan, updated 9/14/22, indicated the resident preferred have short facial hair and short hair. A Care Plan, updated 9/14/22, indicated the resident had an ADL self-care performance deficit. Interview with the Director of Nursing on 10/24/22 at 2:00 p.m., indicated the resident should have been provided with morning and evening care every day, including oral care The resident should have been bathed from head to toe if provided a complete bed bath.2. On 10/20/22 at 1:46 p.m., Resident H was observed with facial hair and long fingernails. On 10/21/22 at 8:34 a.m., the resident was observed sitting in a wheelchair near the nurses' station. His facial hair was still visible, but his fingernails had been trimmed. An interview with LPN 1 and QMA 2 at that time, indicated that sometimes bathing and nail care may depend on		compliance. 2. Any new nursing staff will receive this education during orientation as well. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee will review shower sheets daily 5 times weekly to ensure compliance. The shower sheets must be compared to the POC charting to ensure they match. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. DON/Designee will complete observations 5 x/week for 6 months to ensure ADLs are being completed as documented. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	the resident's mood, as he could be aggressive at times. The record for Resident H was reviewed on 10/20/22 at 2:00 p.m. Diagnoses included, but were not limited to, non-Alzheimer's dementia, syncope (fainting), history of falls, and general muscle weakness. A Quarterly MDS (Minimum Data Set) assessment, dated 8/9/22, indicated the resident was not cognitively intact and needed extensive 1-2 person assist with personal hygiene. A Care Plan, dated 12/2/21, indicated the resident required assistance with ADL's (Activities of Daily Living) related to dementia and muscular weakness. Approaches included, but were not limited to, extensive assistance by 1-2 staff with bathing/showering as a safety precaution for behaviors and transfers, and check nail length and trim and clean on bath day. A Care Plan, dated 1/12/22, indicated the resident's preferences were to have short nails and no facial hair. Approaches included offering the resident choices of when he would like his nails trimmed and when he would bathe/shower. Interview with the Assistant Director of Nursing on 10/25/22 at 1:00 p.m., indicated personal hygiene was to be done as needed, and not necessarily waiting for shower days. 3. On 10/19/22 at 10:30 a.m., Resident J was observed near the nurses' station in his wheelchair. The resident had a growth of facial hair and long fingernails. On 10/20/22 at 10:24 a.m., the resident was again			

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	observed sitting in his wheelchair near the nurses' station. He remained unshaven and his fingernails remained long and dirty. On 10/21/22 at 8:09 a.m., the resident was observed seated in the dining room for breakfast. His facial hair and long fingernails were visible. An interview with CNA 3 at that time, indicated the resident received assistance with bathing when he allowed it, depending on his mood. He preferred the beautician to shave him, but has allowed nursing staff to do if the beautician had not been here for a few days. He doesn't always allow staff to clip his nails and cannot be swayed by attempts to re-direct. The record for Resident J was reviewed on 10/20/22 at 1:00 p.m. Diagnoses included, but were not limited to, Parkinson's, diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, and glaucoma. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/22, indicated the resident had cognitive impairment and required extensive assistance of 1 or more persons for personal hygiene. A Care Plan dated 1/12/22 and revised 6/8/22, indicated the resident preferred short fingernails and short facial hair. Approaches included offering choices of when he would like to bathe, shave, and get his nails trimmed. Interview with the Assistant Director of Nursing on 10/25/22 at 1:00 p.m., indicated personal hygiene was to be done as needed, and not necessarily waiting for shower days. This Federal tag relates to Complaints IN00388294			

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	and IN00389608. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review, and interview, the facility failed to ensure ongoing activities were in place for cognitively dependent residents for 2 of 2 residents reviewed for activities. (Residents 6 and 29) Findings include: 1. On 10/19/22 11:10 a.m., 12:00 p.m., and 1:15 p.m., Resident 6 was observed lying in bed and awake. At those times her roommate's television was turned on a Spanish speaking channel. The resident spoke English. There was no television or radio on near the resident. On 10/20/22 at 8:45 a.m., and 1:10 p.m., the resident was observed lying in bed and awake. At those times her roommate's television was turned on a Spanish speaking channel. There was no television or radio on near the resident.	F 0679	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	12/03/2022

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	On 10/21/22 at 8:16 a.m., and 9:30 a.m., the resident was observed lying in bed and awake. At those times her roommate's television was turned on a Spanish speaking channel. There was no television or radio on near the resident. 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 and awake. At those times there was no television or radio turned on. The record for Resident 6 was reviewed on 10/21/22 at 9:33 a.m. The resident was admitted to 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 was not cognitively intact. She needed extensive assist with a 2 person physical assist for bed mobility and transfers and extensive assist with a 1 person physical assist for eating, dressing, and personal hygiene. The resident had a limitation in range of motion on one side for both upper and lower extremities. She received a mechanically altered diet and therapeutic diet and had 1 stage 3 pressure ulcer. A Care Plan, dated 2/20/22, indicated the resident had little or no activity involvement related to her wishes to not participate. The interventions included, but were not limited to, the resident preferred the following radio stations: jazz music and the news, religious and the Hallmark channels on television. The resident's preferred activities were watching television, spending time with family, and reading the bible.		this plan of correction. We respectfully request a desk review. **F 679**- Activities Meet Interest/Needs Each Resident ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 6 had no negative outcomes. Resident's television was turned on to an English speaking channel. 2. Resident 29 had no negative outcomes. Resident's television was turned on to a Spanish speaking channel. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An in house audit will be completed to ensure ongoing activities are in place for cognitively dependent residents. Any issues identified will be addressed and follow up will be completed. Audits will be completed by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education to all staff r/t ongoing activities for cognitively dependent residents will be completed by date of compliance. 2. Any new staff will receive this education during	

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	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 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 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 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. 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 resident was observed lying in bed awake. At those times, there was no radio or television turned on. The resident's roommate's television		orientation as well. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Management team will 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. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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was on an English speaking channel, however, the privacy curtain was pulled and she could not see the television.

On 10/24/22 at 8:50 a.m., and 10:50 a.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.

The record for Resident 29 was reviewed on 10/24/22 at 10:55 a.m. Diagnoses included, but were not limited to, dementia without behaviors, dysphagia, stroke, anxiety disorder, psychosis, peg tube (a tube inserted directly into the stomach for nutrition) and major depressive disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/10/22, indicated the resident was not cognitively intact and was severely impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility and transfers and extensive assist with a 1 person physical assist for dressing.

A Care Plan, updated 8/10/22, indicated the resident was able to make simple needs/wishes known in Spanish. The resident would be encouraged/included with sensory interaction, visits, and other activities. The interventions included, but were not limited to, encourage the resident to possibly watch spiritual programs on television when available and provide current/available television channels for possible selection of personal interest.

