STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00	Licensure Survey. Investigation of Co IN00417627. Complaint IN0041 related to the allegated to the allegations are Survey dates: Nov December 1, 2023 Facility number: 0 Provider number: AIM number: 100 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type Medicare: 7 Medicaid: 51 Other: 11 Total: 69 These deficiencies accordance with 41	rember 27, 28, 29, 30, and 00365 155423 287460 e: reflect State Findings cited in	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 Correctifor 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 agreen by the provider of the truth fact alleged or conclusion set forth the statement of deficiencies. This plan of correction is preparand/or executed solely becaus is required by the provision of the Survey Team facility appreciated the time and dedication of the Survey Team facility will accept the survey as tool for our facility to use in continuing to better the quality care provided to our Elders in community.	er. of t nent es in ared e it the d ; the s a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Mark Thompson Executive Director 12/15/2023

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2023 FORM APPROVED OMB NO. 0938-039

		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING			COMPLETED	
		155423	B. W	ING		12/01/	2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must in resident; consult we physician; and not her authority, the rewident in- results in injury and requiring physician (B) A significant of physical, mental, of (that is, a deterioral psychosocial statu- conditions or clinical (C) A need to alter	(Injury/Decline/Room, etc.) Itification of Changes. Inmediately inform the vith the resident's Ify, consistent with his or resident representative(s) If wolving the resident which do has the potential for an intervention; In ange in the resident's prescribe processorial status ation in health, mental, or is in either life-threatening and complications); It treatment significantly discontinue an existing			The Plan of Correction submit on December 14, 2023 serves our allegation of compliance. We are requesting a desk revi of this Plan of Correction. Should you have any question concerns regarding the Plan of Correction, please contact metaspectfully, Mark Thompson, HFA Executive Director	as ew or f		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	of treatment); or (D) A decision to the resident from the fine \$483.15(c)(1)(ii). (ii) When making the ground of the fine \$483.15(c)(2) is the ground of the ground of the fine \$483.15(c)(2) is the ground of the ground	ast also promptly notify the esident representative, if som or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Instructory and periodically is section and mail of the section and periodically is section and mail of the section.					
	facility that is a co defined in §483.5) admission agreem configuration, inclu that comprise the and must specify the	uding the various locations composite distinct part, the policies that apply to ween its different locations					
	Based on record rev failed to promptly n medication changes	view and interview, the facility notify the resident's family of for 2 of 2 residents reviewed hange. (Residents 23 and B)	F 0580	This plan of correction is preparand executed because the provisions of state and federal require it and not because Hammond-Whiting Care Centeragrees with the allegations and citations listed. Hammond-Wh	law er d		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. During a phone interview with Resident 23's Care Center maintains that the responsible party on 11/27/23 at 1:18 p.m., she alleged deficiencies do not indicated she was not always made aware of her jeopardize the health and safety of brother's medication changes. the residents nor is it of such character to limit our capabilities The record for Resident 23 was reviewed on to render adequate care. Please 11/29/23 at 9:59 a.m. The resident was admitted to accept this plan of correction as the facility on 9/5/23. Diagnoses included, but our credible allegation of were not limited to, lung, liver and bladder cancer, compliance that the alleged epilepsy, high blood pressure, and major deficiencies have or will be correct depressive disorder. by the date indicated to remain in compliance with state and federal The Admission Minimum Data Set (MDS) regulations, the facility has taken assessment, dated 9/11/23, indicated the resident or will take the actions set forth in was not cognitively intact and needed extensive this plan of correction. We assistance with 1 person physical assist for bed respectfully request a desk review. mobility and transfers. In the last 7 days, the resident received an anti-anxiety medication 6 **F 580-** Notify of Changes times. What Corrective Action will be accomplished for those A Nurses' Note, dated 11/10/23 at 1:25 a.m., residents found to have been indicated the resident was observed having a affected by this deficient seizure that lasted 3 minutes. The Hospice Nurse practice: was notified and indicated someone would be out Resident number 23 to assess the resident. and resident B had no negative outcomes. The resident's A Nurses' Note, dated 11/10/23 at 10:01 a.m., responsible party have been indicated the Hospice Nurse arrived to the facility notified of medication for the follow up regarding the seizure. She had changes. new Physician's Orders for the resident to start on How other residents having the Keppra 1000 milligrams (mg) and Lamotrigine 200 potential to be affected by the mg daily (both were medications to treat seizures). same deficient practice will be identified and what corrective A Nurses' Note, dated 11/15/23 at 12:26 p.m., action will be taken: indicated the Hospice Nurse was in the facility All residents who and had a new a order for Lorazepam (an have a medication change have anti-anxiety medication) 1 milliliter (ml) at bed time. the potential to be affected. The physician and Physician's Orders, dated 11/10/23, indicated responsible parties of residents Lamotrigine oral tablet 200 mg, give 1 tablet by who have had a recent medication

