

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/20/14</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered except those areas cited at K56. The facility has a fire alarm system with hard wired smoke detection in the corridors and in common areas.</p>	K010000	<p>September 5, 2014 Kim Rhoades, Director of Long-Term Care Indiana State Department of Public Health 2 North Meridian St. Indianapolis, IN 46204 Dear Ms Rhoades: Please reference the enclosed 2567 as "Plan of Correction" for the August 20, 2014 Life Safety Code Survey that was conducted at Hammond Whiting Care Center. 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 September 5, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly Ready Executive Director</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K010021 SS=E	<p>Resident sleeping rooms are equipped with battery powered smoke detectors. The facility has a capacity of 80 and had a census of 69 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage, and the kitchen cooler and freezer which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/26/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p>				

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	<p>Based on observation and interview, the facility failed to ensure 2 of 8 doors to hazardous areas, such as a laundry larger than 100 square feet was held open only by a device allowing the door to self-close upon activation of the fire alarm. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects 4 occupants observed in the northeast office wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 1:10 p.m., two self closing corridor access doors to the laundry were not latched into their door frames. The doors were opened and allowed to self close, the inactive door for one doorway, and the door frame of the second doorway prevented the doors from self closing and latching into the door frame. The maintenance assistant acknowledged the doors would not automatically close.</p> <p>3.1-19(b)</p>	K010021	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No resident was immediately affect by this deficient practice. 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: No other residents were immediately affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Quote was acquired from Preferred Window and Door for three new self-closing corridor access doors for the laundry. Installation of new self-closing corridor access doors for the laundry will be completed as soon as possible, all efforts will be made to complete the work by September 19, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will audit the doors on his weekly rounds for three month to assure the doors close and latch properly into the door frame. Any issues identified will be immediately addressed and all audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of</p>	09/19/2014			

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K010022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 3 dining room doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects visitors, staff, and 10 or more residents in the dining room.</p> <p>Findings include:  Based on observation with the maintenance assistant and administrator on 08/20/14 at 11:45 a.m., a glass</p>	K010022	<p>correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On August 26, 2014, the Maintenance Supervisor installed "No Exit" signage directly on glass paneled door in the dining room leading onto the outdoor patio. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All facility residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor</p>	09/19/2014	

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K010038 SS=E	<p>paneled door in the dining room opened onto an outdoor patio with no access to the evacuation point at a public way. No sign was provided to prevent occupants from using this door as an emergency exit. The maintenance assistant acknowledged at the time of observation, the door could be mistaken for a means of exit.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen exit doors was provided with a door knob readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in</p>	K010038	<p>and/or designee will audit "No Exit" signage on his weekly rounds for three months to assure signage is in place. Any issues identified will be immediately addressed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor will remove the deadbolt lock from door providing access to the dining room from the kitchen. In addition, self-closure mechanisms will be installed on</p>	09/19/2014			

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	<p>the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors, staff and 10 or more residents in the dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 12:45 p.m., the door providing access to the dining room from the kitchen was equipped with a deadbolt latch and an independent door knob. The maintenance assistant acknowledged at the time of observation, the door could not be opened with a single action when the deadbolt was engaged.</p> <p>3.1-19(b)</p>		<p>door providing access to the dining room from the kitchen along with the door providing access to the service corridor from the kitchen.</p> <p>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: No other residents were immediately affected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor and/or designee will audit the doors on his weekly rounds for three month to assure the doors close and latch properly into the door frame. Any issues identified will be immediately addressed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice</p>		

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K010039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors was maintained to provide at least a four foot wide clearance to evacuate the facility. This deficient practice affects visitors, staff and an undetermined number of residents utilizing the service corridor as an emergency exit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistance and administrator on 08/20/14 at 12:55 p.m., the service corridor served as an exit for the laundry, break room, kitchen, boiler room and a secondary exit for the main entry, a gathering place for residents. The length of the exit corridor was used for the storage of eight carts, including laundry, maintenance, utility, and a two bin laundry receptacle which effectively reduced the width of the exit path to two and one half feet along the length of the corridor to within four feet of the emergency exit door. The maintenance</p>	K010039	<p>does not reoccur and/or adapt audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On August 20, 2014, the Housekeeping Supervisor removed all carts from the service corridor. 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: No other residents were immediately affected by this deficient practice. 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 educated by the Executive Director and/or designee by September 19, 2014 on proper storage of carts and maintaining at least a four foot wide clearance to evacuate the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will conduct a random audit of the service corridor 5 times per week for</p>	09/19/2014

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K010044 SS=E	<p>assistant acknowledged at the time of observation, the corridor width was not kept clear for emergency use.</p> <p>3.1-(19)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff</p>	K010044	<p>three month to assure at least a four foot wide clearance is maintained. Any issues identified will be immediately addressed and all audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Preferred Windows and Door was contacted by the Maintenance Supervisor to provide service to squared door frame for the fire door set near room 208, so it doors would close and latch properly. 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:</p>	09/19/2014