The resident had received 1 to 1 room visits two times a week by activity staff for the months of

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	9/2022 and 10/2022. Interview with the Activity Director on 10/25/22 at 9:40 a.m., indicated she was aware the resident spoke only Spanish. She did receive 1 to 1 room visits 2 times a week and when she was up in the chair, they did take her to activities. She only had 1 other staff member to help out, therefore, it was difficult to ensure the dependent residents had some type of stimulation going on in their rooms while they were awake. The television or radio should have been on a Spanish speaking channel while she was in her room. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered and areas of scabbing were assessed and monitored for 2 of 5 residents reviewed for skin conditions (non-pressure related). The facility also failed to ensure monitoring and treatment was initiated for elevated blood pressures for 1 of 3 residents reviewed for hospitalization. (Residents F, B, and G) Findings include:	F 0684	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	12/03/2022

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	1. On 10/19/22 at 10:19 a.m., Resident F was observed with a gauze dressing to his left shin. On 10/21/22 at 8:56 a.m., the resident was observed in his room in bed. The dressing to the resident's left shin was dated 10/19/22. The Record for Resident F was reviewed on 10/20/22 at 1:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, adult failure to thrive, protein calorie malnutrition, and neurogenic bladder. The Admission Minimum Data Set (MDS) assessment, dated 10/18/22, indicated the MDS was in progress. The resident was moderately impaired for daily decision making. A Care Plan, dated 10/11/22, indicated the resident had a break in skin integrity to the coccyx, lower left leg, and lower left leg lateral. Interventions included, but were not limited to, treatment as ordered. A Physician's Order, dated 10/18/22, indicated to cleanse the left lower leg with normal saline, pat dry, and cover abrasion with antibiotic ointment one time a day for 7 days. The October 2022 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 10/20/22. The Wound Observation Tool, dated 10/18/22, indicated the resident was admitted with the left lower leg abrasion and the area measured 1 centimeter (cm) x 1 cm. Interview with the Director of Nursing on 10/21/22		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 684**- Quality of Care ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident F had dressing to left shin changed and signed out per order. MD and family were notified. Resident F had no negative outcomes. 2. Resident B no longer resides at facility. 3. Resident G immediately had a skin assessment and treatment orders were obtained. Resident G had no negative outcomes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. In house audit completed with head to toe skin assessments to ensure any skin issues are identified and addressed by nursing	

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	at 12:43 p.m., indicated the resident's treatment was to be completed daily. 2. The closed record for Resident B was reviewed on 10/24/22 at 8:52 a.m. The resident was admitted to the facility on 7/8/22 and discharged to the hospital on 7/25/22. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, type 2 diabetes, anemia, atrial fibrillation, chronic systolic heart failure, hypertensive heart disease with heart failure, and hyperlipidemia. The Admission Minimum Data (MDS) assessment, dated 7/15/22, indicated the resident was cognitively intact. The resident was a limited assist with a 1 person physical assist for eating. The resident had no oral problems, weighed was 249 pounds with no significant weight loss and was on therapeutic diet. 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 7/11/22, indicated hemodialysis on Monday, Wednesday and Friday. Physician's Orders, dated 7/8/22, indicated the following: Losartan 50 milligrams (mg) daily for high blood pressure. Iosorbide Mononitrate 60 mg two times a day for high blood pressure. Hydralazine HCl 100 mg three times a day for high blood pressure. Clonidine HCl 0.2 mg two times a day for high		management by date of compliance. Any new orders received put on TX and/or med sheet, care plan and kardex updated. Any issues identified will be addressed. 2. In house audit completed to ensure monitoring/parameters are in place for any blood pressure medication by date of compliance. Any issues identified will be addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed to licensed and certified nursing staff to ensure any skin issue or abnormal finding needs reported and documented in the clinical record, MD and Responsible party need notified and care plan and Kardex to be updated to reflect new orders and/or include any new interventions by Nursing management by date of compliance. New licensed or certified nursing employees will receive this education prior to working. 2. Education will be completed to all licensed nursing staff to ensure monitoring/parameters are in place for residents with BP medications by nursing management by date of compliance. New licensed nursing employees will receive education	

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	blood pressure. Carvedilol 6.25 mg two times a day for high blood pressure. Amiodarone HCl 200 mg every 12 hours for high blood pressure. The resident's blood pressures were documented as follows: 7/10/22 at 7:43 p.m., 185/105 7/13/22 at 8:23 a.m., 167/100 7/13/22 at 8:23 a.m., 176/100 7/17/22 at 8:51 a.m., 176/111 7/25/22 at 8:50 a.m. and 9:01 a.m., 157/141 Nurses' Notes, dated 7/25/22 at 8:35 p.m., indicated the resident was admitted to the hospital. There was no documentation in the clinical record regarding what was done, if anything, regarding the high blood pressures. Interview with the Director of Nursing (DON) on 10/25/22 at 9:40 a.m., indicated the resident was admitted to the hospital from dialysis on 7/25/22. Interview with the DON on 10/25/22 at 10:20 a.m., indicated nothing was done regarding the high blood pressures because there were no Physician ordered parameters for monitoring the blood pressure. The resident's blood pressure was not within the normal range. The resident was sent to dialysis with the high blood pressure recorded earlier that morning.3. On 10/19/22 at 2:00 p.m., Resident G was observed on her way to bingo in the dining room. Scabs and redness were noted to the right lower shin. On 10/21/22 at 12:35 p.m., the resident was		prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee will review 24/72 hour report 5 times weekly to ensure treatment orders are obtained and in place for any skin issues, and care plan is updated x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. Competencies will be completed by date of compliance on aides and nurses for the appropriate protocol for skin assessments and accurate follow through and documentation by Nursing Management. 2. DON/Designee will review 24/72 hour report 5 times weekly to ensure orders for BP medications contain monitoring/parameters x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The	

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	observed seated at a table in the dining room. The right lower leg remained red with flaky skin and scabs. On 10/24/22 at 9:52 a.m., the resident was observed in the hallway near her room in her wheelchair. The right ankle was visibly red with dry, flaky skin and scabs. The record for Resident G was reviewed on 10/19/22 at 3:00 p.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus (DM), non-Alzheimer's dementia, and left heel pressure ulcer. The Annual Minimum Data Set (MDS) assessment, dated 7/20/22, indicated the resident required extensive assistance with bed mobility and transfers. A Care Plan, dated 10/4/22 and revised 10/5/22, indicated the resident was at risk for a break in skin integrity related to diabetes mellitus, muscle weakness, and incontinence. Interventions included, but were not limited to, treatment as ordered and weekly skin checks. There was no order for any treatment to the resident's right lower leg. There was also no assessment of the area. On 10/24/22 at 10:42 a.m., a Weekly Skin assessment, dated 10/24/22, indicated the area to the right lower leg had been addressed. Interview with the Assistant Director of Nursing (ADON) on 10/24/22 at 10:42 a.m., indicated she had spoken with the Physician and new orders were obtained.		Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	This Federal tag relates to Complaint IN00386810. 3.1-37(a)			
F 0686 SS=E Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered and treatment orders were obtained for 4 of 5 residents reviewed for pressure ulcers. (Residents F, D, E, and C) Findings include: 1. On 10/21/22 at 9:50 a.m., Resident F was seated on the side of his bed. Therapy staff were in the room with the resident. The resident's jacket was lifted and the dressing to his right upper back was dated 10/19/22. The Record for Resident F was reviewed on 10/20/22 at 1:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, adult failure to thrive, protein calorie malnutrition, and	F 0686	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	12/03/2022

