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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	06/21/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00403028, IN00407586, and IN00410149. Complaint IN00403028 - No deficiencies related to the allegations are cited. Complaint IN00407586 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00410149 - Federal/State deficiencies related to the allegations are cited at F624. Survey dates: June 20 and 21, 2023 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 8 Medicaid: 47 Other: 7 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/22/23.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Verna Meacham	Executive Director	07/07/2023

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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	A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to ensure residents' discharges to home were safe and orderly, related to lack of documented home health information, follow up Physician appointments and wound treatments for 3 of 3 residents reviewed for discharges. (Residents D, E and F) Findings include: 1. The closed record for Resident D was reviewed on 6/20/23 at 11:45 a.m. The resident was admitted to the facility on 5/16/23 and discharged home on 6/2/23. Diagnoses included, but were not limited to, convulsions, stroke, vascular dementia without behaviors, blindness in the right eye, high blood pressure, muscle weakness, history of falling, and emphysema. The Admission Minimum Data Set (MDS), dated 5/22/23, indicated the resident was moderately impaired for decision making. A Physician's Progress Note, dated 5/17/23 at 11:43 a.m., indicated the resident was admitted to the facility from the hospital after having a seizure at home. The resident had vascular dementia and was noncompliant with his medications. The resident had an unsteady gait and was admitted here for rehab (therapy). The therapy department had conducted another brief interview of mental status on 6/1/23, and deemed the resident with a slightly higher score,	F 0624	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond Whiting Care Center agrees with the allegations and citations listed. Hammond Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. - **F 624 –** Preparation for Safe/Orderly Transfer/Discharge ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident D no longer resides at facility 2. Resident E no longer resides	07/17/2023

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	but still moderately impaired for decision making. The Discharge Summary/Instructions, dated 6/2/23, indicated the resident would be discharged home and was accompanied by 2 ambulance attendants due to Medicare days being exhausted. The instructions indicated the resident should call the Physician to schedule an appointment, however, there was no phone number or name listed. Home Health for Physical and Occupational therapy as well as a rolling walker and a manual wheelchair were recommended for the resident, however, there was no information as to what company, contact name, or telephone number documented on the discharge instructions. A Nurses' Note, dated 6/2/23 at 4:20 p.m., indicated the emergency medical team arrived to the facility to transport the resident home. The resident had voiced no complaints of pain or distress at that time. The resident was given discharge paperwork, including medication scripts, and all parties were aware of the resident's discharge. Interview with the Social Service Director (SSD) on 6/21/23 at 8:51 a.m., indicated she had spoken to the resident's niece who was listed as the responsible party on 5/30/23. Because the resident was not cognitively intact, she called the niece to inform her of the insurance ending. She informed the niece that a home health agency would be set up for him for in-home services. There was no documentation on the discharge instructions regarding the home health information nor was there any documentation in the resident's clinical record she had spoken to the resident's niece regarding his discharge.		at facility 3. Resident F no longer resides at facility ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All residents scheduled to be discharged from facility have the potential to be affected. 2. Audit of all residents that have been discharged in last 30 days to be audited for completion, including follow up by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Licensed Nurses, therapy, social services, and nurse management to receive education r/t discharge process (including follow up information for PCP along with any services needed after discharge) prior to date of compliance. All newly hired staff to receive this education prior to working. 2. Social services to receive education r/t process of setting up outside services (including documentation) prior to date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance***	

