| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/18/2016 |
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| HAMMOND-WHITING CARE CENTER | 1000 114TH ST<br>WHITING, IN 46394 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00198000.<br><br>This visit was in conjunction with the Recertification and State Licensure Survey.<br><br>Complaint IN00198000 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.<br><br>Survey dates: April 11, 12, 13, 14, 15 and 18, 2016<br><br>Facility number: 000365<br>Provider number: 155423<br>Aim number: 100287460<br><br>Census bed type:<br>SNF/NF: 71<br>Total: 71<br><br>Census payor type:<br>Medicare: 20<br>Medicaid: 43<br>Other: 8<br>Total: 71<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | Please reference the enclosed 2567 as "Plan of Correction" for the April 18, 2016 Complaint Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.The Plan of Correction submitted on May 2, 2016 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.Respectfully, Kimberly ReadyExecutive Director | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| | Quality review completed by 32883 on 4/21/16. | | | |
| F 0441<br>SS=E<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or | | | |

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| | their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure infection control was maintained related to the storage of urinals, wash basins, and bed pans. The facility also failed to ensure uncontained soiled linens were not left lying on the floor on 2 of 2 units. (The North and South units) (Resident #B)<br><br>Findings include:<br><br>1. On 4/12/16 at 8:39 a.m., Room 205 was observed with two dirty hospital gowns, three wet wash cloths and two towels on the floor by a chair. At that time, there was also a urinal observed on the floor with no lid and full of urine by Resident #B's bed. There were two residents who resided in the room.<br><br>On 4/12/16 at 8:42 a.m., Resident #B was observed sitting by the Nurses' station. At that time, the resident was observed with an indwelling foley catheter. | F 0441 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The urinals in room 205 (Resident #B), bathroom of room 102, and room 223 have been discarded and replaced with new urinals that are now labeled and stored in a sanitary manner within residents' rooms in accordance with facility policy by the DON and/or designee.The wash basins in the bathroom of room 102 and on the counter top in room 201 have been discarded and replaced with new wash basins that are now labeled and stored in a sanitary manner within the residents' rooms in accordance with facility policy by the DON and/or designee.The bedpan in room 105 has been discarded and replaced with a new bedpan that is now labeled and stored in a sanitary manner with the resident's room in accordance with facility policy by the DON and/or designee.Upon identification by CNA of uncontained soiled linens lying on | 05/18/2016 |

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| | Interview with the Staff Development Nurse on 4/15/16 at 2:36 p.m., indicated the linens should not have been left on the floor. She further indicated Resident #B had a foley catheter and was not capable of emptying his own catheter. She further indicated the CNA's would have had to do that for him.<br><br>The current and undated Bed Making policy provided by the Staff Development Nurse on 4/18/16 at 9:35 a.m., indicated "The following procedure will be adhered to when performing any type of bed making. Do not place soiled linen on the floor. As you remove it, place it into the container you are using for soiled linen/laundry."<br><br>2. During the Environmental Tour on 4/15/16 at 1:30 p.m., with the Administrator, Maintenance Supervisor, and the Housekeeping Supervisor the following was observed:<br><br>North Unit<br><br>a. There was a pink wash basin stored on the floor and a urinal hanging from the toilet seat riser in the bathroom of Room 102, both were uncovered. Four | | the floor in room 205, staff member properly removed items from resident's room as per facility policy.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:Per completion of room audits by Executive Director, any unlabeled resident care equipment was immediately discarded and new items redistributed. No issues were identified via this audit with uncontained soiled linens lying on the floor.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Facility staff will be re-educated by the Staff Development Coordinator and/or DON by May 18, 2016 relating to proper storage of wash basins, urinals, and bed pans along with not placing uncontained soiled linen on the floor prior to removing from residents' room as per facility policy.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:For the next 6 months, department managers to complete weekly rounds on various shifts for 5 resident rooms to validate infection control is maintained related to the storage of wash basins, urinals, and bed pans along with ensuring uncontained soiled linens are not left lying on the floor as per facility policy. Any issues identified will | |

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| | residents shared this bathroom.<br><br>b. There was a bedpan stored on the chair next to the bed and a urinal stored on the bedside table in Room 105, both were uncovered. Two residents shared this room.<br><br>3. South Unit<br><br>a. There was a pink wash basin stored on the counter top uncovered in Room 201. Two residents shared this room.<br><br>b. There was a uncovered urinal stored on the bedside table in Room 223. Two residents shared this room.<br><br>Review of the current and undated Offering And Removing The Urinal Policy provided by the Staff Development Nurse on 4/18/16 at 9:35 a.m., indicated ..."Clean the urinal. Wipe dry with a clean paper towel. Discard paper towel in waste paper receptacle. Store the urinal. Do not leave it in the bathroom or on the floor." Infection control measures were to clean and store equipment after use.<br><br>Interview with the Administrator at the time, indicated the above were improperly stored. | | be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. | |

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| | This Federal Tag relates to Complaint IN00198000.<br><br>3.1-18(b)(1) | | | |