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K010056 SS=D	<p>and 10 or more residents in the center and north smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 1:15 p.m., the fire door set near room 208 was tested twice manually with the maintenance assistant. One door in the fire door set failed to latch each time the doors were released to close. The door failed to latch again at 1:17 p.m. on 08/20/14 when the fire alarm was activated. The maintenance assistant agreed at the times of observation, there was a problem with the latching mechanism.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with</p>		<p>All facility residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor and/or designee will audit all fire door sets on weekly rounds for three month to assure doors close and latch properly. Any issues identified will be immediately addressed How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p>				

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	<p>NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on record review, observation and interview; the facility failed to ensure the walk in freezer and cooler in 1 of 1 kitchens were provided with an automatic sprinkler to ensure sprinkler system coverage in all portions of the building. This deficient practice could affect visitors and 3 or more staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 12:55 p.m., no sprinkler was found in the walk in kitchen cooler and freezer. The maintenance assistant acknowledged at the time of observation, these areas had no sprinkler.</p> <p>3.1-19(b) 3.1-19(ff)</p>	K010056	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility does have a sprinkler coverage within the walk in freezer and cooler; although, stock was delivered and placed in walk in freezer/cooler on the day of survey and the facility staff failed to ensure the sprinkler heads were not obstructed.</p> <p>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: No other residents were immediately affected by this deficient practice.</p> <p>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 Executive Director and/or designee by September 19, 2014 on proper storage of supply and food items, so clearance between sprinkler deflectors and top of storage is 18 inches or more.</p> <p>How the corrective action(s) will be monitored to ensure the</p>	09/19/2014

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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 portable fire extinguishers were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less</p>	K010064	<p>deficient practice will not recur: The Maintenance Supervisor and/or designee will conduct a random audit on all storage areas (including the walk in cooler and freezer) 5 times per week for three month to assure at least the 18 inch clearance is maintained. Any issues identified will be immediately addressed and all audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On August 22, 2014, the Maintenance Assistant lowered the portable fire extinguisher near room 216, so the top of the portable fire extinguisher was</p>	09/19/2014	

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	<p>should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects visitors, staff and 10 or more residents on the north wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 1:20 p.m., the portable fire extinguisher near room 216 was measured at 70 inches above the finished floor. The maintenance director acknowledged at the time of observation, the fire extinguisher was mounted above the maximum height of 60 inches.</p> <p>3.1-19(b)</p>		<p>below five feet (60 inches) above the floor and no more than three and one half feet (42 inches) above the floor.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor and/or designee will audit all portable fire extinguishers during weekly rounds for three month to assure proper placement is maintained. Any issues identified will be immediately addressed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce facility smoking regulations and ensure smoking was limited to 1 of 1 designated smoking areas. This deficient practice affects staff, visitors and any resident in the north courtyard.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 between 11:30 a.m. and 2:00 p.m., two staff were sitting on milk crates</p>	K010066	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On September 4, 2014, the Maintenance Supervisor placed "No Smoking" signage was placed in the North Courtyard. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All residents had the potential to be affected. What measures will be put into place or what systemic changes</p>	09/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394		
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	<p>behind the outside access to the service corridor. Cigarette butts littered the mulch on both sides of the exit discharge path immediately adjacent to the gate providing access to the public way. The maintenance assistant said at the time of observation, these were not designated smoking areas. The facility smoking policy titled Smoking (Updated 4/20/12) was reviewed with the maintenance assistant and administrator on 08/20/14 at 2:20 p.m.. The policy identifies a single designated smoking site for smokers provided with equipment appropriate for the disposal of smoking materials on the patio outside the dining room. The policy states residents may not smoke in any other outside area. The policy further says Associates may smoke at the same site and in the cars during their lunch break. The administrator confirmed at the time of record review, the smoking was prohibited in any other areas and acknowledged there was evidence the policy was not followed.</p> <p>3.1-19(b)</p>		<p>will be made to ensure that the deficient practice does not recur: An education letter will be sent out to all residents and family members outlining the Non-Smoking policy. In addition, facility staff will be re-educated on the smoking policy and designated smoking areas by the Executive Director and/or designee by September 19, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will audit the facility grounds during weekly rounds for three month to assure associates, residents, and family are only utilizing designated smoking areas. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage rooms was separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects visitors, staff and 10 or more residents in the adjacent entry gathering area and dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 11:55 a.m., the oxygen storage room located in the center smoke compartment was used for the storage of four large liquid oxygen containers as</p>	K010076	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Additional sheet of drywall to be installed above ceiling of oxygen storage room along with the gap repaired along the ceiling vent in the room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All facility residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor and/or designee will audit the oxygen storage room during weekly rounds for three month to assure the one-hour fire separation is maintained. Any issues identified will be immediately addressed.</p>	09/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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K010143 SS=E	<p>well as helium and oxygen gases stored in cylinders. A gap of one by three inches was observed adjacent to the ceiling vent in the room. It appeared the ceiling was constructed of a single sheet of drywall which would not provide the one hour fire resistance. The maintenance assistant said at the time of observation, he knew the ceiling was constructed of a single sheet of drywall because he had installed the ceiling fan and had cut the ceiling to install it.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the</p>	K010143	How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	09/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2014	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside. This deficient practice affects visitors, staff and 10 or more residents in the adjacent entry gathering area and dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 at 11:55 a.m., the oxygen transfer and storage room located in the center smoke compartment was identified by the maintenance assistant. The mechanical vent for the room appear to be the type installed in household bathrooms which generally vent into attic spaces. The maintenance assistant acknowledged at the time of observation, this was the type of vent installed and said it vented into the attic rather than directly to the outside.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the deficient practice: The oxygen storage room vent is not vented to the outside. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All facility residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor and/or designee will audit the oxygen storage room during weekly rounds for three month to assure proper ventilation is maintained. Any issues identified will be immediately addressed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt</p>				