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	Interview with the Director of Nursing (DON) on 6/21/23 at 9:00 a.m., indicated at the time of discharge, they print off all of the resident's medications including any treatments, and medication scripts were faxed to the pharmacy or given to the family before they leave. The discharge instructions lacked information regarding the Physician's name and number and home health information. 2. The closed record for Resident E was reviewed on 6/20/23 at 2:10 p.m. The resident was admitted to the facility on 5/25/23 and discharged home on 6/11/23. Diagnoses included, protein malnutrition, type 2 diabetes, high blood pressure, cancer, disorientation and stroke. The 5/31/23 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The Discharge Summary/Instructions, dated 6/11/23, indicated there was no information for a follow up appointment for Physician care. There was no documentation related to dietary, rehabilitation services, or nursing services. Social Services documented home health services would start on 6/12/23, however, only the name of the home health agency was listed, there was no contact name or phone information. Interview with the Social Service Director (SSD) on 6/21/23 at 8:51 a.m., indicated she had called the resident's daughter on 6/10/23 to ask about home health services. The daughter indicated she would like home health for her father and she had used a specific group before and would like to continue with that one. She sent a referral package to the home health agency, however, they did not get the information regarding the discharge on		***program will be put in place:*** 1. DON/Designee to audit discharge summary for all residents with scheduled discharge date for completion of all sections x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 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: 7.17.23. The Administrator at Hammond Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	6/11/23, so another referral and phone call was sent out on 6/13/23. There was no documentation on the Discharge Summary/Instruction sheet of any contact information for the home health agency. Interview with the Director of Nursing (DON) on 6/21/23 at 9:00 a.m., indicated at the time of discharge they print off all of the resident's medications including any treatments, and medication scripts were faxed to the pharmacy or given to the family before they leave. The discharge instructions lacked information regarding the Physician's name and number and home health information. Other facility departments should be completing their sections on the discharge instruction summary sheet. 3. The closed record for Resident F was reviewed on 6/20/23 at 1:30 p.m. The resident was admitted to the facility on 4/26/23 and discharged home on 6/2/23. Diagnoses included, but were not limited to, absence of the right leg above the knee, dementia, high blood pressure, falling, and severe protein calorie malnutrition. The Admission Minimum Data Set (MDS), dated 5/2/23, indicated the resident was not cognitively intact. Physician's Orders, dated 4/27/23 and listed as current on the 6/2023 Order Summary, indicated cleanse right buttocks and sacrum with normal saline, pat dry then apply calcium alginate and cover with dry dressing every day shift for stage 3 pressure ulcers. Physician's Orders, dated 5/9/23 and listed as current on the 6/2023 Order Summary, indicated apply dry dressing to right above the knee			

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	amputation one time a day. The Discharge Summary/Instructions, dated 6/2/23, indicated the resident would be discharged home by automobile and with her daughter. Home health services were recommended as well a wheelchair for mobility. There was no information of the home health agency's name or contact number. There was no documentation of the follow up information for the next Physician's visit. There was no documentation of the pressure ulcer treatments or the resident's skin condition upon discharge. Interview with the Social Service Director (SSD) on 6/21/23 at 8:51 a.m., indicated she had spoken to the resident's daughter when she called about the Medicare days ending. She asked the daughter if her mom needed home health and if so which one, the daughter informed her of a home health agency that was used in the past and she would like for them to continue. The SSD sent a referral package to the home health agency. She indicated she did not document any of that information on the discharge instructions. Interview with the Director of Nursing on 6/21/23 at 9:00 a.m., indicated copies of the resident's medications and treatments were made and given to the resident/responsible party at the time of discharge, however, there were no specific instructions regarding the resident's wounds on the discharge summary sheet. This Federal tag relates to Complaint IN00410149. 3.1-12(a)(21)			
F 0842 SS=D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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Bldg. 00	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in			

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	compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to a scratch on a resident's nose for 1 of 3 resident's reviewed for non-pressure related skin conditions. (Resident C) Finding includes: The closed record for Resident C was reviewed on 6/20/23 at 10:34 a.m. Diagnoses included, but were not limited to, stroke, high blood pressure, diabetes, aphasia, dementia, anxiety, and	F 0842	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	07/17/2023

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	depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/7/23, indicated the resident was not cognitively intact. A Nurses' Note, dated 4/12/23 at 10:16 p.m., indicated the resident's mother came into the nursing station and indicated the resident was touched by a male nursing aide inappropriately. The resident was assessed from head to toe, and a small scratch to the right side of the nose was noted. The resident had no other obvious skin issues. There was no other documentation or an assessment of the scratch on the resident's nose in the clinical record. Interview with the Director of Nursing on 6/21/23 at 1:25 p.m. indicated she recalled the scratch to the resident's nose and after it was cleaned, it was a very tiny area. She did not document anything regarding the area in the clinical record. Interview with the Assistant Director of Nursing (ADON) on 6/21/23 at 1:50 p.m., indicated she had assessed the area on the resident's nose and after it was cleaned, there was nothing there. The ADON indicated she did not document her findings in the resident's clinical record. This Federal tag relates to Complaint IN00407586. 3.1-50(a)(1)		to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 842 –** Resident Records – Identifiable Information ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. No negative outcomes noted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All residents with non-pressure related skin issues have the potential to be affected. 2. Audit of weekly skin assessments for all current residents with non-pressure related skin issues to ensure follow up documentation is present to be completed by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient***	

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			practice doesn't recur: 1. Licensed Nurses to receive education r/t documentation procedure for non-pressure related skin issues (including follow up) prior to date of compliance. All newly hired licensed nurses to receive this education prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee to audit 24/72 hour report to ensure all current residents with non-pressure related skin issues have follow up documentation present 5x/week x 6 months. 2. DON/Designee to audit weekly skin assessments to ensure proper follow up documentation for all current residents with non-pressure related skin issues weekly x 6 months. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 7.17.23. The Administrator at Hammond Whiting Care Center is responsible in ensuring	

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			compliance in this Plan of Correction.	