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	LETED
		155423	B. WING	j		12/01/	/2023
			<u> </u>			<u> </u>	
NAME OF	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					14TH ST		
HAMMO	ND-WHITING CARE	E CENTER	I `	WHITIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	'IE	DATE
		day and Keppra oral tablet 1000			change have been notified.		
		mouth two times a day.			change have been healied.		
	mg, give i tablet by	mount we times a day.			What measures and what		
	Physician's Orders	dated 11/15/23, indicated			systemic changes will be ma	ndo	
		l oral concentrate 2 mg/ml, give				iue	
	_	edtime for agitation and			to ensure that the deficient		
	I				practice doesn't recur:	•••	
	_	l oral concentrate 2 mg/ml, give			1 DON/designee w		
	0.5 ml by mouth thi	ree times a day for anxiety.			provide education to licensed		
					nursing staff on the notification		
		mentation the resident's			process to the responsible par	-	
		as notified of the new			and physician when a residen		
	medication orders.				a medication change. Educati	on	
					will be completed by date of		
		Nurse Consultant on 11/30/23			compliance.		
		ated the resident's family			2 All new licensed		
	member should hav	re been notified of the change			nursing staff will receive this		
	in medications. The	ey had thought hospice was			education prior to working.		
	notifying the family	, however, they had no			How the corrective action w	ill	
	documentation to p	rove they were informing the			be monitored to ensure the		
	family.				deficient practice will not red	cur,	
					i.e., what quality assurance		
	2. During an intervi	iew with Resident B's spouse			program will be put in place.	:	
	on 11/28/23 at 9:38	a.m., they indicated the facility			1 DON/designee w	ill	
	was not always call	ing them when new			review 24/72 hour report 5 tim	ies a	
	medications were o	rdered.			week x's 6 months to ensure		
					responsible party notification I	nas	
	The record for Resi	dent B was reviewed on			been made for residents ident		
		n. Diagnoses included, but were			to have medication change.		
	_	bolic encephalopathy, protein			2 Results will be		
		, stroke, Atrial Fibrillation (A			presented to QAPI x 6 months		
		rhythm), pacemaker, anemia,			and QAPI will determine the n		
	1	e, and alcohol dependence.			for further audits.	oou	
	Ingli oloog pressure	, and arconor depondence.			The results of the	200	
	The 10/23/23 Media	care 5 day Minimum Data Set			reviews will be discussed at the		
		indicated the resident was not					
	` '				monthly facility Quality Assura		
		The resident received an			Committee meeting monthly for	ла	
	anupsychotic and a	ntiplatelet medication.			total of 3 months and then		
		1.10/10/02 10.22			quarterly thereafter once		
	A Nurses' Note, dat	red 10/19/23 at 10:29 a.m.,			compliance is at 100%.		

indicated the resident's spouse gave verbal

Frequency and duration of reviews

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER		1000 1	address, city, state, zip cod 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	consent for the residentipsychotic medicibedtime. The residential the use of the medicinotified if there were the use of the medicinotified if there were the use of the medicinotified if there were the use of the medicinotic and the Pharman received and the Pharman recei	dent to have Quetiapine (an eation) 25 milligrams (mg) at ent's spouse was made aware of eation and wanted to be re any adverse reactions from eation. Led 11/8/23 at 12:52 p.m., by recommendation was expected the GDR (Gradual Dose estiapine 25 mg at bed time to		will be increased as needed, if compliance is below 100%. Compliance date: 12/29/23. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	ne e
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provide §483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good g, and personal and oral	F 0677	This plan of correction is prepa	ared 12/29/2023
	residents received a daily living (ADL's	ty failed to ensure dependent ssistance with activities of related to shaving and esidents reviewed for ADL's.		and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center	

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(Residents B and C)

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agrees with the allegations and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155423 B. WING 12/01/2023

	135423	b. wing	12/01/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD	
WHILE OF I	TROVIDER OR SOLITEIER	1000 114TH ST	
HAMMO	ND-WHITING CARE CENTER	WHITING, IN 46394	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID PROVIDENCE N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD)	IN
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	DATE
		citations listed. Hammond-V	Whiting
	Findings include:	Care Center maintains that	-
		alleged deficiencies do not	
	1. During an interview with Resident B's spouse	jeopardize the health and s	afety of
	on 11/28/23 at 9:38 a.m., they indicated they did	the residents nor is it of suc	•
	not think the resident was receiving a shower at	character to limit our capab	ilities
	least 2 times a week.	to render adequate care. P	
		accept this plan of correction	n as
	The record for Resident B was reviewed on	our credible allegation of	
	11/28/23 at 1:25 p.m. Diagnoses included, but were	compliance that the alleged	
	not limited to, metabolic encephalopathy, protein	deficiencies have or will be	correct
	calorie malnutrition, stroke, Atrial Fibrillation (A	by the date indicated to ren	nain in
	Fib - irregular heart rhythm), pacemaker, anemia,	compliance with state and f	ederal
	high blood pressure, and alcohol dependence.	regulations, the facility has	taken
		or will take the actions set f	orth in
	The 10/23/23 Medicare 5 day Minimum Data Set	this plan of correction. We	
	(MDS) assessment indicated the resident was not	respectfully request a desk	review.
	cognitively intact. The resident needed some help	F 677- ADL Care Provided	<u>for</u>
	and partial assistance from another person to	<u>Dependent Residents</u>	
	complete bathing, dressing, using the toilet, and	What Corrective Action w	ill be
	walking.	accomplished for those	
		residents found to have b	een
	The Care Plan, revised on 9/22/23, indicated the	affected by this deficient	
	resident had an ADL self-care performance deficit.	practice:	
		1 Resident B wa	s
	The resident received a shower or bed bath 2	offered/given a shower	
	times a week from 9/21/23 to 11/26/23 except for	immediately. No negative	
	the weeks of 10/22, 10/29, and 11/5/23, where only	outcomes noted.	
	1 shower was documented as being given.	2 Resident C wa	
	L	shaven. No negative outcor	mes
	Interview with the Nurse Consultant on 12/1/23 at 9:15 a.m., indicated the resident was to receive at	noted.	41
	least 2 showers a week.	How other residents having	_
	icasi 2 shuwcis a week.	potential to be affected by	
	2. On 11/27/23 at 11:25 a.m., on 11/28/23 at 9:45	same deficient practice was identified and what correct	
	a.m., 1:21 p.m., and 2:50 p.m., Resident C was	action will be taken:	.uve
	observed with long white facial hair on their	1 An in house au	ıdit
	cheeks, chin and neck area.	will be completed by nursin	
	enecks, enin and neck area.	management on residents f	<u> </u>
	The record for Resident C was reviewed on	POC charting and completi	
	The record for resident C was reviewed on	FOC charting and completi	UII UI

