STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 26, 27, 28, 29, and 30, 2021 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 6 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/4/21.	F 0000	Please reference the enclosed 2567 as “Plan of Correction” for the July 30, 2021 Recertification and State Licensure that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on August 19, 2021 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	subpart. Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to residents dressed in hospital gowns during the day while in bed for 2 of 5 residents reviewed for dignity. (Residents 12 and 24) Findings include: 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 dressed in a hospital gown. On 7/27/21 at 9:05 a.m., 7/28/21 at 8:53 a.m. and 9:54 a.m., the resident was observed in bed dressed in a hospital gown. The record for Resident 12 was reviewed on 7/27/21 at 2:40 p.m. Diagnoses included, but were limited to, stroke, vascular dementia, type 2 diabetes, major depressive disorder, stiffness in the left hand, delusional disorder, atrial fibrillation, convulsions, muscle weakness, and muscle atrophy. The Quarterly, 4/29/21 Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented. He needed extensive assist with 1 person physical assist for dressing and personal hygiene. The resident had a feeding tube and received a mechanically altered diet. He received 51% or more of his calories with the tube feeding and had no skin issues. A Care Plan, revised on 7/23/21, indicated the resident's preferences were as follows: gown/pajamas, remove as needed. Keep his nails short and remove facial hair (wants a clean shave) with an electric razor. The approaches were to	F 0550	**F 550**- Resident Rights ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident number 12 and 24 had no negative outcomes. Both residents were immediately assisted into clothes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An in house audit will be completed by activities and SSD and/or designee for current residents to update their personal preferences. If unable to make decision POA and/or family will be contacted to give information. 2. Preferences will be updated and put on care plans and kardex by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. SSD and Activities will be in serviced by ED and/or designee on updating preferences at least quarterly with care plans and prn as indicated. Education to include if resident unable to make preference decision then POA and/or family to be contacted for preference. SSD and activities will	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ask or offer the resident a clean shave on his shower days with his electric shaver as he preferred. Ask or offer the resident with help with his selection of clothing. Offer to cut the resident's nails short as he preferred. There was no Care Plan the resident preferred to be dressed in a hospital gown during the day. Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the resident should have been dressed in regular clothes during the day even if he was in bed. 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 dressed in a hospital gown. On 7/27/21 9:02 a.m., and 7/28/21 at 8:50 a.m., the resident was observed in bed dressed in a hospital gown. The record for Resident 24 was reviewed on 7/28/21 at 10:08 a.m. Diagnoses included, but were not limited to, dementia without behaviors, type 2 diabetes, COPD, dysphagia, atrial fibrillation, high blood pressure, anxiety, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was not alert and oriented, rarely understood and rarely understands, and was severely impaired for decision making. The resident had no mood or behavior problems including rejection of care. The resident needed extensive assist for dressing and did not receive oxygen while a resident. A Care Plan, revised on 6/9/21, indicated the resident's preferences were as follows: to		be responsible for updating care plan and kardex with changes. Education will be completed by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. ED and or designee will audit 5 charts weekly x 8 weeks, then 3 charts weekly x 8 weeks, then 2 charts weekly x 8 weeks. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	remove her gowns or pajamas daily. The approaches were to offer and/or ask the resident what clothing she would like to wear. Interview with the resident's daughter on 7/26/21 at 2:45 p.m., indicated there were clothes available for the resident to wear and she would like her dressed during the day. Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the resident should have been dressed in regular clothes during the day. 3.1-3(t)			
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4) (ii) and (c)(8) of this section, the notice of transfer or discharge required under this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the	F 0623	**F 623**- Notice requirements	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure a resident's Responsible Party was notified in writing related to a transfer to the hospital for 3 of 5 residents reviewed for hospitalization. (Residents 29, 56 and 28) 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. A Nurses' Note, dated 5/28/21 at 10:55 a.m., indicated the resident was complaining of pain to her left foot. Discoloration was observed to all five toes. The resident's foot was cool to touch and no pedal pulse was present. The Physician was notified and orders were obtained to send the resident to the hospital for evaluation. The resident's Power of Attorney (POA) was also notified. There was no documentation indicating the resident's POA received a copy of the transfer form. Interview with the Social Service Designee on 7/29/21 at 10:57 a.m., indicated the resident's POA was not sent a written transfer notice. 