

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2013
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/13/13</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p>	K010000	<p>May 22, 2013</p> <p>Kim Rhoades, Director of Long-Term Care Indiana State Department of Public Health 2 North Meridian St., Sec 4-B Indianapolis, IN 46204-3006</p> <p>Dear Ms Rhoades</p> <p>Please reference the enclosed 2567-L as "Plan of Correction" for the May 13, 2013 Life Safety Code Survey that was conducted at Hammond Whiting Care Center.</p> <p>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.</p> <p>The Plan of Correction submitted on May 22, 2013 serves as our allegation of compliance. Should</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 80 with a census of 76 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the maintenance shed used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/16/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidence by:</p>		<p>you have any question or concerns regarding the Plan of Correction, please contact me.</p> <p>Respectfully,</p> <p>Caryn G. Moore RN, MSN Executive Director</p>		

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice had the potential to affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 05/13/13 at 9:45 a.m. with the Maintenance Director, the Alert Alarm Inc., document titled "Agreement and Report of Inspection" sprinkler inspection dated 03/28/13 provided no documentation to indicate an internal inspection of the dry</p>	K010062	<p><b>K 062</b></p> <ol style="list-style-type: none"> <li>The corrective action taken for the resident found to have been affected by the deficient practice: No residents were immediately affected by this deficient practice.</li> <li>The corrective action for those residents having the potential to be affected by the same deficient practice is: No residents were immediately affected by this deficient practice.</li> <li>The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: K&amp;S Sprinkler was contacted and a request was made for every 5 year sprinkler inspection examination. On May 16, 2013 Bob from K&amp;S sprinkler came out and inspected all the sprinklers in the facility, checking the Wet and Dry System. Documentation was emailed to Joe Brown, Life Safety Inspector.</li> <li>To ensure the deficient practice does not reoccur, the monitoring system established is: The Executive Director will ensure that the Maintenance Supervisor /designee has scheduled an appointment every five years in a timely manner. After scheduled sprinkler inspection the results will</li> </ol>	05/16/2013			

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	<p>sprinkler system had been done in the past five years. Based on interview with the Maintenance Director at the time of record review, he stated the inspections have not yet been scheduled.</p> <p>3.1-19(b)</p>		<p>be discussed in the following PI Committee meeting.</p>		

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect staff utilizing the designated employee smoking area.</p> <p>Findings include:</p>	K010066	<p><b>K 066</b></p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were immediately affected by this deficient practice.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: No residents were immediately affected by this deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: In-service will be</p>	05/30/2013

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	<p>Based on observations and interview on 05/13/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., there were discarded cigarette butts on the ground in the designated smoking area. Further observation revealed an employee smoking, discarding ashes and cigarette butts on to the ground. Based on interview at the time of observation on 05/13/13 at 1:30 p.m., the Maintenance Director acknowledged observing an employee discarding cigarette butts and ashes on the ground.</p> <p>3.1-19(b)</p>		<p>provided to all associates and any resident smoker by the SDC by 5/30/13 including facility smoking policy and proper disposal of all smoking items.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: Maintenance Supervisor /designee will audit the designated smoking area Monday thru Friday and provide the Executive Director with results of those audits. The Executive Director will discuss results in the Morning Stand Up Meeting every Friday. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		