

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 09/25/2015
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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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(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
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/11/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/24/15</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>At this PSR survey, Hammond-Whiting Care Center was found in substantial 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> <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 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 68 at</p>	K 0000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the September 25, 2015 revisit to the Life Safety Code Survey of August 11, 2015 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 October 7, 2015 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.Respectfully, Kimberly ReadyExecutive Director</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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K 0130 SS=B Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage.</p> <p>Quality Review completed on 09/28/15 - DA</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>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:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific</p>	K 0130	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The fire wall was immediately repaired on 9/25/2015 after identification to ensure the fire resistance of the barrier - see photo attached. 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 fire walls on weekly rounds for three month to ensure the penetration of fire barrier walls are maintained to ensure the fire resistance of the barrier. Any issues identified will</p>	09/25/2015

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	<p>purpose.</p> <p>(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:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and up to 38 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 09/24/15 at 9:36 a.m., a three feet by three feet penetration from the drywall falling off in the North fire wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>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 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.</p>		