

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 10/08/2014
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/20/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/08/14</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this PSR survey, Hammond-Whiting Care Center was found in substantial 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 300 halls and the center hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire</p>	K010000	<p>October 20, 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 October 8, 2014 revisit to the Life Safe Safety Code Survey of August 20, 2014 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 October 20, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly M. Ready, HFA</p>	
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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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K010029 SS=B	<p>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 66 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Speciality-Medical Surveyor on 10/09/14.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the</p>	K010029	What corrective action(s) will be	11/07/2014	

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	<p>facility failed to ensure 1 of 2 sets of doors serving hazardous areas such as a laundry closed and latched to prevent the passage of smoke. This deficient practice would not affect residents but could affect an undetermined number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:00 p.m. on 10/08/14, the soiled laundry double set of doors were provided with door closer's but lacked automatic positive latching hardware on the doors. One of the doors was provided with a manual slide bolt at the top of the inactive door and the active door latched into the inactive door. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the facility had replaced the previous set of doors to the aforementioned hazardous area without automatic positive latching hardware. In order for the set of doors to be closed and latched into the door frame, the manual flush bolt on the inactive door would have to be manually latched before the active door could be latched.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the deficient practice.No resident was immediately affect by this deficient practice.<u>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</u>:No other residents were immediately affected by this deficient practice.<u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</u>: Automatic positive latching hardware has been ordered from vendor, Preferred Window and Door, for installation on the inactive door leading into the laundry room. Installation of new hardware will be completed as soon as possible, all efforts will be made to complete the work by November 7, 2014. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur</u>:The Maintenance Supervisor and/or designee will audit the doors on his weekly rounds for three months 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 correction developed and implemented as deemed necessary. The criteria for</p>				

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K010039 SS=B	<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 1 service corridors was maintained to provide at least 44 inches in clear and unobstructed width. Exception #1 of 19.2.3.3 states aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 inches in clear and unobstructed width. This deficient practice affects staff utilizing the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 10/08/14 at 11:50 a.m., two soiled laundry carts and one clean linen cart were on one side of the service corridor reducing the clear and</p>	K010039	<p>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 October 8, 2014, the Housekeeping Supervisor removed all carts from the service corridor. <u>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:</u> No other residents were immediately affected by this deficient practice. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Facility staff will be re-educated by the Executive Director and/or designee by November 7, 2014 on proper storage of carts and maintaining at least a four foot wide clearance to evacuate the facility. <u>How the corrective action(s) will be monitored to ensure the deficient</u></p>	11/07/2014

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	unobstructed width to 28 inches. Based on interview, the Maintenance Supervisor and Administrator acknowledged at the time of observation, the clear and unobstructed width was less than 44 inches. 3.1-(19)		<u>practice will not recur:</u> The Maintenance Supervisor and/or designee will conduct a random audit of the service corridor 5 times per week for three months 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.		