PRINTED: 01/11/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/08/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COE 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the Irraccordance with 42 Survey Date: 12/08 Facility Number: 00 Provider Number: 1002 At this Emergency Hammond-Whiting compliance with Erracquirements for Nequirements for Nequirements for Nequirements for Mercipating Provides 483.73. The facility census of 59 at the second conducted by the Irracquirements for Nequirements fo	200365 155423 287460 Preparedness survey, Care Center was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR	E 00	000	This plan of correction is prepand executed because the provisions of state and federa require it and not because Hammond-Whiting Care Centagrees with the allegations are citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safethe residents nor is it of such character to limit our capabilit to render adequate care. Pleasaccept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be copy the date indicated to remacompliance with state and federegulations, the facility has tate or will take the actions set for this plan of correction. We respectfully request a desk residence.	al law ter and niting e ety of ies ase as orrect in in deral ken th in	
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0	000	This plan of correction is prep and executed because the provisions of state and federa require it and not because Hammond-Whiting Care Cent	ıl law	
	Survey Date: 12/08	3/22			agrees with the allegations ar		

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

Facility Number: 000365

Provider Number: 155423

AIM Number: 100287460

TITLE (X6) DATE

Care Center maintains that the

jeopardize the health and safety of

alleged deficiencies do not

Verna Meacham **Executive Director** 01/06/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155423	B. W	ING		12/08/	2022
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
					14TH ST		
HAMMON	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	At this Life Safety (Codo guerror			the residents nor is it of such		
		Care Center was found not in			character to limit our capabiliti to render adequate care. Plea		
		equirements for Participation in			accept this plan of correction a		
		, 42 CFR Subpart 483.90(a),			our credible allegation of	13	
		re and the 2012 edition of the			compliance that the alleged		
	· ·	ction Association (NFPA) 101,			deficiencies have or will be co	rrect	
		LSC), Chapter 19, Existing			by the date indicated to remain		
		ancies and 410 IAC 16.2.			compliance with state and fed		
					regulations, the facility has tak		
	This one story facili	ity was determined to be of			or will take the actions set fort		
	Type V (111) construction and was fully				this plan of correction. We		
	sprinklered. The facility has a monitored fire alarm				respectfully request a desk rev	/iew.	
	system with smoke detection in the corridors,				' ' '		
	1 -	orridors and hard wired smoke					
	detectors in the resi	dent rooms. The facility has a					
	capacity of 80 and l	nad a census of 59 at the time					
	of this survey.						
	All areas where the	residents have customary					
		ered. All areas providing					
	facility services wer						
	Quality Review con	npleted on 12/12/22					
K 0211	NFPA 101						
SS=E	Means of Egress -	- General					
Bldg. 01	Means of Egress -	- General					
	Aisles, passagewa	ays, corridors, exit					
	discharges, exit lo	cations, and accesses are					
	in accordance with	n Chapter 7, and the means					
	of egress is contin	nuously maintained free of					
	all obstructions to	full use in case of					
		s modified by 18/19.2.2					
	through 18/19.2.1						
	18.2.1, 19.2.1, 7.1						
		on and interview, the facility	K 0	211	This plan of correction is prepare	ared	01/07/2023
		f 4 corridor means of egresses			and executed because the		
	were continuously r				provisions of state and federal	law	
	obstructions. LSC 1	9.2.3.4 (4) states projections			require it and not because		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPLETED	
		155423	B. WING			12/08/	2022
			S	TDEET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			4TH ST		
наммоі	ND-WHITING CARI	E CENTER			G, IN 46394		
TIAMMO	·	LOLIVIER		VIIIIIN	G, IIV 40394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	•	idth shall be permitted for			Hammond-Whiting Care Center	er	
	wheeled equipment, provided that all of the				agrees with the allegations an		
	following condition				citations listed. Hammond-Wh	iting	
		uipment does not reduce the			Care Center maintains that the	Э	
		corridor width to less than 60			alleged deficiencies do not		
	in.(1525 mm).				jeopardize the health and safe	ty of	
		occupancy fire safety plan and			the residents nor is it of such		
		ldress the relocation of the			character to limit our capabiliti		
		during a fire or similar			to render adequate care. Plea		
	emergency.				accept this plan of correction a	as	
		ipment is limited to the			our credible allegation of		
	following:				compliance that the alleged		
	i. Equipment in use and carts in use				deficiencies have or will be co		
		ncy equipment not in use			by the date indicated to remain		
		ransport equipment			compliance with state and fed		
	-	ice affects at least 15 residents			regulations, the facility has tak		
	on the South Hall.				or will take the actions set fort	h in	
					this plan of correction. We		
	Findings include:				respectfully request a desk rev	view.	
	Based on an observ	ration during a tour of the			K211 – Means of Egress -		
	facility with the Ma	aintenance Director and			<u>General</u>		
		12/08/22 between 12:50 and			What Corrective Action will I	be	
	1:44 p.m., in South	Hall corridor, Personal			accomplished for those		
		ent (PPE) carts were in use but 4			residents found to have been	n	
		with wheels allowing the carts			affected by this deficient		
		he halls during an emergency.			practice:		
		ew at the time of observations,			The 4 PPE carts in which were		
		irector stated most of the carts			found unequipped with wheels		
	•	4 located did not have them			have been replaced by carts the		
	and would replace	them.			are properly equipped with wh		
					How other residents having		
	_	viewed with the Executive			potential to be affected by the		
		aintenance Director during the			same deficient practice will l		
	exit conference.				identified and what correctiv	e	
					action will be taken:		
	3.1-19(b)				All other PPE carts have been		
					inspected and any cart found i		
					to code have been removed a		
	I			ı	discarded along with new PPI	-	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVE COMPLETED 12/08/2022		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPROPRIATE	(X5) PLETION DATE	
IAU	REGULATORY OF	A LOC IDENTIFITING INFORMATION	IAG	carts provided that are equipped with wheels. What measures and w systemic changes will to ensure that the definity practice doesn't recurred. Re-education to be provided facility staff by Executive and/or designee prior to compliance to ensure understanding and improper equipment in the blocking any means of How the corrective act be monitored to ensure deficient practice will i.e., what quality assurprogram will be put in Executive Director and/designee will conduct a mentioned areas 1x per weeks, then 1x per mor months, and then quart 100% compliance is act Any issues identified with immediately addressed. The results of these revisions discussed at the month Quality Assurance Commeeting monthly for a tomoths and then quarte thereafter once complianted thereafter once complianted in 100%. Frequency and reviews will be increase needed, if compliance in 100%. Compliance date: 01/07 Administrator at Hammond-Whiting Carresponsible in ensuring	that the made cient the wided to the Director to date of the halls, and the egress tion will the the the mot recur, trance place: tor udits of the week for 4 the for 3 the for 3 the field will the week for 4 the for 3 the for 3 the field will the will be the motion of the field as the field will be the motion of the field as the field will be the field	ZALE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLI			ETED	
		155423	B. WI	NG		12/08/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				14TH ST		
HAMMON	ND-WHITING CARE	CENTER			IG, IN 46394		
77.0.75			1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					compliance in this Plan of Correction.		
					Correction.		
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01	Exit Signage						
ŭ	2012 EXISTING						
		al signs are displayed in					
		.10 with continuous					
	illumination also se	erved by the emergency					
