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	12/01/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00417083 and IN00417627. Complaint IN00417083 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00417627 - No deficiencies related to the allegations are cited. Survey dates: November 27, 28, 29, 30, and December 1, 2023 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 7 Medicaid: 51 Other: 11 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. v Quality review completed on 12/6/23.	F 0000	December, 14, 2023 Brenda Buroker, Director of Long-Term Care Indiana State Department of Public Health 2 North Meridian St. Indianapolis, IN 46204 Dear Ms. Buroker, Please reference the enclosed CMS 2567 as “Plan of Correction” for the December 01, 2023 Recertification and State Licensure with Complaint (IN004172627, IN00417083) Survey that was conducted at Hammond Whiting Care Center. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Thompson	Executive Director	12/15/2023

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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			The Plan of Correction submitted on December 14, 2023 serves as our allegation of compliance. We are requesting a desk review of this Plan of Correction. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Mark Thompson, HFA Executive Director	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse			

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	consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to promptly notify the resident's family of medication changes for 2 of 2 residents reviewed for notification of change. (Residents 23 and B) Findings include:	F 0580	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	12/29/2023

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	1. During a phone interview with Resident 23's responsible party on 11/27/23 at 1:18 p.m., she indicated she was not always made aware of her brother's medication changes. The record for Resident 23 was reviewed on 11/29/23 at 9:59 a.m. The resident was admitted to the facility on 9/5/23. Diagnoses included, but were not limited to, lung, liver and bladder cancer, epilepsy, high blood pressure, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 9/11/23, indicated the resident was not cognitively intact and needed extensive assistance with 1 person physical assist for bed mobility and transfers. In the last 7 days, the resident received an anti-anxiety medication 6 times. A Nurses' Note, dated 11/10/23 at 1:25 a.m., indicated the resident was observed having a seizure that lasted 3 minutes. The Hospice Nurse was notified and indicated someone would be out to assess the resident. A Nurses' Note, dated 11/10/23 at 10:01 a.m., indicated the Hospice Nurse arrived to the facility for the follow up regarding the seizure. She had new Physician's Orders for the resident to start on Keppra 1000 milligrams (mg) and Lamotrigine 200 mg daily (both were medications to treat seizures). A Nurses' Note, dated 11/15/23 at 12:26 p.m., indicated the Hospice Nurse was in the facility and had a new a order for Lorazepam (an anti-anxiety medication) 1 milliliter (ml) at bed time. Physician's Orders, dated 11/10/23, indicated Lamotrigine oral tablet 200 mg, give 1 tablet by		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 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. **F 580**- Notify of Changes ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Resident number 23 and resident B had no negative outcomes. The resident's responsible party have been notified of medication changes. ***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 All residents who have a medication change have the potential to be affected. 2 The physician and responsible parties of residents who have had a recent medication	

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	mouth two times a day and Keppra oral tablet 1000 mg, give 1 tablet by mouth two times a day. Physician's Orders, dated 11/15/23, indicated Lorazepam intensol oral concentrate 2 mg/ml, give 1 ml by mouth at bedtime for agitation and Lorazepam intensol oral concentrate 2 mg/ml, give 0.5 ml by mouth three times a day for anxiety. There was no documentation the resident's responsible party was notified of the new medication orders. Interview with the Nurse Consultant on 11/30/23 at 11:50 a.m., indicated the resident's family member should have been notified of the change in medications. They had thought hospice was notifying the family, however, they had no documentation to prove they were informing the family. 2. During an interview with Resident B's spouse on 11/28/23 at 9:38 a.m., they indicated the facility was not always calling them when new medications were ordered. The record for Resident B was reviewed on 11/28/23 at 1:25 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, protein calorie malnutrition, stroke, Atrial Fibrillation (A Fib - irregular heart rhythm), pacemaker, anemia, high blood pressure, and alcohol dependence. The 10/23/23 Medicare 5 day Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident received an antipsychotic and antiplatelet medication. A Nurses' Note, dated 10/19/23 at 10:29 a.m., indicated the resident's spouse gave verbal		change have been notified. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 DON/designee will provide education to licensed nursing staff on the notification process to the responsible party and physician when a resident has a medication change. Education will be completed by date of compliance. 2 All new licensed nursing staff will 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 a week x's 6 months to ensure responsible party notification has been made for residents identified to have medication change. 2 Results will be presented to QAPI x 6 months and 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	

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	consent for the resident to have Quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime. The resident's spouse was made aware of the use of the medication and wanted to be notified if there were any adverse reactions from the use of the medication. A Nurses' Note, dated 11/8/23 at 12:52 p.m., indicated a Pharmacy recommendation was received and the Physician accepted the recommendation to GDR (Gradual Dose Reduction) the Quetiapine 25 mg at bed time to 12.5 mg at bed time. Physician's Orders, dated 11/8/23, indicated Quetiapine 25 mg give 0.5 tablet by mouth at bedtime. There was no documentation the resident's spouse had been notified of the reduction. Interview with the Nurse Consultant on 11/30/23 at 3:15 p.m., indicated the resident's family should have been notified of the medication change. 3.1-5(a)(3)		will be increased as needed, if compliance is below 100%. Compliance date: 12/29/23. 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; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL's) related to shaving and bathing for 2 of 6 residents reviewed for ADL's. (Residents B and C)	F 0677	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	12/29/2023

