PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>		
		155423	B. WING		07/30/2021	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		14TH ST		
HAMMO	ND-WHITING CARE	ECENTER		NG, IN 46394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
	This visit was for a	Recertification and State	F 0000	Please reference the enclosed	1	
	Licensure Survey.		1 0000	2567 as "Plan of Correction" for	or	
	ĺ			the July 30, 2021 Recertification		
	Survey dates: July	26, 27, 28, 29, and 30, 2021		and State Licensure that was		
				conducted at Hammond Whiti	ng	
	Facility number: 00	00365		Care Center. I am respectfull	·	
	Provider number: 1			requesting paper compliance	·	
	AIM number: 100287460 Census Bed Type:			this survey.		
				Preparation and/or execution	of	
SNF/NF: 54			this plan of correction does no			
	Total: 54			constitute admission or agreer	ment	
				by the provider of the truth fac	ts	
	Census Payor Type	:		alleged or conclusion set forth	I	
	Medicare: 5			the statement of deficiencies.		
	Medicaid: 43			This plan of correction is		
	Other: 6			prepared and/or executed sole	ely	
	Total: 54			because it is required by the		
				provision of the Federal and S	tate	
	These deficiencies i	reflect State Findings cited in		Laws. This facility appreciated	d l	
	accordance with 41	0 IAC 16.2-3.1.		the time and dedication of the		
				Survey Team; the facility will		
	Quality review com	pleted on 8/4/21.		accept the survey as a tool for	our	
				facility to use in continuing to		
				better the quality of care provi	ded	
				to our Elders in our community	/.	
				The Plan of Correction submit	ted	
				on August 19, 2021 serves as	our	
				allegation of compliance. Sho		
				you have any question or		
				concerns regarding the Plan of	f	
				Correction, please contact me		
F 0550	483.10(a)(1)(2)(b)	(1)(2)				
SS=D	Resident Rights/E	xercise of Rights				
Bldg. 00	§483.10(a) Reside	ent Rights.				

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

TITLE

000365

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION			
	existence, self-det communication wi and services insid	a right to a dignified ermination, and th and access to persons e and outside the facility, ecified in this section.						
	resident with responder for each resident in environment that put enhancement of horecognizing each in the side of	acility must treat each ect and dignity and care in a manner and in an eromotes maintenance or is or her quality of life, resident's individuality. The ect and promote the rights of						
	access to quality of diagnosis, severity source. A facility n identical policies a transfer, discharge	of condition, or payment nust establish and maintain and practices regarding e, and the provision of e State plan for all residents						
	her rights as a res	se of Rights. he right to exercise his or ident of the facility and as nt of the United States.						
	the resident can e without interference	facility must ensure that xercise his or her rights e, coercion, reprisal from the facility.						
	be free of interfered discrimination, and in exercising his oupported by the f	resident has the right to ence, coercion, d reprisal from the facility r her rights and to be acility in the exercise of s required under this						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 2 of 47

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155423	B. WI	NG		07/30/	2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8		l	ADDRESS, CITY, STATE, ZIP CODE		
		- 0511755			14TH ST		
HAMMOI	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	subpart.						
	Based on observation	on, record review and	F 05	550	F 550- Resident Rights		08/29/2021
		ty failed to ensure each	1 00	,,,,,	What Corrective Action will be		00/29/2021
		as maintained related to			accomplished for those		
		hospital gowns during the			residents found to have been	า	
	day while in bed for 2 of 5 residents reviewed for				affected by this deficient	•	
	dignity. (Residents				practice:		
	diginty. (Residents	12 una 2 1)			1. Resident number 12	2	
	Findings include:				and 24 had no negative outcome		
	1. On 7/26/21 at 10:15 a.m., 11:25 a.m., and 2:20 p.m., Resident 12 was observed in bed				Both residents were immediate		
					assisted into clothes.	Ciy	
					How other residents having	tho	
	dressed in a hospital gown.				potential to be affected by th		
	dressed in a nospital gown.				same deficient practice will be		
	On 7/27/21 at 9:05 a.m., 7/28/21 at 8:53 a.m.				identified and what correctiv		
		esident was observed in bed			action will be taken:	C	
	dressed in a hospita				1. An in house audit w	rill	
	dressed iii a nospita	n gown.			be completed by activities and		
	The maneral for Desi	dent 12 was reviewed on			SSD and/or designee for curre		
					_		
		. Diagnoses included, but			residents to update their person		
		oke, vascular dementia, type 2			preferences. If unable to make		
		ressive disorder, stiffness in			decision POA and/or family wi	ii be	
	· · · · · · · · · · · · · · · · · · ·	ional disorder, atrial			contacted to give information. 2. Preferences will be		
		sions, muscle weakness, and					
	muscle atrophy.				updated and put on care plans	5	
	TEL 0 1 1/00	V21.16"			and kardex by date of		
		0/21 Minimum Data Set			compliance.		
		indicated the resident was			What measures and what		
		ed. He needed extensive			systemic changes will be ma	ide	
		physical assist for dressing			to ensure that the deficient		
		ne. The resident had a feeding			practice doesn't recur:	•••	
	tube and received a mechanically altered diet.				1. SSD and Activities	Will	
		r more of his calories with			be in serviced by ED and/or		
	the tube feeding and had no skin issues.				designee on updating preferer		
					at least quarterly with care pla		
		d on 7/23/21, indicated the			and prn as indicated. Education		
	resident's preferences were as follows:				include if resident unable to m		
		ove as needed. Keep his nails			preference decision then POA		
		acial hair (wants a clean shave)			and/or family to be contacted f		
	with an electric raze	or. The approaches were to			preference. SSD and activities	will	

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155423	B. W	ING		07/30/	′2021
				CEDEFE	A DDDDGG GUTU GTATE TID GODE		-
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
	ND WULLTING OAD	- OFNITED			14TH ST		
HAMMO	ND-WHITING CARI	ECENTER		WHITIN	NG, IN 46394		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dent a clean shave on his			be responsible for updating ca		
		is electric shaver as he			plan and kardex with changes		
	_	offer the resident with help			Education will be completed b	y	
		f clothing. Offer to cut the			date of compliance.		
	resident's nails shor	t as he preferred.			How the corrective action w	ill	
					be monitored to ensure the		
		Plan the resident preferred to			deficient practice will not re	cur,	
	be dressed in a hosp	pital gown during the day.			i.e., what quality assurance		
					program will be put in place		
		Interim Director of Nursing			1. ED and or designe	е	
		a.m., indicated the resident			will audit 5 charts weekly x 8	. 0	
		ressed in regular clothes			weeks, then 3 charts weekly x		
	during the day even if he was in bed.				weeks, then 2 charts weekly		
	2 0 7/20/21 -4 10/21 11/07 1				weeks. Results will be presen		
	2. On 7/26/21 at 10:21 a.m., 11:07 a.m., and 2:10 p.m., Resident 24 was observed in bed				to QAPI x 6 months and QAP		
	-				determine the need for further	-	
	dressed in a hospita	ıı gown.			audits. 2. The results of these	•	
	On 7/27/21 0:02 a.s	m., and 7/28/21 at 8:50 a.m.,			reviews will be discussed at the		
		served in bed dressed in a			monthly facility Quality Assura		
	hospital gown.	served in bed dressed in a			Committee meeting monthly f		
	nospitai gowii.				total of 3 months and then	oi a	
	The record for Resi	dent 24 was reviewed on			quarterly thereafter once		
		n. Diagnoses included, but			compliance is at 100%.		
		dementia without behaviors,			Frequency and duration of		
		PPD, dysphagia, atrial			reviews will be increased as		
		ood pressure, anxiety, and			needed, if compliance is below	N	
	major depressive di	-			100%.		
					Compliance date: 8/29/21. Th	е	
	The Annual Minim	um Data Set (MDS)			Administrator at		
	assessment, dated 5	5/19/21, indicated the resident			Hammond-Whiting Care Cent	er is	
	was not alert and or	riented, rarely understood and			responsible in ensuring		
	rarely understands,	and was severely impaired for			compliance in this Plan of		
	decision making. T	The resident had no mood or			Correction.		
	behavior problems	including rejection of care.					
		d extensive assist for dressing					
	and did not receive	oxygen while a resident.					
		d on 6/9/21, indicated the					
	resident's preferenc	es were as follows: to					

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL		
		155423	B. W	ING		07/30/	2021
	PROVIDER OR SUPPLIER		<u> </u>	1000 11	DDRESS, CITY, STATE, ZIP CODE 4TH ST G, IN 46394	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0623 SS=A Bldg. 00	remove her gowns of approaches were to what clothing she will like her dressed during the day. Interview with the rest like her dressed during the day. 3.1-3(t) 483.15(c)(3)-(6)(8) Notice Requireme Transfer/Discharg §483.15(c)(3) Notige Before a facility transfer, the facility in a language and the reasons for in a language and The facility must so a representative of Long-Term Care (ii) Record the readischarge in the r	or pajamas daily. The offer and/or ask the resident ould like to wear. esident's daughter on 7/26/21 ed there were clothes ident to wear and she would ing the day. Interim Director of Nursing a.m., indicated the resident ressed in regular clothes on the Before estate the resident resident's of the transfer or discharge or the move in writing and manner they understand, rend a copy of the notice to fine Office of the State of the Office of the State of the transfer or resident's medical record in aragraph (c)(2) of this record in the office the items described of this section.		TAG	DEFICIENCY		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 5 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155423		(X2) MULTIPLE A. BUILDING B. WING	construction 00	COM	(X3) DATE SURVEY COMPLETED 07/30/2021		
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ION SHOULD BE COMPLE' THE APPROPRIATE		
TAG	section must be in 30 days before the discharged. (ii) Notice must be practicable before when- (A) The safety of would be endanged (1)(i)(C) of this see (B) The health of would be endanged (1)(i)(D) of this see (C) The resident's sufficiently to allow transfer or dischad (1)(i)(B) of this see (D) An immediate required by the reneeds, under parasection; or (E) A resident has for 30 days. §483.15(c)(5) Conwritten notice spee of this section musical (ii) The effective of discharge; (iii) The location to transferred or discharge; (iii) The location to transferred or discharge; (iv) A statement or rights, including the and email), and the entity which receinformation on how and assistance in submitting the application of the name, additional contents and the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitting the application of the name, additional contents are submitted to the name of the name	individuals in the facility ered, under paragraph (c) ection; health improves a more immediate rge, under paragraph (c) ection; transfer or discharge is sident's urgent medical agraph (c)(1)(i)(A) of this is not resided in the facility entents of the notice. The cified in paragraph (c)(3) est include the following: transfer or discharge; late of transfer or which the resident is	TAG	DEFICIENCY)		DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 6 of 47