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	neurogenic bladder. The Admission Minimum Data Set (MDS) assessment, dated 10/18/22, indicated the MDS was in progress. The resident was moderately impaired for daily decision making. A Care Plan, dated 10/11/22, indicated the resident had a pressure ulcer to his coccyx and he had the potential for pressure ulcer development related to immobility. Interventions included, but were not limited to, administer treatments as ordered. A Physician's Order, dated 10/18/22, indicated the right posterior lower thoracic area was to be cleansed with normal saline, pat dry, then apply Xeroform and cover with a dry dressing every night shift for wound care and as needed (prn). The October 2022 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 10/20/22. The Braden scale assessment, dated 10/18/22, indicated the resident was at high risk for developing pressure ulcers. The Wound Observation Tool, dated 10/18/22, indicated the resident had an unstageable pressure ulcer to his right posterior lower thoracic area that measured 2 centimeters (cm) x 1.5 cm. Interview with the Director of Nursing on 10/21/22 at 12:43 p.m., indicated the resident's treatment was to be completed daily. 2. The Closed Record for Resident D was reviewed on 10/20/22 at 10:17 a.m. Diagnoses included, but were not limited to, aspiration pneumonia, history of stroke, and congestive		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 686- Treatment/Services to prevent/heal pressure ulcer What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident F had dressing to right upper back changed immediately. Resident F had no negative outcomes. 2. Resident C and D no longer resides at facility. 3. Resident E had skin assessment completed with MD notified and treatment orders obtained. Resident E had no negative outcomes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. In house audit completed with head to toe skin assessments to ensure any skin issues are identified and addressed by nursing management by date of compliance. Any new orders received put on TX and/or med sheet, care plan and kardex updated. Any issues identified will be addressed. What measures and what systemic changes will be made to ensure that the deficient practice	

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	heart failure. The resident was admitted to the facility on 9/30/22. A Physician's Order, dated 9/30/22, indicated wound care was to evaluate and treat. Nurses' Notes, dated 10/1/22 at 12:20 a.m., indicated the resident was noted with skin impairment to the sacral area and wound care was to treat and evaluate. The Braden Scale assessment, dated 9/30/22, indicated the resident was a high risk for developing pressure ulcers. The Wound Observation Tool, dated 9/30/22, indicated the resident was noted with an open area to the sacrum and wound care was to treat and evaluate. The area was identified as a Stage 3 pressure ulcer that measured 4 centimeters (cm) x 3 cm x 1 cm. 75% slough was present with a moderate amount of sanguineous (bloody drainage). The wound had an odor and the resident had pain related to the wound. The resident had no treatment order for the wound. Interview with the Nurse Consultant on 10/25/22 at 11:30 a.m., indicated a treatment order for the pressure ulcer should have been obtained on admission. 3. On 10/19/22 at 9:22 a.m., 10:27 a.m., 12:08 p.m., 1:25 p.m., and 2:45 p.m., Resident E was observed in bed lying on his right side. At those times, his head was lying directly on a pillow and the right ear was not offloaded. On 10/20/22 at 8:42 a.m., and 1:10 p.m., the resident was observed lying in bed on the right side. At those times, his head was lying directly		doesn't recur: 1. Education will be completed to licensed and certified nursing staff to ensure any skin issue or abnormal finding needs reported and documented in the clinical record, MD and Responsible party need notified and care plan and Kardex to be updated to reflect new orders and/or include any new interventions by Nursing management by date of compliance. New licensed or certified nursing employees will receive this education prior to working. 2. Education will be completed to licensed nursing staff staff regarding the following: i. Notification of physician upon identification of new pressure ulcer for treatment ii. Notification of responsible party and or resident regarding newly identified pressure ulcers and treatment iii. Documentation of newly identified pressure ulcers to include site, description, measurement, notification of responsible party/resident and physician and treatment plan/orders. iv. Bath sheets are documented with each bath and any identified wounds documented and reported to the licensed nurse. v. Weekly skin assessments for each in house resident are completed on the due date	

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	on a pillow and the right ear was not offloaded. On 10/20/22 at 1:36 p.m., CNA 1 and Agency CNA 1 entered the room to check for incontinence and reposition the resident. The resident was placed on his right side with a pillow under his head. The right ear was not offloaded. CNA 1 removed the heel protectors from his feet and there was a bandage observed on the left heel and dark scabbed area on the bottom of his right foot with the remnants of betadine (an orange solution used for wound care) on the scab. Interview with the CNA 1 at that time, indicated the resident was severely contracted in his legs and neck and he was only able to be repositioned on the right side. On 10/21/22 at 7:52 a.m., and 9:31 a.m., the resident was observed lying in bed on the right side. At those times, his head was lying directly on a pillow and the right ear was not offloaded. On 10/21/22 at 9:56 a.m., CNA 2 was observed preparing to provide morning care for the resident. Interview with CNA 1 at that time, indicated she started her shift at 6:30 a.m. and had not turned or repositioned the resident since she had been there. Interview with the Director of Nursing on 10/21/22 at 10:15 a.m., indicated the ear was to be offloaded to prevent the pressure ulcers. On 10/25/22 at 8:45 a.m., LPN 2 provided wound care for the pressure ulcers. There was a dark 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		vi. Communication with the DON and/or wound nurse with any newly identified pressure ulcer How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee will review 24/72 hour report 5 times weekly to ensure treatment orders are obtained and in place for any skin issues and care plan is updated x 6 months. DON/Designee will review TAR 5 times weekly to ensure treatments are completed as ordered x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. 2. DON/Wound Nurse will complete observations 5 x/week for 6 months to ensure wound care is being completed as documented. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of	

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	heel which was not open. All of the open areas 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 Resident E was reviewed on 10/20/22 at 1:18 p.m. Diagnoses included, but were not limited to, multiple sclerosis, seizures, pressure ulcer left heel, quadriplegia, schizophrenia, abnormal posture, falls, muscle wasting, contractures, neuromuscular bladder, bipolar disorder, peg tube (a tube inserted directly into the stomach for nutrition), major depressive disorder, dysphagia, and moderate intellectual disabilities. The Annual Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident was not cognitively intact and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and personal hygiene. The resident was totally dependent on staff for bathing and had range of motion impairment to both sides for both upper and lower extremities. The resident had 1 unstageable pressure ulcer. A Care Plan, updated on 10/14/22, indicated the resident was at risk for a break in skin integrity. The approaches were for nursing staff to do frequent rounds to ensure proper positioning and to provide treatments as ordered. A Care Plan, dated 6/10/22, indicated the resident had an abrasion to the right ear. Physician's Orders, dated 9/4/22, indicated to offload right ear every shift. Physician's Orders, dated 10/20/22, indicated left heel plantar: cleanse with normal saline pat dry		Correction.	

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and apply skin prep daily. Cover right ear with a dry dressing daily. Left medial heel: cleanse with normal saline pat dry and apply calcium alginate and gauze sponge and then wrap with kerlix daily.

The Weekly Pressure Ulcer Tracking Report indicated the resident was readmitted with a blistered area to the right plantar foot on 9/2/22. A measurement on 9/6/22 indicated the blister measured 2.5 cm by 1 cm and the treatment was to monitor until resolved. On 9/13/22 the pressure ulcer was 100% dry and black and measured 1.5 cm by 1.0 cm. The treatment was "change to betadine." On 9/20/22 the measurements remained the same with the same treatment. On 9/27/22, the pressure ulcer measured 1.5 cm by 1.0 cm and the treatment was "change to skin prep." On 10/4 and 10/11/22 the measurements and treatment remained the same and the pressure ulcer was still 100% black. On 10/18/22 the right plantar foot ulcer measured 1 cm by 1 cm and was 100% dry black. The treatment remained the same.

There were no Physician's Orders for the Betadine or Skin Prep to be applied to the right plantar foot pressure ulcer.