	lighting system.						
	19.2.10.1						
	(Indicate N/A in or						
	occupancies with I	less than 30 occupants					
		exit travel is obvious.)					
		on and interview, the facility	K 0293		This plan of correction is prepa	ared	01/07/2023
	failed to ensure 1 of				and executed because the		
		nated. This deficient practice			provisions of state and federal law		
		10 residents and staff on the			require it and not because		
	South Hall				Hammond-Whiting Care Cente		
	T 1 1 1 1 1				agrees with the allegations and		
	Findings include:				citations listed. Hammond-Whi	•	
	D1				Care Center maintains that the	;	
		ons on 12/08/22 during a tour 12:50 p.m. to 1:44 p.m. with the			alleged deficiencies do not	L £	
	•	or and Executive Director, the			jeopardize the health and safe the residents nor is it of such	ty oi	
		next to the nurses station was				20	
		sed on an interview with the			character to limit our capabilitie to render adequate care. Pleas		
		or at the time of observation, it			accept this plan of correction a		
		ign light was planned to be			our credible allegation of	13	
		ave the parts for replacement.			compliance that the alleged		
					deficiencies have or will be con	rect	
	Findings were discu	ssed with the Executive			by the date indicated to remain		
		enance Director at exit			compliance with state and fede		
	conference.				regulations, the facility has tak		
					or will take the actions set forth		
	3.1.19(b)				this plan of correction. We		
					respectfully request a desk rev	iew.	
					_		
					K293 – Exit Signage		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/08/2022	
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY UN	LISC IDENTIF LING INFORMATION	IAG	What Corrective Action will accomplished for those residents found to have bee affected by this deficient practice: The Exit sign was fixed, so the sign is visible and illuminated properly. How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken: All other Exit signs were review with no issues identified. What measures and what systemic changes will be more to ensure that the deficient practice doesn't recur: Re-education to be provided maintenance staff by Executive Director and/or designee priodate of compliance to ensure understanding and importance properly lit signage and fire set How the corrective action where the deficient practice will not refice, what quality assurance program will be put in place executive Director and/or designee will conduct audits of months until 100% compliant is achieved. Any issues identified will be immediately addressed. The results of these reviews will discussed at the monthly facilied Quality Assurance Committee meeting monthly for a total of the set of the set of total of the set of	the he be wed ade ade afety. iill cur, : of h for noce fied d will be iity e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423			A. BUILDING <u>01</u> COM			(X3) DATE COMPL 12/08/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					months and then quarterly thereafter once compliance is 100%. Frequency and duratio reviews will be increased as needed, if compliance is below 100%. Compliance date: 01/07/2023. Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	n of v The	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric Contional Fire Alari Records of system and testing are respected to maintain that it had accurate accordance with the 2012 edition, Sectionactic could affect visitors. Findings include: Based on observational districts accordance with the 2012 edition, Sectionactic could affect visitors.	m is tested and maintained in an approved program recovered progra	K 0	345	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilities represented.	law er d iting e ty of	01/07/2023
	_	at 1:26 p.m. during a tour of the			to render adequate care. Plea		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	ETED
		155423	B. W	ING		12/08/2	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			14TH ST		
HAMMON	ND-WHITING CARE	ECENTER			NG, IN 46394		
	T				-, - ··	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		the time and date on the fire			our credible allegation of		
alarm control panel were incorrect. The display on				compliance that the alleged			
		control panel indicated the date			deficiencies have or will be co		
		4/91 at 14:29 p.m. Based on			by the date indicated to remain	I	
		e of observation, the			compliance with state and fed		
		for indicated he was unaware			regulations, the facility has tak	I	
		and would contact the alarm			or will take the actions set fort	n in	
		e displayed date and time			this plan of correction. We	viou:	
	updated on the fire	alarm control panel.			respectfully request a desk rev	view.	
	This finding was reviewed with the Maintenance				- K345 Fire Alarm System -		
		tive Director at the exit			Testing and Maintenance		
	conference.				What Corrective Action will I	be	
					accomplished for those		
	2. Based on record	review and interview, the			residents found to have been	n	
	facility failed to ens	sure 1 of 1 fire alarm systems			affected by this deficient		
	was maintained in a	accordance with LSC 9.6.1.3.			practice:		
	LSC 9.6.1.3 require	s a fire alarm system to be			SafeCare was contacted and		
	installed, tested, and	d maintained in accordance			assisted in the updating of the	;	
	with NFPA 70, Nat	ional Electrical Code and NFPA			date and time of our fire panel	l.	
	72, National Fire A	larm Code. NFPA 72, Section			How other residents having	the	
	14.4.5 states unless	otherwise permitted by other			potential to be affected by th	ne e	
	sections of this Cod	le, testing shall be performed			same deficient practice will l	be	
		the schedules in Table 14.4.5,			identified and what corrective	⁄e	
		uired by the authority having			action will be taken:		
	l *	72, Section 14.4.5.3.1 states			Maintenance Director was		
		sitivity shall be checked within			educated on the fire panel and	b	
	l -	tion. NFPA 72, 14.4.5.3.2 states			how to update the system in		
		sitivity shall be checked every			house.		
	· ·	after unless otherwise			What measures and what		
		iance with Section 14.4.5.3.3.			systemic changes will be ma	ade	
	This deficient pract	ice could affect all occupants.			to ensure that the deficient		
					practice doesn't recur:		
	Findings include:				Re-education to be provided to		
					maintenance staff by Executiv		
		view with the Maintenance			Director and/or designee prior	to	
		2 between 9:47 a.m. and 12:45			date of compliance to ensure		
		test documented for 4/13/21			understanding and importance		
	1	g", but had no marked			proper date and time on pane	1	
	sensitivity point on	the inspection report. Based			How the corrective action will	ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155423	B. WI	NG		12/08/	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			14TH ST		
	ND-WHITING CAR	E CENTED			NG, IN 46394		
TIAMMO	ND-WHITING CAN	LE CENTER		VVIIIIIV	NG, IN 40394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	on interview at the	time of record review, the			be monitored to ensure the		
	Maintenance Director acknowledged the				deficient practice will not red	cur,	
aforementioned condition and would contact the				i.e., what quality assurance			
	contracted entity.				program will be put in place:	!	
					Executive Director and/or		
		eviewed with the Executive			designee will conduct audits o	f fire	
	Director and Main	tenance Director at the exit			panel cabinet 1x per month fo	r 6	
	conference.				months until 100% compliance	e is	
	3.1-19(b)				achieved. Any issues identifie	d will	
					be immediately addressed		
					The results of these reviews w	<i>i</i> ill be	
					discussed at the monthly facili	ty	
					Quality Assurance Committee		
					meeting monthly for a total of	3	
					months and then quarterly		
					thereafter once compliance is	at	
					100%. Frequency and duration	n of	
					reviews will be increased as		
					needed, if compliance is below	V	
					100%.		
					Compliance date: 01/07/23. T	he	
					Administrator at		
					Hammond-Whiting Care Cent	er is	
					responsible in ensuring		
					compliance in this Plan of		
					Correction.		
					This plan of correction is prepared	ared	
					and executed because the		
					provisions of state and federal	law	
					require it and not because		
					Hammond-Whiting Care Cent		
					agrees with the allegations an		
					citations listed. Hammond-Wh	_	
					Care Center maintains that the	9	
					alleged deficiencies do not		
					jeopardize the health and safe	ty of	
					the residents nor is it of such		
					character to limit our capabiliti		
					I IO FEDRAL SARCHISTA CORA DICO	C 🗅	•