2. The closed record for Resident 56 was reviewed on 7/29/21 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, convulsions, and		before Transfer and Discharge ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Residents 29, 56, and 28 had no negative outcomes. Families were sent transfer paper work immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. SSD will audit in house residents that have been transferred to hospital and/or other facility for last 90 days to assure transfer paper requirements have been completed appropriately. Any issues will be addressed immediately and families will receive transfer paper work. This will be completed by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. ED and/or designee will educate SSD on the appropriate transfer paper work requirements by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 3/23/21, indicated the resident was cognitively impaired for daily decision making. Nurses' Notes, dated 5/14/21 at 4:40 p.m., indicated the resident was convulsing and produced brown emesis with undigested food. 911 was called and the resident was transferred to the hospital. The resident's sister was informed of the transfer, however, documentation was lacking regarding the resident's sister being mailed a copy of the transfer form. Interview with the Social Service Designee on 7/30/21 at 1:04 p.m., indicated the resident's family was not sent a written transfer form. 3. Resident 28's record was reviewed on 7/28/21 at 10:10 a.m. Diagnoses included, but were not limited to Alzheimer's dementia and a history of falls. Nursing Notes indicated, on 5/23/21, the resident was sent to the hospital for a change in mental status. She was admitted to the hospital and returned to the facility on 5/25/21. There was no Transfer/Discharge paperwork in the record or notation that it had been mailed to the resident's family. Interview with the Social Service Designee on, 7/29/21 at 10:57 a.m., indicated she thought she had mailed it to the family, but had not. 3.1-12(a)(6)(A)		***program will be put in place:*** 1. Any transfer that occurs will be reviewed in morning meeting 5 days weekly ongoing to assure compliance. SSD will log this information for all transfers and keep current. ED and/or designee will review daily and validate in morning meeting 5 days weekly and/or all open business days x 6 months. Results will be presented to QAPI and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(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 had received an anticoagulant within the last 7 days. A Physician's Order, dated 6/10/21, indicated the resident was to receive Plavix (an antiplatelet medication) 75 milligrams (mg) daily. Interview with the MDS Coordinator on 7/30/21 at 12:55 p.m., indicated the MDS had been coded wrong related to anticoagulant use. 2. The record for Resident 41 was reviewed on 7/28/21 at 11:18 a.m. Diagnoses included, but	F 0641	**F 641**- Accuracy of Assessments ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 29, 41, and 13 have had no negative outcomes. The residents involved have had modifications completed and submitted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. MDS will complete an in house audit on residents receiving anticoagulants and on hospice services to assure accuracy. Any issues identified will be corrected and a modification MDS submitted by day of compliance. This audit will include care plan reviews to assure care plan is accurate as well. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. CRS will educate MDS on appropriate coding r/t medications by date of	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, chronic kidney disease, chronic embolism and thrombosis of other specified veins, and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 6/19/21, indicated the resident was cognitively impaired for daily decision making. Section N - Medications, indicated the resident had received an anticoagulant within the last 7 days. A Physician's Order, dated 3/16/21, indicated the resident was to receive Plavix (an antiplatelet medication) 75 milligrams (mg) daily. Interview with the MDS Coordinator on 7/30/21 at 12:55 p.m., indicated the MDS had been coded wrong related to anticoagulant use. 3. The record for Resident 13 was reviewed on 7/27/21 at 11:41 a.m. Diagnoses included, but were not limited to, delusional disorder, history of falling, dementia with behavior disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated the resident was cognitively impaired for daily decision making. Section O, Special Treatments and Programs indicated the resident had not received hospice services while a resident of the facility during the assessment reference period. A Physician's Order, dated 1/10/21, indicated the resident was admitted to hospice services.		compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/designee will audit any residents MDS that is on hospice services and receiving any medication that requires observation of skin for bleeding, bruising, or abnormalities to assure accuracy x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the MDS Coordinator on 7/30/21 at 1:45 p.m., indicated the MDS had been coded wrong related to receiving hospice services. 3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to develop and implement a care plan for a resident admitted with a pressure ulcer for 1 of 17 residents whose Care Plans were reviewed. (Resident 205) Finding includes: Resident 205's record was reviewed on 7/27/21 at 2:18 p.m. The resident was admitted on 7/2/21. Diagnoses included, but were not limited to, aftercare following digestive surgery and a pressure ulcer to the sacrum. There was no care plan for pressure ulcers. Interview with the MDS (Minimum Data Set) Nurse on 7/27/21 at 3:40 p.m., indicated the resident had been admitted with the pressure ulcer to his sacrum and there should have been a care plan initiated. 3.1-35(a)	F 0656	**F 656-** Development/Implementation Comprehensive Care Plan ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident # 205 had no negative outcomes. The care plan was put in place immediately. Resident 205 had all appropriate interventions and treatments in place on admission. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. RDCS completed an in house audit of resident's with pressure ulcers to assure care plans in place by date of compliance. No other issues have been identified. ***What measures and what systemic changes will be made***	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to ensure that the deficient practice doesn't recur: 1. DON/Designee will educate licensed nursing staff on appropriately completing nursing admission assessment to assure any skin issues are identified and care planned on admission by date of compliance. 2. New licensed nurses hired will complete this education in orientation. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. New admissions and readmission charts will be brought to morning meeting and audited 5 days weekly by IDT to assure admission skin assessment is accurate and base line care plans are in place for any skin concerns and WOT is present if applicable. This is to be ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			responsible in ensuring compliance in this Plan of Correction.