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

r i i		î ´		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	ING	00	COMPL	
		155423	B. WING			07/30/	2021
NAME OF P	ROVIDER OR SUPPLIER		S	ΓREET A	DDRESS, CITY, STATE, ZIP CODE		
101111111111111111111111111111111111111	No vident on borreien				4TH ST		
IOMMAH	ND-WHITING CARE	ECENTER	V	/HITIN	G, IN 46394		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	I	D	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)	I C	DATE
	State Long-Term	Care Ombudsman;					
	(vi) For nursing fac	cility residents with					
	intellectual and de	velopmental disabilities or					
	related disabilities	, the mailing and email					
	address and telep	hone number of the					
	agency responsibl	e for the protection and					
		duals with developmental					
		shed under Part C of the	1				
	•	sabilities Assistance and					
	-	of 2000 (Pub. L. 106-402,					
		.C. 15001 et seq.); and					
(vii) For nursing facility residents with a							
mental disorder or related disabilities, the							
mailing and email address and telephone							
	_	ency responsible for the					
	•	ocacy of individuals with a					
		stablished under the					
	Individuals Act.	vocacy for Mentally III					
	iliulviuuais Act.						
	§483.15(c)(6) Cha	inges to the notice.					
	- ' ' ' '	n the notice changes prior					
	to effecting the tra	nsfer or discharge, the					
	facility must updat	e the recipients of the					
	notice as soon as	practicable once the					
	updated information	on becomes available.					
		ce in advance of facility					
	closure						
		ity closure, the individual					
		strator of the facility must					
	· •	tification prior to the					
		to the State Survey	1				
		e of the State Long-Term n, residents of the facility,					
		epresentatives, as well as					
		epresentatives, as well as insfer and adequate					
		esidents, as required at §					
	483.70(I).	Joine Strate of the strate of					
	` '	riew and interview, the	F 0623		F 623- Notice requirements		08/29/2021
		,	1 0025				30/27/2021

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 7 of 47

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		155423	B. W	ING		07/30/2	2021
				CENTER	A DDDDGG GITYL GTA TO GID GODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
	facility failed to ens	sure a resident's Responsible			before Transfer and Discharge	<u> </u>	
	Party was notified i	n writing related to a transfer			What Corrective Action will I	be	
	to the hospital for 3	of 5 residents reviewed for			accomplished for those		
	hospitalization. (Re	esidents 29, 56 and 28)			residents found to have been	n	
					affected by this deficient		
	Findings include: 1. The record for Resident 29 was reviewed on 7/28/21 at 3:07 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, orthopedic aftercare following surgical amputation, and type 2 diabetes.				practice:		
					1. Residents 29, 56, a	nd	
					28 had no negative outcomes		
					Families were sent transfer pa	per	
					work immediately.		
					How other residents having	the	
					potential to be affected by th	ie	
					same deficient practice will l	be	
	The Significant Change Minimum Data Set				identified and what corrective	re	
	(MDS) assessment, dated 6/16/21, indicated the				action will be taken:		
	resident was cognit	ively impaired for daily			1. SSD will audit in		
	decision making.				house residents that have bee	n	
					transferred to hospital and/or		
	A Nurses' Note, dat	ted 5/28/21 at 10:55 a.m.,			other facility for last 90 days to		
		nt was complaining of pain to			assure transfer paper		
	her left foot. Disco	loration was observed to all			requirements have been		
	five toes. The resid	lent's foot was cool to touch			completed appropriately. Any		
	and no pedal pulse	was present. The Physician			issues will be addressed		
	was notified and or	ders were obtained to send the			immediately and families will		
	resident to the hosp	ital for evaluation. The			receive transfer paper work. T	his	
	resident's Power of	Attorney (POA) was also			will be completed by date of		
	notified.				compliance.		
					What measures and what		
		mentation indicating the			systemic changes will be ma	ide	
	resident's POA rece	eived a copy of the transfer			to ensure that the deficient		
	form.				practice doesn't recur:		
					1. ED and/or designed	•	
		Social Service Designee on			will educate SSD on the		
		n., indicated the resident's			appropriate transfer paper wo	rk	
	POA was not sent a	written transfer notice.			requirements by date of		
					compliance.		
		rd for Resident 56 was			How the corrective action wi	11	
		1 at 2:58 p.m. Diagnoses			be monitored to ensure the		
	included, but were	not limited to, dementia			deficient practice will not red	cur,	
	without behavior di	sturbance convulsions and	1		i o what quality assurance		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		155423	B. W	ING		07/30/	/2021
				CED FEET	ADDRESS OF A STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
HAMMON	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	adult failure to thriv	re.			program will be put in place:		
					1. Any transfer that		
		mum Data Set (MDS)			occurs will be reviewed in mor	•	
		/23/21, indicated the resident			meeting 5 days weekly ongoin	-	
	was cognitively imp	paired for daily decision			assure compliance. SSD will lo	og	
	making.				this information for all transfers	3	
					and keep current. ED and/or		
	Nurses' Notes, dated 5/14/21 at 4:40 p.m.,				designee will review daily and		
	indicated the resident was convulsing and produced brown emesis with undigested food. 911 was called and the resident was transferred				validate in morning meeting 5		
					days weekly and/or all open		
					business days x 6 months. Re	sults	
	to the hospital. The resident's sister was				will be presented to QAPI and		
	informed of the transfer, however, documentation was lacking regarding the				QAPI will determine the need	for	
					further audits.		
	resident's sister being mailed a copy of the				The results of these	;	
	transfer form.				reviews will be discussed at th	е	
					monthly facility Quality Assura	nce	
	Interview with the S	Social Service Designee on			Committee meeting monthly for	or a	
	7/30/21 at 1:04 p.m	., indicated the resident's			total of 3 months and then		
	family was not sent	a written transfer form. 3.			quarterly thereafter once		
	Resident 28's record	l was reviewed on 7/28/21 at			compliance is at 100%.		
	10:10 a.m. Diagnos	ses included, but were not			Frequency and duration of		
	limited to Alzheime	er's dementia and a history of			reviews will be increased as		
	falls.				needed, if compliance is below	/	
					100%.		
	Nursing Notes indic	cated, on 5/23/21, the			Compliance date: 8/29/21. The	9	
	resident was sent to	the hospital for a change in			Administrator at		
	mental status. She v	vas admitted to the hospital			Hammond-Whiting Care Cente	er is	
		facility on 5/25/21. There			responsible in ensuring		
	was no Transfer/Dis	scharge paperwork in the			compliance in this Plan of		
	record or notation the	nat it had been mailed to the			Correction.		
	resident's family.						
	ĺ						
	Interview with the S	Social Service Designee on,					
		n., indicated she thought she					
		family, but had not.					
	3.1-12(a)(6)(A)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 9 of 47

A BUILDING 00 COMPLETED 07/30/2021 NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR41 483.20(g) SABA ACCURACY OF Assessments Bldg. 00 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR41 483.20(g) SABA ACCURACY OF Assessments Bldg. 00 FOR41 483.20(g) SABA ACCURACY OF Assessments The assessment must accurately reflect the resident's fature. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to anticoagulant medication use and hospice services for 3 of 17 MDS assessments reviewed. (Residents 29, 41 and 13) Findings include: 1. The record for Resident 29 was reviewed on 7/28/21 at 3:07 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, orthopedic aftercare following surgical amputation, and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment, dated 6/16/21, indicated the resident was cognitively impaired for daily decision making. The Significant Change Minimum Data Set (MDS) assessment, dated 6/16/21, indicated the resident was cognitively impaired for daily decision making. Section N - Medications, indicated the resident had received an anticoagulant within the last 7	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY BUILL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR41 483,20(g) SS=A Accuracy of Assessments S483,20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to anticoagulant medication use and hospice services for 3 of 17 MDS assessments reviewed. (Residents 29, 41 and 13) Findings include: 1. The record for Resident 29 was reviewed on 7/28/21 at 3:07 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, orthopedic aftercare following surgical amputation, and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment, dated 6/16/21, indicated the resident was cognitively impaired for daily decision making. Section N - Medications, indicated the resident STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394 WHITING, IN 46394 WHITING, IN 46394 WHITING, IN 46394 ID PREFIX TAG DAY PREFIX TAG PREFIX TA	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLET			TED
MAMOND-WHITING CARE CENTER 1000 114TH ST WHITING, IN 46394			155423	B. W	NG		07/30/2	2021
MAMOND-WHITING CARE CENTER 1000 114TH ST WHITING, IN 46394			.		STREET	ADDRESS CITY STATE ZIP CODE	<u> </u>	
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		Section N - Medica	tions, indicated the resident			•	. l	
·								
days. modification MDS submitted by							_v	
day of compliance. This audit will							-	
A Physician's Order, dated 6/10/21, indicated the include care plan reviews to		A Physician's Order	r, dated 6/10/21, indicated the					
resident was to receive Plavix (an antiplatelet assure care plan is accurate as		1				-	s l	
medication) 75 milligrams (mg) daily.			· -			·		
What measures and what			5 (8)).					
Interview with the MDS Coordinator on 7/30/21 systemic changes will be made		Interview with the	MDS Coordinator on 7/30/21				nde	
at 12:55 p.m., indicated the MDS had been coded to ensure that the deficient							-	
wrong related to anticoagulant use. practice doesn't recur:								
1. CRS will educate MDS		3	<i>5</i>			l *	_{IDS}	
2. The record for Resident 41 was reviewed on on appropriate coding r/t		2. The record for R	Resident 41 was reviewed on				-	
7/28/21 at 11:18 a.m. Diagnoses included, but medications by date of								

