STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING -- B. WING	12/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/08/22 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Emergency Preparedness survey, Hammond-Whiting Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 80 and had a census of 59 at the time of this survey. Quality Review completed on 12/12/22	E 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 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/08/22 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Verna Meacham	Executive Director	01/06/2023

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	At this Life Safety Code survey, Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 59 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/12/22		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.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections	K 0211	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because	01/07/2023

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	into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects at least 15 residents on the South Hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Executive Director 12/08/22 between 12:50 and 1:44 p.m., in South Hall corridor, Personal Protective Equipment (PPE) carts were in use but 4 were not equipped with wheels allowing the carts to be move out of the halls during an emergency. Based on an interview at the time of observations, the Maintenance Director stated most of the carts had wheels, but the 4 located did not have them and would replace them. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		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. **K211 – Means of Egress - General** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The 4 PPE carts in which were found unequipped with wheels have been replaced by carts that are properly equipped with wheels. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other PPE carts have been inspected and any cart found not to code have been removed and discarded, along with new PPE	

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			carts provided that are properly equipped with wheels. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to facility staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of proper equipment in the halls, and blocking any means of egress ***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:*** Executive Director and/or designee will conduct audits of mentioned areas 1x per week for 4 weeks, then 1x per month for 3 months, and then quarterly until 100% compliance is achieved. Any issues identified will be immediately addressed 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: 01/07/2023. The Administrator at Hammond-Whiting Care Center is responsible in ensuring	

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			compliance in this Plan of Correction.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 10 exit signs were continuously illuminated. This deficient practice could affect at least 10 residents and staff on the South Hall Findings include: Based on observations on 12/08/22 during a tour of the facility from 12:50 p.m. to 1:44 p.m. with the Maintenance Director and Executive Director, the South Hall exit sign next to the nurses station was not illuminated. Based on an interview with the Maintenance Director at the time of observation, it was stated the exit sign light was planned to be replaced and they have the parts for replacement. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1.19(b)	K 0293	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. **K293 – Exit Signage**	01/07/2023

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			What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: The Exit sign was fixed, so the sign is visible and illuminated properly. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other Exit signs were reviewed with no issues identified. ***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 Director and/or designee prior to date of compliance to ensure understanding and importance of properly lit signage and fire safety. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of mentioned areas 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3	

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			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: 01/07/2023. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 12/08/22 at 1:26 p.m. during a tour of the facility with the Maintenance Director and	K 0345	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	01/07/2023

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	Executive Director, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 08/04/91 at 14:29 p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 12/08/22 between 9:47 a.m. and 12:45 p.m., the sensitivity test documented for 4/13/21 had devices "passing", but had no marked sensitivity point on the inspection report. Based		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. **K345 Fire Alarm System – Testing and Maintenance** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** SafeCare was contacted and assisted in the updating of the date and time of our fire panel. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** Maintenance Director was educated on the fire panel and how to update the system in house. ***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 Director and/or designee prior to date of compliance to ensure understanding and importance of proper date and time on panel. ***How the corrective action will***	

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	on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and would contact the contracted entity. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		***be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of fire panel cabinet 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction. 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	

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			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. **K345 (2) Fire Alarm System – Testing and Maintenance** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** SafeCare was contacted and will be preforming another sensitivity test and completing form entirely, and will properly mark sensitivity points on the inspection report. Inspection is scheduled for 1/3/2023. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** Maintenance Director was educated on the importance of properly marked sensitivity points and 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	

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			Director and/or designee prior to date of compliance to ensure understanding and importance of fully completed reports by contracted entities. ***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:*** Executive Director and/or designee will conduct audits of inspection tests/reports to assure 100% compliance is achieved. Any issues identified will be immediately addressed 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: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be			

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	evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director on 12/29/21 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0346	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. **K346 Fire alarm System – Out of Service** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Gateway link, and backup E-mail will be added to Hammond-Whiting Care Center's Fire watch Policy	01/07/2023

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			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The Fire watch Policy will be updated, and inspected for compliance by Jensen Hughes. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to facility staff by Executive Director and/or designee prior to date of compliance to ensure understanding of the Fire watch 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:*** Executive Director and/or designee will conduct audits of Emergency preparedness binder, and Fire watch Policy 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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	