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	Findings include: 1. During an interview with Resident B's spouse on 11/28/23 at 9:38 a.m., they indicated they did not think the resident was receiving a shower at least 2 times a week. The record for Resident B was reviewed on 11/28/23 at 1:25 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, protein calorie malnutrition, stroke, Atrial Fibrillation (A Fib - irregular heart rhythm), pacemaker, anemia, high blood pressure, and alcohol dependence. The 10/23/23 Medicare 5 day Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident needed some help and partial assistance from another person to complete bathing, dressing, using the toilet, and walking. The Care Plan, revised on 9/22/23, indicated the resident had an ADL self-care performance deficit. The resident received a shower or bed bath 2 times a week from 9/21/23 to 11/26/23 except for the weeks of 10/22, 10/29, and 11/5/23, where only 1 shower was documented as being given. Interview with the Nurse Consultant on 12/1/23 at 9:15 a.m., indicated the resident was to receive at least 2 showers a week. 2. On 11/27/23 at 11:25 a.m., on 11/28/23 at 9:45 a.m., 1:21 p.m., and 2:50 p.m., Resident C was observed with long white facial hair on their cheeks, chin and neck area. The record for Resident C was reviewed on		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 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. **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 B was offered/given a shower immediately. No negative outcomes noted. 2 Resident C was shaven. No negative outcomes noted. ***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 and completion of	

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	11/29/23 at 11:56 a.m. The resident was admitted to the facility on 5/10/23. Diagnoses included, but were not limited to, fracture of left femur, dementia without behaviors, Parkinson's disease, cellulitis of the right lower limb, dermatitis, history of falling, difficulty walking, and high blood pressure. The 9/30/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for personal hygiene. The Care Plan, revised on 11/25/23, indicated the resident had an ADL self-care performance deficit related to dementia. There was no Care Plan indicating the resident refused care. The resident's shower schedule was on Wednesdays and Saturdays. The resident received a bed bath on 11/28/23 and the removal of facial hair was blank. Interview with the Director of Nursing on 11/30/23 at 11:50 a.m., indicated she had no additional information regarding the resident being unshaven. This citation relates to Complaint IN00417083. 3.1-38(a)(2)(A) 3.1-38(a)(3)(D)		shower sheets 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 shaving and 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 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. 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	

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			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: 12/29/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0684 SS=E 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 areas of bruising, scratches, sutures, and glued lacerations were assessed and monitored for 3 of 4 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure neurological checks were completed as well as fall follow-up documentation for 2 of 3 residents reviewed for falls. (Residents 2, 19, 23, B, and C)	F 0684	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	12/29/2023

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	Findings include: 1. On 11/27/23 at 10:53 a.m., Resident 2 was observed with scattered areas of reddish/purple discoloration to her bilateral forearms. On 11/28/23 at 10:45 a.m., the scattered areas of discoloration remained to the resident's bilateral forearms. On 11/29/23 at 9:38 a.m., the resident was observed in her room in bed. A new area of dark purple bruising was observed on the top of the resident's left hand and wrist area. The record for Resident 2 was reviewed on 11/29/23 at 10:42 a.m. Diagnoses included, but were not limited to, Alzheimer's late onset, dementia with agitation, Atrial Fibrillation (A Fib - irregular heart rhythm), and hemiplegia/hemiparesis (muscle weakness/paralysis) following a stroke. The Significant Change Minimum Data Set (MDS) assessment, dated 10/31/23, indicated the resident was cognitively impaired for daily decision making. The resident had received an antiplatelet medication during the last 7 days of the assessment reference period. The Quarterly MDS assessment, dated 9/30/23, indicated the resident required extensive assist with bed mobility and she was totally dependent on staff for transfers. A Care Plan, dated 3/9/21 and revised on 10/26/23, indicated the resident was at risk for bleeding/injury related to long term use of Aspirin and Plavix (an antiplatelet medication).		the residents nor is it of such character to limit our capabilities 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. **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 # 2 had skin assessment completed and orders obtained immediately and put in place to monitor bruising until resolved. Family was notified. No negative outcomes noted. 2 Resident # 19 had skin assessment completed and orders obtained immediately and put in place to monitor bruising until resolved. Family was notified. No negative outcomes noted. 3 Resident #23 had no negative outcomes noted. 4 Resident B had no negative outcomes noted. 5 Resident C had skin assessment completed and tx orders obtained and put in place. Resident C had no negative	