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		A. BUILDING B. WING	01	COMPLETED 12/08/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				accept this plan of correction a our credible allegation of compliance that the alleged deficiencies have or will be coby the date indicated to remain compliance with state and fediregulations, the facility has take or will take the actions set forth this plan of correction. We respectfully request a desk reverse to the set of this plan of correction. We respectfully request a desk reverse to the set of this plan of correction. We respectfully request a desk reverse to the set of this plan of correction. We respectfully request a desk reverse to the set of this plan of correction will be accomplished for those residents found to have been affected by this deficient practice: SafeCare was contacted and we be preforming another sensitive test and completing form entire and will properly mark sensitive points on the inspection report Inspection is scheduled for 1/3/2023. How other residents having to the protection will be taken: Maintenance Director was educated on the importance of properly marked sensitivity points completed reports. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: Re-education to be provided to maintenance staff by Executive maintenance staff by Executive to the set of the secutive to the provided to the maintenance staff by Executive to the set of the secutive to the provided to the maintenance staff by Executive to the set of the secutive to the secu	rrect n in eral eral en h in view. be n will vity ely, ity : the ee be f ints	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY LETED 3/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	(X5) COMPLETION DATE		
K 0346	NEDA 101			Director and/or designed date of compliance to e understanding and imp fully completed reports contracted entities. How the corrective ac be monitored to ensure deficient practice will i.e., what quality assure program will be put in Executive Director and designee will conduct a inspection tests/reports 100% compliance is ac Any issues identified with immediately addressed. The results of these rediscussed at the month Quality Assurance Conmeeting monthly for a temporal months and then quarte thereafter once compliance in the compliance in 100%. Compliance date: 01/01 Administrator at Hammond-Whiting Carresponsible in ensuring compliance in this Plant Correction.	ensure ortance of by tion will re the not recur, rance place: /or audits of to assure chieved. iill be liviews will be ally facility nmittee total of 3 erly ance is at duration of ed as is below 7/23. The			
K 0346 SS=C Bldg. 01	services for more period, the author							