The Weekly Pressure Ulcer Tracking Report indicated the resident acquired a left plantar heel pressure ulcer on 9/20/22 that measured 2 cm by 3 cm and was a dark purple fluid filled blister. The treatment was "Nursing to cleanse with normal saline and apply skin prep daily." On 9/27/22 the pressure ulcer measured 1 cm by 2 cm and was now an unstageable black intact eschar. The treatment remained the same. On 10/4 and 10/11/22 the measurements and treatment remained the same as on 9/27/22. On 10/18/22 the pressure sore measured 1 cm by 1 cm and was still 100% black eschar. The treatment of skin prep

daily was the same.

There was no Physician's Orders for the skin prep to be applied daily to the left plantar heel pressure ulcer until 10/20/22.

There were no treatment orders on the Treatment Record or on the Medication Record for the betadine or skin prep to the right plantar foot and the left plantar heel for the month of 9/2022 and up until 10/20/22 for the left heel.

Interview with LPN 2 on 10/25/22 at 9:00 a.m., indicated she worked part time at the facility and only came in on Tuesdays to provide wound care and measure all the wounds. The regular shift nurses were to complete 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 was never obtained and nothing was ever transcribe onto the treatment record. An order was obtained for the left plantar heel on 10/20/22.

Interview with the Director of Nursing on 10/25/22 at 10:10 a.m., indicated the resident was to be turned and repositioned at least every 2 hours. There were no treatments obtained for the pressure ulcers on the right plantar foot and left plantar heel.

Interview with the Nurse Consultant on 10/25/22 at 11:30 a.m., indicated the treatments for right plantar foot and left heel pressure ulcers were lacking in the clinical record, but they were on the facility's Weekly Pressure Ulcer Tracking Report.

4. The closed record for Resident C was reviewed on 10/20/22 at 9:50 a.m. The resident was admitted on 7/12/22 and discharged home on 7/30/22.

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	Diagnoses included, but were not limited to, atrial fibrillation, heart disease, polyneuropathy, low back pain, insomnia, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 7/19/22, indicated the resident was cognitively intact. In the last 7 days, the resident received an antidepressant medication 7 times, an anticoagulant medication 6 times, an antibiotic medication 5 times, a diuretic medication 6 times and an opioid medication 6 times. A Care Plan, dated 7/12/22, indicated the resident had an unstageable pressure ulcer to the left heel. The approaches were to provide treatments as ordered. Physician's Orders, dated 7/19/22, indicated cleanse left heel with normal saline, pat dry, then apply manuka honey and cover with dry dressing every night shift. The Treatment Administration Record for the month of 7/2022, indicated the left heel treatment was not signed out as being completed on 7/19, 7/20, 7/23, and 7/26/22. A Wound Observation Tool, dated 7/12/22, indicated the resident was admitted to the facility with pressure ulcer on the left heel. The area was 100% black necrotic tissue that measured 5.5 centimeters (cm) by 6 cm. On 7/19/22 the pressure ulcer measured 5.5 cm by 6 cm and had granulation tissue noted. The treatment was changed at that time. On 7/26/22 the pressure ulcer measured 2 cm by 2 cm and was improving. Interview with the Nurse Consultant on 10/25/22 at 11:30 a.m., indicated the left heel pressure ulcer treatment was not signed out as being completed			

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	on the above mentioned days. This Federal tag relates to Complaints IN00388294 and IN00392720. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review, and interview, the facility failed to ensure residents with a limited range of motion had splints and/or anticontracture devices applied as ordered by the Physician for 3 of 3 residents reviewed for limited range of motion (ROM). (Residents 6, E and 23) Findings include: 1. On 10/19/22 11:10 a.m., 12:00 p.m., and 1:15 p.m., Resident 6 was observed lying in bed. At	F 0688	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	12/03/2022

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	those times her right hand was clenched in the shape of a fist. There was no anticontracture device in the hand. On 10/20/22 at 8:45 a.m., and 1:10 p.m., the resident was observed lying in bed. At those times her right hand was clenched in the shape of a fist. There was no anticontracture device in the hand. On 10/21/22 at 7:55 a.m., 8:16 a.m., and 9:30 a.m., the resident was observed lying in bed. At those times her right hand was clenched in the shape of a fist. There was no anticontracture device in the hand. 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 times her right hand was clenched in the shape of a fist. There was no anticontracture device in the hand. The record for Resident 6 was reviewed on 10/21/22 at 9:33 a.m. The resident was admitted to 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 was not cognitively intact. She needed extensive assist with a 2 person physical assist for bed mobility and transfers and extensive assist with a 1 person physical assist for eating, dressing, and personal hygiene. The resident had a limitation in range of motion on one side for both upper and lower extremities. A Care Plan, dated 3/16/22, indicated the resident had hemiplegia due to a stroke affecting the		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 688 –** Increase/Prevent Decrease in ROM/Mobility ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 6 had right hand splint applied immediately. Resident 6 had no negative outcomes. 2. Resident E had left hand washed and new rolled washcloth placed inside so that it covered the entire hand so there was no skin to skin contact. Resident E had no negative outcomes. 3. Resident 23 had green carrot applied to left hand. Resident 23 had no negative outcomes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***	

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	dominant side (right side). Physician's Orders, dated 8/3/22, indicated to don a right hand rolled splint daily. The resident was to wear the right hand rolled splint as tolerated. Staff were to remove the splint for hand hygiene and range of motion and check skin for redness/irritation. The Treatment Administration Record (TAR) and the Medication Administration (MAR) for the months of 9/2022 and 10/2022 lacked documentation of the right hand splint being donned and doffed daily. Interview with LPN 1 on 10/24/22 12:15 p.m., indicated she was unaware the resident had a splint. She had placed a washcloth in her right hand earlier that morning. Interview with the Director of Nursing on 10/24/22 at 2:00 p.m., indicated there was no documentation on the MAR or TAR of donning or doffing the splint. 2. On 10/19/22 at 9:22 a.m., 10:27 a.m., 12:08 p.m., 1:25 p.m., and 2:45 p.m., Resident E was observed in bed lying on his right side. There was a rolled wash cloth inside the resident's left hand. The wash cloth was only 1/4 of the way inside of the hand. On 10/20/22 at 8:42 a.m., 1:10 p.m., and 1:36 p.m., the resident was observed lying in bed on the right side. At those times, there was a rolled wash cloth inside the resident's left hand. The wash cloth was only 1/4 of the way inside the hand. On 10/21/22 at 7:52 a.m., and 9:31 a.m., the resident was observed lying in bed on the right side. At		1. In house audit completed with all residents noted to have a contracture to ensure anti-contracture device is in place as ordered by nursing management by date of compliance. Any issues identified will be addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed to licensed and certified nursing staff to ensure any resident with a contracture has appropriate anti-contracture device in place as ordered by date of compliance. New licensed or certified nursing employees will receive this education prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee will review MAR/TAR 5 times weekly to ensure anti-contracture devices are in place for any resident with a contracture x 6 months. Management will observe residents with contractures 5 times weekly to ensure anti-contracture devices are in place as ordered. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits.	