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	Physician's Orders, dated 9/5/23, indicated to monitor bruises to the bilateral forearms every shift until healed and monitor for signs and symptoms of bleeding including black tarry stools, bleeding gums, bruising, and nose bleed related to anticoagulant use every shift. Document "+" if signs and symptoms were present and "-" if not present. The November 2023 Physician's Order Summary (POS), indicated the resident received Aspirin 81 milligrams (mg) daily and Plavix 75 mg daily. The Weekly Skin Integrity form, dated 11/28/23, indicated no areas of bruising were identified. There was no documentation related to the new areas of discoloration on 11/29/23. The 11/2023 Medication Administration Record (MAR), indicated there were no anticoagulant side effects present for all 3 shifts 11/20 through 11/28/23. Interview with the Nurse Consultant on 11/30/23 at 2:44 p.m., indicated the areas of bruising should have been assessed and monitored. She also indicated a head to toe skin assessment would be completed for the resident. 2. On 11/27/23 at 12:03 p.m., Resident 19 was observed with a fading purple bruise to her left forearm. On 11/30/23 at 10:30 a.m., the resident was observed with a fading purple bruise to her right forearm. The record for Resident 19 was reviewed on 11/28/23 at 2:50 p.m. Diagnoses included, but		outcomes noted. ***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. Any new orders received will be 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 receive this education prior to working. ***How the corrective action will be monitored to ensure the deficient practice will not recur,***	

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	were not limited to, Atrial Fibrillation (A Fib - irregular heart rhythm), gastrostomy (an opening into the stomach from the abdominal wall for the introduction of food), anemia, and dementia without behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 9/7/23, indicated the resident was cognitively impaired for daily decision making and she required extensive assist with bed mobility. She was also totally dependent for transfers. The resident had received an anticoagulant (blood thinner) 7 times during the assessment reference period. A Care Plan, dated 9/8/23, indicated the resident had an occlusive DVT (deep vein thrombosis - blood clot) in the left axilla (armpit) area. Interventions included, but were not limited to, observe and report as needed (PRN) any signs and symptoms of DVT complications: pulmonary embolism (sudden onset of chest pain and difficulty breathing (dyspnea)), restlessness, anxiety, cough, palpitations, nausea, vomiting, syncope (fainting), and abnormal bleeding and bruising related to anticogulant use. The November 2023 Physician's Order Summary (POS), indicated the resident received Aspirin 81 milligrams (mg) daily and Eliquis (an anticoagulant) 2.5 mg twice a day. Monitor for signs and symptoms of bleeding including black tarry stools, bleeding gums, bruising, and nose bleed related to anticoagulant use every shift. Document "+" if signs and symptoms were present and "-" if not present. The November 2023 Medication Administration Record (MAR) indicated no anticoagulant side effects were present for all 3 shifts 11/20 through		***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 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: 12/29/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	11/28/23. The Weekly Skin Integrity form, dated 11/23/23, indicated the resident's skin was intact. There was no documentation related to the bruising on the forearms. Interview with the Nurse Consultant on 11/30/23 at 2:44 p.m., indicated the resident's bruises should have been assessed and monitored. 3. On 11/27/23 at 11:16 a.m., Resident 23 was observed sitting on the side of his bed with a bandaid on his forehead. The record for Resident 23 was reviewed on 11/29/23 at 9:59 a.m. The resident was admitted to the facility on 9/5/23. Diagnoses included, but were not limited to, lung, liver and bladder cancer, epilepsy, high blood pressure, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 9/11/23, indicated the resident was not cognitively intact and needed extensive assistance with 1 person physical assist for bed mobility and transfers. In the last 7 days the resident received an anti-anxiety medication 6 times, an antidepressant medication 2 times, and an opioid medication 6 times. The resident had no falls while in the facility and 2 or more prior to admission. The Care Plan, revised on 11/20/23, indicated the resident was at risk for falls. A Nurses' Note, dated 9/22/23 at 11:00 a.m., indicated the Executive Director informed the nurse the resident was laying on the floor in the middle of the hallway. The resident was assessed and no new injuries were noted.			

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	There was no fall follow up assessment or documentation after the fall. A Neurological Observation was initiated on 9/22/23 at 1:48 p.m., but not completed. A Nurses' Note, dated 10/31/23 at 2:57 p.m., indicated the resident was observed on the floor in the hallway. They were assessed and had no apparent injuries. There was no fall follow up assessment or documentation after the fall. Nurses' Notes, dated 11/19/23 at 2:25 p.m., indicated the resident was found on the floor in front of the nurses' station. A skin tear was observed to the forehead. A Neurological Observation was initiated on 11/19/23 but not completed to its entirety. There was no fall follow up assessment or documentation after the fall. A Nurses' Note, dated 11/25/23 at 3:55 a.m., indicated the resident was found on the floor by the bed and there was blood noted from the eye brow. The resident was sent to the emergency room for treatment. A Nurses' Note, dated 11/25/23 at 11:39 a.m., indicated the resident would be returning from the hospital. The hospital nurse informed the facility the resident received 4 sutures to the forehead and they should be removed in 10 days. A Neurological Observation was initiated on 11/25/23 at 5:06 a.m., however, it was incomplete.			