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155423	B. W	ING		12/08/	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			14TH ST		
	ND-WHITING CARI	E CENTED			NG, IN 46394		
ПАІИІИО	ND-WHITING CARI	ECENTER		VVIIIIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	evacuated or an approved fire watch shall be						
	provided for all parties left unprotected by the						
	shutdown until the	e fire alarm system has					
	been returned to	service.					
	9.6.1.6						
	Based on record rev	view and interview, the facility	K 0	346	This plan of correction is prepa	ared	01/07/2023
	_	complete 1 of 1 written policy			and executed because the		
	_	f residents indicating			provisions of state and federal	law	
	_	llowed in the event the fire			require it and not because		
		be placed out of service for			Hammond-Whiting Care Cente	er	
		in a twenty four hour period in			agrees with the allegations an	d	
	accordance with LSC, Section 9.6.1.6. This				citations listed. Hammond-Wh	iting	
	deficient practice affects all occupants.				Care Center maintains that the	9	
					alleged deficiencies do not		
	Findings include:				jeopardize the health and safe	ty of	
					the residents nor is it of such		
		eview with the Maintenance			character to limit our capabiliti		
		21 at 9:35 a.m., the fire watch			to render adequate care. Plea		
	_	de contacting the Indiana			accept this plan of correction a	as	
	_	lth via the IDOH Gateway link			our credible allegation of		
		sdh.in.gov as the primary			compliance that the alleged		
	1	econdary method when the			deficiencies have or will be co		
	1	nonoperational by completing			by the date indicated to remain		
	_	ing form and e-mailing it to			compliance with state and fed		
		gov. Based on interview during			regulations, the facility has tak		
		he Maintenance Director			or will take the actions set fort	h in	
	_	ire watch documentation			this plan of correction. We		
	_	contact the IDOH but not via			respectfully request a desk rev	/iew.	
	_	link or at the e-mail address			-		
	listed above.				K346 Fire alarm System – Ou	<u>ıt</u>	
	This fact	ani arang di ani da da a Ta			of Service	L_	
	_	viewed with the Executive			What Corrective Action will k	pe	
		enance Director during the exit			accomplished for those	_	
	conference.				residents found to have been	7	
	2 1 10(b)				affected by this deficient		
	3.1-19(b)				practice:	aail	
					Gateway link, and backup E-m	idli	
					will be added to	or'o	
					Hammond-Whiting Care Center	ers	
	1				Fire watch Policy		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		A. BUILDING B. WING	01	COMPLETED 12/08/2022	
	ROVIDER OR SUPPLIEF		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken: The Fire watch Policy will be updated, and inspected for compliance by Jensen Hugher What measures and what systemic changes will be measure to ensure that the deficient practice doesn't recur: Re-education to be provided a facility staff by Executive Direction and/or designee prior to date compliance to ensure understanding of the Fire wate Policy, How the corrective action we be monitored to ensure the deficient practice will not reside, what quality assurance program will be put in place executive Director and/or designee will conduct audits of Emergency preparedness bin and Fire watch Policy 1x permonth for 6 months until 1009 compliance is achieved. Any issues identified will be immediately addressed. The results of these reviews we discussed at the monthly facil Quality Assurance Committee meeting monthly for a total of months and then quarterly thereafter once compliance is 100%. Frequency and durative reviews will be increased as peeded, if compliance is below.	he be ve