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155423	B. W	NG		07/30/2021	
		1					
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
IOMMAH	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	chronic kidney disease,			compliance.		
	chronic embolism a	and thrombosis of other			How the corrective action w	11	
	specified veins, and	l type 2 diabetes.			be monitored to ensure the		
					deficient practice will not red	cur,	
	The Quarterly Mini	mum Data Set (MDS)			i.e., what quality assurance		
	assessment, dated 6	5/19/21, indicated the resident			program will be put in place.		
	was cognitively imp	paired for daily decision			1. DON/designee will		
	making.				audit any residents MDS that	s on	
	-				hospice services and receiving		
	Section N - Medica	tions, indicated the resident			any medication that requires		
	had received an anticoagulant within the last 7				observation of skin for bleedin	g,	
	days.				bruising, or abnormalities to		
					assure accuracy x 6 months.		
	A Physician's Order, dated 3/16/21, indicated the				Audits will be presented to QA	PLX	
	resident was to receive Plavix (an antiplatelet				6 months and QAPI will determ		
	medication) 75 mill	· -			the need for further audits.		
	,				2. The results of these	,	
	Interview with the I	MDS Coordinator on 7/30/21			reviews will be discussed at th	e l	
		ated the MDS had been coded			monthly facility Quality Assura	I	
	wrong related to an				Committee meeting monthly for		
	J				total of 3 months and then		
	3. The record for R	Resident 13 was reviewed on			quarterly thereafter once		
	7/27/21 at 11:41 a.r	n. Diagnoses included, but			compliance is at 100%.		
		delusional disorder, history			Frequency and duration of		
		with behavior disturbance,			reviews will be increased as		
	and anxiety.	,			needed, if compliance is below	v I	
	1				100%.		
	The Quarterly Mini	mum Data Set (MDS)			Compliance date: 8/29/21. Th	e	
		30/21, indicated the resident			Administrator at		
		paired for daily decision			Hammond-Whiting Care Cent	er is	
	making.	,			responsible in ensuring		
	5				compliance in this Plan of		
	Section O. Special	Treatments and Programs			Correction.		
	_	nt had not received hospice					
		ident of the facility during					
	the assessment refer						
		r					
	A Physician's Order	r, dated 1/10/21, indicated the					
		red to hospice services.					
	- 1 3 5 1 4 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION OO	COMI	E SURVEY PLETED 0/2021
	PROVIDER OR SUPPLIER		1000	r address, city, state, zip co 114TH ST ING, IN 46394	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	at 1:45 p.m., indicat wrong related to rec	ADS Coordinator on 7/30/21 ed the MDS had been coded eiving hospice services.				
F 0656 SS=D Bldg. 00	Plan §483.21(b) Compres §483.21(b)(1) The implement a compare plan for each the resident rights and §483.10(c)(3) objectives and times resident's medical psychosocial needs comprehensive as the attain or maintain practicable physic psychosocial well-§483.24, §483.25 (ii) Any services the required under §44 but are not provide exercise of rights at the right to refuse §483.10(c)(6). (iii) Any specialize rehabilitative serviprovide as a result recommendations the findings of the its rationale in the	nursing, and mental and list hat are identified in the sessment. The re plan must describe the re plan must describe the at are to be furnished to the resident's highest al, mental, and being as required under or §483.40; and list would otherwise be 83.24, §483.25 or §483.40 and list would otherwise be list. All the resident's light and the services or specialized ces the nursing facility will at of PASARR. If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 12 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COME		COMPL	ETED
		155423	B. W	NG		07/30/	2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
	ID MUUTING OAD	E OFNITED			14TH ST		
HAMMOI	ND-WHITING CARI	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(A) The resident's	goals for admission and					
	desired outcomes	3.					
	(B) The resident's	preference and potential					
	for future discharg	ge. Facilities must					
	document whethe	r the resident's desire to					
	return to the comr	munity was assessed and					
	any referrals to lo	cal contact agencies					
	and/or other appro	opriate entities, for this					
	purpose.						
	(C) Discharge pla	ns in the comprehensive					
	care plan, as app	ropriate, in accordance					
	with the requireme	ents set forth in paragraph					
	(c) of this section.						
		view and interview, the	F 0	556	<u>F 656-</u>		08/29/2021
	_	velop and implement a care			Development/Implementation		
	-	admitted with a pressure ulcer		Comprehensive Care Plan			
		s whose Care Plans were		What Corrective Action will be		oe -	
	reviewed. (Resider	nt 205)			accomplished for those		
					residents found to have beer	า	
	Finding includes:				affected by this deficient		
					practice:		
		ord was reviewed on 7/27/21			1. Resident # 205 had		
	_	esident was admitted on			negative outcomes. The care	olan	
	_	included, but were not			was put in place immediately.		
		e following digestive surgery			Resident 205 had all appropria		
	and a pressure ulce	r to the sacrum.			interventions and treatments in	ו	
	TO I	1 6			place on admission.	41	
	There was no care j	plan for pressure ulcers.			How other residents having		
	T 4 ' '41 41 1	MDC (M' ' D (C ()			potential to be affected by th		
		MDS (Minimum Data Set)			same deficient practice will be identified and what corrective		
		t 3:40 p.m., indicated the dmitted with the pressure			action will be taken:	E	
		and there should have been a			1. RDCS completed a	n in	
	care plan initiated.	and mere should have been a			house audit of resident's with	11 111	
	care plan illinated.				pressure ulcers to assure care	1	
	3.1-35(a)				plans in place by date of		
	J.1-JJ(a)				compliance. No other issues h	ave	
					been identified.	440	
					What measures and what		
					systemic changes will be ma	de	
					Oyotonno onanges win be ma		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 13 of 47

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155423	B. WING		07/30/2021
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, IN 46394	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				to ensure that the deficient practice doesn't recur: 1. DON/Designee we ducate licensed nursing state appropriately completing nursing skin issues are identified care planned on admission that date of compliance. 2. New licensed nursing will complete this education orientation. How the corrective action we deficient practice will not rive., what quality assurance program will be put in place. 1. New admissions are readmission charts will be but to morning meeting and audid days weekly by IDT to assur admission skin assessment accurate and base line care are in place for any skin con and WOT is present if application that is to be ongoing. 2. The results of the reviews will be discussed at monthly facility Quality Assurance of the reviews will be discussed at monthly facility Quality Assurance of the reviews will be increased as needed, if compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is beling. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Celebraters.	ill aff on rsing ssure d and by ses cation will e ecur, e e: and rought ited 5 re is plans cerns cable. se the rance for a

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 14 of 47

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLE'	
		155423			07/30/2	UZ I
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
	ND-WHITING CARE	CENTED		14TH ST		
HAIVIIVIOI	ND-WHITING CARE	CENTER	VVHIIII	NG, IN 46394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE PRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
				responsible in ensuring compliance in this Plan of		
				Correction.		
F 0657	483.21(b)(2)(i)-(iii)					
SS=D	Care Plan Timing					
Bldg. 00		ehensive Care Plans				
J	- , , .	omprehensive care plan				
	must be-	·				
		in 7 days after completion				
	of the comprehens					
		n interdisciplinary team,				
	that includes but is					
	(A) The attending	pnysician. urse with responsibility for				
	the resident.	urse with responsibility for				
		vith responsibility for the				
	resident.	······, ····				
	, ,	ood and nutrition services				
	staff.					
	(E) To the extent p					
	participation of the					
		ntative(s). An explanation in a resident's medical				
		ipation of the resident and				
	•	esentative is determined				
		the development of the				
	resident's care pla	•				
		ate staff or professionals				
	· ·	etermined by the resident's				
		sted by the resident.				
	(iii)Reviewed and	-				
		am after each assessment,				
	quarterly review as	comprehensive and				
		riew and interview, the	F 0657	F 657- Care Plan Timing an	d	08/29/2021
		ure Care Plan conferences	1 005/	Revision	_	00/27/2021
		I failed to ensure Care Plans		What Corrective Action wi	ill be	
	were revised as need	ded for 2 of 17 residents		accomplished for those		
	whose Care Plans w	vere reviewed. (Residents 24		residents found to have be	ee <i>n</i>	
1			1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 15 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155423	B. W		<u></u>	07/30/2	
		.55.125				31,00/2	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and 47)				affected by this deficient		
					practice:		
	Findings include:				1. Residents 24 and	47	
					had no negative outcomes. (Care	
	1. The record for R	esident 24 was reviewed on			Plan for resident 24 was upd	ated	
		n. Diagnoses included, but			and revised immediately.		
	· ·	dementia without behaviors,			How other residents having	the	
	type 2 diabetes, CO	PD, dysphagia, atrial			potential to be affected by	the	
		ood pressure, anxiety, and			same deficient practice will	be	
	major depressive di	sorder.			identified and what correct	ive	
					action will be taken:		
	The Annual Minim	um Data Set (MDS)			1. An in house audi	it will	
	assessment, dated 5	5/19/21, indicated the resident			be completed by nursing to		
	was not alert and or	riented, rarely understood and			assure all antibiotic care plar	ns are	
	rarely understands,	and was severely impaired for			updated and current by date	of	
	decision making. T	The resident had no mood or			compliance.		
	behavior problems	including rejection of care.			2. SSD will complet	te an	
	The resident needed	d extensive assist for dressing			in house audit of residents fo	or the	
	and did not receive	oxygen while a resident.			last 90 days to assure care p	lans	
					have been taking place. Any		
	The Care Plan, date	ed 6/14/21, indicated the			issues identified will be addre	essed	
	resident was on ant	ibiotic therapy related to an			by date of compliance.		
	infection.				What measures and what		
	The approaches we	re to administer antibiotic			systemic changes will be n	nade	
	medications as orde	ered by physician.			to ensure that the deficient		
					practice doesn't recur:		
		dated 6/25/21, indicated			1. CRS will educate		
		te Tablet (an antibiotic) 100			on regulations related to care		
		ve 1 tablet two times a day for			planning to include perimeter		
	an urinary tract infe	ection for 13 administrations.			completion and inviting famil	ies	
	The antibiotic was	discontinued on 7/2/21.			and residents.		
					2. IP will inform		
		Interim Director of Nursing			MDS/DON when antibiotic is	I	
		a.m., indicated the Care Plan			completed to ensure antibiot		
	for the antibiotic the	erapy was outdated.			care plan is removed. This w	rill be	
					completed by date of		
	2. During an interv	riew with Resident 47 on			compliance.		
	7/26/21 at 9:56 a.m	., she indicated she had not			How the corrective action v	vill	
	been invited to a ca	re conference since she had			be monitored to ensure the		
	been admitted.				deficient practice will not re	ecur.	