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure Care Plan conferences were completed and failed to ensure Care Plans were revised as needed for 2 of 17 residents whose Care Plans were reviewed. (Residents 24	F 0657	**F 657**- Care Plan Timing and Revision ***What Corrective Action will be accomplished for those residents found to have been***	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 47) Findings include: 1. The record for Resident 24 was reviewed on 7/28/21 at 10:08 a.m. Diagnoses included, but were not limited to, dementia without behaviors, type 2 diabetes, COPD, dysphagia, atrial fibrillation, high blood pressure, anxiety, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was not alert and oriented, rarely understood and rarely understands, and was severely impaired for decision making. The resident had no mood or behavior problems including rejection of care. The resident needed extensive assist for dressing and did not receive oxygen while a resident. The Care Plan, dated 6/14/21, indicated the resident was on antibiotic therapy related to an infection. The approaches were to administer antibiotic medications as ordered by physician. Physician's Orders, dated 6/25/21, indicated Doxycycline Hyclate Tablet (an antibiotic) 100 milligrams (mg) give 1 tablet two times a day for an urinary tract infection for 13 administrations. The antibiotic was discontinued on 7/2/21. Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the Care Plan for the antibiotic therapy was outdated. 2. During an interview with Resident 47 on 7/26/21 at 9:56 a.m., she indicated she had not been invited to a care conference since she had been admitted.		***affected by this deficient practice:*** 1. Residents 24 and 47 had no negative outcomes. Care Plan for resident 24 was updated and revised immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An in house audit will be completed by nursing to assure all antibiotic care plans are updated and current by date of compliance. 2. SSD will complete an in house audit of residents for the last 90 days to assure care plans have been taking place. Any issues identified will be addressed by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. CRS will educate SSD on regulations related to care planning to include perimeters for completion and inviting families and residents. 2. IP will inform MDS/DON when antibiotic is completed to ensure antibiotic care plan is removed. This will be completed by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur,***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident 47 was reviewed on 7/27/21 at 11:30 a.m. Diagnoses included, but were not limited to, type 2 diabetes, anemia, rheumatoid arthritis, anxiety, pain, muscle weakness, COVID-19. The resident was admitted to the facility on 12/15/20. The Quarterly Minimum Data Set (MDS) assessment, dated 6/24/21, indicated the resident was alert and oriented with some mild confusion. There was no documentation the resident had a care conference since admission. Interview with the Social Service Director on 7/28/21 at 1:50 p.m., indicated the resident had not had a care conference since admission. 3.1-35(d)(2)(B)		***i.e., what quality assurance program will be put in place:*** 1. IP will audit care plans for residents on antibiotics to assure compliance ongoing. ED will audit 3 charts weekly x 8 weeks, then 2 charts weekly x 8 weeks, then 1 chart weekly x 8 weeks to assure care plans are occurring, resident and/or family invited, and this is being documented. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to shaving, nail care, hair care, and bathing for 2 of 2 residents reviewed for ADL's (Residents 24 and 205) Findings include: 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 dressed in a hospital gown. At those times his nails on his right hand were dirty and he was unshaven. On 7/27/21 at 9:05 a.m., 11:27 a.m., 1:03 p.m., 1:17 p.m., 2:24 p.m., and 4:00 p.m., the resident was observed unshaven with dirty fingernails to his right hand. 7/28/21 at 8:53 a.m., the resident was observed unshaven with dirty fingernails to his right hand. At 9:54 a.m., LPN 1 performed a skin assessment for the resident. She removed his left hand from under the linens. His fingernails on his left hand were thick and yellow/black discolored. The LPN indicated at that time, she was unaware of the color of his nails. The record for Resident 12 was reviewed on 7/27/21 at 2:40 p.m. Diagnoses included, but were limited to, stroke, vascular dementia, type 2 diabetes, major depressive disorder, stiffness in the left hand, delusional disorder, atrial fibrillation, convulsions, muscle weakness, and muscle atrophy. The Quarterly 4/29/21 Minimum Data Set (MDS) assessment, indicated the resident was	F 0677	**F 677**- ADL Care Provided for Dependent Residents ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 205 was shaved, given a full bed bath per his preference and has his hair washed as well immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An in house audit will be completed by nursing management on residents for the POC charting to assure completed per policy. Any issues will be identified and follow up will be completed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education to the aides, licensed nurses, and SSD for completion of POC/PCC documentation related to refusal of shower/bed bath. Shower sheet to be completed and turned into nurse each shift. MD and POA and/or family to be notified of refusal. Nursing to notify SSD of refusal(s). SSD to ensure care plan is updated to reflect refusal(s). This will be completed	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shower sheet, dated 7/23/21, indicated the resident had a bed bath, but hair was not washed. There were no additional shower sheets. Interview with the resident on 7/26/21 at 10:38 a.m., indicated he wanted his hair washed, and it had not been washed for a couple weeks. Interview with the CNA on 7/27/21 at 2:35 p.m., indicated she thought the resident had refused baths before. She indicated a shower sheet should be completed even if the resident refused. 3.1-38(a)(2)(A) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)		Correction.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure an open scabbed area was assessed and monitored for 1 of 1 residents reviewed for skin conditions (non-pressure related) and antiembolic stockings (TED hose) were in place for 1 of 1 residents reviewed for edema. (Residents 12 and 21) Findings include: 1. On 7/26/21 at 10:15 a.m., Resident 12 was	F 0684	**F 684**- Quality of Care ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident # 12 had txs orders obtained immediately and put in place. MD and family were notified. Resident # 21 had an order for Ted hose put in place	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the CNA reported the resident's toenail on the left foot pinky toe had fallen off. Upon observation the toe was bleeding and there was no toenail attached. The toe was cleansed with normal saline and a dry dressing was secured over the toe. The Physician was noted via fax. Nurses' Notes, dated 7/7/21 at 12:55 p.m., indicated there was a dressing to the left pinky toe due to the nail falling off. Nurses' Notes, dated 7/8/21 at 3:50 a.m., indicated the 5th digit on the left foot dressing was