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	155423	A. BUILDING 00 B. WING	10/25/2022

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	those times, there was a rolled wash cloth inside the resident's left hand. The wash cloth was only 1/4 of the way inside the hand. On 10/21/22 at 9:56 a.m., CNA 2 was observed preparing to provide morning care for the resident. She was asked to remove the wash cloth from the resident's left hand. At the time of removal of the wash cloth, a large amount of orange/yellow dried debris was observed on the wash cloth. The resident's hand was dry and the skin was flaking off. There was an odor from the resident's hand. The CNA cleaned the resident's hand and new rolled wash cloth was placed inside the that covered the entire hand so there was no skin to skin contact. The record for Resident E was reviewed on 10/20/22 at 1:18 p.m. Diagnoses included, but were not limited to, multiple sclerosis, seizures, pressure ulcer left heel, quadriplegia, schizophrenia, abnormal posture, falls, muscle wasting, contractures, neuromuscular bladder, bipolar disorder, peg tube (a tube inserted directly into the stomach for nutrition), major depressive disorder, dysphagia, and moderate intellectual disabilities. The Annual Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident was not cognitively intact and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and personal hygiene. The resident was totally dependent on staff for bathing and had range of motion impairment to both sides for both upper and lower extremities. There was no Care Plan for contractures or a limited range of motion.		2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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Interview with Director of Nursing on 10/24/22 at 2:00 p.m., indicated the resident was screened by therapy and they indicated a rolled washcloth in the resident's hand was fine. The rolled wash cloth needed to be all the way in the hand.
3. On 10/19/22 at 10:00 a.m., Resident 23 was observed in bed, lying on his back, asleep. His left hand was clenched in a fist and he had no anticontracture device in place.

On 10/19/22 at 12:00 p.m., the resident was observed still in bed, lying on his back, asleep. His left hand was clenched in a fist and he had no anticontracture device in place.

On 10/20/22 at 1:22 p.m., the resident was observed near the nurses' station reclined in a geri chair. His left hand was clenched in a fist and he had no anticontracture device in place.

On 10/21/22 at 9:58 a.m., QMA 1 uncovered the resident's arms to visualize for any bruising. No bruises were seen, but his left hand was swollen and clenched. QMA 1 indicated the resident kept his left hand clenched 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, lying on his back, there was no anticontracture device in his left hand.

The record for Resident 23 was reviewed on 10/19/22 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, non-Alzheimer's dementia, psychotic disorder, and seizure disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 7/27/22 indicated the resident was cognitively impaired and required extensive

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	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)			
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			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to ensure adaptive equipment were provided as ordered and meal consumption was monitored for a resident with a history of weight loss and/or were a nutritional risk for 1 of 2 residents reviewed for nutrition. (Resident 6) Finding includes: On 10/19/22 11:10 a.m., Resident 6 was observed lying in bed. At that time, her right hand was clenched in the shape of a fist and contracted. The resident was trying to eat jello in the container with a soup spoon. She was observed using her left hand with the spoon and the container kept falling over as she could not use her right hand. There were no staff in the room to help the resident. There was no built up utensils noted or a compartment plate for food. On 10/19/22 at 1:15 p.m., the resident was observed sitting in bed. Her lunch was in front of	F 0692	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because of 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 alleged deficiencies have or will be corrected 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	12/03/2022

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	her which consisted of broth and jello. All the food was in separate containers. The resident was not able to hold any of the bowls with her right hand and was using plastic utensils to eat the food. There was no adaptive equipment observed. No staff were in the room helping the resident. On 10/20/22 at 1:10 p.m. the resident was observed in bed eating lunch. Again she was served a clear liquid diet in separate containers with plastic utensils. No staff were in the room helping the resident. On 10/21/22 at 8:16 a.m., the resident was observed in bed eating breakfast. There were no built up silverware and all the food was in separate containers. On 10/24/22 at 12:33 p.m., the resident was observed in bed eating lunch. A regular mechanically altered diet was served on a plate. She was eating with her left hand with a plastic spoon. The food was not placed in a compartment plate nor did she have the adaptive utensils. The record for Resident 6 was reviewed on 10/21/22 at 9:33 a.m. The resident was admitted to 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 was not cognitively intact. She needed extensive assist with a 2 person physical assist for bed mobility and transfers and extensive assist with a 1 person physical assist for eating, dressing, and		review. **F692-Nutrition/Hydration Status Maintenance** ***What Corrective Action will be accomplished for those residents found to be affected by this deficient practice:*** 1. Residents 6 had no negative outcomes. MD was notified and order was received to discontinue use of adaptive silverware related to resident refusal of use. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. In house audit of all residents with adaptive equipment completed to ensure meal consumption is documented in POC/PCC by date of compliance. 2. In house audit of all residents with adaptive equipment completed to ensure adaptive equipment is available during meals. ***What measures and what systemic changes will be made to ensure that the deficient practice does not recur:*** 1. Consumption report will be audited to ensure documentation of consumption for all residents with adaptive equipment. 2. Education provided to all staff related to documentation of consumption to be completed by date of compliance.	

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	personal hygiene. The resident had a limitation in range of motion on one side for both upper and lower extremities. She received a mechanically altered diet and therapeutic diet and had 1 stage 3 pressure ulcer. A Care Plan, dated 10/4/22, indicated the resident had a significant weight loss of 17.1% in the last 180 days. The approaches were to provide assistance with meals as needed. The resident weighed 170 pounds on 6/6/22, 169 pounds on 7/5, 164 pounds on 8/22, 150 pounds on 9/26 and 151 pounds on 10/18/22. Physician's Orders, dated 10/18/22, indicated full liquid diet, regular texture, thin consistency broths, cream soups, jello, apple or cranberry juice due to mild ileus until 10/23/22. Provide a regular diet, mechanically altered texture, thin consistency for after completion of her liquid diet. Physician's Orders, dated 7/11/22, indicated the resident was to have a compartmental plate with all meals, necessary to increase independence in self feeding. Physician's Orders, dated 7/19/22, indicated the resident was to have a left angular built up utensil during all meals, necessary to increase independence in self feeding. A Registered Dietitian's (RD) Progress Note, dated 9/27/22 at 8:26 a.m., indicated the resident had a significant weight loss over the last months. The resident received a mechanically altered diet. Continue to monitor oral intake as tolerated. The meal consumption logs indicated there was no documentation of any meals on 9/27 and		3. Education provided to all staff related to use of adaptive equipment to be completed by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put in place:*** 1. The management team will observe random meal times to ensure adaptive equipment is in place x 6 months. 2. The DON/Designee will audit consumption report to ensure documentation of meal intakes 5 times a week for 4 weeks, then 4 times a week x 4 weeks, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22 The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	10/15/22. There was no documentation of breakfast and dinner on 9/30/22 and no documentation of dinner on 10/11/22. Interview with LPN 1 on 10/24/22 at 12:33 p.m., indicated the resident's food was not served in the 3 compartment plate, nor did she have the built up silverware as ordered. Interview with the Director of Nursing on 10/24/22 indicated the resident should have had the special utensils and compartment plate with her meals. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent on enteral tube feedings received adequate nutrition after readmission and the head of the bed was raised while the feedings were infusing for 1 of 1 residents reviewed for tube feeding. (Resident E) Finding includes: On 10/20/22 at 1:36 p.m., the room door for Resident E was closed. At that time, upon entering the room, there were 2 CNAs standing on each side of the bed preparing to reposition and provide incontinence care for the resident. The head of the bed was completely flat and the enteral tube feeding was infusing at 60 cubic centimeters (cc) per hour. CNA 1 and Agency CNA 1 continued to turn and reposition the resident as well as change the incontinent brief all the while the head of the bed was flat the tube feeding was infusing. Interview with CNA 1 at that time, indicated the enteral feeding was not on hold or turned off while providing care. The nurse usually came in and placed it on hold or turned it off while care was provided. She was questioned as if this was a normal practice of providing care with the head of bed flat and the tube feeding infusing, the CNA indicated it was not. She was aware the resident was not supposed to be lying flat in bed while the tube was infusing. The record for Resident E was reviewed on 10/20/22 at 1:18 p.m. Diagnoses included, but were not limited to, multiple sclerosis, seizures, pressure ulcer left heel, quadriplegia, schizophrenia, abnormal posture, falls, muscle wasting, contractures, neuromuscular bladder,	F 0693	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 693**- Tube Feeding Management/Restore Eating Skills ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident E had no negative outcomes. MD and POA notified of head of bed being flat while tube feeding was running while providing ADL care. Education provided to CNA # 1 and Agency CNA # 1 immediately. ***How other residents having the***	12/03/2022