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) M	· ·			SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			ETED
		155423	B. W	NG		07/30/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				I4TH ST		
НАММОР	ND-WHITING CARE	CENTER			IG, IN 46394		
			_				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
					i.e., what quality assurance		
		dent 47 was reviewed on			program will be put in place:		
		n. Diagnoses included, but			1. IP will audit care pla	ans	
		type 2 diabetes, anemia,			for residents on antibiotics to		
		, anxiety, pain, muscle			assure compliance ongoing. E	D	
		19. The resident was admitted			will audit 3 charts weekly x 8		
	to the facility on 12	/15/20.			weeks, then 2 charts weekly x		
					weeks, then 1 chart weekly x 8		
		mum Data Set (MDS)			weeks to assure care plans are		
	· ·	/24/21, indicated the resident			occurring, resident and/or fami	ıly	
	was alert and orient	ed with some mild confusion.			invited, and this is being		
					documented. Audits will be		
		nentation the resident had a			presented to QAPI x 6 months		
	care conference since	ce admission.			QAPI will determine the need to	for	
					further audits.		
		Social Service Director on			2. The results of these		
	-	, indicated the resident had			reviews will be discussed at th		
	not had a care confe	erence since admission.			monthly facility Quality Assura		
	2.1.25(1)(2)(D)				Committee meeting monthly fo	or a	
	3.1-35(d)(2)(B)				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: 8/29/21. The	;	
					Administrator at	ar ie	
					Hammond-Whiting Care Center	51 15	
					responsible in ensuring compliance in this Plan of		
					Correction.		
					Correction.		
F 0677	483.24(a)(2)						
SS=D	, , , ,	d for Dependent Residents					
Bldg. 00		esident who is unable to					
2.59.00	. , , ,	of daily living receives the					
		s to maintain good					
		g, and personal and oral					
	hygiene;	,,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 17 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155423	B. W	B. WING 07/30/2021			
				CENTER	ADDRESS SITU STATE TIP SORE		
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
HAMMOI	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Based on observation	on, record review and	F 06	677	F 677- ADL Care Provided for	08/29/2021	
	interview, the facili	ity failed to ensure dependent			Dependent Residents		
	residents received a	assistance with ADL's			What Corrective Action will	be	
	(activities of daily l	living) related to shaving, nail			accomplished for those		
	care, hair care, and	bathing for 2 of 2 residents			residents found to have bee	n	
	reviewed for ADL's	s (Residents 24 and 205)			affected by this deficient		
					practice:		
	Findings include:				1. Resident 205 was		
					shaved, given a full bed bath	per	
	1. On 7/26/21 at 1	0:15 a.m., 11:25 a.m., and			his preference and has his ha	ir	
	2:20 p.m., Resident	t 12 was observed in bed			washed as well		
	dressed in a hospita	al gown. At those times his			immediately.		
	nails on his right hand were dirty and he was				How other residents having	the	
	unshaven.				potential to be affected by the	he	
					same deficient practice will	be	
	On 7/27/21 at 9:05	a.m., 11:27 a.m., 1:03 p.m.,			identified and what corrective	/e	
	1:17 p.m., 2:24 p.m	n., and 4:00 p.m., the resident			action will be taken:		
	was observed unsha	aven with dirty fingernails to			1. An in house audit v	vill	
	his right hand.				be completed by nursing		
					management on residents for	the	
	7/28/21 at 8:53 a.m	., the resident was observed			POC charting to assure comp	leted	
	unshaven with dirty	y fingernails to his right hand.			per policy. Any issues will be		
					identified and follow up will be	;	
	At 9:54 a.m., LPN	1 performed a skin			completed.		
	assessment for the	resident. She removed his			What measures and what		
	left hand from unde	er the linens. His fingernails			systemic changes will be ma	ade	
	on his left hand we	re thick and yellow/black			to ensure that the deficient		
	discolored. The LF	PN indicated at that time, she			practice doesn't recur:		
	was unaware of the	color of his nails.			1. Education to the		
					aides, licensed nurses, and S	SD	
	The record for Resi	ident 12 was reviewed on			for completion of POC/PCC		
	7/27/21 at 2:40 p.m	n. Diagnoses included, but			documentation related to refu	sal	
	were limited to, stre	oke, vascular dementia, type 2			of shower/bed bath. Shower s	sheet	
	diabetes, major dep	pressive disorder, stiffness in			to be completed and turned ir	nto	
	the left hand, delus	ional disorder, atrial			nurse each shift. MD and PO	4	
	fibrillation, convuls	sions, muscle weakness, and			and/or family to be notified of		
	muscle atrophy.				refusal. Nursing to notify SSD	of	
					refusal(s). SSD to ensure care	e	
	The Quarterly 4/29	/21 Minimum Data Set			plan is updated to reflect		
		, indicated the resident was			refusal(s). This will be comple	ted	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DA	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 CO.	COMPLETED	
<u> </u>	7/30/2021	
	70072021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
1000 114TH ST		
HAMMOND-WHITING CARE CENTER WHITING, IN 46394		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
not alert and oriented. He needed extensive by DON/Designee by date of		
assist with 1 person physical assist for dressing compliance.		
and personal hygiene. The resident had a feeding 2. Any new nursing staff		
tube and received a mechanically altered diet. will receive this education during		
He received 51% or more of his calories with orientation as well.		
the tube feeding and had no skin issues.		
How the corrective action will		
A Care Plan, revised on 7/23/21, indicated the be monitored to ensure the		
resident's preferences were as follows: deficient practice will not recur,		
gown/pajamas, remove as needed. Keep his nails i.e., what quality assurance		
short and remove facial hair (wants a clean shave) program will be put in place:		
with an electric razor. The approaches were to 1. DON/Designee will		
ask or offer the resident a clean shave on his review shower sheets daily 5		
shower days with his electric shaver as he times weekly to assure		
preferred. Ask or offer the resident with help compliance. The shower sheets		
with his selection of clothing. Offer to cut the must be compared to the POC		
resident's nails short as he preferred. charting to assure they match.		
Any refusals that are ongoing		
Interview with LPN 1 on 7/28/21 at 10:00 a.m., need to be reported to SSD and		
indicated the resident was in need of a shave and SSD will discuss with		
his nails cleaned.2. On 7/26/21 at 10:38 a.m., resident/POA/family. Audits will be		
Resident 205 was observed in his bed. His hair presented to QAPI x 6 months and		
appeared greasy and unwashed. QAPI will determine the need for		
further audits.		
The resident's record was reviewed on 7/27/21 at 2. The results of these		
2:18 p.m. The resident was admitted on 7/2/21. reviews will be discussed at the		
Diagnoses included, but were not limited to, monthly facility Quality Assurance		
aftercare following digestive surgery and a Committee meeting monthly for a		
pressure ulcer to the sacrum. The resident was total of 3 months and then		
cognitively intact. quarterly thereafter once		
compliance is at 100%.		
The Point of Care charting (CNA documentation) Frequency and duration of		
indicated there were no baths or showers reviews will be increased as		
documented since the resident's admission. needed, if compliance is below		
100%.		
The shower book indicated the resident was Compliance date: 8/29/21. The		
scheduled to have a shower on Tuesdays and Administrator at		
Fridays. There was a shower sheet completed on Hammond-Whiting Care Center is		
7/5/21 which indicated the resident had a bed responsible in ensuring		
bath and his linen had been changed. Another compliance in this Plan of		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155423	B. WING	00	07/30/2021
		.55120		ADDRESS, CITY, STATE, ZIP CODE	31703/2021
NAME OF P	ROVIDER OR SUPPLIER			14TH ST	
HAMMON	ND-WHITING CARE	CENTER		IG, IN 46394	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION) 7/23/21, indicated the	TAG	Correction.	DATE
		ath, but hair was not washed.		Correction.	
		ional shower sheets.			
		esident on 7/26/21 at 10:38			
		anted his hair washed, and it			
	nad not been washed	d for a couple weeks.			
	Interview with the C	CNA on 7/27/21 at 2:35 p.m.,			
	_	nt the resident had refused			
		ndicated a shower sheet			
	should be completed	d even if the resident refused.			
	3.1-38(a)(2)(A)				
	3.1-38(a)(3)(D)				
	3.1-38(a)(3)(E)				
F 0684	483.25				
SS=D	Quality of Care				
Bldg. 00	§ 483.25 Quality o	f care			
	_	a fundamental principle that			
		ment and care provided to			
	facility residents. E	sessment of a resident, the			
	•	e that residents receive			
	treatment and care	e in accordance with			
	· -	ards of practice, the			
	comprehensive pe and the residents'	rson-centered care plan,			
		on, record review and	F 0684	F 684- Quality of Care	08/29/2021
		ry failed to ensure an open	1 0004	What Corrective Action will b	
		sessed and monitored for 1		accomplished for those	
		ved for skin conditions (non-		residents found to have beer	'
		d antiembolic stockings place for 1 of 1 residents		affected by this deficient practice:	
		. (Residents 12 and 21)		1. Resident # 12 had t	xs
		,		orders obtained immediately a	
	Findings include:			put in place. MD and family we	re
	1 On 7/26/21 at 10	:15 a.m., Resident 12 was		notified. Resident # 21 had an order for Ted hose put in place	<u> </u>
	1. On //20/21 at 10	.13 a.m., resident 12 was		order for red flose put in place	·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 20 of 47

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155423 NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX A. BUILDING O STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED O7/30/2021
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)
HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
UNUSS-REFERENCED TO THE APPROPRIATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE
observed in bed. At that time, his feet were immediately with an MD order and
observed on top of the bed linens. Both feet family aware as well.
were dry and scaly skin was noted. A blood How other residents having the
tinged scabbed open area was observed on his potential to be affected by the
left pinky toe. same deficient practice will be
identified and what corrective
On 7/28/21 at 9:54 a.m., LPN 1 was going to action will be taken:
perform a skin assessment on the resident. At 1. In house audit
that time, the bed linens were removed from his completed with head to toe skin
feet. There was an open blood tinged scabbed assessments to assure any skin
area to the left pinky toe. She indicated she was issues are identified and
not aware of the open area or that the resident's addressed by nursing
pinky toenail had fallen off. management by date of
compliance. This audit will also
The record for Resident 12 was reviewed on include noting edema of lower
7/27/21 at 2:40 p.m. Diagnoses included, but extremities, validating if ted hose
were limited to, stroke, vascular dementia, type 2 ordered and in place and if not
diabetes, major depressive disorder, stiffness in MD to be notified. Any new orders
the left hand, delusional disorder, atrial received put on TX and/or med
fibrillation, convulsions, muscle weakness, and sheet, care plan and kardex
muscle atrophy. updated. Any issues identified will
be addressed.
The Quarterly, 4/29/21 Minimum Data Set What measures and what
(MDS) assessment, indicated the resident was systemic changes will be made
not alert and oriented. He needed extensive to ensure that the deficient
assist with 1 person physical assist for dressing practice doesn't recur:
and personal hygiene. The resident had a feeding 1. Education will be
tube and received a mechanically altered diet. completed to licensed and
He received 51% or more of his calories with certified nursing staff to assure
the tube feeding and had no skin issues. any skin issue or abnormal finding
needs reported and documented
A Care Plan, dated 7/20/21, indicated the in the clinical record, MD and
resident had a detached left toenail. Responsible party need notified
and care plan and Kardex to be
A Care Plan, revised on 7/23/21, indicated the updated to reflect new orders
resident has Diabetes. The approaches were to and/or include any new
inspect feet daily for open areas, sores, pressure interventions by Nursing
areas, blisters, edema or redness. management by date of
compliance. New licensed or
Nurses' Notes, dated 7/6/21 at 8:45 p.m., certified nursing employees will

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155423	B. WING 07/30/2021				
			0.7007				
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
HAMMO	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the CNA	reported the resident's toenail			receive this education prior to		
	on the left foot pink	ty toe had fallen off. Upon			working.		
	observation the toe	was bleeding and there was			How the corrective action w	ill	
	no toenail attached.	The toe was cleansed with			be monitored to ensure the		
	normal saline and a	dry dressing was secured			deficient practice will not re	cur,	
	over the toe. The P	hysician was noted via fax.			i.e., what quality assurance		
					program will be put in place.	:	
	Nurses' Notes, date	d 7/7/21 at 12:55 p.m.,			1. DON/Designee will		
	indicated there was	a dressing to the left pinky			review 24/72 hour report 5 tim	ies	
	toe due to the nail f	alling off.			weekly to ensure treatment or	ders	
					are obtained and in place for a	any	
	Nurses' Notes, date	d 7/8/21 at 3:50 a.m.,			skin issues including edema,	and	
	indicated the 5th di	git on the left foot dressing			care plan is updated x 6 mont	hs.	
	was clean, dry and	intact.			Audits will be presented to QA	API x	
					6 months and QAPI will deteri	mine	
	There was no further	er documentation regarding			need for further audits.		
	the left pinky toe.				Competencies will be complet	ted	
					by date of compliance on aide	es .	
	Weekly skin assess	ments, dated 7/6, 7/13, 7/20,			and nurses for the appropriate	•	
	and 7/27/21, indica	ated "left toe Pink toe on left			protocol for skin assessments	and	
	foot fell off. Bleedi	ng noted." (sic)			accurate follow through and		
					documentation by Nursing		
	Nurses' Notes, date	d 7/28/21 at 10:29 a.m.,			Management.		
	indicated staff spok	e to the physician in regards			2. The results of these	е	
	of resident's thick, y	yellow nails and left pinky			reviews will be discussed at the	ne	
	toenail missing. The	e Physician ordered aquaphor			monthly facility Quality Assura	ance	
	ointment for the fee	et, and for the left pinky toe			Committee meeting monthly for		
	to be cleaned with r	normal saline, apply			total of 3 months and then		
	Bacitracin and cove	er with bandage daily.			quarterly thereafter once		
					compliance is at 100%.		
	Physician Orders, d	ated 7/28/21, indicated			Frequency and duration of		
	Aquaphor Ointmen	t (Emollient) apply to feet			reviews will be increased as		
		day for dry skin and clean			needed, if compliance is below	N	
	open area to left pir	nky toe with normal saline,			100%.		
	apply Bacitracin, ar	nd cover with dry bandage			Compliance date: 8/29/21. Th	е	
	every evening shift.	-			Administrator at		
					Hammond-Whiting Care Cent	er is	
	Interview with the I	LPN 1 on 7/28/21 at 10:00			responsible in ensuring		
	a.m., indicated the	resident's feet were very dry			compliance in this Plan of		
		unaware of any open area to			Correction.		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2021
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	the left pinky toe or off. 2. On 7/26/21 a observed in her roof. There were TED he used to treat edemathe resident's feet with the resident's feet with the resident's feet with the resident's feet with the resident with the resident with the resident's record 11:23 a.m. Diagnor limited to, cirrhosis history of falls. The Minimum Data Set indicated the reside impairment and need assistance for dress. There was no Physical hose. Interview with the reside impairment and need assistance for dress. There was no Physical hose. Interview with the reside impairment and need assistance for dress. There was no Physical hose. Interview with the reside impairment and need assistance for dress. There was no Physical hose. The resident has no Physical has no	that his toenail had fallen at 1:02 p.m., Resident 21 was m with a family member. See (compression stockings) on the end of her bed and the reslightly edematous. a.m., the resident was ther bed, barefoot. The TED in the bed next to her. At 2:10 has observed seated in a lose on, the TED hose did. did was reviewed on 7/27/21 at loses included, but were not of the liver, weakness and a lee Significant Change assessment, dated 5/25/21, and had moderate cognitive had extensive one person ing. cian's Order for the TED resident and her family, on the indicated the staff were to lying the TED hose as she			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 23 of 47

