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 08/11/2015

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
K 0000 Bldg. 01	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). Survey Date: 08/11/15 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 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. 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 71 at the time of this survey.	K 0000	Please reference the enclosed 2567 as “Plan of Correction” for the August 11, 2015 the Life Safety Code Recertification and State Licensure Survey that was conducted at Hammond Whiting Care Center. Preparation and/or execution of this plan ofcorrection 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 24, 2015 serves as our allegation of compliance. Should you have any question or concernsregarding the Plan of Correction, please contact me. Respectfully, Kimberly Ready Executive Director	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155423		08/11/2015

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	All areas where residents have customary access were sprinklered. The facility has one detached building providing storage.			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient	K 0025	**What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** The four by four inch square of drywall cut out in the Northwest Hall's corridor wall has been repaired. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective actions(s) will be taken:** No other residents had the potential to be affected. **What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The MaintenanceSupervisor and/or designee will audit the facility	09/10/2015

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	practice could affect at least 20 residents in one of three smoke compartments. Findings include: Based on observations with Maintenance Director on 08/11/15 at 12:39 p.m., the Northwest Hall had a four inch by four inch square of drywall cut out in the corridor wall. Based on interview at the time observation, the Maintenance Director said their new manual fire alarm box was relocated and acknowledged the aforementioned condition. 3.1-19(b)		corridor walls during weekly rounds for three months to assure the one-hour fire separation is maintained. Any issues identified will be immediately addressed. **How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur:** The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview,	K 0029	**K029 What corrective action(s)**	09/10/2015

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	155423		08/11/2015

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	the facility failed to ensure 1 of 1 kitchens, a hazardous area, was separated from other spaces by smoke resisting partitions and doors provided with self closer and would latch into the frame. This deficient practice could affect staff and all residents using the dining room and main entrance area. Findings include: Based on observation on 08/11/15 at 1:08 p.m., the Maintenance Director and Administrator confirmed the kitchen door opening into the dining room and the two sets of dining room doors open to the corridor did not self close and latch into the frame. 3.1-19(b) 2. Based on interview and observation; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors at the opening in the kitchen wall, a hazardous area, was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and		**will be accomplished for those residents found to have been affected by the deficient practice:** Automatic hingeclosers have been placed on the kitchen door opening into the dining room along with both sets of dining room doors. In addition, the paperwork has been received from the vendor relating to the annual inspection of the rolling fire door protecting the opening from the kitchen to the main dining room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance Supervisor and/or designee will audit the doors on his weekly rounds for three months to assure the doors close and latch properly into the door frame. Any issues identified will be immediately addressed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of	

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	155423		08/11/2015

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	tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident that would be in the main dining room. Findings include: Based on interview with the Maintenance Director on 08/11/15 at 11:28 a.m., the Maintenance Director indicated the facility has a rolling fire door protecting the opening from the kitchen to the main dining room and no documentation for testing was available for review. The Maintenance Director acknowledged the aforementioned condition. Based on observation, a rolling fire door was discovered during a tour of the facility. 3.1-19(b)		correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview,	K 0038	**What corrective action(s) will**	09/10/2015

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	the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 in 2 of 3 egress paths. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect 48 residents, staff and visitors. Findings include: Based on observation on 08/11/15 at 12:18 p.m. the Maintenance Director and Administrator, the egress path through the North exit required entering the code to exit the Hall, the exit door let to a path to a courtyard gate with an unapproved lock which contained a padlock and a hammer to break the padlocked hinge. Based on interview at the time of observation, the Maintenance Director and the Administrator acknowledged the aforementioned condition.		**be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Supervisor will remove the padlock and hammer from North Courtyard gate exit. In addition, vendors have been contacted for quotes to install a new gate with panic bar. All efforts will be made to have new gate installed on or prior to September 10, 2015. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No other residents were immediately affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor and/or designee will audit all egresses onweekly rounds for three month to ensure the egresses shall be continuously maintained free from impediments to full instant use in the case of fire or other emergency. Any issues identified will be immediately addressed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure egress reliability on 1 of 6 exit discharges. LSC 7.1.10.1 states the mean of egress shall be continuously maintained free from impediments to full instant use in the case of fire or other emergency. This deficient practice could affect staff and at least 12 residents that could use the exterior exit. Findings include: Based on observation on 08/11/15 at 12:18 p.m. the Maintenance Director and Administrator, the North courtyard exit has a sign indicating that a person would need to hit a padlock with a hammer to leave the courtyard. A hammer is attached to a string next to the padlock. Based on interview at the time of observation, the Maintenance Director and the Administrator explained that the pin for the gate latch would need to be hit with the ladder to exit the courtyard. 3.1-19(b)		correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 20 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect staff and up to 16 residents that would use that light in an emergency. Findings include: Based on observation with Maintenance Director and Administrator on 08/11/15 at 12:28 p.m., the battery operated emergency light near resident room 211 failed to illuminate when tested. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition. 3.1-19(b)	K 0046	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On August 11, 2015, the Maintenance Supervisor removed the battery operated light by room 211. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All battery operated lights have been removed from the facility, as they were deemed not necessary. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** All battery operated lights have been removed from the facility, as they were deemed not necessary.	09/10/2015
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for			