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	bipolar disorder, peg tube (a tube inserted directly into the stomach for nutrition), major depressive disorder, dysphagia, and moderate intellectual disabilities. The Annual Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident was not cognitively intact and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and personal hygiene. The resident was totally dependent on staff for bathing and had range of motion impairment to both sides for both upper and lower extremities. The resident had 1 unstageable pressure ulcer. The resident received greater than 51% of nutrition through enteral feedings. A Care Plan, updated 9/14/22, indicated the resident required a tube feeding related to dysphagia. The approaches were to ensure the head of the bed was elevated to 45 degrees during and 30 minutes after the tube feeding. The resident needed tube feedings and water flushes. The resident was admitted to the hospital on 9/1/22 and returned back to the facility on 9/2/22 at 6:51 p.m. Physician's Orders, dated 9/2/22 indicated NPO (nothing by mouth). Physician's Orders, dated 9/4/22, indicated flush peg tube with 300 cc of water every 6 hours. Enteral feed order of Jevity 1.5 at 60 cc per hour for peg tube: on at 10:00 a.m. and off at 6:00 a.m. The Medication Administration Record (MAR), for the month of 9/2022, indicated the water flushes were signed out for the first time after readmission on 9/5/22 at 12:00 a.m., and the enteral		***potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Residents with tube feeding have been audited to ensure orders are in place per MD. Nursing Management observed these residents with no other issues noted by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Nursing Management will educate licensed nursing staff on admission process for residents with tube feeding per policy by date of compliance. 2. Nursing Management will educate all licensed and certified nursing staff on ADL care of a resident with tube feed running per policy by date of compliance. 3. New licensed and certified nursing staff will receive this education prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee will audit all admission/readmission charts with tube feeding to ensure appropriate orders are obtained r/t tube feeding x 6 months. 2. DON/Designee will	

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	tube feeding was signed out for the first time at 10:00 a.m. on 9/5/22. Nurses' Notes, dated 9/3/22 at 10:03 p.m., and 9/4/22 at 1:27 a.m., indicated there was no information or documentation indicating the enteral tube feeding was infusing. Interview with the Director of Nursing on 10/21/22 at 7:55 a.m., indicated the resident was not to be lying flat in bed with the enteral feeding infusing. The CNA should have called the nurse in to turn off or place the tube feeding on hold during ADL care. Interview with the Nurse Consultant on 10/25/22 at 11:30 a.m., indicated she was notified of the incident regarding lack of documentation of the tube feeding flushes and enteral feedings when the resident returned from the hospital. There was no documentation of the enteral feeding being started or turned off or of any water flushes from 9/2-9/4/22. This Federal tag relates to Complaint IN00389608. 3.1-44(a)(2)		make random observations 5 x/week to ensure HOB is not flat during ADL care for residents with tube feed running x 6 months. This will be rotated on shifts. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 her oxygen use.	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. ***How other residents having the***	12/03/2022

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	A Physician's Order, dated 9/14/22, indicated the resident was to receive 2 liters of oxygen per minute continuously per a nasal cannula. Interview with the Director of Nursing on 10/21/22 at 12:43 p.m., indicated the resident's oxygen concentrator should have been set at 2 liters. 2. On 10/19/22 at 10:23 a.m., 1:25 p.m., and 2:40 p.m., Resident 47 was observed in her room in bed. The resident's oxygen concentrator was set at 2 1/2 liters and she was wearing a nasal cannula. On 10/20/22 at 9:40 a.m., 1:14 p.m. and 3:40 p.m., the resident was wearing her nasal cannula and her oxygen concentrator was set at 2 1/2 liters. The Record for Resident 47 was reviewed on 10/20/22 at 2:53 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident was cognitively impaired for daily decision making. The resident received oxygen while she was a resident of the facility. A Care Plan, reviewed 9/15/22, indicated the resident had oxygen therapy related to her respiratory status. Interventions included, but were not limited to, oxygen via nasal prongs/mask at 2 liters continuously. A Physician's Order, dated 5/26/22, indicated the resident was to receive oxygen at 2 liters continuously per nasal cannula.		***potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An Audit was completed on residents in house with current 02 orders to ensure orders accurate and clinical team observed liter flow being administered per order. No other issues have been identified. Audit completed by nursing management by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. DON and/or designee have educated licensed nursing staff and certified aides to observe liter flow on residents using 02 and ensure liter flow is accurate per order by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Don/Nursing management will observe 5 residents daily Monday through Friday x 8 weeks, then 3 residents daily Monday through Friday x 8 weeks, then 2 residents daily Monday through Friday x 8 weeks to assure compliance. Audits will be presented to QAPI x 6 months and then QAPI will determine the need for further audits. Any noted	

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	Interview with the Director of Nursing on 10/21/22 at 12:43 p.m., indicated the resident's oxygen concentrator should have been set at 2 liters. 3.1-47(a)(6)		issues will be addressed immediately. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing			

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	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 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	F 0732	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	12/03/2022

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	have been updated daily at the beginning of the day shift.		this plan of correction. We respectfully request a desk review. **F 732**- Posted Nurse Staffing Information ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. No residents were affected. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. No residents have the potential to be affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. DON and/or designee have educated scheduling department on posted nurse staffing policy and procedure by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON and/or designee will audit posted staffing sign 5 x/week x 8 weeks, then 3 x/week x 8 weeks, then 2 x/week x 8 weeks to ensure compliance. Audits will be presented to QAPI x 6 months and then QAPI will	

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			determine the need for further audits. Any noted issues will be addressed immediately. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility			

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	must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on record review and interview, the facility failed to ensure medications were obtained timely from the pharmacy related to admission medications for 1 of 3 residents reviewed for hospitalization. (Resident D) Finding includes: The Closed Record for Resident D was reviewed on 10/20/22 at 10:17 a.m. Diagnoses included, but were not limited to, aspiration pneumonia, history of stroke, and congestive heart failure. The resident was admitted to the facility on 9/30/22 at 3:20 p.m. The resident had the following admission orders on 9/30/22 for medications: - Cefuroxime Axetil (an antibiotic) tablet 250 milligrams (mg) every 12 hours for infection. - Doxycycline Hyclate (an antibiotic) 100 mg every 12 hours for infection. - Amiodarone HCl (a heart medication) 200 mg daily.	F 0755	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 if 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.	12/03/2022