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	of correction (155423) To provider/supplier/clia identification number:	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2021
	PROVIDER OR SUPPLIER ND-WHITING CARE CENTER	1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST IG, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Interview with CNA 1, on 7/28/21 at 2:25 p.m., indicated she was not aware the resident had TED hose or that she should assist her with putting them on until today. 3.1-37(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's			
	clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review and interview, the facility failed to ensure tube feeding medications and flushes were instilled via gravity and the feeding was infusing at the correct time for 1 of 1 residents reviewed for tube feeding. (Resident 12)	F 0693	F 693- Tube Feeding Management/Restore eating s What Corrective Action will t accomplished for those residents found to have been affected by this deficient practice:	be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 24 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155423	B. W	NG		07/30/	2021
				CED FEET	A PARTIE OF COMMUNICATION CONTRACTOR CONTRAC		-
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					I4TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	' ⁻	DATE
	Finding includes:				1. Resident 12 had no		
					negative outcomes. MD and P	OA	
	On 7/26/21 at 11:25	5 a.m., Resident 12 was			notified of tube feeding hung a	ıt	
	observed in bed we	aring a hospital gown. The			wrong time. Education provide	d to	
	enteral tube feeding	was infusing at 65 cubic			LPN # 1 immediately.		
	centimeters (cc) per	hour.			How other residents having t	the	
					potential to be affected by th	е	
	On 7/27/21 at 1:03	p.m. to 1:17 p.m., the			same deficient practice will b	oe	
	resident was observ	ed sitting up in a broda chair			identified and what correctiv	e	
	by the nurses' statio	n. The resident's enteral			action will be taken:		
	feeding was not turn	ned on.			 Residents with tube 	;	
					feeding orders have been aud	ited	
	The record for Resident 12 was reviewed on				to assure orders in place for		
	7/27/21 at 2:40 p.m. Diagnoses included, but				specific times for infusion per I	MD	
	were limited to, stroke, vascular dementia, type 2				order. Nursing Management		
	diabetes, major dep	ressive disorder, stiffness in		observed these residents for			
	the left hand, delusi	onal disorder, atrial			appropriate times of infusion w	/ith	
	fibrillation, convuls	ions, muscle weakness, and			no other issues noted by date	of	
	muscle atrophy.				compliance.		
					What measures and what		
		21 Minimum Data Set			systemic changes will be ma	de	
	, ,	indicated the resident was not			to ensure that the deficient		
		He needed extensive assist			practice doesn't recur:		
		cal assist for dressing and			 Nursing Manageme 		
		The resident had a feeding			will educate licensed nursing s		
		mechanically altered diet.			on infusing tube feeding per M	ID	
		more of his calories with			order, flushing and giving	_	
	the tube feeding and	d had no skin issues.			medications per policy by date	of	
					compliance.		
		d on 7/23/21, indicated the			2. Competencies will be		
		itional risk for possible			completed on licensed Nursing	·	
	decrease intake and				med administration, flushes, a		
		provide a diet and enteral			assuring following MD orders f	or	
	nutrition formula ar	nd fluid flushes as ordered.			Tube feedings.		
		1 . 111/0/20			3. New licensed nursing	ng	
	1 -	dated 11/9/20, indicated			staff will not work until this	_	
	1	al feeding) at 65 milliliters			education and a competency is	s	
	` ' *	18 hours, on at 1 p.m. and			completed.	,,	
	off at 7 a.m.				How the corrective action will	"	
					be monitored to ensure the		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155423	B. WING		07/30/2021
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	L		14TH ST	
HAMMON	ND-WHITING CARE	ECENTER		NG, IN 46394	
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	<u> </u>	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT	ION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE DATE
1710		nterim Director of Nursing	ind	deficient practice will no	
		a.m., indicated the resident's		i.e., what quality assurar	-
		be infusing according to the		program will be put in pl	
	_	On 7/29/21 at 12:50 p.m.,		1. Don/Designee	
	-	d preparing medications for		observe and/or have them	
		PN indicated the resident		verbalize appropriate flush	
	received his medica			medication administration	<u> </u>
		tube inserted in the abdomen		infusion of tube feedings 3	
		. She crushed two sodium		weekly x 3 months, then 2	
		that were 650 milligrams		weekly x 3 months to assu	
		nem in a medication cup and		compliance. This will be ro	
	diluted them with w	vater.		shifts. Audits will be prese	nted to
				QAPI x 6 months then QA	.PI will
	The LPN proceeded	l to enter the resident's room		determine the need for fur	ther
	_	strostomy tube for placement.		audits.	
	_	rater into a syringe for a water		2. The results of the	
		g the medication. The LPN		reviews will be discussed	
		sing the plunger on the		monthly facility Quality As	
		letting the flush infuse via		Committee meeting month	•
		rew up the medication in the		total of 3 months and then	1
		sed the plunger on the syringe		quarterly thereafter once	
		tion instead of letting the		compliance is at 100%.	£
		ia gravity. The LPN then		Frequency and duration of	
	did not let the flush	to flush the tube. Again, she		reviews will be increased a needed, if compliance is b	
				100%.	
	Interview with the I	nterim Director of Nursing		Compliance date: 8/29/21	. The
		.m., indicated the water flush		Administrator at	
		s should have been given via		Hammond-Whiting Care C	Center is
	gravity.			responsible in ensuring	
	TTI C 11: 1:	total magnitude		compliance in this Plan of	
	The facility policy t	atled, "Medication gh an Enteral Tube" was		Correction.	
		gh an Enteral Tube" was ministrator on 7/30/21 at 8:40			
	-	as current. The policy			
		nedications to flow down the			
		via gravity. Medications			
	were not to be push				
	ere not to be push	- a mough a taot.			
	3.1-44(a)(2)				
	- · - · · · · · · · · · · · · · · · · ·			1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 26 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155423		(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 07/30/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goad 483.65 of this sub Based on observation interview, the facility respiratory care and the correct flow rate reviewed for oxyger. 1. On 7/26/21 at 11 Resident 9 was obsessive was wearing ox liters per minute. On 7/27/21 at 11:55 resident was observed was wearing oxyger. On 7/28/21 at 1:30 pobserved in bed. A oxygen at 2 liters per The record for Resi 7/27/21 at 1:12 p.m. were not limited to, diabetes, respiratory blood pressure, con	e and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, s and preferences, and part. on, record review and ty failed to provide proper services related to oxygen at er for 2 of 3 residents in. (Residents 9 and 24) :29 a.m. and 2:07 p.m., erved in bed. At those times, ygen per nasal cannula at 3 if a.m. and 4:00 p.m., the end in bed. At those times, she in at 2 liters per minute.	F 0695	F 695- Respiratory/Tracheosto Care and Suctioning What Corrective Action will a accomplished for those residents found to have been affected by this deficient practice: 1. Resident 9 and 24 no negative outcomes. MD wanotified on inaccurate liter flow O2 sats were taken immediate with no issues noted and O2 liflows adjusted to ordered liter immediately. How other residents having potential to be affected by the same deficient practice will a identified and what corrective action will be taken: 1. An Audit was completed on residents in hou with current 02 orders to assu orders accurate and clinical te observed liter flow being administered per order. No oth issues have been identified. A completed by nursing	had as v. ely iter flow the ne be ve

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 27 of 47

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155423	B. W	NG		07/30/2	2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			14TH ST		
	ND-WHITING CAR	E CENTED			NG, IN 46394		
HAIVIIVIOI	ND-WHITING CAR	ECENTER		VVIIIIN	NG, IN 40394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and major depressiv	ve disorder.			management by date of		
					compliance.		
	The Annual Minimum Data Set (MDS)				What measures and what	_	
	· ·	2/22/21 indicated the resident			systemic changes will be m	ade	
		ted. The resident received			to ensure that the deficient		
	oxygen while a resi	dent.			practice doesn't recur:		
	TEI 1 C 41	.1.			1. Don and/or design		
	The record for the resident was reviewed on				have educated licensed nursi staff and certified aides to	ng	
	07/27/21 01:12 PM Diagnoses included, but				observe liter flow on residents	,	
	were not				using 02 and assure liter flow		
	The Care Plan, revised on 5/1/21 indicated the				accurate per order. This will b		
	resident had altered respiratory status/difficulty				completed by date of complia		
	breathing related to respiratory failure and				How the corrective action w		
	COPD. The approaches were to provide oxygen				be monitored to ensure the	<i>"'</i>	
	at 2 liters per nasal				deficient practice will not re	cur.	
	an 2 mons per masar				i.e., what quality assurance	·,	
	Physician's Orders,	dated 5/5/21, indicate			program will be put in place	:	
	-	ninute continuously per nasal			1. Don/Nursing		
	cannula.				management will observe 5		
					residents daily Monday through	gh	
	The Medication Ad	ministration Record for			Friday x 8 weeks, then 3 resid	dents	
	7/2021 indicated ox	tygen 5 liters was signed out			daily Monday through Friday :	x 8	
	as being administer	red 7/1-7/27/21.			weeks, then 2 residents daily		
					Monday through Friday x 8 w		
		Interim Director of Nursing			to assure compliance. Audits	will	
		a.m., indicated the oxygen			be presented to QAPI x 6 mo		
	should be at the rate	e ordered by the physician.			and then QAPI will determine		
					need for further audits. Any ne	oted	
		0:21 a.m., Resident 24 was			issues will be addressed		
		essed in a hospital gown. At			immediately.		
		cannula for the oxygen was			2. The results of thes		
	•	The concentrator in the room			reviews will be discussed at the		
	was set at 3 liters po	er minute.			monthly facility Quality Assura		
	On 7/26/21 at 11:03	7 a.m. and 2:10 n.m. tha			Committee meeting monthly f	u a	
		7 a.m., and 2:10 p.m., the			total of 3 months and then quarterly thereafter once		
		yed in bed. She was wearing			compliance is at 100%.		
	oxygen per nasal ca	annula at 3 liters per minute.			Frequency and duration of		
	On 7/27/21 0:02 a a	n., the resident was observed			reviews will be increased as		
	On //2//21 9:02 a.f	ii., the resident was observed			Teviews will be increased as		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2021
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	in bed. She was we cannula at 3 liters p On 7/27/21 at 11:28 and 4:04 p.m., the r in a broda chair. S nasal cannula at 3 li On 7/28/21 at 8:50 observed in bed. The concentrator in the minute. On 7/28/21 at 10:00 observed in bed. She nasal cannula at 3 li The record for Resi 7/28/21 at 10:08 a.r were not limited to, type 2 diabetes, CO fibrillation, high blomajor depressive di The Annual Minima assessment, dated 5 was not alert and or rarely understands, decision making. The heavior problems in the resident needed and did not receive The Care Plan, reviresident was at risk related to the COVI approach was to adminimate the covice of	aring oxygen per nasal er minute. 3 a.m., 1:03 p.m., 2:25 p.m., esident was observed sitting he was wearing oxygen per ters per minute. a.m., the resident was he nasal cannula for the ed on top of her head. The room was set at 3 liters per a.m., the resident was he nasal cannula for the ed on top of her head. The room was set at 3 liters per a.m., the resident was he was wearing oxygen per ters per minute. dent 24 was reviewed on h. Diagnoses included, but dementia without behaviors, PD, dysphagia, atrial bood pressure, anxiety, and sorder.		needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	v e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 29 of 47