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			100%. Compliance date: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 4 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless	K 0351	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	01/07/2023

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	otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect up to 20 residents in 1 smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 12/08/22 between 12:50 p.m. and 1:44 p.m., a quick response spinkler head was located in the South Hall corridor, which contained standard response sprinkler heads; near the exit doors. Based on an interview at the time of observations, the Maintenance Director concurred the aforementioned condition and agreed there was a mixed response heads. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		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. **K351 Sprinkler System - Installation** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** SafeCare was contacted and sent a technician to inspect South Unit sprinkler heads, and found all to be Standard response time. A letter of declaration has been written in response confirming that all sprinkler heads in south hall are in fact standard release and the only difference is the reflector plates. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** No resident was affected. ***What measures and what***	

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			systemic changes will be made to ensure that the deficient practice doesn't recur: Maintenance director was educated by SafeCare on identifying the different bulbs on the sprinkler heads and how to confirm whether the sprinkler heads are in fact standard, or quick release heads ***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:*** Executive Director and/or designee will conduct audits of fire of any changed sprinkler heads to 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 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: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed,	K 0353	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	05/10/2023

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	the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the 5-year Internal Pipe Inspection report on 12/08/22 at 11:19 a.m. with the Maintenance Director and Executive Director present, the sprinkler report dated 07/13/22 stated system #1 "Found that system is full of rust scale and needs to be flushed". The Maintenance Director acknowledged what the 07/13/22 inspection report stated and said the flush had been done, but could not provide any documentation for the flush. Maintenance Director stated that the sprinkler vendor had been contacted and will follow up with them. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3-1.19(b)		regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. K353 Sprinkler System – Maintenance and testing What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: Safe care was contacted to schedule a full system flush. They provided a quote as well as a letter of notification that the requested work cannot be completed until the spring. SafeCare has scheduled the flush for May 1, 2023. A completed Life Safety Code Waiver form, requesting a temporary waiver to May 10, 2023 is submitted with this Plan of Correction to the Indiana State Department of Health – Long Term Care Division. 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 flushed out as per recommendation of contracted entity What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: SafeCare will be providing inspections, and Maintenance staff will inspect the system on a monthly basis	

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			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: Executive Director and/or designee will conduct audits of wet/dry systems 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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: 05/10/2023. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0354 SS=E Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more			

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	than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director on 12/29/21 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to	K 0354	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. **K354 Sprinkler System – Out of Service** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Gateway link, and backup E-mail will be added to Hammond-Whiting Care Center's	01/07/2023

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	incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		Fire watch Policy ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The Fire watch Policy will be updated, and inspected for compliance by Jensen Hughes. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to facility staff by Executive Director and/or designee prior to date of compliance to ensure understanding of the Fire watch 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:*** Executive Director and/or designee will conduct audits of Emergency preparedness binder, and Fire watch Policy 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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	

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			needed, if compliance is below 100%. Compliance date: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 2 portable fire extinguishers in the kitchen each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire	K 0355	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.	01/07/2023

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	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 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 12/08/22 between 1:55 p.m. 2:44 p.m., the monthly inspection tag on the K-class 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 K-class 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)		**K355 Portable Fire Extinguishers** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Safecare was contacted and will be bringing a new tag for the K-class extinguisher on 1/3/2023. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other Extinguishers were reviewed and found to be without issues. ***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, and Kitchen staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of Extinguisher tags and labeling. ***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:*** Executive Director and/or designee will conduct audits of Fire Extinguishers 1x per week for 3 months and once a month hereafter as marked in TELS to	

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			assure 100% compliance is achieved. Any issues identified will be immediately addressed 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: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: During records review with the Maintenance Director on 12/08/22 at 11:51 a.m., documentation of a four hour run test for the emergency	K 0918	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	01/07/2023

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	generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director stated they could not locate documentation for a 4 hour load test. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		respectfully request a desk review. **K918 Electrical systems – Essential Electric System** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** After further investigation with 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 the 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 made to ensure that the deficient practice doesn't recur:*** Safecare was able to find the proper documentation previously not provided, and also scheduled a 4 hour test for the year 2023. ***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:*** Found to be 100% compliant. Will review all documentation to ensure any inspections completed are properly filed, and reviewed. The results of these reviews will be discussed at the monthly facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	12/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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: 01/07/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	