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 11/29/23 at 11:56 a.m. The resident was admitted to shower sheets to assure the facility on 5/10/23. Diagnoses included, but completed per policy. Any issues were not limited to, fracture of left femur, dementia will be identified and follow up will without behaviors, Parkinson's disease, cellulitis be completed. of the right lower limb, dermatitis, history of What measures and what falling, difficulty walking, and high blood systemic changes will be made pressure. to ensure that the deficient practice doesn't recur: The 9/30/23 Quarterly Minimum Data Set (MDS) Education to the assessment indicated the resident was not aides, licensed nurses, and SSD cognitively intact and needed extensive assist for completion of POC/PCC with 2 person physical assist for bed mobility and documentation related to shaving transfers. The resident needed extensive assist and refusal of shower/bed bath. with 1 person physical assist for personal Shower sheet to be completed hygiene. and turned into nurse each shift. MD and POA and/or family to be The Care Plan, revised on 11/25/23, indicated the notified of refusal. Nursing to notify resident had an ADL self-care performance deficit SSD of refusal(s). SSD to ensure related to dementia. care plan is updated to reflect refusal(s). This will be completed There was no Care Plan indicating the resident by DON/Designee by date of refused care. compliance. Any new nursing The resident's shower schedule was on staff will receive this education Wednesdays and Saturdays. during orientation as well. The resident received a bed bath on 11/28/23 and How the corrective action will the removal of facial hair was blank. be monitored to ensure the deficient practice will not recur, Interview with the Director of Nursing on 11/30/23 i.e., what quality assurance at 11:50 a.m., indicated she had no additional program will be put in place: information regarding the resident being DON/Designee will unshaven. review shower sheets daily 5 times weekly to assure This citation relates to Complaint IN00417083. compliance. Any refusals that are ongoing need to be reported to

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3.1-38(a)(2)(A)

3.1-38(a)(3)(D)

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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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/01/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				for further audits. 2 The results of the reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of review will be increased as needed, it compliance is below 100%. Compliance date: 12/29/23. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	e nce or a iews iews	
F 0684 SS=E Bldg. 00	applies to all treating facility residents. Expending the facility must ensure treatment and care professional stand comprehensive per and the residents' Based on observation interview, the facility bruising, scratches, were assessed and reviewed for skin controlled the facility also fail checks were complete.	a fundamental principle that ment and care provided to Based on the seessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan, choices. In record review, and ty failed to ensure areas of sutures, and glued lacerations nonitored for 3 of 4 residents onditions non-pressure related. Led to ensure neurological eted as well as fall follow-up to 63 residents reviewed for	F 0684	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Who Care Center maintains that the alleged deficiencies do not jeopardize the health and safe	law er d iting	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: the residents nor is it of such character to limit our capabilities 1. On 11/27/23 at 10:53 a.m., Resident 2 was to render adequate care. Please observed with scattered areas of reddish/purple accept this plan of correction as discoloration to her bilateral forearms. our credible allegation of compliance that the alleged On 11/28/23 at 10:45 a.m., the scattered areas of deficiencies have or will be correct discoloration remained to the resident's bilateral by the date indicated to remain in forearms. compliance with state and federal regulations, the facility has taken On 11/29/23 at 9:38 a.m., the resident was or will take the actions set forth in observed in her room in bed. A new area of dark this plan of correction. We purple bruising was observed on the top of the respectfully request a desk review. resident's left hand and wrist area. F 684- Quality of Care The record for Resident 2 was reviewed on What Corrective Action will be 11/29/23 at 10:42 a.m. Diagnoses included, but accomplished for those were not limited to, Alzheimer's late onset, residents found to have been dementia with agitation, Atrial Fibrillation (A Fib affected by this deficient practice: irregular heart rhythm), and hemiplegia/hemiparesis (muscle Resident # 2 had 1 weakness/paralysis) following a stroke. skin assessment completed and orders obtained immediately and The Significant Change Minimum Data Set (MDS) put in place to monitor bruising assessment, dated 10/31/23, indicated the resident until resolved. Family was notified. was cognitively impaired for daily decision No negative outcomes noted. making. The resident had received an antiplatelet Resident # 19 had medication during the last 7 days of the skin assessment completed and assessment reference period. orders obtained immediately and put in place to monitor bruising The Quarterly MDS assessment, dated 9/30/23, until resolved. Family was notified. indicated the resident required extensive assist No negative outcomes noted. with bed mobility and she was totally dependent Resident #23 had no on staff for transfers. negative outcomes noted. Resident B had no A Care Plan, dated 3/9/21 and revised on 10/26/23, negative outcomes noted. indicated the resident was at risk for Resident C had skin bleeding/injury related to long term use of Aspirin assessment completed and tx and Plavix (an antiplatelet medication). orders obtained and put in place.