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPI			ETED
		155423	B. WI	NG		07/30/	2021
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cannula. Interview with the I	nterim Director of Nursing a.m., indicated the resident's					
	oxygen should have minute as ordered by	e been set at 2 liters per					
F 0744 SS=D Bldg. 00	diagnosed with de appropriate treatm or maintain his or physical, mental, a well-being. Based on observation interview, the facility plan of care was foll appropriate demention residents reviewed for 28) Finding includes: On 7/26/21 at 9:11 and observed seated along television or radio of the relothing and who observation of the recon 7/28/21 at 8:45 and 9:49 a.m., 10:45 a.m.	esident who displays or is amentia, receives the ment and services to attain ther highest practicable and psychosocial on, record review, and ty failed to ensure a resident's lowed related to providing in care to resident for 1 of 3 for dementia care. (Resident a.m., Resident 28 was the in her room. There was no on and she was fidgeting with	F 07	744	F 744- Treatment/Service for Dementia What Corrective Action will to accomplished for those residents found to have been affected by this deficient practice: 1. Resident 28's (busy) aprovate located in the facility laund and provided to resident, along with activity items on-hand and made available as per plan of care. How other residents having to potential to be affected by the same deficient practice will to identified and what corrective action will be taken:	on dry 3 d the e oe	08/29/2021
	10:10 a.m. Diagnos	d was reviewed on 7/28/21 at ses included, but were not cr's dementia and a history of			 Full audit to be completed Activity Director and Social Service Director and/or design prior to August 29, 2021 of 		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 30 of 47

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLETED	
		155423	B. W	ING		07/30/2021	
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
		- OFMITED			14TH ST		
HAMMO	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	falls.				current residents with diagnos	is of	
					dementia to ensure activity ite	ms	
	The Activity Care I	Plan, updated 2/10/21,			as outlined in care plan are		
	indicated, "Encou	rage [resident's name] with			on-hand and available to		
	interaction during d	aily visits with small talk,			resident(s). Any issue identifie	d	
	snacks, short stories	s, music/video therapy and if			via this audit will be immediate	ely	
	possible exercise su	ich as balloon toss" and,			addressed.		
	"provide mental s	timulation and reality			What measures and what		
	orientation such as	magazines, music, adult			systemic changes will be ma	de	
	coloring, busy apro-	n"			to ensure that the deficient		
					practice doesn't recur:		
	The May and June 2	2021 Record of One-To-One			Re-education to be provided.	ded	
	Activities for the re	sident was provided by the			to staff by Executive Director		
		AD) on 7/29/21 at 11:00 a.m.			and/or designee prior to Augu		
	There were seven e	ntries for May and eight			29, 2021 to ensure understand	ding	
	entries for June.				and importance following		
					resident(s)' plan of care relate		
		AD on 7/29/21 at 10:49 a.m.,			providing appropriate dementi	a	
		ot visit or do activities with			care.		
		she did not have a schedule					
		he would visit when she saw			How the corrective action wi		
		in the hallway. She indicated			be monitored to ensure the		
		ald be in the resident's room,			deficient practice will not red	cur,	
		to locate it in the closet or			i.e., what quality assurance		
	drawers.				program will be put in place:		
	2.1.27()				Executive Director and/or designed will conduct 5		
	3.1-37(a)				and/or designee will conduct 5		
					resident observations on vario		
					shifts and times weekly x 8 we	ers,	
					then monthly for 4 months to ensure residents plan of care		
					followed related to providing	3	
					appropriate dementia care. A	nv	
					issues identified will be	''	
					immediately addressed. Audits	s will	
					be presented to QAPI x 6 mor		
					then QAPI will determine the r		
					for further audits.		
					io. iditioi dudito.		
					2. The results of these	,	
					∠. The results of these		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/30/2021
	ROVIDER OR SUPPLIER		1000 1 ² WHITIN	ADDRESS, CITY, STATE, ZIP CODE 14TH ST IG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
F 0759	483.45(f)(1)			reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for 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: 8/29/21. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	nce or a
SS=D Bldg. 00	Free of Medication §483.45(f) Medica The facility must e §483.45(f)(1) Med	nsure that its- ication error rates are not			
	interview, the facility medication error rate residents observed of Three errors were of opportunities for error administration. This error rate of 11%. (Findings include: 1. On 7/28/21 at 5:: preparing medication indicated the resident units of Novolog instance.)	on, record review, and ty failed to ensure a e of less than 5% for 3 of 9 during medication pass.	F 0759	F 759- Free of Mediation Error 5% or More What Corrective Action will It accomplished for those residents found to have been affected by this deficient practice: 1. Resident 27, 42 and 36 had no negative outcomes. LPN # 1, 2, and 3 were educatimmediately. MD was notified medication errors and no new orders were received. How other residents having a potential to be affected by the same deficient practice will It.	the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 32 of 47

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155423	B. W	NG		07/30/2	2021
		1					
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
IOMMAH	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed to be diale	ed to 4 units and the insulin			identified and what corrective	⁄e	
	was administered in	the resident's arm. The LPN			action will be taken:		
	was not observed to	prime the insulin pen.			1. An in house audit w	vill	
					be completed on residents		
	The record for Resi	dent 27 was reviewed on			receiving insulin via insulin pe	ns.	
	7/29/21 at 9:00 a.m	. Diagnoses included, but			Nursing managers will validate	е	
	were not limited to,	type 2 diabetes mellitus with			appropriate use and priming o	f	
		The July 2021 Physician's			insulin pens ongoing by date of	of	
	Order Summary (Po	OS), indicated the resident			compliance. Random observa	tions	
		olog insulin by the way of an			of med pass will be performed		
		ing scale: if $150 - 200 = 2$;			ongoing by nursing managers		
		- 300 = 6; 301 - 350 = 8;			What measures and what		
351 - 400 = 10 Notify MD if blood sugar < 60 or				systemic changes will be ma	ade		
>400, subcutaneously with meals.				to ensure that the deficient			
					practice doesn't recur:		
	Interview with the I	LPN at the time, indicated the			1. Education will be		
		each time before use. She			provided to all licensed nursin	a l	
	1	ly just "dials up a little extra			staff and medication aides by	Ŭ	
	insulin."	1			nursing management on the		
					proper procedure and policy for	or	
	2. On 7/29/21 at 11	1:28 a.m., LPN 1 was			administering insulin with a pe		
		Resident 42's Lispro insulin			and on the 7 rights of medicat		
		cated the resident was going			pass by date of compliance,		
	_	f insulin. She dialed up 6			2. Competencies will	be	
		I to the resident's room.			performed on all licensed nurs		
					staff on insulin pen administra	-	
	After checking the	resident's blood sugar, the			and licensed nursing staff and		
	_	the insulin in the resident's			medication aides on medication	I	
		ot prime the insulin pen prior			pass by date of compliance.		
	to giving the insulir				3. New licensed		
	to graing the mount	-			medication aides and nurses	will	
	The record for Resi	dent 42 was reviewed on			not work until this education a		
		. Diagnoses included, but			competencies have been	-	
	_	type 2 diabetes and end stage			completed.		
		July 2021 Physician's Order			How the corrective action w	_{iII}	
		idicated the resident was to			be monitored to ensure the		
		lin 6 units by the way of an			deficient practice will not rec	eur.	
	insulin pen before n	•			i.e., what quality assurance	· · · · · ·	
	mount pen before i	nouis.			program will be put in place.	.	
	Interview with the I	Interim Director of Nursing			1. Don/Designee will	·	
	I TITLE TO ALL AND AND THE HILL I	menin Director of Ivulating	1		I I. Doi/Designed Will	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	JILDING	00	COMPL	ETED
		155423	B. W	ING		07/30/	/2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
	ND MUUTING OAD	E OFNITED			14TH ST		
HAMMOI	ND-WHITING CARI	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	, L	DATE
	on 7/30/21 at 11:20	a.m., indicated the insulin			observe 3 residents weekly		
	pen should have be	en primed using 2 units of			receiving insulin via insulin pe	n x	
	insulin shot into the	e air before each use.			3 months, then 2 residents we	ekly	
					x 3 months rotating shifts.	-	
	Manufacturer recor	nmendations, provided by the			2. DON/Designee will		
	Interim Director of	Nursing on 7/30/21 at 11:20			observe random medication pa	ass	
	a.m., indicated the	insulin pen was to always be			2 times weekly x 3 months, the	en 1	
		injection. Two units of			time weekly x 3 months rotatin		
	insulin was to be di	aled on the pen and then the			shifts. Audits will be presented	l to	
	button was to be pr	essed to shoot insulin into the			QAPI x 6 moths then QAPI wil	I	
	air to make sure the	e pen worked.			determine the need for further		
					audits.		
	3. On 7/30/21 at 9:	03 a.m., LPN 2 was observed			The results of these)	
	preparing medication	ons for Resident 36. The LPN			reviews will be discussed at th	e	
	placed one Keppra	(an anticonvulsant) Extended			monthly facility Quality Assura	nce	
	Release (ER) 500 n	nilligram tablet in the			Committee meeting monthly for	or a	
	medication cup alor	ng with her other morning			total of 3 months and then		
	medications. The I	LPN indicated the resident			quarterly thereafter once		
	received one tablet	of each medication.			compliance is at 100%.		
					Frequency and duration of		
	The record for Resi	ident 36 was reviewed on			reviews will be increased as		
	7/30/21 at 9:45 a.m	. The July 2021 Physician's			needed, if compliance is belov	٧	
	Order Summary (Po	OS) indicated the resident was			100%.		
	to receive Keppra F	ER 500 mg, 2 tablets to equal			Compliance date: 8/29/21. The	Э	
	1,000 mg daily.				Administrator at		
					Hammond-Whiting Care Cente	er is	
		Interim Director of Nursing			responsible in ensuring		
		a.m., indicated the resident			compliance in this Plan of		
		ed two tablets of Keppra			Correction.		
	instead of one.						
	3.1-48(c)(1)						
E 0704	400 45/ \(\)(\)(\)(\)(\)						
F 0761	483.45(g)(h)(1)(2)						
SS=D	Label/Store Drugs	_					
Bldg. 00		ng of Drugs and Biologicals					
		cals used in the facility					
		n accordance with currently					
	1	onal principles, and include					
	the appropriate ac	ccessory and cautionary					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 34 of 47