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423 A. BUILDING B. WING		COMPLETED 12/08/2022				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
				100%. Compliance date: 01/07/23. The Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.			
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II construction measures where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and the closet footprint Standard for Install Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1	Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler Instruction, alternative hes are permitted to be inkler protection in specific for local regulations prohibit had are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers as required by NFPA 13, llation of Sprinkler 19.3.5.3, 19.3.5.4, 9.3.5.10, 9.7, 9.7.1.1(1)					
	failed to ensure only i.e. quick response of installed in 1 of 4 sr 2010 Edition, Install Section 8.3.3.2 state sprinklers are install	on and interview, the facility one type of sprinkler head or standard sprinklers were noke compartments. NFPA 13, lation of Sprinkler Systems, s where quick-response led, all sprinklers within a be quick-response unless	K 0351	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the	law er d iting		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155423	B. W	B. WING 12/08/2022			2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L					
11004040	ND WUITING OADI	CENTED			14TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	otherwise permitted	l in Section 8.3.3.3 Section			alleged deficiencies do not		
	8.3.3.4 states when	existing light hazard systems			jeopardize the health and safe	etv of	
		e quick response or residential			the residents nor is it of such	, l	
		klers in a compartmented space			character to limit our capabiliti	es	
		This deficient practice could			to render adequate care. Plea		
	_	lents in 1 smoke compartment.			accept this plan of correction a		
					our credible allegation of		
	Findings include:				compliance that the alleged		
					deficiencies have or will be co	rrect	
	Based on observation	on during a tour of the facility			by the date indicated to remain		
		ce Director and the Executive			compliance with state and fed		
		2 between 12:50 p.m. and 1:44			regulations, the facility has tak		
		nse spinkler head was located			or will take the actions set fort		
		orridor, which contained			this plan of correction. We	'''''	
		prinkler heads; near the exit			respectfully request a desk rev	view	
		interview at the time of			respectfully request a desk fe	/ICW.	
		aintenance Director			- K351 Sprinkler System -		
		mentioned condition and			Installation		
		mixed response heads.			What Corrective Action will I	ho	
	agreed there was a r	inxed response neads.			accomplished for those	,,,	
	Findings were disci	assed with the Administrator			residents found to have been	,	
	_	irector at exit conference.			affected by this deficient	<i>'</i>	
	una mantenance B	nector at exit conference.			practice:		
	3.1-19(b)				SafeCare was contacted and	sent	
	3.1 17(0)				a technician to inspect South		
					sprinkler heads, and found all		
					be Standard response time. A		
					letter of declaration has been		
					written in response confirming	that	
					all sprinkler heads in south ha		
				an sprinkler neads in south ha			
					the only difference is the reflect	JUI	
					plates.	4h.a	
					How other residents having		
					potential to be affected by the		
					same deficient practice will l		
					identified and what corrective	e	
					action will be taken:		
					No resident was affected.		
					What measures and what		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/08/2022		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
HAMMOI	ND-WHITING CARE	CENTER		1000 11 WHITIN	41H ST G, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		TAG	systemic changes will be may to ensure that the deficient practice doesn't recur: Maintenance director was educated by SafeCare on identifying the different bulbs of the sprinkler heads and how to confirm whether the sprinkler heads are in fact standard, or quick release heads How the corrective action with be monitored to ensure the deficient practice will not recipe, what quality assurance program will be put in place. Executive Director and/or designee will conduct audits of any changed sprinkler heads assure all are standard or quick release in the future to assure 100% compliance. Any issues identified will be immediately addressed The results of these reviews will discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of months and then quarterly thereafter once compliance is 100%. Frequency and duration reviews will be increased as needed, if compliance is below 100%. Compliance date: 01/07/23. Total compliance date: 01/07/23. Total compliance in this Plan of Correction.	on of the late of	DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/08/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record reversaled to ensure a further performed on 1 of 2 systems that were in by NFPA 25, 2011 Inspection, Testing Water-Based Fire P 14, Obstruction Prerequires systems should be obstructed piper an obstruction investors in the condition of pipin states if the condition is one obstruction of pipin obstruction	supply source RKS information on non-required or partial or system. and NFPA 25 view and interview, the facility automatic sprinkler piping internally inspected as required edition, the Standard for the and Maintenance of rotection Systems in Chapter vention. Section 14.3.2 all be examined for internal conditions exist that could bring. Section 14.3.3, states if stigation indicates the int material to obstruct pipe or ete flushing program shall be fied personnel. Section 14.3.1 on has not been corrected or	K 0353	This plan of correction is prepand executed because the provisions of state and federa require it and not because Hammond-Whiting Care Centagrees with the allegations are citations listed. Hammond-Wit Care Center maintains that the alleged deficiencies do not jeopardize the health and saft the residents nor is it of such character to limit our capabilit to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be copy the date indicated to rema compliance with state and federal care.	at law ter nd niting ne ety of ties ase as orrect in in		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 12/08/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		
TAG		LSC IDENTIFYING INFORMATION examined internally for	TAG	regulations, the facility has ta	DATE	
	-	years. This deficient		or will take the actions set for		
	•	t all residents, as well as staff		this plan of correction. We	u	
	and visitors in the fa			respectfully request a desk re	view	
				K353 Sprinkler System –		
	Findings include:			Maintenance and testing		
	C			What Corrective Action will be	e	
	Based on review of	the 5-year Internal Pipe		accomplished for those reside		
		12/08/22 at 11:19 a.m. with		found to have been affected b		
	the Maintenance Di	rector and Executive Director		deficient practice:		
	present, the sprinkle	er report dated 07/13/22 stated		Safe care was contacted to		
	system #1 "Found that system is full of rust scale			schedule a full system flush.	They	
	and needs to be flushed". The Maintenance			provided a quote as well as a	letter	
	Director acknowledged what the 07/13/22			of notification that the reques	ted	
		ated and said the flush had		work cannot be completed un	til	
	been done, but coul			the spring. SafeCare has		
		he flush. Maintenance		scheduled the flush for May 1		
		the sprinkler vendor had been		2023. A completed Life Safet		
	contacted and will f	follow up with them.		Code Waiver form, requesting	-	
				temporary waiver to May 10,	2023	
		viewed with the Executive		is submitted with this Plan of		
		enance Director at the exit		Correction to the Indiana Stat		
	conference.			Department of Health – Long	Term	
	3-1.19(b)			Care Division.		
	3-1.19(0)			How other residents having the potential to be affected by the		
				same deficient practice will be		
				identified and what corrective		
				action will be taken:		
				Sprinkler system will be flush	ed	
				out as per recommendation of		
				contracted entity		
				What measures and what		
				systemic changes will be made	de to	
				ensure that the deficient prac		
				doesn't recur:		
				SafeCare will be providing		
				inspections, and Maintenance	e	
				staff will inspect the system o	na	
				monthly basis		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COME	E SURVEY PLETED 3/2022		
	ROVIDER OR SUPPLIER		1000 1	STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE		
				How the corrective actimonitored to ensure the practice will not recur, quality assurance programmetric put in place: Executive Director and designee will conduct a wet/dry systems 1x per 6 months until 100% or is achieved. Any issues will be immediately add. The results of these rediscussed at the month Quality Assurance Commeeting monthly for a months and then quart thereafter once compliance in the compliance of the compliance date: 05/1 and the co	e deficient i.e., what gram will be I/or audits of r month for ompliance s identified dressed views will be nly facility mmittee total of 3 gerly ance is at duration of ed as is below 0/2023. The re Center is			
K 0354 SS=E Bldg. 01	extent and duration been determined, are inspected and recommendations management or durand the fire depart having jurisdiction	- Out of Service er system is impaired, the en of the impairment has areas or buildings involved risks are determined,						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/08/2022	
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	than 10 hours in a building or portion evacuated or an a provided until the returned to service 18.3.5.1, 19.3.5.1. Based on record reversiled to provide 1 of the event the automorphaced out-of-service 24-hour period in a 9.7.5. LSC 9.7.6 recorded procedures comply the Standard for the Maintenance of Was Systems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained period the affected a extinguishers and the fire department consider. During the should not only be 1 sure that the other find building such as egain are available and further deficient practice of facility. Findings include: Based on records representation of the last https://gateway.is method or by the set IDOH Gateway is met	24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0354	This plan of correction is pregand executed because the provisions of state and federa require it and not because Hammond-Whiting Care Cenagrees with the allegations and citations listed. Hammond-Whome Care Center maintains that the alleged deficiencies do not jeopardize the health and safthe residents nor is it of such character to limit our capabilit to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be on by the date indicated to remacompliance with state and federegulations, the facility has tare or will take the actions set for this plan of correction. We respectfully request a desk respectfully req	al law Iter Ind Ind Ind Ind Ind Iter Ind Ind Ind Iter Ind