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	There was no fall follow up or assessment of the sutures after the resident returned from the hospital. Interview with the Nurse Consultant on 11/30/23 at 11:50 a.m., indicated follow up after a fall should be documented every shift for 72 hours. There was no documentation or assessments of the resident's injury and the 4 sutures when he came back with from the hospital on 11/25/26. 4. The record for Resident B was reviewed on 11/28/23 at 1:25 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, protein calorie malnutrition, stroke, Atrial Fibrillation (A Fib - irregular heart rhythm), pacemaker, anemia, high blood pressure, and alcohol dependence. The 10/23/23 Medicare 5 day Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The resident needed some help and partial assistance from another person to complete bathing, dressing, using the toilet, and walking. The resident received an antipsychotic and antiplatelet medication. A Nurses' Note, dated 9/27/23 at 9:00 a.m., indicated the resident started complaining of abdominal pain and was guarding their right side. The Physician and responsible party were made aware, and orders were received to obtain an X-ray of the right side of the abdomen. At 10:09 a.m., the resident started yelling for help and complaining of more pain to the right abdomen. The Physician was made aware and orders were obtained to send the resident to the hospital. The resident was admitted to the hospital with acute cholecystitis (inflamed gallbladder).			

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	A Change of Condition Assessment, dated 9/27/23, indicated there were no current vital signs checked at the time of the status change. The vital signs that were documented all had the date of 9/27/23 and the time of 4:14 a.m. A Nurses' Note, dated 11/2/23 at 10:12 a.m., indicated the resident fell and hit their head. A Nurses' Note, dated 11/3/23 at 2:27 a.m., indicated the resident's steri strips were dry and intact. There were no neurological observations after the fall. There was no fall follow up assessment or documentation and there was no documentation the resident was sent out to the hospital after the fall. There was no assessment of the forehead after the fall. Interview with the Nurse Consultant on 11/30/23 at 11:50 a.m., indicated follow up after a fall should be documented every shift for 72 hours. Interview with the Nurse Consultant on 11/30/23 at 3:15 p.m., indicated the resident did not have steri strips on their forehead. The resident was sent out to the emergency room and the laceration was glued. There was no monitoring of the laceration after it happened and there was no documentation of neurological checks or assessment after the fall. 5. On 11/28/23 at 9:45 a.m., fresh blood was observed to the outer sock of Resident C's left foot. The resident was also observed with a large fading yellow and brown bruise to the right side of their face with scabbed abrasions.			

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	On 11/28/23 at 1:21 p.m., and 2:50 p.m., the resident was observed in bed. Both of their feet were laying directly on the bed and not suspended or offloaded. The resident did not have socks on either foot, but was observed with geri sleeves to their legs. A white bandage could be seen to the left outer ankle with no date on it. On 11/29/23 at 2:25 p.m., the resident was observed in bed and both of their feet were not offloaded or suspended. At 2:28 p.m., QMA 1 was asked to remove the resident's plain white socks from both feet. At that time, there was a white bandage noted to the left outer ankle with no date and a white bandage noted to the right lower leg with no date on it. Interview with QMA 1 at that time, indicated she was unaware the resident had any open areas. Interview with LPN 1 on 11/29/23 at 2:33 p.m., indicated she was not made aware the resident had any open areas. The record for Resident C was reviewed on 11/29/23 at 11:56 a.m. The resident was admitted to the facility on 5/10/23. Diagnoses included, but were not limited to, fracture of the left femur, dementia without behaviors, Parkinson's disease, cellulitis of the right lower limb, dermatitis, history of falling, difficulty walking, and high blood pressure. The 9/30/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for personal hygiene and had 2 or more falls with no injury since the			

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	last assessment. Physician's Orders, dated 7/10/23, indicated to offload heels while in bed and confirm every shift. There were no orders for any type of treatment for the areas on the ankle and lower leg. There was no documentation in Nursing Progress Notes regarding any type of open area or skin conditions to the ankle or leg. A Weekly Skin Integrity Assessment, dated 11/28/23 at 2:51 p.m., indicated the resident's skin was not intact and there were old issues of a laceration and faded bruising to the face. There was no documentation regarding the left ankle or right lower leg. Interview with LPN 1 on 11/29/23 at 3:03 p.m., indicated she assessed the left ankle and right lower leg open areas. The left outer ankle looked like it was a blister that opened. The area was red and measured 1 centimeter (cm) by 1 cm, and the right lower leg was scabbed and measured 1.3 cm. Interview with the Nurse Consultant on 11/30/23 at 11:50 a.m., indicated the resident scratched their skin and the open areas were a result of scratching. The order for the heels to be offloaded while in bed was going to be changed to add the words "as tolerated". There was no treatment order or documentation of the open areas prior to 11/29/23. A Change of Condition Evaluation dated 7/29/23 at 9:22 a.m., indicated the resident had a fall post fractured hip. The resident was sent to the emergency room and had X-rays to determine there were no other fractures or a dislocation.			

