

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 05/11/2016
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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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K 0000 Bldg. 01	<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: 05/11/16</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</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. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and in common areas. The facility has a capacity of 80 and had a census of 65 at the time of this survey.</p>	K 0000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the May 11, 2016 Life Safety Code Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. I will submit signature sheets of in-servicing, content of in-services, audit tools, and documentation of work completed on June 10, 2016. 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 27, 2016 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>	
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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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K 0025 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage.</p> <p>Quality Review completed on 05/17/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed</p>	K 0025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The two inch unsealed penetration in the North smoke barrier wall located in the attic, along with the quarter inch unsealed penetration around conduit of the South smoke barrier wall in the attic has been repaired. 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</p>	06/10/2016

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K 0029 SS=D Bldg. 01	<p>for the specific purpose. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 05/11/16 at 1:13 p.m. then again at 1:16 p.m., the North smoke barrier wall had a two inch unsealed penetration in the attic. Then again, the South smoke barrier wall had a quarter inch unsealed penetration around conduit in the attic. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p>		<p>recur: The Maintenance Supervisor and/or designee will audit the facility smoke barrier walls during weekly rounds for three month to ensure the penetrations caused by the passage of wire and/or conduit through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier. 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>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</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 Folding Room, 1 of 1 Food storage room greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/11/16 at 12:11 p.m. then again at 12:25 p.m., the Folding room was being used to store all the clean clothes from the Laundry room. The corridor door did not contain self-closing hardware. Then again the Food storage room contained at least 50 cardboard boxes of food storage, containers of vegetable oil, and other miscellaneous storage. The room contained two corridor doors, one of the doors only latches into the frame per a manual latch. Neither door contained self-closing hardware. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p>	K 0029	<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 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: Automatic hinge closers have been placed on the Folding room door. Quote was acquired from Preferred Window and Door for a new self-closing corridor access doors with auto latching mechanism for the Food storage room. Installation of new self-closing corridor access doors with auto latching mechanism for the Food storage room will be completed as soon as possible, all efforts will be made to complete the work by June 10, 2016. The auto latch for the set of double Laundry corridor doors has been repaired along with the automatic hinge closers for the</p>	06/10/2016	

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K 0046 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 Laundry and 1 of 1 Kitchen containing fuel-fired equipment, a hazardous area, would latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/11/16 at 12:20 p.m. then again at 12:30 p.m., the set of double Laundry corridor door latched into each other but not one door latched into the frame. Then again, the Kitchen corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview; the facility failed to ensure 1 of 3 200</p>	K 0046	<p>Kitchen corridor door, so doors latch into the frame. The Maintenance Supervisor and/or designee will audit the doors on his weekly rounds for three months to ensure 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 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</p>	06/10/2016			

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	<p>Hall exterior discharge battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect staff and at least 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/11/16 at 11:40 a.m., the battery operated emergency light outside the exit discharge near resident room 201 failed to illuminate when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>the deficient practice: The battery operated emergency light outside of the exit Northeast 200 hallway will be repaired prior to June 10, 2016. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(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: The Maintenance Supervisor and/or designee will test the battery operated emergency lights outside of each exit door during weekly rounds for three month to ensure the battery operated emergency lights outside of the exits doors are 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</p>		

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires Diesel-powered Emergency Power Supply (EPS) installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available Emergency Power Supply System (EPSS) load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the</p>	K 0144	<p>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 facility ran and properly documented a 30-minute load test at 30% as per regulation. In addition, a 2-hour continuous test as per regulation will be completed prior to June 10, 2016. 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 on or prior to June 10, 2016 by Executive Director and/or designee on proper duration, frequency, and percentage of generator load tests. How the corrective action(s) will be monitored to ensure the</p>	06/10/2016

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	Maintenance Director on 05/11/16 at 1:20 p.m., the facility did not exercise the generator monthly with the available EPSS load in that the monthly generator testing for 08/27/15 documented the generator load percentage as "N/A." Additionally, an annual load bank was performed for only a hour and a half. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3-1.19(b)		deficient practice will not recur: The Maintenance Supervisor and/or designee will perform and properly document in the TELS system a 30-minute load test for at least 30% of the EPS nameplate rating 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.				
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed	K 0147	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The surge protectors located in the Activity office were removed on May 11, 2016. The Activity staff members were immediately provided education relating to not using flexible cords and cables as a	06/10/2016			

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	<p>wiring of a structure. This deficient practice affects staff and up to 29 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/11/16 at 12:50 p.m. a surge protector was powering another surge protector powering a radio in the Activities room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>substitute for fixed wiring of a structure. 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: Facility wide audit was completed on May 23, 2016 by the Executive Director and Maintenance Director to ensure no other power strip extension cords were in use within the facility. No issues were identified via this audit. 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 to ensure flexible cords and cables are not used as a substitute for fixed wiring of a structure. This education will take place on or prior to June 10, 2016. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor and/or designee will conduct 5 room audits each week to ensure no flexible cords and cables are used as a substitute for fixed wiring within 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>	

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			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.		