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	155423		08/11/2015

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

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	planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drills" forms with the Maintenance Director on 08/11/15 at 10:05 a.m., three sequential second and third shift fire drills took place between 2:05 p.m. and 3:00 p.m. and between 10:00 p.m. and 11:00 p.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)	K 0050	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A fire drill schedule has been created through the end of 2016 and reviewed by the Executive Director and Maintenance Supervisor. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No other residents were immediately affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor will report the last monthly fire drill results to the facility's Safety Committee monthly. This report will include the date, time, and shift that the fire drill occurred. Any identified issues will be immediately addressed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA	09/10/2015

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	155423		08/11/2015

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HAMMOND-WHITING CARE CENTER	1000 114TH ST WHITING, IN 46394

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			Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0062 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to replace 1 of 5 sprinkler heads in the Maintenance Shop. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only.	K 0062	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** Thevendor, Safe Care has been contacted and scheduled to inspect the sprinklerhead and pipe located in the maintenance shop. Any issues will be immediately addressed with all efforts to have anynecessary repairs completed on or prior to September 10, 2015. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions(s) will be**	09/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155423		08/11/2015

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	Findings include: Based on observation with the Maintenance Director and Administrator on 08/11/15 at 1:05 p.m., one of the Maintenance shop sprinkler heads was covered in grime and large amount of duct tape surrounded the sprinkler head and sprinkler pipe. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition. 3.1-19(b)		**taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur:** The Maintenance Supervisorand/or designee will audit all sprinkler heads and piping during weekly roundsfor three month to ensure there is no paint, corrosion, damage, load, and in ismaintained in proper orientation. Any issues identified will beimmediately addressed. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, auditsshall continue at the same schedule for an additional three months. At thattime, analysis of data will be done to ensure the deficient practice does notreoccur and/or adapt audit schedules.	
K 0064	NFPA 101			

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SS=D Bldg. 01	LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher pressure gauge readings was in the acceptable range in the Residential Smoking Area. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 1 residents that is allowed to smoke. Findings include: Based on observation with the Maintenance Director and Administrator on 08/11/15 at 1:13 p.m., the gauge on the portable fire extinguisher located in the Residential Smoking Area indicated the extinguisher was overcharged. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.	K 0064	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** Vendor hasrecharged the fire extinguisher, located in the Residential Smoking Area, correctlyto ensure the pressure gauge reading is in the operable range. In addition, the pressure gauge was replacedby the vendor. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur:** The Maintenance Supervisorand/or designee will audit all portable fire extinguishers during monthlyrounds for three month to ensure the pressure gauge reading is in the operablerange. Any issues identified will be immediately addressed.	09/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155423		08/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
	3.1-19(b)		**How the corrective action(s) will bemonitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, auditsshall continue at the same schedule for an additional three months. At thattime, analysis of data will be done to ensure the deficient practice does notreoccur and/or adapt audit schedules.	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in one of six corridors. This deficient practice could affect staff and at least 16 residents. Findings include:	K 0072	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** The chairwas immediately removed from the Southeast corridor exterior exit door andplaced back in the resident's room.	09/10/2015

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 08/11/2015
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	Based on observation with the Maintenance Director and Administrator on 08/11/15 at 1:35 p.m. a resident room chair was stored in the Southeast corridor in front of the exterior exit door. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition. 3.1-19(b)		**How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur:** The Maintenance Supervisor and/or designee will audit all egresses on weeklyrounds for three month to ensure the egresses shall be continuously maintainedfree from impediments to full instant use in the case of fire or otheremergency. Any issues identified will be immediately addressed. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, auditsshall continue at the same schedule for an additional three months. At thattime, analysis of data will be	

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	155423		08/11/2015

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			done to ensure the deficient practice does notreoccur and/or adapt audit schedules.	
K 0075 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 4 of 4 of resident room areas. This deficient practice could affect staff and all residents. Findings include: Based on observation with the Maintenance Director and Administrator on 08/11/15 between 12:03 p.m. and 1:36 p.m., two adjacent 32 gallon containers of biohazardous soiled linens and biohazardous trash were discovered at: a) The Northeast Hall	K 0075	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** The 32gallon containers for soiled linens and trash will be removed from the facilityand replaced with smaller containers as per Life Safety Code Standard. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur:**	09/10/2015