clean, dry and intact. There was no further documentation regarding the left pinky toe. Weekly skin assessments, dated 7/6, 7/13, 7/20, and 7/27/21, indicated "left toe Pink toe on left foot fell off. Bleeding noted." (sic) Nurses' Notes, dated 7/28/21 at 10:29 a.m., indicated staff spoke to the physician in regards of resident's thick, yellow nails and left pinky toenail missing. The Physician ordered aquaphor ointment for the feet, and for the left pinky toe to be cleaned with normal saline, apply Bacitracin and cover with bandage daily. Physician Orders, dated 7/28/21, indicated Aquaphor Ointment (Emollient) apply to feet topically one time a day for dry skin and clean open area to left pinky toe with normal saline, apply Bacitracin, and cover with dry bandage every evening shift. Interview with the LPN 1 on 7/28/21 at 10:00 a.m., indicated the resident's feet were very dry and scaly. She was unaware of any open area to		receive this education prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee will review 24/72 hour report 5 times weekly to ensure treatment orders are obtained and in place for any skin issues including edema, and care plan is updated x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. Competencies will be completed by date of compliance on aides and nurses for the appropriate protocol for skin assessments and accurate follow through and documentation by Nursing Management. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the left pinky toe or that his toenail had fallen off. 2. On 7/26/21 at 1:02 p.m., Resident 21 was observed in her room with a family member. There were TED hose (compression stockings used to treat edema) on the end of her bed and the resident's feet were slightly edematous. On 7/28/21 at 9:45 a.m., the resident was observed laying on her bed, barefoot. The TED hose were laying on the bed next to her. At 2:10 p.m., the resident was observed seated in a wheelchair, with shoes on, the TED hose remained on the bed. The resident's record was reviewed on 7/27/21 at 11:23 a.m. Diagnoses included, but were not limited to, cirrhosis of the liver, weakness and a history of falls. The Significant Change Minimum Data Set assessment, dated 5/25/21, indicated the resident had moderate cognitive impairment and needed extensive one person assistance for dressing. There was no Physician's Order for the TED hose. Interview with the resident and her family, on 7/26/21 at 1:02 p.m., indicated the staff were to assist her with applying the TED hose as she could not put them on herself. Interview with LPN 4, on 7/28/21 at 2:15 p.m., indicated there was a Physician's Order for the TED hose. She indicated the resident had swelling to her right ankle and staff would help her apply the hose in the morning and remove at night. The LPN was unable to locate the order for the TED hose in the electronic or hard record. She was unable to say what had happened but would clarify.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 skills ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: On 7/26/21 at 11:25 a.m., Resident 12 was observed in bed wearing a hospital gown. The enteral tube feeding was infusing at 65 cubic centimeters (cc) per hour. On 7/27/21 at 1:03 p.m. to 1:17 p.m., the resident was observed sitting up in a broda chair by the nurses' station. The resident's enteral feeding was not turned on. The record for Resident 12 was reviewed on 7/27/21 at 2:40 p.m. Diagnoses included, but were limited to, stroke, vascular dementia, type 2 diabetes, major depressive disorder, stiffness in the left hand, delusional disorder, atrial fibrillation, convulsions, muscle weakness, and muscle atrophy. The Quarterly 4/29/21 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. He needed extensive assist with 1 person physical assist for dressing and personal hygiene. The resident had a feeding tube and received a mechanically altered diet. He received 51% or more of his calories with the tube feeding and had no skin issues. A Care Plan, revised on 7/23/21, indicated the resident was at nutritional risk for possible decrease intake and poor appetite. The approaches were to provide a diet and enteral nutrition formula and fluid flushes as ordered. Physician's Orders, dated 11/9/20, indicated Glucerna 1.2 (enteral feeding) at 65 milliliters (ml) per hour times 18 hours, on at 1 p.m. and off at 7 a.m.		1. Resident 12 had no negative outcomes. MD and POA notified of tube feeding hung at wrong time. Education provided to LPN # 1 immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Residents with tube feeding orders have been audited to assure orders in place for specific times for infusion per MD order. Nursing Management observed these residents for appropriate times of infusion with no other issues noted by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Nursing Management will educate licensed nursing staff on infusing tube feeding per MD order, flushing and giving medications per policy by date of compliance. 2. Competencies will be completed on licensed Nursing on med administration, flushes, and assuring following MD orders for Tube feedings. 3. New licensed nursing staff will not work until this education and a competency is completed. ***How the corrective action will be monitored to ensure the***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the resident's tube feeding should be infusing according to the Physician's Orders.On 7/29/21 at 12:50 p.m., LPN 1 was observed preparing medications for Resident 12. The LPN indicated the resident received his medications through his gastrostomy tube (a tube inserted in the abdomen to receive nutrition). She crushed two sodium bicarbonate tablets that were 650 milligrams (mg) each, placed them in a medication cup and diluted them with water. The LPN proceeded to enter the resident's room and checked the gastrostomy tube for placement. She then drew up water into a syringe for a water flush prior to giving the medication. The LPN instilled the water using the plunger on the syringe rather than letting the flush infuse via gravity. She then drew up the medication in the syringe and again used the plunger on the syringe to instill the medication instead of letting the medication infuse via gravity. The LPN then drew up more water to flush the tube. Again, she did not let the flush infuse via gravity. Interview with the Interim Director of Nursing on 7/30/21 at 9:45 a.m., indicated the water flush and the medications should have been given via gravity. The facility policy titled, "Medication Administered through an Enteral Tube" was provided by the Administrator on 7/30/21 at 8:40 a.m. and identified as current. The policy indicated to allow medications to flow down the medication syringe via gravity. Medications were not to be pushed through a tube. 3.1-44(a)(2)		***deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Don/Designee will observe and/or have them verbalize appropriate flushing, medication administration, and infusion of tube feedings 3 times weekly x 3 months, then 2 times weekly x 3 months to assure compliance. This will be rotated on shifts. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate for 2 of 3 residents reviewed for oxygen. (Residents 9 and 24) Findings include: 1. On 7/26/21 at 11:29 a.m. and 2:07 p.m., Resident 9 was observed in bed. At those times, she was wearing oxygen per nasal cannula at 3 liters per minute. On 7/27/21 at 11:55 a.m. and 4:00 p.m., the resident was observed in bed. At those times, she was wearing oxygen at 2 liters per minute. On 7/28/21 at 1:30 p.m., the resident was observed in bed. At that time, she was wearing oxygen at 2 liters per minute. The record for Resident 9 was reviewed on 7/27/21 at 1:12 p.m. Diagnoses included, but were not limited to, multiple sclerosis, type 2 diabetes, respiratory failure, chronic pain, high blood pressure, contracture of multiple sites, COPD, gastroesophageal reflux disease (gerd),	F 0695	**F 695**- Respiratory/Tracheostomy Care and Suctioning ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 9 and 24 had no negative outcomes. MD was notified on inaccurate liter flow. O2 sats were taken immediately with no issues noted and O2 liter flows adjusted to ordered liter flow immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An Audit was completed on residents in house with current 02 orders to assure orders accurate and clinical team observed liter flow being administered per order. No other issues have been identified. Audit completed by nursing	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 4/22/21 indicated the resident was alert and oriented. The resident received oxygen while a resident. The record for the resident was reviewed on 07/27/21 01:12 PM Diagnoses included, but were not The Care Plan, revised on 5/1/21 indicated the resident had altered respiratory status/difficulty breathing related to respiratory failure and COPD. The approaches were to provide oxygen at 2 liters per nasal cannula. Physician's Orders, dated 5/5/21, indicate oxygen at 5 liters/minute continuously per nasal cannula. The Medication Administration Record for 7/2021 indicated oxygen 5 liters was signed out as being administered 7/1-7/27/21. Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the oxygen should be at the rate ordered by the physician. 2. On 7/26/21 at 10:21 a.m., Resident 24 was observed in bed dressed in a hospital gown. At that time, her nasal cannula for the oxygen was on top of her head. The concentrator in the room was set at 3 liters per minute. On 7/26/21 at 11:07 a.m., and 2:10 p.m., the resident was observed in bed. She was wearing oxygen per nasal cannula at 3 liters per minute. On 7/27/21 9:02 a.m., the resident was observed		management by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Don and/or designee have educated licensed nursing staff and certified aides to observe liter flow on residents using 02 and assure liter flow is accurate per order. This will be completed by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Don/Nursing management will observe 5 residents daily Monday through Friday x 8 weeks, then 3 residents daily Monday through Friday x 8 weeks, then 2 residents daily Monday through Friday x 8 weeks to assure compliance. Audits will be presented to QAPI x 6 months and then QAPI will determine the need for further audits. Any noted issues will be addressed immediately. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in bed. She was wearing oxygen per nasal cannula at 3 liters per minute. On 7/27/21 at 11:28 a.m., 1:03 p.m., 2:25 p.m., and 4:04 p.m., the resident was observed sitting in a broda chair. She was wearing oxygen per nasal cannula at 3 liters per minute. On 7/28/21 at 8:50 a.m., the resident was observed in bed. The nasal cannula for the oxygen was observed on top of her head. The concentrator in the room was set at 3 liters per minute. On 7/28/21 at 10:00 a.m., the resident was observed in bed. She was wearing oxygen per nasal cannula at 3 liters per minute. The record for Resident 24 was reviewed on 7/28/21 at 10:08 a.m. Diagnoses included, but were not limited to, dementia without behaviors, type 2 diabetes, COPD, dysphagia, atrial fibrillation, high blood pressure, anxiety, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was not alert and oriented, rarely understood and rarely understands, and was severely impaired for decision making. The resident had no mood or behavior problems including rejection of care. The resident needed extensive assist for dressing and did not receive oxygen while a resident. The Care Plan, revised on 6/9/21, indicated the resident was at risk for respiratory infection related to the COVID 19 pandemic. The approach was to administer oxygen as ordered. Physician's Orders, date 6/25/21, indicated		needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	oxygen at 2 liters/minute continuously per nasal cannula. Interview with the Interim Director of Nursing on 7/29/21 at 10:15 a.m., indicated the resident's oxygen should have been set at 2 liters per minute as ordered by the physician. 3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure a resident's plan of care was followed related to providing appropriate dementia care to resident for 1 of 3 residents reviewed for dementia care. (Resident 28) Finding includes: On 7/26/21 at 9:11 a.m., Resident 28 was observed seated alone in her room. There was no television or radio on and she was fidgeting with her clothing and wheelchair. The same observation of the resident in her room was made on 7/28/21 at 8:45 and 11:07 a.m., 7/29/21 at 9:49 a.m., 10:45 a.m., 11:20 a.m. and 1:45 p.m. There were no magazines or an activity (busy) apron in the room. The resident's record was reviewed on 7/28/21 at 10:10 a.m. Diagnoses included, but were not limited to Alzheimer's dementia and a history of	F 0744	**F 744**- Treatment/Service for Dementia ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 28's (busy) apron was located in the facility laundry and provided to resident, along with activity items on-hand and made available as per plan of care. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Full audit to be completed by Activity Director and Social Service Director and/or designee prior to August 29, 2021 of	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	falls. The Activity Care Plan, updated 2/10/21, indicated, "...Encourage [resident's name] with interaction during daily visits with small talk, snacks, short stories, music/video therapy and if possible exercise such as balloon toss...." and, "...provide mental stimulation and reality orientation such as magazines, music, adult coloring, busy apron...." The May and June 2021 Record of One-To-One Activities for the resident was provided by the Activity Director (AD) on 7/29/21 at 11:00 a.m. There were seven entries for May and eight entries for June. Interview with the AD on 7/29/21 at 10:49 a.m., indicated she did not visit or do activities with her every day, and she did not have a schedule with the resident. She would visit when she saw the resident seated in the hallway. She indicated the busy apron should be in the resident's room, but she was unable to locate it in the closet or drawers. 3.1-37(a)		current residents with diagnosis of dementia to ensure activity items as outlined in care plan are on-hand and available to resident(s). Any issue identified via this audit will be immediately addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Re-education to be provided to staff by Executive Director and/or designee prior to August 29, 2021 to ensure understanding and importance following resident(s)' plan of care related to providing appropriate dementia care. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct 5 resident observations on various shifts and times weekly x 8 weeks, then monthly for 4 months to ensure residents plan of care is followed related to providing appropriate dementia care. Any issues identified will be immediately addressed. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 2. The results of these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 9 residents observed during medication pass. Three errors were observed during 26 opportunities for errors during medication administration. This resulted in a medication error rate of 11%. (Residents 27, 42, and 36) Findings include: 1. On 7/28/21 at 5:05 p.m., LPN 3 was observed preparing medications for Resident 27. The LPN indicated the resident was going to receive 4 units of Novolog insulin by the way of an insulin pen for a blood sugar of 232. The pen was	F 0759	**F 759**- Free of Mediation Error 5% or More ***What Corrective Action will be 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 educated immediately. MD was notified of medication errors and no new orders were received. ***How other residents having the potential to be affected by the same deficient practice will be***	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed to be dialed to 4 units and the insulin was administered in the resident's arm. The LPN was not observed to prime the insulin pen. The record for Resident 27 was reviewed on 7/29/21 at 9:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy. The July 2021 Physician's Order Summary (POS), indicated the resident was to receive Novolog insulin by the way of an insulin pen per sliding scale: if 150 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Notify MD if blood sugar <60 or >400, subcutaneously with meals. Interview with the LPN at the time, indicated the pen is to be primed each time before use. She indicated she usually just "dials up a little extra insulin." 2. On 7/29/21 at 11:28 a.m., LPN 1 was observed preparing Resident 42's Lispro insulin pen. The LPN indicated the resident was going to receive 6 units of insulin. She dialed up 6 units and proceeded to the resident's room. After checking the resident's blood sugar, the LPN administered the insulin in the resident's left arm. She did not prime the insulin pen prior to giving the insulin. The record for Resident 42 was reviewed on 7/28/21 at 4:11 p.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The July 2021 Physician's Order Summary (POS), indicated the resident was to receive Lispro insulin 6 units by the way of an insulin pen before meals. Interview with the Interim Director of Nursing		***identified and what corrective action will be taken:*** 1. An in house audit will be completed on residents receiving insulin via insulin pens. Nursing managers will validate appropriate use and priming of insulin pens ongoing by date of compliance. Random observations of med pass will be performed ongoing by nursing managers. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be provided to all licensed nursing staff and medication aides by nursing management on the proper procedure and policy for administering insulin with a pen and on the 7 rights of medication pass by date of compliance, 2. Competencies will be performed on all licensed nursing staff on insulin pen administration and licensed nursing staff and medication aides on medication pass by date of compliance. 3. New licensed medication aides and nurses will not work until this education and competencies have been completed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Don/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 7/30/21 at 11:20 a.m., indicated the insulin pen should have been primed using 2 units of insulin shot into the air before each use. Manufacturer recommendations, provided by the Interim Director of Nursing on 7/30/21 at 11:20 a.m., indicated the insulin pen was to always be primed before each injection. Two units of insulin was to be dialed on the pen and then the button was to be pressed to shoot insulin into the air to make sure the pen worked. 3. On 7/30/21 at 9:03 a.m., LPN 2 was observed preparing medications for Resident 36. The LPN placed one Keppra (an anticonvulsant) Extended Release (ER) 500 milligram tablet in the medication cup along with her other morning medications. The LPN indicated the resident received one tablet of each medication. The record for Resident 36 was reviewed on 7/30/21 at 9:45 a.m. The July 2021 Physician's Order Summary (POS) indicated the resident was to receive Keppra ER 500 mg, 2 tablets to equal 1,000 mg daily. Interview with the Interim Director of Nursing on 7/30/21 at 9:50 a.m., indicated the resident should have received two tablets of Keppra instead of one. 3.1-48(c)(1)		observe 3 residents weekly receiving insulin via insulin pen x 3 months, then 2 residents weekly x 3 months rotating shifts. 2. DON/Designee will observe random medication pass 2 times weekly x 3 months, then 1 time weekly x 3 months rotating shifts. Audits will be presented to QAPI x 6 moths then QAPI will determine the need for further audits. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were not left unattended at the bedside for 1 of 1 residents reviewed for medication storage. (Resident 9) Finding includes: On 7/26/21 at 2:07 p.m., Resident 9 was observed in bed. At that time, there was a small container of pink round shape tablets on her night stand. Interview with Resident 9 indicated they were her Tums that she takes when she has heartburn. On 7/27/21 at 11:55 a.m., the resident was observed in bed. The container of Tums was still observed on her night stand.	