Resident C had no negative

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155423	B. WI	NG		12/01/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF I	PROVIDER OR SUPPLIE	R			14TH ST		
НАММО	ND-WHITING CAR	E CENTER			IG, IN 46394		
11/ ((V))(V)	THE WINNEST CONTROL OF THE CONTROL O			VVI II I II			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	,	, dated 9/5/23, indicated to			outcomes noted.		
		the bilateral forearms every			How other residents having		
		nd monitor for signs and			potential to be affected by t		
		ling including black tarry			same deficient practice will		
		ms, bruising, and nose bleed			identified and what correcti	ve	
	_	ulant use every shift.			action will be taken:		
		gns and symptoms were			1 In house audit		
	present and "-" if n	ot present.			completed with head to toe sl		
					assessments to assure any s	kin	
		23 Physician's Order Summary			issues are identified and		
	(POS), indicated the resident received Aspirin 81				addressed by nursing		
	milligrams (mg) daily and Plavix 75 mg daily.				management by date of		
	The Weekly Skin Integrity form, dated 11/28/23,				compliance. Any new orders		
					received will be put on TX and		
	indicated no areas	of bruising were identified.			med sheet, care plan and kar		
	l				updated. Any issues identified	lliw b	
		mentation related to the new			be addressed.		
	areas of discolorati	on on 11/29/23.			What measures and what		
					systemic changes will be m	ade	
		cation Administration Record			to ensure that the deficient		
		there were no anticoagulant			practice doesn't recur:		
	_	t for all 3 shifts 11/20 through			1 Education will be	;	
	11/28/23.				completed to licensed and		
	Tukamaia 141 4	Nurse Consultant on 11/30/23			certified nursing staff to assur		
					any skin issue or abnormal fir	-	
	_	ated the areas of bruising should			needs reported and documen	ited in	
		l and monitored. She also toe skin assessment would be			the clinical record, MD and		
					Responsible party need notifi		
	completed for the r	esident.			and care plan and Kardex to		
	2 On 11/27/22 of	12.02 mm Desident 10 year			updated to reflect new orders		
		12:03 p.m., Resident 19 was ding purple bruise to her left			and/or include any new		
		ang purple ordise to her left			interventions by Nursing		
	forearm.				management by date of compliance. New licensed or		
	On 11/30/22 at 10.	30 a.m., the resident was			compliance, New licensed or certified nursing employees w		
		ding purple bruise to her right					
		ang parpie oraise to her right			receive this education prior to	'	
	forearm.				working.	,;u	
	The record for D	ident 19 was reviewed on			How the corrective action w	'III	
					be monitored to ensure the		
	11/28/23 at 2:50 p.	 m. Diagnoses included, but 	ı		deficient practice will not re	cur,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155423	B. WI	NG		12/01/	2023
				CTREET	ADDRESS OF A STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
LIANANAO	ND WUITING OAD	CENTED			14TH ST		
HAMMO	ND-WHITING CAR	ECENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were not limited to,	Atrial Fibrillation (A Fib -			i.e., what quality assurance		
	irregular heart rhytl	nm), gastrostomy (an opening			program will be put in place:		
	into the stomach fro	om the abdominal wall for the			1 DON/Designee w	ill	
	introduction of food	d), anemia, and dementia			review 24/72 hour report 5 tim	es	
	without behavior di	sturbance.			weekly to ensure treatment or	ders	
					are obtained and in place for a	any	
	The Significant Cha	ange Minimum Data Set (MDS)			skin issues and care plan is		
	assessment, dated 9	7/7/23, indicated the resident			updated x 6 months. Audits w	ll be	
	was cognitively imp	paired for daily decision making			presented to QAPI x 6 months	;	
	and she required ex	tensive assist with bed			and QAPI will determine need	for	
	mobility. She was	also totally dependent for			further audits. Competencies	will	
	transfers. The resid	lent had received an			be completed by date of		
	anticoagulant (blood thinner) 7 times during the				compliance on aides and nurs	es	
	assessment reference	ce period.			for the appropriate protocol for	rskin	
					assessments and accurate fol	low	
		9/8/23, indicated the resident			through and documentation by	/	
		VT (deep vein thrombosis -			Nursing Management.		
	·	ft axilla (armpit) area.			2 The results of the	se	
		led, but were not limited to,			reviews will be discussed at th	e	
	_	as needed (PRN) any signs			monthly facility Quality Assura		
		VT complications: pulmonary			Committee meeting monthly for	or a	
	·	onset of chest pain and			total of 3 months and then		
		(dyspnea)), restlessness,			quarterly thereafter once		
		pitations, nausea, vomiting,			compliance is at 100%.		
		and abnormal bleeding and			Frequency and duration of rev		
	bruising related to a	anticogulant use.			will be increased as needed, i	İ	
	T 1 202	2 PL - : : 1 G 1 G			compliance is below 100%.		
		3 Physician's Order Summary			Compliance date: 12/29/23. T	ne	
	, ,	e resident received Aspirin 81			Administrator at		
	milligrams (mg) da				Hammond-Whiting Care Cent	er is	
		ng twice a day. Monitor for			responsible in ensuring		
		s of bleeding including black			compliance in this Plan of		
	-	ing gums, bruising, and nose			Correction.		
		icoagulant use every shift.					
		gns and symptoms were					
	present and "-" if no	n present.					
	The Nevertee 202	2 Madigation Administration					
		3 Medication Administration					
		icated no anticoagulant side					
	effects were presen	t for all 3 shifts 11/20 through					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155423	B. W	B. WING			2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
		CENTED			14TH ST IG, IN 46394		
HAMMOND-WHITING CARE CENTER			VVIIIIN	IG, IN 40394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	11/28/23.						
	The Weekly Skin In	ntegrity form, dated 11/23/23,					
	indicated the reside	nt's skin was intact. There					
	was no documentat	ion related to the bruising on					
	the forearms.						
		Nurse Consultant on 11/30/23					
	_	ted the resident's bruises					
		ssessed and monitored. 3. On					
		.m., Resident 23 was observed					
	sitting on the side of his bed with a bandaid on						
	his forehead.						
		dent 23 was reviewed on					
		m. The resident was admitted to					
	1	3. Diagnoses included, but					
		lung, liver and bladder cancer,					
		d pressure, and major					
	depressive disorder	•					
		nimum Data Set (MDS)					
		0/11/23, indicated the resident					
		intact and needed extensive					
	_	erson physical assist for bed					
	-	fers. In the last 7 days the					
		n anti-anxiety medication 6					
	_	ssant medication 2 times, and					
	_	on 6 times. The resident had no					
		cility and 2 or more prior to					
	admission.						
	The Complete week						
		sed on 11/20/23, indicated the					
	resident was at risk	for falls.					
	A NImeINT 4 1 4	to d 0/22/22 at 11:00					
		ted 9/22/23 at 11:00 a.m.,					
		ative Director informed the					
		vas laying on the floor in the					
		ay. The resident was assessed					
	and no new injuries	s were noted.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 12/01/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)		(X5) COMPLETION DATE	
	A Neurological Ob 9/22/23 at 1:48 p.m A Nurses' Note, dat indicated the reside in the hallway. The	bollow up assessment or r the fall. servation was initiated on, but not completed. set 10/31/23 at 2:57 p.m., ont was observed on the floor y were assessed and had no					
	documentation afte Nurses' Notes, date indicated the reside	d 11/19/23 at 2:25 p.m., nt was found on the floor in station. A skin tear was					
	11/19/23 but not co	servation was initiated on empleted to its entirety. bllow up assessment or r the fall.					
	indicated the reside the bed and there w	at ded 11/25/23 at 3:55 a.m., and was found on the floor by as blood noted from the eye was sent to the emergency					
	indicated the reside hospital. The hospithe resident receive	ted 11/25/23 at 11:39 a.m., and would be returning from the tal nurse informed the facility d 4 sutures to the forehead removed in 10 days.					
	A Neurological Ob	servation was initiated on					