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	A Neurological Observation was initiated on 7/29/23 at 9:10 a.m., however, they were incomplete and not fully documented. There was no fall follow up or assessment completed. A Nurses' Note, dated 11/14/23 at 7:09 p.m., indicated the resident was observed face down on the floor next to the bed. The resident hit their head and had a laceration to the right eye. The Physician was notified and orders were obtained to send the resident to the hospital. A Nurses' Note, dated 11/15/23 at 1:30 a.m., indicated the resident returned from the hospital. There was no assessment of the resident's injuries. A Nurses' Note, dated 11/17/23 at 11:14 a.m., indicated the bruising and swelling remained to the right eye and the laceration was observed with a glued closure. The above note was the first time the laceration was identified as being a glued closure. There was no other documentation, assessment or monitoring of the glued closure. Interview with the Nurse Consultant on 11/30/23 at 11:50 a.m., indicated follow up after a fall should be documented every shift for 72 hours. There was no documentation or assessment of the resident's injury and glued laceration after the fall on 11/14/23. The revised and current 4/7/22 "Fall Management" policy, provided by the Regional Vice President of Operations indicated the			

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	Lippincott Procedures for fall management were "even if the resident shows no signs of distress or has sustained only minor injuries, increase the frequency of monitoring of blood pressure, pulse, and respirations for the next 72 hours or as directed by your facility.... Monitor neurologic status, as directed by your facility. Notify the practitioner if you note any changes from baseline." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents had access to receive services for impaired vision for 2 of 3 residents reviewed for vision and hearing. (Residents 31 and 18) Findings include: 1. On 11/27/23 at 3:49 p.m., Resident 31 was observed in her room watching television. The resident indicated she wore glasses and she needed new glasses. At that time, the resident	F 0685	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	12/29/2023

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	also indicated she had asked multiple times to be placed on the list to see an eye doctor. The record for Resident 31 was reviewed on 11/28/23 at 1:59 p.m. The resident was admitted to the facility on 11/18/21. Diagnoses included, but were not limited to, anemia, atrial fibrillation (abnormal heart rhythm), heart failure, hypertension (high blood pressure), diabetes, dementia, hemiplegia, anxiety, and depression. The 9/1/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and had no vision impairment or corrective lens. A Physician's Order, dated 2/2/23, indicated the resident may have Dental, Podiatry, Audiology, and Optometry care as needed. There was no documentation the resident had seen an eye doctor since admission. Interview with the Regional Vice President of Operations on 11/29/23 at 3:17 p.m., indicated the resident had not seen the eye doctor since being at the facility and was put on the list today to be seen. Interview with the Social Service Director on 12/1/23 at 12:45 p.m., indicated the resident had not seen the eye doctor since arriving to the facility in 2021. 2. On 11/28/23 at 10:05 a.m. Resident 18 was observed in his room. At that time, the resident indicated he needed cataract surgery. He had complained about it at last month's resident council meeting.		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. **F 685-** Treatment/Devices to Maintain Hearing/Vision ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Resident # 31 is scheduled to be seen by vision services at next visit in December. No negative outcomes noted. 2 Resident # 18 is scheduled to be seen by vision services at next visit in December. No negative outcomes noted. ***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 All residents have the potential to be affected. 2 In house audit to be completed for all residents to ensure residents have routine appointments to be seen by vision/hearing provider. Any issues identified will be addressed.	

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	The record for Resident 18 was reviewed on 11/28/23 at 2:14 p.m. The resident was admitted to the facility on 12/19/22. Diagnoses included, but were not limited to, heart failure, hypertension (high blood pressure), hemiplegia (muscle weakness), asthma, and cellulitis (infection) in the right and left leg. The 9/13/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and had corrective lens. A Physician's Order, dated 7/28/23, indicated the resident may have Dental, Podiatry, Audiology, and Optometry care as needed. There was no Care Plan for impaired vision. There was no documentation the resident had seen an eye doctor since admission. A History and Physical (H&P), dated and signed by the Physician on 7/28/23, indicated the resident had a premature left eye cataract. Interview with the Regional Vice President of Operations on 11/29/23 at 3:17 p.m., indicated there were no documents to provide, Resident 18 had not seen the eye doctor, and no appointment was made prior to today. 3.1-39(a)(1)		***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 Education will be completed to SSD to ensure all residents have routine vision/hearing services 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 review all new admissions to ensure consent/appointment completed/scheduled x 3 months, then will audit 2 admissions/week x 3 months. Audits will be presented to QAPI x 6 months and QAPI will determine 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: 12.29.23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure reducing measures were in use for a resident with a deep tissue injury (DTI) for 1 of 1 resident reviewed for pressure ulcers. (Resident 2) Finding includes: On 11/28/23 at 3:38 p.m., Resident 2 was observed in her room in bed. No heel protectors were in use at that time. On 11/29/23 at 9:38 a.m. and 11:28 a.m., the resident was observed in her room in bed. The resident had no sock on her right foot and her foot was resting on a pillow. The resident's left foot was resting on the mattress. The record for Resident 2 was reviewed on 11/29/23 at 10:42 a.m. Diagnoses included, but were not limited to, Alzheimer's late onset, dementia with agitation, Atrial Fibrillation (A Fib -	F 0686	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 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	12/29/2023