F 0761	**F 761**- Label/Store Drugs and Biologicals ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident # 1 had no negative outcomes. MD notified. Family member who bought Tums in educated by DON. MD gave order for Tums. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Observation rounds	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident 9 was reviewed on 7/27/21 at 1:12 p.m. Diagnoses included, but were not limited to, multiple sclerosis, type 2 diabetes, respiratory failure, chronic pain, high blood pressure, contracture of multiple sites, COPD, gastroesophageal reflux disease (gerd), and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 4/22/21 indicated the resident was alert and oriented. The resident received oxygen while a resident. There was no Physician's Orders for the Tums antacid medication. There was no Care Plan for the resident to self administer her medications. There was no self administration of medication assessment. Interview with the Interim Director of Nursing on 7/28/21 at 8:56 a.m., indicated the resident does not have an order to self administer her own medications. She indicated she would call the doctor and get an order for the medication. The Tums tablets should not have been in the resident's room, however, her family will bring her in anything she wants. 3.1-25(b)		were completed by department heads and Nursing Management by date of compliance and no other issues identified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education to be provided by ED to all staff that if any medications or possibly inappropriate items are noted in resident's rooms to notify ED/DON immediately. Education to be completed by date of compliance. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Observational rounds will be completed by department heads and nursing management daily x 6 months to assure no medications or inappropriate items noted in resident rooms or at bedside. SSD will be notified if family is bringing items in and will educate families/resident and document as well. Audits will be presented to QAPI x 6 months and QAPI will determine the need for ongoing audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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 is responsible in ensuring compliance in this Plan of Correction.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to maintain a sanitary kitchen related to expired, unlabeled and	F 0812	**F 812**- Food Procurement, Store/Prepare/Serve-Sanitary ***What Corrective Action will be***	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	improperly stored food in the main kitchen. This had the potential to affect 50 of 54 residents who consumed food prepared in the main kitchen. Findings include: During the initial tour of the kitchen on, 7/26/21 at 8:45 a.m., with the Dietary Manager (DM) the following observations were made: 1. In the reach in refrigerator, there was jar of marinara sauce with an open date of 7/1, and a use by date of 7/8, a large open plastic container of pears dated 7/13, with "use in 3 days" date and an opened bottle of jalapeno peppers that was undated. 2. In the walk in refrigerator, there was a box of liquid eggs and a case of whipped topping sitting directly on the floor. There were items stacked on the shelves up to the ceiling, including a box of oranges that was touching the ceiling. 3. In the walk in freezer, there were boxes of food piled into the freezer in a manner that made it impossible to enter the freezer. The boxes were sitting directly on the floor and not stacked, but in a disorganized pile. On the shelves, items in the back of the freezer were stacked to the ceiling, however, it was not possible to access those items to identify them. 4. In the dry storage room, there was a 25 pound bag of sugar, a case of cooking spray, a case of cereal and a case of soup sitting directly on the floor. The policy, "Food Safety", dated 11/28/17, was provided by the DM, on 7/28/21 at 2:21 p.m., indicated, "...Food is stored a minimum of six		***accomplished for those residents found to have been affected by this deficient practice:*** 1. Upon identification on 7/26/21, the undated and expired items were removed from the reach in refrigerator and discarded. Walk in refrigerator and freeze with re-organized, along with any items on floor or touching ceiling were discarded. No adverse reactions were noted by this deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents had the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education for dietary staff will be completed by the Executive Director and/or designee prior to August 29, 2021 related to use of leftover food to ensure residents' food is served prior to expiration time as per facility policy, along with proper storage of stock items. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 minimum of 3 times weekly on various shifts for the next 60 days and then twice weekly for 60 days and then weekly for 60 days. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed before and after glove removal, wearing gloves in the hallway, and not disinfecting multi-use equipment for 3 of 9 residents observed during medication administration. (Residents 5, 13, and 36) Findings include: 1. On 7/29/21 at 9:57 a.m., QMA 1 was observed administering eye drops to Resident 5. The QMA used hand sanitizer, donned a clean	F 0880	**F 880-** Infection Prevention/Control ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Residents 5, 13, and 36 had no negative outcomes. QMA # 1 and LPN # 3 were educated immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***	08/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pair of gloves and placed one drop of Cosopt eye drops into each eye. After administering the eye drops, the QMA removed her gloves and proceeded to check the resident's vital signs. She did not use hand sanitizer or perform hand hygiene after removing her gloves. After checking the resident's vital signs, the QMA left the room and placed the wrist blood pressure cuff on top of the medication cart. She did not wipe down the blood pressure cuff when she was done. 2. On 7/30/21 at 8:50 a.m., LPN 2 was observed preparing medications for Resident 13. The LPN indicated the resident took her medications crushed and in applesauce. The LPN walked to the medication cart next to the nurses' station to get some applesauce for the resident's medications. She donned a pair of gloves at the medication cart, she did not use hand sanitizer prior to applying the gloves. The LPN then proceeded to the resident's room with the medications. She was wearing the gloves in the hallway while walking to the resident's room. After leaving the resident's room, she removed the gloves in the hallway. She did not use hand sanitizer or perform hand hygiene after removing her gloves. The LPN proceeded to the medication cart and started to prepare Resident 36's medications. After placing all of the resident's medications in the medication cup, the LPN went to the medication cart by the nurses' station to get the blood pressure monitor. The LPN donned gloves without hand sanitizing prior and proceeded down the hall wearing the gloves. She checked the resident's blood pressure, then checked her temperature and her oxygen saturation level		1. Clinical nursing is continuing to make observational rounds ongoing to assure compliance. No other issues have been noted at this time. Any issues identified will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be provided by Nursing Management to licensed nursing staff and medication aide's r/t the appropriate use of gloves with medications and the use of multi-use equipment by date of compliance. 