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED
		155423	B. WI	NG		07/30/	2021
HAMMO	PROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	instructions, and t applicable.	he expiration date when					
	§483.45(h) Storag	e of Drugs and Biologicals					
	Federal laws, the and biologicals in under proper tem	accordance with State and facility must store all drugs locked compartments perature controls, and rized personnel to have s.					
	separately locked compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the f package drug dist the quantity stored dose can be readi	e facility must provide , permanently affixed storage of controlled drugs II of the Comprehensive ention and Control Act of rugs subject to abuse, facility uses single unit ribution systems in which d is minimal and a missing fily detected. on, record review and	E 03	7.6.1	F 761- Label/Store Drugs and		08/20/2021
	interview, the facili medications were n	ty failed to ensure ot left unattended at the esidents reviewed for	F 07	701	Biologicals What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident # 1 had no	oe 1	08/29/2021
	observed in bed. A container of pink ro stand. Interview we were her Tums that heartburn.	p.m., Resident 9 was t that time, there was a small bund shape tablets on her night ith Resident 9 indicated they she takes when she has			negative outcomes. MD notifie Family member who bought To in educated by DON. MD gave order for Tums. How other residents having a potential to be affected by th same deficient practice will be identified and what corrective	ed. ums e the e oe	
		he container of Tums was still			action will be taken: 1. Observation rounds		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 35 of 47

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155423	B. W	ING		07/30/2021
				CENTER	A DDDDEGG CKEY CEATE THE CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE	
					14TH ST	
HAMMOI	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					were completed by departmen	nt
	The record for Resi	ident 9 was reviewed on			heads and Nursing Managem	ent
	7/27/21 at 1:12 p.m	n. Diagnoses included, but			by date of compliance and no	
	were not limited to	, multiple sclerosis, type 2			other issues identified.	
	diabetes, respirator	y failure, chronic pain, high			What measures and what	
	blood pressure, con	tracture of multiple sites,			systemic changes will be ma	ade
	COPD, gastroesopl	nageal reflux disease (gerd),			to ensure that the deficient	
	and major depressi	ve disorder.			practice doesn't recur:	
					1. Education to be	
	The Annual Minim	um Data Set (MDS)			provided by ED to all staff tha	t if
		1/22/21 indicated the resident			any medications or possibly	
		ted. The resident received			inappropriate items are noted	in
	oxygen while a resi				resident's rooms to notify	
	7.5				ED/DON immediately. Educat	ion
	There was no Physician's Orders for the Tums				to be completed by date of	
	antacid medication				compliance.	
					How the corrective action w	ill
	There was no Care	Plan for the resident to self			be monitored to ensure the	
	administer her med				deficient practice will not re	cur.
					i.e., what quality assurance	,
	There was no self a	dministration of medication			program will be put in place	:
	assessment.				1. Observational roun	
					will be completed by departme	ent
	Interview with the	Interim Director of Nursing			heads and nursing manageme	
		a.m., indicated the resident			daily x 6 months to assure no	
		der to self administer her own			medications or inappropriate	
	medications. She is	ndicated she would call the			items noted in resident rooms	or
		rder for the medication. The			at bedside. SSD will be notified	
		d not have been in the			family is bringing items in and	
	resident's room, ho	wever, her family will bring			educate families/resident and	
	her in anything she				document as well. Audits will	
					presented to QAPI x 6 months	
	3.1-25(b)				QAPI will determine the need	
					ongoing audits.	
					2. The results of these	e
					reviews will be discussed at the	
					monthly facility Quality Assura	
					Committee meeting monthly f	
					total of 3 months and then	=: =:
					quarterly thereafter once	

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155423	B. WING		07/30/	2021
	ROVIDER OR SUPPLIER		1000 11	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	Ī		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
				compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	е	
F 0812 SS=E Bldg. 00	§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro approved or considered federal, state or local (i) This may included directly from local applicable State and regulations. (ii) This provision of facilities from using gardens, subject to applicable safe ground practices. (iii) This provision residents from comprodured by the fall §483.60(i)(2) - Stote serve food in accostandards for food	de food items obtained producers, subject to and local laws or does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude assuming foods not icility.	E 0012	F 812- Food Procurement,		09/20/2021
	interview, the facilit	on, record review and ty failed to maintain a ated to expired, unlabeled and	F 0812	Store/Prepare/Serve-Sanitary What Corrective Action will be		08/29/2021

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

5

If continuation sheet

Page 37 of 47

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPI	ETED
		155423	B. WI	NG		07/30	/2021
				CED FEE	ADDRESS STEV STATE STE SODE		
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE		
	ND 14# UTING 04 D	- OFNITED	1000 114TH ST				
HAMMO	ND-WHITING CARI	E CENTER		WHIIIN	NG, IN 46394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	improperly stored f	Good in the main kitchen. This			accomplished for those		
	had the potential to	affect 50 of 54 residents who			residents found to have been	n	
	consumed food prepared in the main kitchen.				affected by this deficient		
		•			practice:		
	Findings include:				1. Upon identification on		
					7/26/21, the undated and expi	red	
	During the initial to	our of the kitchen on, 7/26/21			items were removed from the		
	_	he Dietary Manager (DM) the			reach in refrigerator and		
	following observati				discarded. Walk in refrigerator	•	
					and freeze with re-organized,		
	1. In the reach in re	efrigerator, there was jar of			along with any items on floor o	or	
		h an open date of 7/1, and a			touching ceiling were discarde		
		a large open plastic container			No adverse reactions were no		
	1	, with "use in 3 days" date and			by this deficient practice.		
	_	jalapeno peppers that was			How other residents having	the	
	undated.	3 1 111			potential to be affected by th		
					same deficient practice will k		
	2. In the walk in re	efrigerator, there was a box of			identified and what corrective		
		ase of whipped topping sitting			action will be taken:		
		r. There were items stacked			Other residents had the		
	1	the ceiling, including a box			potential to be affected by this		
	_	touching the ceiling.			deficient practice.		
		5			What measures and what		
	3. In the walk in fr	reezer, there were boxes of			systemic changes will be ma	nde	
	food piled into the	freezer in a manner that made			to ensure that the deficient		
	_	er the freezer. The boxes			practice doesn't recur:		
	_	y on the floor and not stacked,			1. Education for dietar	γ	
		ed pile. On the shelves, items			staff will be completed by the		
		reezer were stacked to the			Executive Director and/or		
	ceiling, however, it	was not possible to access			designee prior to August 29, 2	021	
	those items to ident				related to use of leftover food		
		-			ensure residents' food is serve		
	4. In the dry storag	ge room, there was a 25 pound			prior to expiration time as per		
		e of cooking spray, a case of			facility policy, along with prope	er	
		f soup sitting directly on the			storage of stock items.		
	floor.				How the corrective action wi	III	
					be monitored to ensure the		
	The policy, "Food S	Safety", dated 11/28/17, was			deficient practice will not red	cur,	

provided by the DM, on 7/28/21 at 2:21 p.m.,

indicated, "...Food is stored a minimum of six

i.e., what quality assurance

program will be put in place:

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
ANDILAN	155423	B. WING	00	07/30/2021
	133423			07/30/2021
	PROVIDER OR SUPPLIER	1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	inches off the floor", "food is stored away from all sewer and water lines, drains and condensation drippings from pipes or ceiling", "There will be adequate circulation of air around refrigerated products", and "leftovers are dated properly and discarded in 72 hours unless otherwise indicated: Interview with the DM during the initial tour, indicated the boxes should not be on the floor or touching the ceiling. She indicated the areas needed to be reorganized. She removed the undated, expired items from the reach in refrigerator. 3.1-21(i)(3)		1. Executive Director and/or designee to perform random audits of the reach-in refrigerator and walk-in refrigerator/freezer a minimun 3 times weekly on various shir for the next 60 days and then twice weekly for 60 days and weekly for 60 days. Any concidentified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for 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: 8/29/21. The Administrator at Hammond-Whiting Care Cent responsible in ensuring compliance in this Plan of Correction.	ifts then terns s need e ne nor a
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 39 of 47

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	00	COMPL		
		155423	B. W	ING		07/30	/2021
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
HAMMOI	ND-WHITING CAR	E CENTER			IG, IN 46394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		eases and infections.		mo			DATE
	0400 00/ \ \ f = 1						
	§483.80(a) Infecti program.	on prevention and control					
	. •	establish an infection					
	· ·	ntrol program (IPCP) that					
	must include, at a elements:	minimum, the following					
	ciements.						
	- , , , ,	ystem for preventing,					
		ng, investigating, and					
	_	ons and communicable					
	diseases for all residents, staff, volunteers, visitors, and other individuals providing						
		contractual arrangement					
	based upon the fa	<u> </u>					
	conducted accord	ing to §483.70(e) and					
	following accepted	d national standards;					
	§483.80(a)(2) Wri	tten standards, policies,					
	and procedures fo	or the program, which must					
	include, but are no						
	* * * * * * * * * * * * * * * * * * * *	veillance designed to					
	• •	ommunicable diseases or					
	persons in the fac	hey can spread to other					
		hom possible incidents of					
		ease or infections should					
	be reported;						
	` '	transmission-based					
		followed to prevent spread					
	of infections;	ricolation about the used					
	` '	risolation should be used uding but not limited to:					
		duration of the isolation,					
		ne infectious agent or					
	organism involved	<u> </u>					
		that the isolation should be					
		e possible for the resident					
	under the circums	tances.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 40 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMP		COMPL	ETED
		155423	B. W	B. WING 07/30/			/2021
				CED FEET	ADDRESS OF A STATE OF SORE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
		- OFNITED			I4TH ST		
HAMMOI	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	(v) The circumstances under which the facility must prohibit employees with a						
	communicable dis	sease or infected skin					
	lesions from direct	t contact with residents or					
	their food, if direct	contact will transmit the					
	disease; and						
	(vi)The hand hygic	ene procedures to be					
	1 ' '	nvolved in direct resident					
	contact.						
	§483.80(a)(4) A s	ystem for recording					
	incidents identified under the facility's IPCP and the corrective actions taken by the						
	facility.						
	§483.80(e) Linens						
	Personnel must ha	andle, store, process, and					
		o as to prevent the spread					
	of infection.						
	§483.80(f) Annual						
	I -	nduct an annual review of					
	· ·	ate their program, as					
	necessary.						
		on, record review, and	F 0	380	F 880- Infection		08/24/2021
		ty failed to ensure infection			Prevention/Control		
	control guidelines v	_			What Corrective Action will k	Эе	
	_	ding those to prevent and/or			accomplished for those		
		, related to hand hygiene not			residents found to have been	า	
		nd after glove removal,			affected by this deficient		
	wearing gloves in the				practice:		
		ise equipment for 3 of 9			1. Residents 5, 13, an		
	residents observed	_			36 had no negative outcomes.		
	administration. (Re	esidents 5, 13, and 36)			QMA # 1 and LPN # 3 were		
	F: 1: : 1 1				educated immediately.	4la a	
	Findings include:				How other residents having		
	1 0 7/20/21 : 2	57 OMA 1			potential to be affected by th		
		57 a.m., QMA 1 was			same deficient practice will k		
		ring eye drops to Resident 5.			identified and what correctiv	е	
	The QMA used han	d sanitizer, donned a clean			action will be taken:	ļ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 41 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155423	B. WI		<u> </u>	07/30/	
		100 120		_		017007	202.
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					14TH ST		
IOMMAH	ND-WHITING CARE	E CENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pair of gloves and placed one drop of Cosopt eye				1. Clinical nursing is		
	drops into each eye. After administering the eye				continuing to make observation	nal	
	drops, the QMA rer	noved her gloves and			rounds ongoing to assure		
	proceeded to check	the resident's vital signs.			compliance. No other issues h	nave	
	She did not use han	d sanitizer or perform hand			been noted at this time. Any		
	hygiene after remov	ing her gloves.			issues identified will be addre	ssed	
					immediately.		
	After checking the	resident's vital signs, the			What measures and what		
	QMA left the room	and placed the wrist blood			systemic changes will be ma	ade	
	pressure cuff on top	of the medication cart. She			to ensure that the deficient		
	did not wipe down the blood pressure cuff when				practice doesn't recur:		
	she was done.				1. Education will be		
					provided by Nursing Manager	nent	
	2. On 7/30/21 at 8:	50 a.m., LPN 2 was observed			to licensed nursing staff and		
	preparing medication	ons for Resident 13. The LPN			medication aide's r/t the		
		nt took her medications			appropriate use of gloves with	1	
	crushed and in appl	esauce. The LPN walked to			medications and the use of		
		next to the nurses' station to			multi-use equipment by date of	of	
	get some applesauc	e for the resident's			compliance.		
		onned a pair of gloves at the			2. Competency check	(S	
		e did not use hand sanitizer			will be completed by date of		
	prior to applying the	e gloves. The LPN then			compliance for hand hygiene.		
		sident's room with the			Education will be provided du	ring	
	-	vas wearing the gloves in the			orientation for new hires.	J	
		ing to the resident's room.			How the corrective action w	ill	
	-	sident's room, she removed			be monitored to ensure the		
		llway. She did not use hand			deficient practice will not red	cur,	
		hand hygiene after removing			i.e., what quality assurance	,	
	her gloves.	, ,			program will be put in place	:	
	C				1. Clinical managers v		
	The LPN proceeded	l to the medication cart and			observe hand hygiene/glove ι		
	-	esident 36's medications.			and disinfection of multi-use		
		the resident's medications in			equipment 3 times weekly x 3		
		the LPN went to the			months, then 2 times weekly		
	_	the nurses' station to get the			months rotating shifts to assu		
		itor. The LPN donned gloves			compliance. Any concerns		
	-	zing prior and proceeded down			identified will be addressed		
		gloves. She checked the			immediately. Audits will be		
	_	ssure, then checked her			presented to QAPI x 6 months	3	
	-	r oxygen saturation level			then QAPI will determine the		
	1	,	1		1 40.0		