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	b) The Northwest Hall c) The Southwest Hall d) The Southeast Hall Based on an interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned conditions. 3.1-19(b)		The Executive Director and/or designee will be provide education tofacility staff on or prior to September 10, 2015 related to mobile soiled linenor trash collection receptacles with capacities greater than 32 gallon are onlylocated in a room protected as a hazardous area when not attended. The Housekeeping Director and/or designee will audit all hallways on weeklyrounds for three month to ensure mobile soiled linen or trash collectionreceptacles with capacities greater than 32 gallon are only located in a roomprotected as a hazardous are when not attended. Any issues identified will beimmediately addressed. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, auditsshall continue at the same schedule for an additional three months. At thattime, analysis of data will be done to ensure the deficient practice does notreoccur and/or	

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	155423		08/11/2015

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			adapt audit schedules.	
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:	K 0130	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** The Southfire wall and North fire wall will be repaired to either eliminate fire wallpenetrations or use appropriate through penetration firestop systems. This work will be completed on or prior toSeptember 10, 2015. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions(s) will be taken:** No otherresidents were immediately affected by this deficient practice. **What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not recur:** The Maintenance Supervisor and/or designee will audit all fire walls onweekly rounds for three month to ensure the penetration of fire barrier wallsare maintained ensure the fire resistance of the barrier. Any issues identifiedwill be immediately addressed. **How the corrective action(s)**	09/10/2015

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 08/11/2015

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

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	a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect residents in 2 of 3 smoke compartments. Findings include: Based on an observation with the Maintenance Director on 08/11/15 at 2:01 p.m., a three inch by four inch penetration was noted in the South fire wall. Other fire wall penetrations contained green putty. At 2:07 p.m., a fourteen inch by sixteen inch penetration was noted in the North fire wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned conditions and was unable to provide documentation the green putty was approved for use in through penetration firestop systems. 3.1-19(b)		**will bemonitored to ensure the deficient practice will not recur:** The above stated audit results and system components will be reviewed bythe QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, auditsshall continue at the same schedule for an additional three months. At thattime, analysis of data will be done to ensure the deficient practice does notreoccur and/or adapt audit schedules.	
K 0144 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	Based on record review, the facility failed to maintain a complete written record of monthly generator load testing of 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Chapter 13, "Other" Health Care Facilities, 13-3.3.2.1 requires if electrical life support equipment is required, the essential electrical distribution system shall conform to Type 1 system as described in Chapter 3 of NFPA 99. Chapter 3-4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. This deficient practice could affect all residents and staff. Findings include: Based on record review with the	K 0144	**Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** The facility rana 30-minute load test at 30%. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective actions(s) will be taken:** All facilityresidents had the potential to be affected. **What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Maintenance staffwill be educated on or prior to September 10, 2015 by Executive Director and/ordesignee on proper duration, frequency, and percentage of generator load tests. **How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur:** The MaintenanceSupervisor and/or designee will perform and document in the TELS system a30-minute load test for at least 30% of the EPS nameplate rating at least oncemonthly. Any issues identified will be immediately addressed. All audit resultsand system components will be reviewed by the QA Committee on a monthly basiswith subsequent plans of correction	09/10/2015

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	Maintenance Director on 08/11/15 at 10:29 a.m., the monthly load testing was done weekly for 13 minutes. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		developed and implemented as deemednecessary. The criteria for determining that monitoring is no longer necessarywill be 90% accuracy. If audits do not meet this criteria, audits shallcontinue at the same schedule for an additional three months. At that time,analysis of data will be done to ensure the deficient practice does not reoccurand/or adapt audit schedules.	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents. Findings include: Based on observation with Maintenance Director and Administrator on 08/11/15 between 1:05 p.m. to 1:46 p.m. the following was discovered:	K 0147	**Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** All equipment andsupplies along with power strip extension cords were removed from affectedareas on August 11, 2015. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective actions(s) will be taken:** Facility wideaudit will be perform to assure no other power strip extension cords were inuse within the facility. **What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:**	09/10/2015

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	a) An extension cord powering a fish tank in the Library. b) A power strip powering two refrigerators, a DVD player, and television in resident room 207. c) A power strip powering a power strip in the South Unit powering computer equipment. d) A power strip powering a refrigerator in the Business office. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged each aforementioned condition. 3.1-19(b)		Facility staffwill be educated by Executive Director and/or designee to ensure flexible cordsare not used as a substitute for fixed wiring to provide power equipment with ahigh current draw along with flexible cords and cables are not used as asubstitute for fixed wiring of a structure. This education will take place on or prior to September 10, 2015. **How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur:** The Maintenance Supervisorand/or designee will conduct 5 room audits each week to ensure no power stripextension cords are in use within the facility. Any issues identified will beimmediately addressed. All audit results and system components will be reviewedby the QA Committee on a monthly basis with subsequent plans of correctiondeveloped and implemented as deemed necessary. The criteria for determiningthat monitoring is no longer necessary will be 90% accuracy. If audits donot meet this criteria, audits shall continue at the same schedule for anadditional three months. At that time, analysis of data will be done to ensurethe deficient practice does not reoccur and/or adapt audit schedules.	