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11/25/23 at 5:06 a.m., however, it was incomplete.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155423	B. WIN		00	12/01/2023		
		100.120				12/01	,2020	
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD 4TH ST			
HAMMOI	ND-WHITING CARE	E CENTER			G, IN 46394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` `	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	sutures after the res hospital. Interview with the l	ollow up or assessment of the ident returned from the Nurse Consultant on 11/30/23						
		ated follow up after a fall should						
		ry shift for 72 hours. There						
		ion or assessments of the I the 4 sutures when he came						
		hospital on 11/25/26.						
	4. The record for R	esident B was reviewed on						
	_	n. Diagnoses included, but were						
		bolic encephalopathy, protein						
		, stroke, Atrial Fibrillation (A						
		rhythm), pacemaker, anemia,						
	high blood pressure	, and alcohol dependence.						
	The 10/23/23 Medic	care 5 day Minimum Data Set						
	, ,	indicated the resident was not						
	, ,	The resident needed some help						
	-	ce from another person to						
		ressing, using the toilet, and						
	and antiplatelet med	ent received an antipsychotic						
	and antiplatelet med	neation.						
	A Nurses' Note, dat	ed 9/27/23 at 9:00 a.m.,						
	indicated the reside	nt started complaining of						
	_	was guarding their right side.						
	-	responsible party were made						
	· ·	vere received to obtain an						
	, ,	ide of the abdomen. At 10:09						
		arted yelling for help and						
		re pain to the right abdomen.						
	-	made aware and orders were e resident to the hospital.						
	ootamed to send the	resident to the nospital.						

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The resident was admitted to the hospital with acute cholecystitis (inflamed gallbladder).