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	TE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155423	B. WING 07/30/2021			2021	
				CTD FFT A	ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE		
	ID MULITING CADE	CONTER			14TH ST		
HAMMON	ND-WHITING CARE	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	using a pulse oxime	eter. When she was done, she			for further audits.		
	did not disinfect the	multi-use resident			The results of these	ţ	
	equipment. The LP	N removed her gloves in the			reviews will be discussed at th	е	
	resident's room and	washed her hands with soap			monthly facility Quality Assura	nce	
	and water.				Committee meeting monthly for	or a	
					total of 3 months and then		
		nterim Director of Nursing			quarterly thereafter once		
		o.m., indicated gloves should			compliance is at 100%.		
		nallway, hand hygiene should			Frequency and duration of		
		glove removal, and equipment			reviews will be increased as		
	cleaned immediatel	y after use.			needed, if compliance is below	1	
					100%.		
	The facility "Hand Hygiene" policy, provided by				Compliance date: 8/24/21. The)	
		of Nursing on 7/30/21 at			Administrator at		
	-	ified as current, indicated			Hammond-Whiting Care Cente	er is	
		be completed before			responsible in ensuring		
	applying gloves and	l after removal of gloves.			compliance in this Plan of		
	21.10(1)				Correction.		
	3.1-18(b)						
F 0921	483.90(i)						
SS=B	` '	anitary/Comfortable					
Bldg. 00	Environ	armary/Commontable					
Blag. 00		Environmental Conditions					
	- ,,	provide a safe, functional,					
	•	fortable environment for					
	residents, staff an						
		on and interview, the facility	F 09	21	F 921-		08/29/2021
		sident's environment clean	1 0,	21	Safe/Functional/Sanitary/comf	orta	00/29/2021
	•	elated to marred and chipped			ble Environment		
		ed registers and gouged night			What Corrective Action will b	ре	
		its. (The North and South			accomplished for those		
	Units)				residents found to have beer	า	
					affected by this deficient		
	Findings include:				practice:		
					1. The marred walls and		
	During the Environ	mental Tour with the			chipped paint was repaired in		
	Administrator and t	he Maintenance Director on			rooms 101, 102, 104, 209. The	€	
	7/30/21 at 9:10 a.m.	., the following was			night stand in room 102 was		
	observed:				replaced, along with the base	of	
I			1			l	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 43 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			COMPLETED
		155423	B. WING 07/30/2021			07/30/2021
				CED FEET A	ADDRESS CHANGE THE SAN CODE	
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE	
			1000 114TH ST			
HAMMON	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DECLIDED IN AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
					the floor register in room 104 v	vas
	1. North Unit				cleaned and repainted.	
	1. Ivoitii Oliit				How other residents having t	the
	a Room 101 - The	wall behind bed 1 was marred			potential to be affected by th	
		hipped. There were 2			same deficient practice will k	
	residents who reside				identified and what correctiv	
	residents who resid	ed in the room.			action will be taken:	
	h Room 102 The	e walls were marred and the			Other residents had the	
		The night stand next to the			potential to be affected by this	
		The night stand next to the here were 2 residents who			deficient practice.	
	resided in the room				What measures and what	
	resided in the room					
	- D 104 Th-	walls were marred and the			systemic changes will be ma to ensure that the deficient	de
	-					
		The base of the floor register			practice doesn't recur:	
		cratched and marred. There	Environmental rounds have			
	were 2 residents wh	no resided in the room.	been completed by maintenance			
	6 G . 4 TT !:				department and plan has beer	1 put
	2. South Unit				in place to address	
					scratched/marred/chipped wal	IS,
		walls were marred and			gouged night stands, and	
	scuffed. There was	s 1 resident who resided in the			scratched/marred floor register	
	room.				on or prior to August 29, 2021.	
					2. The Maintenance Directo	r
		Maintenance Director at that			and/or designee will include	
	1	of the above was in need of			identified areas in the current	
	repair.				preventive maintenance progra	
					and conduct routine resident ro	
	3.1-19(f)				rounds according to the facility	<i>'</i>
			1		protocol.	[
					How the corrective action wi	
					be monitored to ensure the	
					deficient practice will not red	cur,
			1		i.e., what quality assurance	
					program will be put in place:	
					1. Maintenance Direct	or
					and/or designee to conduct	
			1		resident room observations 5x	
					weekly for next 6 months to	
					ensure the resident's environn	nent
					is in good repair from	

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155423	A. BUILDING B. WING	00	COMPLETED 07/30/2021	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) marred/scuffed walls, chipped paint, gouged night stands, an marred/scratched floor registe Any concerns identified will be addressed immediately. Audits be presented to QAPI x 6 mon then QAPI will determine the re	d rs. s will ths	
				for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for 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: 8/29/21. The Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.	e nce or a	
F 9999						
Bldg. 00	education and traini advance for all perso include, but not be I (1) Residents' rights (u) In addition to the subsection (l), staff	n organized ongoing inservice ng program planned in onnel. This training shall imited to, the following:	F 9999	F 9999- Personnel What Corrective Action will to accomplished for those residents found to have been affected by this deficient practice: 1. The Dietary Cook 1, Housekeeper 1, CNA 2, and Activity Aide 1 have completed annual 3 hours of dementia training. The Dietary Cook 1 and Activity Cook 1 and Activity Aide 1 have completed annual 3 hours of dementia training.	d the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet Page 45 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155423			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2021
NAME OF I	PROVIDER OR SUPPLIEF	· {		ADDRESS, CITY, STATE, ZIP COD	E
	ND-WHITING CAR			14TH ST NG, IN 46394	
				T	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT	TION (X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE DATE
	hours of dementia-s	specific training within six (6)		RN 1 have completed the	ir annual
		nployment, or within thirty		resident right training.	
	(30) days for person	nnel assigned to the		How other residents hav	ving the
		mentia special care unit, and		potential to be affected l	by the
		ually thereafter to meet the		same deficient practice	
	_	es, or both, of cognitively		identified and what corre	ective
		and to gain understanding of		action will be taken:	
	the current standard dementia.	ls of care for residents with		Full audit on employed personnel files was comp	
	dementia.			any outstanding dementia	
	This rule was not m	net as evidenced by:		resident rights training wil	
	This rate was not in	iet as evidenced by.		completed on or prior to A	
	Based on record review and interview, the			29, 2021.	
	facility failed to ensure annual resident rights and			What measures and wha	at
	dementia training w	vas completed for 5 of 5		systemic changes will b	e made
	employee records re	eviewed. (Dietary Cook 1,		to ensure that the deficie	ent
	Housekeeper 1, CN	A 2, RN 1, and Activity Aide		practice doesn't recur:	
	1)			Re-education to be p	
				to staff by Executive Direct	
	Finding includes:			and/or designee prior to A	_
	The ampleyee reco	rds were reviewed on 7/28/21		29, 2021 to ensure undersand importance of the pol	_
		dicated the following:		completing annual training	-
	ut 2. 15 p.m., und m	dicated the following.		(dementia, resident rights	
	a. Dietary Cook 1,	who was hired on 9/20/17,		a timely manner.	,,
	1	ion indicating he had received		How the corrective action	on will
	his annual resident	rights inservice. The Cook		be monitored to ensure	the
	had also not receive	ed 3 hours of annual dementia		deficient practice will no	
	training.			i.e., what quality assura	
				program will be put in pl	
		who was hired on 11/1/19,		1. Executive Direction of the conduction of the	
		ion indicating she had 3 hours of dementia training.		and/or designee will cond audits of training transcrip	
	received her annual	o nours of dementia training.		HealthCare Academy sys	
	c. CNA 2. who was	s hired on 3/17/17, had no		random employees weekl	
		cating she had received her		for next 6 months. Any iss	
	annual 3 hours of d	-		identified will be immediate	
		-		addressed. Audits will be	
		hired on 2/18/16, had no		presented to QAPI x 6 mg	onths
	documentation indi	cating she had received her		then QAPI will determine	the need

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155423		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE : COMPL 07/30/	ETED	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			1000 1	ADDRESS, CITY, STATE, ZIP CODE 14TH ST NG, IN 46394		
(X4) ID PREFIX TAG	e. Activity Aide 1 had no documentar received her annual Interview with the 7/28/21 at 3:00 p.m. training and reside	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) hts inservice. , who was hired on 2/25/15, tion indicating she had al 3 hours of dementia training. Human Resources Director on n., indicated annual dementia nt rights inservices had not r the above employees.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for 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: 8/29/21. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring	e ne nnce or a	(X5) COMPLETION DATE
				compliance in this Plan of Correction.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RIUI11

Facility ID: 000365

If continuation sheet

Page 47 of 47