2. Competency checks will be completed by date of compliance for hand hygiene. Education will be provided during orientation for new hires. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Clinical managers will observe hand hygiene/glove use and disinfection of multi-use equipment 3 times weekly x 3 months, then 2 times weekly x 3 months rotating shifts to assure compliance. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	using a pulse oximeter. When she was done, she did not disinfect the multi-use resident equipment. The LPN removed her gloves in the resident's room and washed her hands with soap and water. Interview with the Interim Director of Nursing on 7/30/21 at 1:35 p.m., indicated gloves should not be worn in the hallway, hand hygiene should be completed after glove removal, and equipment cleaned immediately after use. The facility "Hand Hygiene" policy, provided by the Interim Director of Nursing on 7/30/21 at 1:35 p.m. and identified as current, indicated hand hygiene was to be completed before applying gloves and after removal of gloves. 3.1-18(b)		for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/24/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0921 SS=B Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to marred and chipped walls, marred floored registers and gouged night stands for 2 of 2 units. (The North and South Units) Findings include: During the Environmental Tour with the Administrator and the Maintenance Director on 7/30/21 at 9:10 a.m., the following was observed:	F 0921	**F 921-** Safe/Functional/Sanitary/comfortable Environment ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The marred walls and chipped paint was repaired in rooms 101, 102, 104, 209. The night stand in room 102 was replaced, along with the base of	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. North Unit a. Room 101 - The wall behind bed 1 was marred and the paint was chipped. There were 2 residents who resided in the room. b. Room 102 - The walls were marred and the paint was chipped. The night stand next to the bed was gouged. There were 2 residents who resided in the room. c. Room 104 - The walls were marred and the paint was chipped. The base of the floor register next to bed 2 was scratched and marred. There were 2 residents who resided in the room. 2. South Unit a. Room 209 - the walls were marred and scuffed. There was 1 resident who resided in the room. Interview with the Maintenance Director at that time, indicated all of the above was in need of repair. 3.1-19(f)		the floor register in room 104 was cleaned and repainted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents had the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Environmental rounds have been completed by maintenance department and plan has been put in place to address scratched/marred/chipped walls, gouged night stands, and scratched/marred floor registers on or prior to August 29, 2021. 2. The Maintenance Director and/or designee will include identified areas in the current preventive maintenance program and conduct routine resident room rounds according to the facility protocol. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Maintenance Director and/or designee to conduct resident room observations 5x weekly for next 6 months to ensure the resident's environment is in good repair from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			marred/scuffed walls, chipped paint, gouged night stands, and marred/scratched floor registers. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6)	F 9999	**F 9999**- Personnel ***What Corrective Action will be 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 the annual 3 hours of dementia training. The Dietary Cook 1 and	08/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual resident rights and dementia training was completed for 5 of 5 employee records reviewed. (Dietary Cook 1, Housekeeper 1, CNA 2, RN 1, and Activity Aide 1) Finding includes: The employee records were reviewed on 7/28/21 at 2:45 p.m., and indicated the following: a. Dietary Cook 1, who was hired on 9/20/17, had no documentation indicating he had received his annual resident rights inservice. The Cook had also not received 3 hours of annual dementia training. b. Housekeeper 1, who was hired on 11/1/19, had no documentation indicating she had received her annual 3 hours of dementia training. c. CNA 2, who was hired on 3/17/17, had no documentation indicating she had received her annual 3 hours of dementia training. d. RN 1, who was hired on 2/18/16, had no documentation indicating she had received her		RN 1 have completed their annual resident right training. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Full audit on employee personnel files was completed and any outstanding dementia and resident rights training will be completed on or prior to August 29, 2021. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Re-education to be provided to staff by Executive Director and/or designee prior to August 29, 2021 to ensure understanding and importance of the policy on completing annual training (dementia, resident rights, etc) in a timely manner. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct audits of training transcripts in HealthCare Academy system for 5 random employees weekly times for next 6 months. Any issues identified will be immediately addressed. Audits will be presented to QAPI x 6 months then QAPI will determine the need	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 00 B. WING	07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	annual resident rights inservice. e. Activity Aide 1, who was hired on 2/25/15, had no documentation indicating she had received her annual 3 hours of dementia training. Interview with the Human Resources Director on 7/28/21 at 3:00 p.m., indicated annual dementia training and resident rights inservices had not been completed for the above employees.		for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/29/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	