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155423	B. W	ING		12/01/	2023
	ROVIDER OR SUPPLIER		•	1000 11	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, IN 46394		
			1		I		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	`			PREFIX	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	COMPLETION DATE
TAG	A Change of Conding 9/27/23, indicated the checked at the time signs that were door 9/27/23 and the time. A Nurses' Note, dat indicated the resider indicated the resider intact. There were no neurofall. There was no fadocumentation and the resident was sen fall. There was no a after the fall. Interview with the Nat 11:50 a.m., indicated the resident was sen fall. There was no a after the fall. Interview with the Nat 11:50 a.m., indicated the resident was sen fall. There was no a after the fall. Interview with the Nat 3:15 p.m., indicated the sent out to the emer was glued. There we have a sense out to the emer was glued. There we have a sense out to the emer was glued. There we have a sense out to the emer was glued. There we have a sense out to the emer was glued. There we have a sense of the counter the foot. The resident we observed to the outer foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot. The resident was a sense of the counter the foot.	ed 11/2/23 at 10:12 a.m., at fell and hit their head. ed 11/3/23 at 2:27 a.m., at's steri strips were dry and cological observations after the all follow up assessment or there was no documentation at out to the hospital after the ssessment of the forehead. Nurse Consultant on 11/30/23 ated follow up after a fall should ry shift for 72 hours. Nurse Consultant on 11/30/23 ated the resident did not have forehead. The resident was gency room and the laceration as no monitoring of the appened and there was no eurological checks or a fall. 245 a.m., fresh blood was er sock of Resident C's left was also observed with a large wrown bruise to the right side		TAG	DETRIENCH 1		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155423	B. WI	NG		12/01/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .			4TH ST		
НАММОІ	ND-WHITING CARE	- CENTER			G, IN 46394		
1 17 (1711710)	10-111111111111111111111111111111111111			***************************************			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		p.m., and 2:50 p.m., the					
		red in bed. Both of their feet					
	were laying directly on the bed and not						
	-	ded. The resident did not					
		r foot, but was observed with					
		legs. A white bandage could					
	be seen to the left o	uter ankle with no date on it.					
	On 11/29/23 at 2:25 p.m., the resident was						
		both of their feet were not					
	*	ded. At 2:28 p.m., QMA 1 was					
		e 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						
	_	e noted to the right lower leg					
	with no date on it.						
	Intomious suith OM	A 1 at that time, indicated she					
		sident had any open areas.					
	was unaware the res	sident had any open areas.					
	Interview with I PN	I 1 on 11/29/23 at 2:33 p.m.,					
		ot made aware the resident					
	had any open areas.						
	naa any spen areas.						
	The record for Resi	dent C was reviewed on					
	11/29/23 at 11:56 a	.m. The resident was admitted to					
		23. Diagnoses included, but					
	-	fracture of the left femur,					
	· ·	ehaviors, Parkinson's disease,					
		t lower limb, dermatitis, history					
	_	walking, and high blood					
	pressure.						
	•						
	The 9/30/23 Quarte	rly Minimum Data Set (MDS)					
		d the resident was not					
	cognitively intact an	nd needed extensive assist					
		cal assist for bed mobility and					
		ent needed extensive assist					
		cal assist for personal hygiene					
		alls with no injury since the					
		3 ,					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					0	MB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COM	PLETED
		155423	B. WING		12/0	1/2023
		.55.25				0 0
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COL)	
NAME OF I	ROVIDER OR SUFFLIER		1000 1	14TH ST		
HAMMOI	ND-WHITING CARE	E CENTER	WHITIN	NG, IN 46394		
OVA) ID	CIDALADY	OT A TEMENIT OF DEPLOYENCE		1		(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APP		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	last assessment.					
	Physician's Orders,	dated 7/10/23, indicated to				
	offload heels while	in bed and confirm every shift.				
	There were no orde	rs for any type of treatment for				
		tle and lower leg. There was no				
		Jursing Progress Notes				
		of open area or skin				
	conditions to the an	-				
	conditions to the an	ikie of leg.				
	A W1-1 C1-: I	: 				
		egrity Assessment, dated				
	-	n., indicated the resident's skin				
		here were old issues of a				
	laceration and fadeo	d bruising to the face. There				
	was no documentat	ion regarding the left ankle or				
	right lower leg.					
	Interview with LPN	V 1 on 11/29/23 at 3:03 p.m.,				
		sed the left ankle and right				
		s. The left outer ankle looked				
		that opened. The area was red				
		timeter (cm) by 1 cm, and the				
	right lower leg was	scabbed and measured 1.3 cm.				
	T, the same s	AT 0 1 1 1 100 100				
		Nurse Consultant on 11/30/23				
		ated the resident scratched their				
	•	reas were a result of				
	scratching. The ord	er for the heels to be offloaded				
	while in bed was go	oing to be changed to add the				
	words "as tolerated"	". There was no treatment				
	order or documenta	tion of the open areas prior to				
	11/29/23.					
	A Change of Condi	tion Evaluation dated 7/29/23				
	_	ted the resident had a fall post				
		esident was sent to the				
	•					
		nd had X-rays to determine				
	I there were no other	fractures or a dislocation	1	i .		i

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		00	COMPL	
		155423	B. WING	<u> </u>		12/01/	2023
	PROVIDER OR SUPPLIER		1	1000 11	.DDRESS, CITY, STATE, ZIP COD 4TH ST G, IN 46394	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	Т	ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	i E	DATE
	_	servation was initiated on					
		., 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.,						
		nt was observed face down on					
		bed. The resident hit their					
		ration to the right eye. The					
	-	ied 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.						
	indicated the reside	nt returned from the hospital.					
	There was no assess	sment of the resident's					
	injuries.						
	· ·	ed 11/17/23 at 11:14 a.m.,					
		ng and swelling remained to					
		e laceration was observed with					
	a glued closure.						
	The above note was	s the first time the laceration					
		sing a glued closure. There was					
		ation, assessment or					
	monitoring of the g						
		Nurse Consultant on 11/30/23					
		ated follow up after a fall should					
		ry shift for 72 hours. There					
		ion or assessment of the					
	on 11/14/23.	l glued laceration after the fall					
	011 11/14/23.						
	The revised and cur	rent 4/7/22 "Fall					
		y, provided by the Regional					
		perations indicated the					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155423	B. W	NG		12/01/	2023
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.		l	14TH ST		
HAMMAON	ND-WHITING CARE	CENTER			IG, IN 46394		
TIAWWO	ND-WITHING CARL	CENTER		VVIIIII			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		res for fall management were					
		t shows no signs of distress or					
	-	minor injuries, increase the					
	frequency of monitoring of blood pressure, pulse,						
	and respirations for	the next 72 hours or as					
		eility Monitor neurologic					
	status, as directed by	y your facility. Notify the					
	practitioner if you n	ote any changes from					
	baseline."						
	3.1-37(a)		1				
F 0685	483.25(a)(1)(2)						
SS=D		s to Maintain Hearing/Vision					
Bldg. 00	§483.25(a) Vision						
		sidents receive proper					
		istive devices to maintain					
	_	abilities, the facility must,					
	if necessary, assis	st the resident-					
	§483.25(a)(1) In m	naking appointments, and					
	§483.25(a)(2) By a	arranging for transportation					
	- ',',',	fice of a practitioner					
	specializing in the	treatment of vision or					
	hearing impairmer						
	professional speci	alizing in the provision of					
	vision or hearing a	-					
	_	view and interview, the facility	F 06	585	This plan of correction is prepa	ared	12/29/2023
	failed to ensure resi	dents had access to receive			and executed because the		
	services for impaire	ed vision for 2 of 3 residents			provisions of state and federal	law	
	reviewed for vision	and hearing. (Residents 31			require it and not because		
	and 18)				Hammond-Whiting Care Cente	er	
					agrees with the allegations and		
	Findings include:				citations listed. Hammond-Wh		
	-				Care Center maintains that the	-	
	1. On 11/27/23 at 3:	:49 p.m., Resident 31 was			alleged deficiencies do not		
		m watching television. The			jeopardize the health and safe	ty of	
		he wore glasses and she			the residents nor is it of such	-	
		. At that time, the resident			character to limit our capabiliti	es	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE also indicated she had asked multiple times to be to render adequate care. Please placed on the list to see an eye doctor. accept this plan of correction as our credible allegation of The record for Resident 31 was reviewed on compliance that the alleged 11/28/23 at 1:59 p.m. The resident was admitted to deficiencies have or will be correct the facility on 11/18/21. Diagnoses included, but by the date indicated to remain in were not limited to, anemia, atrial fibrillation compliance with state and federal (abnormal heart rhythm), heart failure, regulations, the facility has taken hypertension (high blood pressure), diabetes, or will take the actions set forth in dementia, hemiplegia, anxiety, and depression. this plan of correction. We respectfully request a desk review. The 9/1/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was F 685- Treatment/Devices to cognitively intact for daily decision making and Maintain Hearing/Vision had no vision impairment or corrective lens. What Corrective Action will be accomplished for those A Physician's Order, dated 2/2/23, indicated the residents found to have been resident may have Dental, Podiatry, Audiology, affected by this deficient and Optometry care as needed. practice: Resident #31 is There was no documentation the resident had scheduled to be seen by vision seen an eye doctor since admission. services at next visit in December. No negative outcomes noted. Interview with the Regional Vice President of Resident # 18 is Operations on 11/29/23 at 3:17 p.m., indicated the scheduled to be seen by vision resident had not seen the eye doctor since being services at next visit in December. at the facility and was put on the list today to be No negative outcomes noted. seen. How other residents having the potential to be affected by the Interview with the Social Service Director on same deficient practice will be 12/1/23 at 12:45 p.m., indicated the resident had identified and what corrective not seen the eye doctor since arriving to the action will be taken: facility in 2021. All residents have the potential to be affected. 2. On 11/28/23 at 10:05 a.m. Resident 18 was In house audit to be observed in his room. At that time, the resident completed for all residents to indicated he needed cataract surgery. He had ensure residents have routine complained about it at last month's resident appointments to be seen by council meeting. vision/hearing provider. Any issues identified will be addressed.