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	- Atorvastatin Calcium (a cholesterol medication) 20 mg daily at 6:00 p.m. - Carvedilol (a blood pressure medication) 25 mg twice a day. - Docusate Sodium (a stool softener) 100 mg daily. - Ezetimibe (a cholesterol medication) 10 mg daily. - Lasix (a diuretic) 20 mg daily. - Hydralazine (a blood pressure medication) 50 mg three times a day. - Nifedipine ER (a blood pressure medication) 30 mg daily. - Polysaccharide Iron Complex Capsule (an iron supplement) 150 mg daily. - Primidone (a seizure medication) 250 mg three times a day. - Tramadol HCl (a pain medication) 50 mg every 6 hours for pain. The September 2022 Medication Administration Record (MAR), indicated the resident had no medications signed out as being administered on 9/30/22. The October 2022 MAR, indicated the resident did not receive the following medications on 10/1/22: - Amiodarone HCl 200 mg. - Docusate Sodium 100 mg. - Nifedipine ER 30 mg. - 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.		**F 755**- Pharmacy Services/Procedures/Pharmacist/ Records **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:** 1. Resident D no longer resides at facility. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** 1. All new admission/readmissions have the potential to be affected. 2. All admission/readmissions will be audited to ensure medications are received in a timely manner. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** 1. Education provided to licensed nursing staff on admission process r/t medication arrival from pharmacy to be completed by date of compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	A Nurses' Note, dated 10/1/22 at 5:10 p.m., indicated the resident was being transported to the emergency room for cough and congestion. The resident was admitted to the hospital and did not return to the facility. Interview with the Director of Nursing on 10/24/22 at 1:30 p.m., indicated if a resident was admitted on the evening shift and if the medications weren't delivered that evening, they should be delivered the next morning, some medications were also available in the EDK kit. This Federal tag relates to Complaint IN00392720. 3.1-25(a)		**in place:** 1. DON/designee to audit all admission/readmissions to ensure medications are received from pharmacy timely x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review, and interview, the facility failed to ensure medications were administered as ordered by the Physician for 1 of 7 residents reviewed for unnecessary medications. (Resident C) Finding includes: The closed record for Resident C was reviewed on 10/20/22 at 9:50 a.m. The resident was admitted on 7/12/22 and discharged home on 7/30/22. Diagnoses included, but were not limited to, atrial fibrillation, heart disease, polyneuropathy, low back pain, insomnia, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 7/19/22, indicated the resident was cognitively intact. In the last 7 days, the resident received an antidepressant medication 7 times, an anticoagulant medication 6 times, an antibiotic medication 5 times, a diuretic medication 6 times and an opioid medication 6 times. A Care Plan, dated 7/22/22, indicated the resident was on pain medication. The approaches were to administer analgesic medications as ordered by the Physician. Physician's Orders, dated 7/13/22, indicated Gabapentin (a medication used to prevent seizures and relieve pain for certain conditions in the nervous system.) 600 milligrams (mg) 1 every 6	F 0757	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 if 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 757** Drug Regimen is Free from unnecessary Drugs ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · Resident C no longer resides at facility.	12/03/2022

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	hours. Hydrocodone-Acetaminophen Tablet 10-325 mg, give 1 tablet by mouth every 6 hours for pain. The 7/2022 Medication Administration Record (MAR) indicated the Gabapentin and Hydrocodone were to be administered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. The Gabapentin was not signed out as being administered on 7/13 at 12 a.m., and 6 a.m. There was a "9" coded on 7/22, 7/23, and 7/30/22 for 12 a.m. dose. The Hydrocodone was not signed out as being administered on 7/13 at 6 a.m. A "7" was coded on 7/13 for 12 p.m. and 6 p.m. doses. A "7" was coded on 7/14 for the 12 p.m. and 6 p.m. doses and a "10" for the 12 a.m.., dose. A "7" was coded for the 12 a.m. and 6 a.m. doses on 7/15/22. A "9" was coded for the 12 a.m. dose on 7/22 and 7/23/22. A "10" was coded for the 12 a.m. and 6 a.m. on 7/29/22 and a "9" was coded for the 12 a.m. on 7/30/22. The legend on the bottom of the MAR indicated a "7" meant hold see progress notes, a "9" meant sleeping, and a "10" meant other see progress notes. Nurses' Notes, dated 7/13/22 at 1:58 p.m., indicated Hydrocodone, medication not available. Nurses' Notes, dated 7/14/22 at 2:10 p.m., indicated this writer spoke with the doctor and was informed the script for the Hydrocodone would be sent out to pharmacy today. Nurses' Notes, dated 7/14/22 at 8:56 p.m.,		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?*** · All residents have the potential to be affected. · Audits to be completed to determine if medication is administered per physician order. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** · MAR to be audited on all residents to determine if medications are administered per physician order by date of compliance. · Nursing Management to educate licensed nursing staff on administration of medications per physician order by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** · The Medication Admin Audit Report will be reviewed by DON/designee to ensure medication is administered per physician order 5x/week x 4 weeks, then 3x/week x 4 weeks, then weekly times 4 months. · The results of these reviews will be discussed at the monthly facility Quality Assurance	

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	indicated Hydrocodone medication not available. Awaiting arrival from pharmacy. Nurses' Notes, dated 7/15/22 at 7:04 a.m., indicated Hydrocodone medication not available. Nurses' Notes, dated 7/29/22 at 1:44 a.m., and 5:48 a.m., indicated the resident needed a new script from the doctor for the Hydrocodone medication. Interview with the Nurse Consultant on 10/25/22 at 11:30 a.m., indicated the Hydrocodone and the Gabapentin were not signed out as being administered as ordered by the Physician. This Federal tag relates to Complaint IN00388294. 3.1-48(a)		Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure AIMS (Abnormal Involuntary Movement Scale - a rating scale that was designed to measure involuntary movement side effects known as tardive dyskinesia) scales were completed for 2 of 7 residents reviewed for unnecessary medications. (Residents 34 and 38) Findings include: 1. The record for Resident 34 was reviewed on	F 0758	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	12/03/2022

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	10/21/22 at 11:04 a.m. Diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies, dementia with agitation, psychosis, and hallucinations. The Annual Minimum Data Set (MDS) assessment, dated 9/23/22, indicated the resident was cognitively impaired and she received an antipsychotic medication on a routine basis. A Physician's Order, dated 11/19/21, indicated the resident received Zyprexa (an antipsychotic medication) 7.5 milligrams (mg) at bedtime. The order was discontinued on 6/27/22. A Physician's Order, dated 8/12/22, indicated the resident was to receive Zyprexa 2.5 mg at bedtime. The resident had not had an AIMS scale completed while receiving the Zyprexa. Interview with the Nurse Consultant on 10/25/22 at 11:25 a.m., indicated the resident didn't have an AIMS scale completed. She also indicated AIMS scales were to be completed quarterly. 2. The record for Resident 38 was reviewed on 10/24/22 at 10:06 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and delusional disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/2/22, indicated the resident was cognitively intact and she received an antipsychotic medication on a routine basis. A Physician's Order, dated 8/25/22, indicated the resident received Asenapine Maleate (an antipsychotic medication) 5 milligrams (mg) sublingually twice a day.		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 758**- Free from Unnecessary Psychotropic Meds/PRN Use ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 34 had AIMS completed. Resident 34 had no negative outcomes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An Audit to be completed on residents in house that require an AIMS assessment to ensure completed per policy by date of compliance. Any issues identified will be addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. DON and/or designee to educate licensed nursing staff	

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	An AIMS scale was completed on 6/25/22. Interview with the Nurse Consultant on 10/25/22 at 11:15 a.m., indicated the resident's last AIMS scale was completed on 6/25/22 and should be completed quarterly. 3.1-48(a)(3)		on requirements of completion of AIMS assessments by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Nursing management will audit UDA schedule to ensure completion of AIMS assessment daily Monday through Friday x 8 weeks, then 3 x/week x 8 weeks, then 2 x/week x 8 weeks to ensure compliance. Audits will be presented to QAPI x 6 months and then QAPI will determine the need for further audits. Any noted issues will be addressed immediately. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors.			