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155423	B. WI	NG		12/08/2022	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	ND WUITING OAD	E OENTED			14TH ST		
HAMMO	HAMMOND-WHITING CARE CENTER			VVHIII	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	incidents@isdh.in.	gov. Based on interview during			Fire watch Policy		
	the record review,	the Maintenance Director			How other residents having	the	
	acknowledged the	fire watch documentation			potential to be affected by th		
	provided stated to	contact the IDOH but not via			same deficient practice will l		
	the IDOH Gateway	link or at the e-mail address			identified and what corrective		
	listed above.				action will be taken:		
					The Fire watch Policy will be		
	This finding was re	eviewed with the Executive			updated, and inspected for		
	Director and Maint	enance Director during the exit			compliance by Jensen Hughe	s.	
	conference.				What measures and what		
					systemic changes will be ma	nde	
	3.1-19(b)				to ensure that the deficient		
					practice doesn't recur:		
					Re-education to be provided to	o	
					facility staff by Executive Direct	otor	
					and/or designee prior to date	of	
					compliance to ensure		
					understanding of the Fire water	ch	
					Policy,		
					How the corrective action wi	ili	
					be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance		
					program will be put in place:	,	
					Executive Director and/or		
					designee will conduct audits o	f	
					Emergency preparedness bind	der,	
					and Fire watch Policy 1x per		
					month for 6 months until 100%	Ó	
				compliance is achieved. Any			
				issues identified will be			
				immediately addressed			
				The results of these reviews w			
				discussed at the monthly facili	-		
					Quality Assurance Committee		
				meeting monthly for a total of	3		
					months and then quarterly		
					thereafter once compliance is		
					100%. Frequency and duration	n of	
				reviews will be increased as			