	K MEDICAKE & MEDIC				ONIB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155423	B. WING		12/01/2023	
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
				14TH ST		
HAMMO	ND-WHITING CARE	E CENTER	WHITI	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DE CAMPERNO DA LAS CONTROS	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
1.10		dent 18 was reviewed on	1110	What measures and what	Ditte	
		n. The resident was admitted to			ode	
	the facility on 12/19/22. Diagnoses included, but			systemic changes will be ma	u c	
		_		to ensure that the deficient		
		heart failure, hypertension		practice doesn't recur:		
		e), hemiplegia (muscle		1 Education will be		
		and cellulitis (infection) in the		completed to SSD to ensure a	II	
	right and left leg.			residents have routine		
				vision/hearing services by date	e of	
	,	rly Minimum Data Set (MDS)		compliance.		
	assessment, indicated the resident was			How the corrective action will	ll	
	cognitively intact for daily decision making and			be monitored to ensure the		
had corrective lens.			deficient practice will not red	cur,		
				i.e., what quality assurance		
	A Physician's Order	r, dated 7/28/23, indicated the		program will be put in place:		
	resident may have I	Dental, Podiatry, Audiology,		1 ED and/or Designee		
	and Optometry care	e as needed.		will review all new admissions to		
				ensure consent/appointment		
	There was no Care	Plan for impaired vision.		completed/scheduled x 3 mon	ths,	
		•		then will audit 2 admissions/week		
	There was no docur	nentation the resident had		x 3 months. Audits will be		
	seen an eye doctor s			presented to QAPI x 6 months		
				and QAPI will determine need		
	A History and Phys	ical (H&P), dated and signed		further audits.		
		7/28/23, indicated the resident		2 The results of the	92	
	had a premature left			reviews will be discussed at th		
	nad a premature ter			monthly facility Quality Assura		
	Interview with the	Regional Vice President of				
		_		Committee meeting monthly for	ла	
	-	9/23 at 3:17 p.m., indicated		total of 3 months and then		
		ments to provide, Resident 18		quarterly thereafter once		
		e doctor, and no appointment		compliance is at 100%.		
	was made prior to to	oday.		Frequency and duration of rev		
				will be increased as needed, if		
	3.1-39(a)(1)			compliance is below 100%.		
				Compliance date: 12.29.23. The	ne	
				Administrator at		
				Hammond-Whiting Care Center	er is	
				responsible in ensuring		
				compliance in this Plan of		

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Correction.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER		1000	ET ADDRESS, CITY, STATE, ZIP COD) 114TH ST TING, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE APP	LD BE COMPLETION	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre Based on the com a resident, the fac (i) A resident rece professional stand pressure ulcers ar pressure ulcers ur condition demons unavoidable; and (ii) A resident with necessary treatme with professional s promote healing, p new ulcers from d Based on observation interview, the facili reducing measures a deep tissue injury reviewed for pressur Finding includes: On 11/28/23 at 3:38 in her room in bed. at that time. On 11/29/23 at 9:38 resident was observ resident had no socl foot was resting on foot was resting on The record for Resi 11/29/23 at 10:42 a	o Prevent/Heal Pressure Integrity I	F 0686	This plan of correction is and executed because the provisions of state and fer require it and not because Hammond-Whiting Care (agrees with the allegation citations listed. Hammond Care Center maintains the alleged deficiencies do not jeopardize the health and the residents nor is it of sicharacter to limit our capator render adequate care. accept this plan of correct our credible allegation of compliance that the alleged deficiencies have or will be by the date indicated to recompliance with state and regulations, the facility has or will take the actions see	prepared e deral law e Center is and d-Whiting at the ot l safety of uch abilities Please tion as ed be correct emain in difederal is taken	