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	irregular heart rhythm), and hemiplegia/hemiparesis (muscle weakness/paralysis) following a stroke. The Significant Change Minimum Data Set (MDS) assessment, dated 10/31/23, indicated the resident was cognitively impaired for daily decision making. The resident also had one deep tissue injury (purple or maroon localized area or discolored intact skin due to damage of underlying soft tissue from pressure and/or shear). The Quarterly MDS assessment, dated 9/30/23, indicated the resident required extensive assist with bed mobility and she was totally dependent on staff for transfers. A Care Plan, dated 10/26/23, indicated the resident had a DTI (deep tissue injury) to her right heel. Interventions included, but were not limited to, heel boots to be applied while in bed. A Physician's Order, dated 9/5/23 and listed as current on the November 2023 Physician's Order Summary, indicated the resident's heels were to be off loaded when in bed. Interview with the Regional Vice President of Operations and the Director of Nursing (DON) on 12/1/23 at 1:09 p.m., indicated both heels should have been off loaded while in bed or the heel boots should have been in use. 3.1-40(a)(2)		respectfully request a desk review. **F686** Treatment/Services to prevent/heal pressure ulcer ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Res #2 immediately had heels offloaded. Orders and care plan updated. No negative outcomes noted. ***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 Audit completed on all current residents with skin integrity impairment/at risk for skin integrity impairment to ensure pressure reducing measures are in place 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 to provide education to all staff r/t pressure reducing measures by date of compliance. 2 All newly hired staff will receive this education during orientation, prior to providing resident 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:***	

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			1 DON and/or designee to complete observations at random times 5 times a week for 2 months, then 3 times a week for 2 months, then 1 time a week for 2 months. Any issues identified will be immediately addressed by the DON/designee. 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: 12/29/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
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			

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	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 a tube feeding was infusing at the correct time. The facility also failed to ensure tube feeding placement was checked and a water flush was completed prior to administering gastrostomy tube (an opening into the stomach from the abdominal wall for the introduction of food) medications for 2 of 2 residents reviewed for tube feeding. (Residents 19 and 33) Findings include: 1. On 11/27/23 at 12:03 p.m., Resident 19 was observed in the dining room eating lunch. Her tube feeding was not infusing at that time. On 11/28/23 at 10:17 a.m., 1:38 p.m., and 3:19 p.m., the resident was observed in her wheelchair throughout the facility. Her tube feeding was not infusing nor connected to the gastrostomy tube. On 11/29/23 at 10:39 a.m., the resident was being pushed down the hallway by a staff member, her tube feeding was not connected. At 11:28 a.m., she was seated on the side of her bed. Again, the tube feeding was not connected. A tube feeding pump was observed next to the resident's bed. At 12:15 p.m., the resident was in the dining room eating lunch. Her tube feeding was not	F 0693	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 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. **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***	12/14/2023

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	connected. At 5:00 p.m., the resident was resting on the couch in the lobby. Her tube feeding was not connected. On 11/30/23 at 10:30 a.m. and 1:14 p.m., the resident was observed in the hallway in her wheelchair. Her tube feeding was not connected at those times. The record for Resident 19 was reviewed on 11/28/23 at 2:50 p.m. Diagnoses included, but were not limited to, Atrial Fibrillation (A Fib - irregular heart rhythm), gastrostomy status (an opening into the stomach from the abdominal wall for the introduction of food), anemia, and dementia without behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 9/7/23, indicated the resident was cognitively impaired for daily decision making and she needed extensive assistance for eating. She also received a tube feeding and a mechanically altered diet. A Physician's Order, dated 11/14/23, indicated the resident was to receive a tube feeding of Jevity 1.2 at 75 milliliters (ml) per hour, times 18 hours via pump. Start at 10:00 a.m. and off at 4:00 a.m. May substitute with Glucerna 1.2. Interview with the Nurse Consultant on 12/1/23 at 8:55 a.m., indicated the Physician discontinued the tube feeding order on 11/30/23 due to the resident was eating an oral diet and gaining weight. 2. On 11/30/23 at 1:24 p.m., QMA 1 was observed preparing a gastrostomy tube (an opening into the stomach from the abdominal wall for the introduction of food) medication for Resident 33. The QMA crushed a 1 milligram (mg) tablet of		***practice:*** 1 Resident 19 had no negative outcomes. MD and POA notified of tube feeding hung at wrong time. Orders received to d/c tube feeding d/t resident consuming meals orally. 2 Resident 33 had no negative outcomes. MD notified with no new orders received. ***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	