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, ´		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLET			ETED
		155423	B. WI	NG		12/08/2	2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					needed, if compliance is below 100%. Compliance date: 01/07/23. To Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.	he	
K 0355	NFPA 101						
SS=E	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extir						
	Portable fire exting	guishers are selected,					
	installed, inspecte	d, and maintained in					
	accordance with N	IFPA 10, Standard for					
	Portable Fire Extinguishers.						
	18.3.5.12, 19.3.5.						
		on and interview, the facility	K 0.	355	This plan of correction is prepared	ared	01/07/2023
	_	f 2 portable fire extinguishers			and executed because the		
		month. NFPA 10, Standard for			provisions of state and federal	l law	
	_	guishers, Section 7.2.1.2 states			require it and not because		
	_	nall be inspected either			Hammond-Whiting Care Cent		
		ns of an electronic device /			agrees with the allegations an		
	· ·	m of 30-day intervals. Section			citations listed. Hammond-Wh	_	
	_	inspection or electronic			Care Center maintains that the	e	
	_	xtinguishers shall include a			alleged deficiencies do not		
	check of at least the	-			jeopardize the health and safe	-	
	(1) Location in desi				the residents nor is it of such		
		o access or visibility			character to limit our capabiliti		
		reading or indicator in the			to render adequate care. Plea		
	operable range or po	ined by weighing or hefting for			accept this plan of correction a	15	
	self expelling-type				our credible allegation of		
		extinguishers, and pump tanks			compliance that the alleged deficiencies have or will be co	rrect	
		es, wheels, carriage, hose, and			by the date indicated to remain		
	nozzle for wheeled				compliance with state and fed		
		nrechargeable extinguishers			regulations, the facility has tak		
	using pushto-test pr				or will take the actions set fort		
		es personnel making manual			this plan of correction. We		
		ep records of all fire			respectfully request a desk rev	view.	