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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 manual emergency generator control panels was maintained to initiate a manual start. LSC 101, 7.9.2.3 requires emergency generators be tested and maintained in accordance with NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems. NFPA 110, Section 3-5.5.2(a) requires cranking control equipment provide the complete cranking cycle. Section 3-5.5.2(b)1. A panel mounted control switch(es) marked "run-off-automatic" to perform the following functions:</p> <p>1. Run: Manually initiate; start, and run prime mover; 2. Off: Stop prime mover or reset safeties or both; 3. Automatic: Allow prime mover to start by closing a remote contact and stop by opening a remote contact.</p> <p>In addition, NFPA 101 at Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could</p>	K010144	<p>audit schedules.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The manual generator toggle switch was replaced by H&amp;G Services on September 3, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All facility residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will be educated by Executive Director and/or designee on proper duration and frequency of generator load tests. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will audit the generator during weekly rounds for three month to assure the manual toggle switch is functional. In addition, the Maintenance Supervisor and/or designee will perform a 30-minute</p>	09/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394		
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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/20/14 at 11:50 a.m., the facility emergency generator did not start manually when the maintenance assistant attempted to demonstrate the manual operation of the generator using the toggle switch on the generator. He said at the time of observation, the manual run toggle switch on the generator panel "didn't work." He immediately entered the facility and, using the remote start, was able to start the generator.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure monthly generator load tests were performed for a minimum of 30 minutes during 12 of the past 12 months. LSC 101, 7.9.2.3 requires emergency generators be tested and maintained in accordance with NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems. Section 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly for a minimum of 30 minutes. This deficient practice could affect all</p>		<p>load test at least once monthly. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p>		

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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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K010147 SS=F	<p>residents.</p> <p>Findings include:</p> <p>Based on review of the past year's "Logbook Documentation, Generators" with the maintenance assistant and administrator on 08/20/14 at 2:15 p.m., the documentation served as the check list for generator load test and routine checks which were conducted weekly. Checklists for every week during the past year noted the generator Load Run Time was 13 minutes. The maintenance assistant said at the time of record review, the generator testing information documentation was correct. He said the generator "was set up that way."</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical equipment rooms in 2 of 3 smoke compartments were provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA</p>	K010147	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All equipment and supplies along with power strip extension cords were removed from affected areas on August 20, 2014. How other residents having the</p>	09/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/20/2014	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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	<p>70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects electrical systems serving all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator between 11:30 a.m. and 2:00 p.m., a Clean Central Supply room shared the space with two electrical panels and the sprinkler riser equipment. Maintenance equipment and supplies were stored in front of, and against, four electrical panels and the two banks of transfer switches in the boiler room. The maintenance assistant acknowledged at the time of observation, access to the electrical equipment was not being maintained.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Facility wide audit will be perform to assure no other power strip extension cords were in use within the facility. 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 educated by Executive Director and/or designee on providing sufficient access and working space to permit ready and safe operation and maintenance of equipment by September 19, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will conduct random audits in central supply room and boiler room 5 times per week for three month to assure sufficient access and working space is maintained. In addition, the Maintenance Supervisor and/or designee will conduct 5 room audits each week to assure no power strip extension cords are in use with the facility. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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	<p>Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 10 or more residents in the center and north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance assistant and administrator on 08/20/14 between 11:30 a.m. and 2:00 p.m., power strip extension cords were used to supply power to:</p> <ul style="list-style-type: none"> <li>a. Four curling irons and a blow dryer in the beauty shop;</li> <li>b. A refrigerator in the boiler room;</li> <li>c. A wound vac used for resident care in room 213.</li> </ul> <p>The maintenance director said at the time of observation, there was a shortage of electrical outlets.</p> <p>3.1-19(b)</p>		necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
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