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	Lorazepam (an anti-anxiety medication) and proceeded to the resident's room. Upon entering the resident's room, the QMA diluted the Lorazepam with approximately 15 milliliters (ml) of purified water. The resident was seated in her wheelchair at that time. The QMA proceeded to lift the resident's shirt and untie the tubing. The tubing was tied in a loose knot. She then placed the syringe into the port and administered the medication. After she was done giving the medication, she flushed the tube with 15 ml's of water. The QMA did not check for tube placement or flush the tubing prior to giving the medication. Interview with the Nurse Consultant on 12/1/23 at 8:55 a.m., indicated g-tube placement should have been checked prior to giving the medication and the tube flushed prior to giving the Lorazepam. The facility policy titled, "Medication Administration via Enteral Access Device [EAD]", was provided by the Regional Vice President of Operations on 11/30/23 at 4:04 p.m. The policy indicated, avoid administration of feedings, fluids, or medications through the EAD until correct position had been confirmed and prior to administering medication, stop the feeding and flush the tube with at least 15 ml of purified water using a 35 ml or larger syringe. 3.1-44(a)(2)		nursing staff will not work until this education and a competency is 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 and/or Designee will observe and/or have staff 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: 12.14.23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 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 ensure oxygen was at the correct flow rate for 1 of 2 residents reviewed for oxygen. (Resident 2) Finding includes: On 11/28/23 at 1:42 p.m., Resident 2 was seated in the hall way across from the nurses' station. The resident was wearing oxygen by the way of a nasal cannula. The portable oxygen tank was set at 2 liters. At 3:38 p.m., the resident was in her room in bed sleeping. She was holding the nasal cannula in her hands. On 11/29/23 at 9:38 a.m. and 11:28 a.m., the resident was in her room in bed sleeping. The resident's nasal cannula was not in place and the oxygen concentrator was set at 2 liters. At 12:10 p.m., the oxygen was in use and the concentrator was set at 2 liters. On 11/30/23 at 10:38 a.m., the resident was observed in her room in bed. The resident's oxygen was in use and the oxygen concentrator was set at 2 liters. The record for Resident 2 was reviewed on 11/29/23 at 10:42 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive	F 0695	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 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. **F 695**- Respiratory/Tracheostomy Care and Suctioning ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient***	12/29/2023

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	pulmonary disease), Alzheimer's late onset, dementia with agitation, Atrial Fibrillation (A Fib - irregular heart rhythm), and hemiplegia/hemiparesis (muscle weakness/paralysis) following a stroke. The Significant Change Minimum Data Set (MDS) assessment, dated 10/31/23, indicated the resident was cognitively impaired for daily decision making and she was receiving oxygen while a resident of the facility. The current Care Plan indicated the resident had altered respiratory status related to COPD and CHF (congestive heart failure). Interventions included, but were not limited to, apply oxygen as ordered. A Physician's Order, dated 3/15/23 and listed as current on the November 2023 Physician's Order Summary, indicated the resident was to receive oxygen at 3 liters continuously per nasal cannula. Interview with the Nurse Consultant on 11/30/23 at 2:44 p.m., indicated the resident's oxygen concentrator should have been set at 3 liters. 3.1-47(a)(6)		***practice:*** 1 Resident 2 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 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	

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			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 needed, if compliance is below 100%. Compliance date: 12.29.23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to complete a post dialysis assessment for 1	F 0698	This plan of correction is prepared and executed because the	12/29/2023

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	of 1 resident reviewed for dialysis. (Resident 25) Finding includes: Resident 25's record was reviewed on 11/28/23 at 2:39 p.m. Diagnoses included, but were not limited to, heart failure, hypertension (high blood pressure), end stage renal disease (renal failure), diabetes, malnutrition, and dependent on renal dialysis. The 11/3/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 11/13/23, indicated the resident received hemodialysis related to renal failure and had an arteriovenous (AV) fistula (dialysis access site). Interventions included, but were not limited to, observe for bleeding at dialysis access site, obtain dry weights from dialysis center, assess shunt site for bruit and thrill, and encourage the resident to go for scheduled dialysis appointments on Monday, Wednesday, and Friday each week. A Physician's Order, dated 9/12/23, indicated the resident was a dialysis patient and received dialysis on Monday, Wednesday, and Friday at a dialysis center. The Dialysis Communication binder included communication forms that had information for the facility to fill out prior to the resident going to the dialysis center and upon return from the dialysis center. The information included vital signs, bruit and thrill was assessed, medication sent to dialysis center, medication received prior to dialysis, and other pertinent information (lunch or snack sent with resident, comments, or concerns).		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 if of such character to limit our capabilities 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. **F 698 –** Dialysis **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:** 1. Resident # 25: No negative outcomes noted. Orders updated to include supplementary documentation for post dialysis assessment. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** 1. All residents who receive	

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	The Dialysis Post Communication sheets were not filled out on 10/2/23, 10/20/23, 10/23/23, 10/27/23, 10/30/23, 11/1/23, 11/3/23, 11/6/23, 11/10/23, 11/13/23, 11/15/23, 11/17/23, 11/20/23, and 11/25/23. A facility policy titled, "Hemodialysis Offsite Policy", reviewed on 8/23/23 and identified as current, indicated ..."1. Obtain vital signs of resident upon return from dialysis and complete Pre/Post Dialysis Communication Form"... Interview with the Regional Vice President of Operations on 11/30/23 at 10:50 a.m., indicated the post dialysis sheet was not being filled out consistently. 3.1-37(a)		dialysis have the potential to be affected. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** 1 Education provided to licensed nursing staff regarding completion of post-dialysis assessment by date of compliance. 2 All newly hired licensed nursing staff will receive this education during 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. DON and/or Designee to audit dialysis communication sheets to ensure post assessment completed 3x/week for 6 months. 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%. Date of compliance: 12.29.23 The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of	