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATIMENT OF DEPICINCIES PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGLIATORY OR LISE IDENTIFICATION INFORMATION TO Extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspections are conducted, the date the manual inspections are conducted, records for the records and to the facility with the Maintenance Director and Executive Director on 1/2/02/23. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action to be provided to Maintenance disconding the proposition of	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 12/08/2022			
PREFIX TAG REGILATORY OR I.SC IDENTIFYING INFORMATION require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspections are reconducted, records for manual inspections are conducted, records for manual inspections shall be kept on at a figure 1.2.4.4 requires where manual inspections shall be kept on at a figure 1.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on 12/08/22 between 1:55 p.m. 2.44 p.m., the monthly inspections on the k.C-alsas fire extinguisher located in the kitchen lacked documentation of monthly inspections for the past 12 months. Based on interview at the time of observation, the Maintenance Director confirmed monthly inspections on the tag of the Kclass fire extinguisher located in the kitchen were not documented. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)				1000 114TH ST				
require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on ICD8/22 between 1:55 p.m. 2:44 p.m., the monthly inspection to go on the K-class fire extinguisher located in the kitchen lacked documentation of monthly inspections on the tag of the K-class fire extinguisher located in the kitchen lacked documentation of monthly inspections on the tag of the K-class fire extinguisher located in the kitchen lacked documentation of monthly inspections on the tag of the K-class fire extinguisher located in the kitchen lacked documentation of monthly inspections to the tag of the K-class fire extinguisher located in the kitchen lacked documentation of monthly inspections on the tag of the K-class fire extinguisher located in the kitchen were not document. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)	PREFIX	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
Fire Extinguishers 1x per week for 3 months and once a month hereafter as marked in TELS to	TAG	extinguishers inspective as where at least mont conducted, the date performed and the inspection 7.2.4.4 requare conducted, reconshall be kept on a tarextinguisher, on an maintained on file, Section 7.2.4.5 requarements at the inspections have be practice could affect Findings include: Based on observation with the Maintenam Director on 12/08/2 the monthly inspect extinguisher located documentation of material part of the monthly inspections extinguisher located documented. Findings were discurbing were discurbing to the monthly inspections extinguisher located documented. Findings were discurbing were discurbing to the monthly inspections extinguisher located documented.	cted, including those found to ction. Section 7.2.4.3 requires hly manual inspections are the manual inspection was nitials of the person ection shall be recorded. The contract of the manual inspections are gor label attached to the fire inspection checklist or by an electronic method. The cords shall be kept to least the last 12 monthly en performed. This deficient at staff in the kitchen. The during a tour of the facility ce Director and Executive 2 between 1:55 p.m. 2:44 p.m., tion tag on the K-class fire d in the kitchen lacked monthly inspections for the sed on interview at the time of tintenance Director confirmed in the kitchen were not assed with the Executive	TAG	Extinguishers What Corrective Action waccomplished for those residents found to have be affected by this deficient practice: Safecare was contacted and be bringing a new tag for the K-class extinguisher on 1/3 How other residents having potential to be affected by same deficient practice widentified and what correct action will be taken: All other Extinguishers were reviewed and found to be wissues. What measures and what systemic changes will be to ensure that the deficient practice doesn't recur: Re-education to be provided Maintenance, and Kitchen Executive Director and/or designee prior to date of compliance to ensure understanding and importate Extinguisher tags and labed How the corrective actions be monitored to ensure the deficient practice will not i.e., what quality assurance program will be put in plate Executive Director and/or designee will conduct audit Fire Extinguishers 1x per will month and once a month.	ill be seen ad will he h/2023. Ing the y the hill be citive be without made ht ad to staff by nce of ling. Ing. Ing. Ing. Ing. Ing. Ing. Ing. I		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COMP	E SURVEY LETED 3/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
K 0918 SS=F Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised in the for 4 continuous hours. It is defined to the format of		assure 100% compliant achieved. Any issues in be immediately address. The results of these rediscussed at the month Quality Assurance Commeeting monthly for a months and then quart thereafter once compliance. Frequency and reviews will be increas needed, if compliance 100%. Compliance date: 01/0 Administrator at Hammond-Whiting Carresponsible in ensuring compliance in this Plant Correction.	dentified will seed views will be only facility mmittee total of 3 serly ance is at I duration of ed as is below 17/23. The		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423		ILDING			(X3) DATE SURVEY COMPLETED 12/08/2022	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		
	loads, and are corpersonnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requof maintenance ar and readily availal and circuits are m and separate from Minimizing the poemergency power consideration for reference of the consideration for reference on the consider	(NFPA 99), NFPA 110, O (NFPA 70) View and interview, the facility of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least three years. Where the eater than 4 hours, it shall be attented the test after 4 hours. 4.1.1.6.1 states that Type 1 and extrical system power sources to Type 10, Class X, Level 1 is deficient practice could	K 09	918	This plan of correction is prepared executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleas accept this plan of correction a our credible allegation of compliance that the alleged deficiencies have or will be conby the date indicated to remain compliance with state and feder regulations, the facility has tak or will take the actions set forth this plan of correction. We	law er d iting e ty of es se as rrect n in eral en	01/07/2023	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
		155423	B. WING 12/08		/2022		
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t		1	14TH ST		
 I∩MMAH	ND-WHITING CARE	- CENTER			IG, IN 46394		
1 1/ (10110101	rie Williamo OAM						.
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LISC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY) DATI		
	~	d within the last 36 months			respectfully request a desk rev		
		or review. Based on interview			-		
		ds review, the Maintenance			K918 Electrical systems –		
	Director stated they				Essential Electric System		
	documentation for a	a 4 hour load test.		What Corrective Action will be		be	
	TE1 ' C' 1'	. 1 M d = 2		accomplished for those			
		viewed with the Executive		residents found to have been			
		enance Director at the exit		affected by this deficient			
	conference.			practice:			
	2.1.10(1)				After further investigation with		
	3.1-19(b)				Safecare we have located		
				paperwork for the 4 hour test			
				completed 03/26/2020 and would			
				not need another until 2023 (every			
					3 years)		
					How other residents having		
					potential to be affected by the		
				same deficient practice will be			
				identified and what corrective			
				action will be taken:			
				No Residents were affected. What measures and what			
					systemic changes will be ma to ensure that the deficient	iae	
					practice doesn't recur:		
					Safecare was able to find the		
					proper documentation previou	elv	
						-	
					not provided, and also schedu 4 hour test for the year 2023.	iicu d	
					How the corrective action wi	ill	
					be monitored to ensure the		
					deficient practice will not red	rur	
					i.e., what quality assurance	· · · · · ·	
					program will be put in place:		
					Found to be 100% compliant.		
					review all documentation to ensure		
					any inspections completed are		
					properly filed, and reviewed.	-	
				The results of these reviews w	ill be		
				discussed at the monthly facili			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/08/2022			
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRE CROSS-REFERE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE	
					Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is 100%. Frequency and duratio reviews will be increased as needed, if compliance is below 100%. Compliance date: 01/07/23. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	at n of v		

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