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	155423	A. BUILDING -- B. WING	08/16/2021

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/16/2021 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Emergency Preparedness survey, Hammond-Whiting Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 53. Quality Review completed on 08/18/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/16/2021 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Life Safety Code survey,	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities	

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

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

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	Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and in common areas. The facility has a capacity of 80 and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage. Quality Review completed on 08/18/21		to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review, and all supporting documentation will be uploaded to Gateway prior to 9/13/2021 for review.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents, staff, and visitors if needing to exit the facility in an emergency at the main entrance. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Interim Executive Director on 08/16/21 between 1:15 p.m. and 2:26 p.m., the main entrance door was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. This finding was reviewed with the Interim Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	**K222 – Egress Doors** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The Maintenance Director immediately placed signage with code and/or combination identifying what the code would be to exit door at front entrance. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other exit doors were reviewed to ensure the right codes were next to the key pad(s) or had identifying information on exit procedures. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance and housekeeping staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of Ktag 222. ***How the corrective action will***	09/13/2021

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of mentioned areas 1x per week for 4 weeks, then 1x per month for 3 months, and then quarterly until 100% compliance is achieved. Any issues identified will be immediately addressed 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: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the egress lighting for 1 of 7 exit	K 0281	**K281 – Illumination of Means of Egress**	09/13/2021

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	means of egress was arranged so the failure of any single lighting fixture would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect 20 residents and staff in North Unit 200 hall. Findings include: Based on observations with the Maintenance Director on 08/16/21 at 2:05 p.m., the exit discharge portion of the means of egress outside the North Unit 200 hall by resident room 223 did not have an operable light fixture. Based on interview at the time of observation, the Maintenance Director stated the bulbs are burnt out in the security light above the exit door and the light outside the door is not working. The Maintenance Director agreed there was not an operable light source outside the 200 hall exit by resident room 223. This finding was reviewed with the Maintenance Director and Interim Executive Director during the exit conference. 3.1-19(b)		***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The bulbs were replaced in the security light above the exit door near room 223 on the North Unit, along with the light outside the door repaired. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other exits doors were reviewed to ensure appropriate egress lighting with no issues identified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of illumination regulation. ***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:*** Executive Director and/or designee will conduct audits of mentioned areas 1x per week for 4 weeks, then 1x per month for 3 months, and then quarterly until 100% compliance is achieved. Any issues identified will be	

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			immediately addressed 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: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility did not provide accurate exit signage in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.2.10.1 and 7.10.6.2. This deficient practice could affect approximately 15 residents, staff and visitors. Findings include: Based on observations on 08/16/21 during a tour	K 0293	**K293 – Exit Signage** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The Exit sign was fixed, so the directional chevron was only visible and pointed towards the main entrance/exit door. In	09/13/2021

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	of the facility with the Interim Executive Director and Maintenance Director from 1:15 p.m. to 2:26 p.m., observation at the main entrance exit door corridor revealed an exit sign in the corridor with both directional chevrons visible "<EXIT>". The directional chevrons pointed towards the main entrance/exit door and into the dining room, which is not an exit. Based on interview at the time of observation, the Maintenance Director agreed one of the the visible directional chevrons pointed to an area that is not an exit. This finding was reviewed with the Interim Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		addition, a new Exit sign was ordered to replace current sign. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other Exit signs were reviewed with no issues identified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of proper directional Exit signs. ***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:*** Executive Director and/or designee will conduct audits of mentioned areas 1x per month 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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%.	

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			Compliance date: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only new sprinklers were available to be utilized for its sprinkler system. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.1.2.2 states reconditioned sprinklers shall not be permitted to be utilized on any new or existing system and Section 6.2.1 states only new sprinklers shall be installed. Additionally, NFPA 25, Standard for the	K 0351	**K351 Sprinkler System - Installation** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The 4 spare sprinklers mentioned were removed from the spare	09/13/2021

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	Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. This deficient practice could affect all occupants within the facility. Findings include: Based on observation with the Maintenance Director on 08/16/21 at 1:32 p.m., the spare sprinkler cabinet located in the sprinkler riser room contained four of over 10 spare sprinklers that appeared to be used sprinklers. The four spare sprinklers had Teflon tape in the threads that had been disturbed in the cabinet. Based on interview at the time of observation, the Maintenance Director acknowledged the four sprinklers in the spare sprinkler cabinet were used. This finding was reviewed with the Interim Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		sprinkler cabinet. SafeCare was contacted for replacement of spare sprinklers. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other spare sprinklers were reviewed without issues. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of only unused spare sprinklers stored in the spare sprinkler cabinet. ***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:*** Executive Director and/or designee will conduct audits of spare sprinkler cabinet 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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	

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			100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were not loaded with foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion,	K 0353	**K353 Sprinkler System – Maintenance and Testing** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** SafeCare was contacted for	09/13/2021

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	foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 20 residents and staff. Findings include: Based on observations with the Interim Executive Director during a tour of the facility from 1:15 p.m. to 2:26 p.m. on 08/16/21, a sprinkler head in the shower room next to resident room 107 showed signs of corrosion and was covered with a green substance. Based on interview at the time of the observations, the Maintenance Director acknowledged the conditions of the the aforementioned automatic sprinkler location. This finding was reviewed with the Interim Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		replacement of sprinkler head in shower room next resident room 107. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** SafeCare scheduled to perform complete inspection of all sprinkler heads prior to date certain. Any issues identified via this inspection will be immediately addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of K353 tag. ***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:*** Executive Director and/or designee will conduct audits of sprinkler heads 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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	

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			100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 boiler rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect at	K 0911	**K911 Electrical systems - Other** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** All cardboard boxes were immediately removed from front of electrical panels. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** Only staff were affected by this deficient practice. ***What measures and what systemic changes will be made***	09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	08/16/2021

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	least two staff. Findings include: Based on observation on 08/16/21 at 1:50 p.m. during a tour of the facility with the Interim Executive Director and Maintenance Director, the boiler room/Maintenance office located next to the kitchen in the Service hall had several cardboard boxes stored in front of and within 15 inches from the high voltage electrical panels. Based on interview at the time of the observation, the Maintenance Director acknowledged the items mentioned are stored there and would clear the area in front of the electrical panels as soon as possible. This finding was reviewed with the Interim Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		***to ensure that the deficient practice doesn't recur:*** Re-education to be provided to maintenance staff by Executive Director and/or designee prior to date of compliance to ensure understanding and importance of keeping high voltage electrical areas free of clutter. Bright colored caution tape to be placed on floor around electrical panels as a visual reminder to keep area free of clutter. ***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:*** Executive Director and/or designee will conduct audits of high voltage electrical panel area 1x per month for 6 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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: 9/13/21. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of	

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