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			Correction.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures			

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	determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure residents received routine dental services for 1 of 4 residents reviewed for dental services. (Resident 31) Finding includes: On 11/27/23 at 3:50 p.m., Resident 31 was observed sitting up in bed watching television. At that time, the resident indicated she had asked to see the dentist and was told she was put on the list "months ago" by social services. The record for Resident 31 was reviewed on 11/28/23 at 1:59 p.m. The resident was admitted on 11/18/21. Diagnoses included, but were not limited to, anemia, atrial fibrillation (abnormal heart rhythm), heart failure, hypertension (high blood pressure), diabetes, dementia, hemiplegia, anxiety, and depression. The 9/1/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 2/2/23, indicated the resident may have Dental, Podiatry, Audiology, and Optometry care as needed. There was no documentation the resident had seen a dentist since admission.	F 0791	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 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. **F 791**- Routine_Emergency Dental Srvcs in NFs ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Resident # 31 is	12/29/2023

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	155423	A. BUILDING 00 B. WING	12/01/2023

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	Interview with the Regional Vice President of Operations on 11/29/23 at 3:17 p.m., indicated the resident had not seen the dentist since being at the facility and and was put on the list today. Interview with the Social Service Director on 12/1/23 at 12:45 p.m., indicated she couldn't recall the resident requesting to see the dentist. 3.1-24(a)(1)		scheduled to be seen by dental services at next visit in December. No negative outcomes noted. ***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 All residents have the potential to be affected. 2 In house audit to be completed for all residents to ensure residents have routine appointments to be seen by dental provider. 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 SSD to ensure all residents have routine dental services 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 review all new admissions to ensure consent/appointment completed/scheduled x 3 months, then will audit 2 admissions/week x 3 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. 2 The results of these reviews will be discussed at the	

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			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: 12.29.23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0921 SS=E 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 ensure the residents' environment was clean and in good repair related to marred walls, marred door frames, discolored floors, rusted and missing toilet bolts, dirty and broken floor baseboards, missing pieces from an air conditioner, and wash basins not contained in a multi resident room on 2 of 2 units. (The North and South Units) Findings include: During the Environmental Tour with the Environmental Director on 12/1/23 at 10:18 a.m., the following was observed: 1. South Hall a. Room 102 - The door frame was observed to be	F 0921	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 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	12/29/2023

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	marred and there was adhered dirt behind the base of the door. One resident resided in the room and two residents shared the bathroom. b. Room 104 - The bathroom walls were observed to be marred and the toilet bolts were missing and rusted. There were two residents who resided in the room and four residents who shared the bathroom. c. Room 106 - The bathroom walls was observed to be marred, the baseboard near bed one was broken, and the air conditioner was missing pieces. There were two residents residing in the room. 2. North Hall a. Room 212 - The bathroom door frame was observed to be marred and there was adhered dirt on the floor. Two plastic wash basins were observed on the counter and not contained. There were two residents who resided in the room and four residents who shared the bathroom. b. Room 214 - The door frame was observed to be marred and chipped. The base board was peeling from the wall in between the two beds. There were two residents who resided in the room and four residents who shared the bathroom. c. Room 221 - The floor beneath the toilet bowel was observed to be discolored. The door frame was gouged. There were two residents who resided in the room and four residents who shared the bathroom. d. Room 222 - The bathroom door frame was observed to be marred and missing a baseboard. The walls in the room were marred. There were		regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **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 door frames were repaired in rooms 102, 104, 106, 212, 214, 221, 222, and 223. The floor tile in the bathrooms of rooms 223 and 221 were cleaned. All wash basins were placed in trash and new were obtained and covered in appropriate plastic bag with resident's name. The toilet bolts were replaced in room 104. The baseboard repaired in rooms 106, 214, and 222. The AC in room 106 was 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:*** 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	

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	two residents who resided in the room and four residents who shared the bathroom. e. Room 223 - The floor beneath the toilet bowel was observed to be discolored. The door frame was gouged. The walls in the room were marred. There were two residents who resided in the room and four residents who shared the bathroom. When interviewed on 12/1/23 at 10:18 a.m., the Environmental Director indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)		rounds have been completed by maintenance department and plan has been put into place to address marred walls, discolored floor tiles in bathrooms, wash basins, toilet bolts, baseboard, and AC units on or prior to 12/29/23. 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 policy. ***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 marred walls, discolored floor tiles in bathrooms, wash basins, toilet bolts, baseboard, and AC unit. 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%.	

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			Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/29/23. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	