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	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 interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 7 residents observed during medication pass. Three errors were observed during 28 opportunities for errors during medication administration. This resulted in a medication error rate of 10.71%. (Residents G, 40, and 56) Findings include: 1. During an observation of medication pass on 10/19/22 at 9:43 a.m., Agency LPN 1 administered Glipizide (a diabetic medication) a 10 milligram (mg) tablet to Resident G. The medication punch card indicated the medication was to be given 30 minutes before meals. The resident could not recall if she had eaten breakfast at that time. Interview with the LPN on 10/19/22 at 9:54 a.m., indicated the resident had already eaten her breakfast. She did not see the information on the punch card, however, the resident should have received the medication prior to eating breakfast. 2. During an observation of medication pass on 10/19/22 at 10:52 a.m., LPN 3 prepared the insulin Lispro 100 unit/milliliter pen for Resident 40 . She opened the insulin pen, wiped the seal with an alcohol swab, attached the needle, dialed the pen to 4 units, and proceeded to administer the medication to the resident. The LPN did not prime the pen before administration of the insulin. Interview with LPN 3 on 10/19/22 at 11:05 a.m., indicated she did not prime the pen before	F 0759	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 759- Free of Mediation Error 5% or More What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident G, 40, and 56 had no negative outcomes. LPN # 1, 3 and QMA #1 were educated immediately. MD was notified of medication errors and no new orders were received. How other residents having the	12/03/2022

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	administering the medication. The facility policy titled, "Insulin Pen Administration" received on 10/20/22 at 1:21 p.m. from the Infection Preventionist, indicated "Procedure...4...a...i. Dial 2 units by turning the dose selector clockwise." 3. During an observation of medication administration on 10/20/22 at 8:40 a.m., QMA 1 was preparing medications for Resident 56. The resident received Lokelma (a medication used to treat high potassium) 10 grams per packet. The packet was mixed with 6 ounces of water. The label on the box indicated the medication was to be given 2 hours before or 2 hours after other medications. The resident had received 12 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 did not exhibit pH-dependent solubility. Interview with the Director of Nursing (DON), on 10/20/22 at 9:25 a.m., indicated the insulin pen should have been primed with 2 units prior to administration, and the orders for the other two medications would be clarified and times would be changed on the orders.		potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. An in house audit will be completed on residents receiving insulin via insulin pens. Nursing managers will validate appropriate use and priming of insulin pens ongoing by date of compliance. Random observations of med pass will be performed ongoing by nursing managers. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be provided to all licensed nursing staff and medication aides by nursing management on the proper procedure and policy for administering insulin with a pen and on the 7 rights of medication pass by date of compliance, 2. Competencies will be performed on all licensed nursing staff on insulin pen administration and licensed nursing staff and medication aides on medication pass by date of compliance. 3. New licensed medication aides and nurses will not work until this education and competencies have been completed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:	

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	3.1-48(c)(1)		1. Don/Designee will observe 3 residents weekly receiving insulin via insulin pen x 3 months, then 2 residents weekly x 3 months rotating shifts. 2. DON/Designee will observe random medication pass 2 times weekly x 3 months, then 1 time weekly x 3 months rotating shifts. Audits will be presented to QAPI x 6 moths then QAPI will determine the need for further audits. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for 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	F 0921	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	12/03/2022

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	South and North Units) Finding includes: During the Environmental Tour, on 10/25/22 at 9:58 a.m. with the Maintenance Supervisor, the following was observed: 1. South Unit a. A strong stale urine odor was noted in Room 100. Two residents resided in the room. Interview with the Maintenance Supervisor at that time, indicated it had been an ongoing issue and he was going to change the resident's mattress. b. The door frames, room walls, and bathroom walls in Room 110 were scratched and marred. There was a brown substance on the floor next to bed B by the window. The floor register was also marred. One resident resided in the room. On 10/20/22 at 8:50 a.m., a clear plastic cylinder was observed on the back of the toilet, not contained and a yellow wash basin was also observed on the toilet seat. On 10/25/22 at 9:58 a.m., two plastic clear cylinders were observed in the glove compartment of the sharps container located behind the toilet. Three residents shared the bathroom. c. The wall behind bed A in Room 112 was scratched and marred. Two residents resided in the room. d. The bathroom door frame in Room 115 was scratched and marred. Four residents shared the bathroom.		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 921-Safe/Functional/Sanitary/Comfortable Environment** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The marred walls and door frames were repaired in rooms 110, 112, 115, 117. The floor tile in the bathrooms of rooms 220 and 221 was cleaned. The Privacy curtain in room 204 was exchanged with a freshly laundered privacy curtain. The mattress in room 100 was exchanged with a new mattress. All wash basins, urinals, and bedpans were placed in trash and new were obtained and covered in	

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	On 10/20/22 at 9:05 a.m., two wash basins were observed tucked inside one another on the bathroom floor. The wash basins were not contained. The wash basins remained on the floor on 10/25/22 at 10:05 a.m. Four residents shared the bathroom. e. The walls in Room 117 as well as the bathroom walls and door frame were scratched and marred. Two residents resided in the room and 4 residents shared the bathroom. On 10/20/22 at 9:05 a.m., two wash basins were observed tucked inside one another on the bathroom floor. The wash basins were not contained. 2. North Unit a. The privacy curtain in Room 204 was stained. Two residents resided in the room. b. The floor tile at the base of the sink in the bathroom of Room 220 was discolored. One resident used the bathroom. c. The floor tile at the base of the sink in the bathroom of Room 221 was discolored. One resident used the bathroom. On 10/20/22 at 9:02 a.m., two wash basins were tucked inside one another, a bed pan was placed on top of the wash basins and the bed pan and wash basins were positioned on top of a gray bucket in the bathroom. The bucket was positioned on the floor and the items were not contained. One resident used the bathroom.		appropriate plastic bag with resident's name. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents had the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Environmental rounds have been completed by maintenance department and plan has been put into place to address scratched/marred walls, discolored floor tiles in bathrooms, privacy curtains, stale urine odor and wash basins, urinals, and bedpans on or prior to 11/23/22. 2. The Maintenance Director and/or designee will include identified areas in the current preventive maintenance program and conduct routine resident room rounds according to the facility policy. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Maintenance Director and/or designee to conduct resident room observations 5x weekly for next 6 months to ensure the resident's environment	

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	On 10/25/22 at 10:10 a.m., the items remained in the bathroom. Interview with the Maintenance Supervisor at that time, indicated the above were in need of cleaning and/or repair and the wash basins and bed pans should have been stored properly. Interview with the Nurse Consultant on 10/25/22 at 11:20 a.m., indicated the above items should have been contained and not stored on the floor. The facility policy titled, "Keeping a Resident's Room in Order" was provided by the Nurse Consultant on 10/25/22 at 12:59 p.m. The policy indicated bedpans and urinals must be covered with a plastic bag and each plastic bag would be marked with the resident's name. This Federal tag relates to Complaint IN00392720. 3.1-19(f)		is in good repair from marred/scuffed walls, chipped paint, gouged night stands, and marred/scratched floors. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will 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 date: 12/3/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	