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dementia with agitation, Atrial Fibrillation (A Fib -

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this plan of correction. We

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE irregular heart rhythm), and respectfully request a desk review. hemiplegia/hemiparesis (muscle F686 Treatment/Services to weakness/paralysis) following a stroke. prevent/heal pressure ulcer What Corrective Action will be The Significant Change Minimum Data Set (MDS) accomplished for those assessment, dated 10/31/23, indicated the resident residents found to have been was cognitively impaired for daily decision affected by this deficient making. The resident also had one deep tissue practice: injury (purple or maroon localized area or Res #2 immediately had discolored intact skin due to damage of heels offloaded. Orders and care underlying soft tissue from pressure and/or plan updated. No negative shear). outcomes noted. How other residents having the The Quarterly MDS assessment, dated 9/30/23, potential to be affected by the indicated the resident required extensive assist same deficient practice will be with bed mobility and she was totally dependent identified and what corrective on staff for transfers. action will be taken: Audit completed on all A Care Plan, dated 10/26/23, indicated the resident current residents with skin had a DTI (deep tissue injury) to her right heel. integrity impairment/at risk for skin Interventions included, but were not limited to, integrity impairment to ensure heel boots to be applied while in bed. pressure reducing measures are in place by date of compliance. A Physician's Order, dated 9/5/23 and listed as What measures and what current on the November 2023 Physician's Order systemic changes will be made Summary, indicated the resident's heels were to be to ensure that the deficient off loaded when in bed. practice doesn't recur: DON and/or designee to Interview with the Regional Vice President of provide education to all staff r/t Operations and the Director of Nursing (DON) on pressure reducing measures by 12/1/23 at 1:09 p.m., indicated both heels should date of compliance. have been off loaded while in bed or the heel All newly hired staff will boots should have been in use. receive this education during orientation, prior to providing 3.1-40(a)(2)resident care. How the corrective action will be monitored to ensure the deficient practice will not recur,

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i.e., what quality assurance program will be put in place:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
				1 DON and/or designee to complete observations at ra times 5 times a week for 2 months, then 3 times a week months, then 1 time a week months. Any issues identifie be immediately addressed to DON/designee. 2 The results of these rewill be discussed at the monfacility Quality Assurance Committee meeting monthly total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rwill be increased as needed compliance is below 100%. Compliance date: 12/29/23. Administrator at Hammond-Whiting Care Ce responsible in ensuring compliance in this Plan of Correction.	ndom k for 2 for 2 d will by the views hthly for a eviews , if The
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percut gastrostomy and piejunostomy, and resident's compre facility must ensur §483.25(g)(4) A reto eat enough alor fed by enteral met	stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a thensive assessment, the te that a resident- esident who has been able the or with assistance is not thods unless the resident's the sidemonstrates that enteral			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155423	B. W	ING		12/01	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			14TH ST		
НАММОІ	ND-WHITING CARE	E CENTER			IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	consented to by the	ne resident; and					
		esident who is fed by enteral					
		ne appropriate treatment					
	and services to restore, if possible, oral						
	_	o prevent complications of					
	_	cluding but not limited to					
	aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.						
				602	This whom of comment is		10/14/0000
	Based on observation, record review, and		F 00	593	This plan of correction is prepared	ared	12/14/2023
	interview, the facility failed to ensure a tube				and executed because the		
	feeding was infusing at the correct time. The				provisions of state and federal	ııaw	
	facility also failed to ensure tube feeding placement was checked and a water flush was				require it and not because	٥.	
	_	administering gastrostomy			Hammond-Whiting Care Cent		
		to the stomach from the			agrees with the allegations an citations listed. Hammond-Wh		
		the introduction of food)			Care Center maintains that the	•	
		f 2 residents reviewed for tube			alleged deficiencies do not	5	
	feeding. (Residents				jeopardize the health and safe	aty of	
	recaing. (Residents	5 17 and 33)			the residents nor is it of such	ty Oi	
	Findings include:				character to limit our capabiliti	es	
	i manigs metade.				to render adequate care. Plea		
	1. On 11/27/23 at 1	12:03 p.m., Resident 19 was			accept this plan of correction a		
		ing room eating lunch. Her			our credible allegation of	40	
		ot infusing at that time.			compliance that the alleged		
		C			deficiencies have or will be co	rrect	
	On 11/28/23 at 10:1	17 a.m., 1:38 p.m., and 3:19 p.m.,			by the date indicated to remain		
		served in her wheelchair			compliance with state and fed		
	throughout the facil	lity. Her tube feeding was not			regulations, the facility has tak		
	infusing nor connec	eted to the gastrostomy tube.			or will take the actions set fort		
					this plan of correction. We		
	On 11/29/23 at 10:3	39 a.m., the resident was being			respectfully request a desk re	view.	
	•	allway by a staff member, her			-		
	_	ot connected. At 11:28 a.m.,			F 693- Tube Feeding		
		he side of her bed. Again, the			Management/Restore eating s		
		ot connected. A tube feeding			What Corrective Action will I	be	
		I next to the resident's bed. At			accomplished for those		
	_	dent was in the dining room			residents found to have been	n	
	eating lunch. Her to	ube feeding was not			affected by this deficient		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155423	B. W	ING		12/01/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
11004040	ND WILLIAMS SADE	CENTED			14TH ST		
HAMMO	ND-WHITING CARE	ECENTER		WHITIN	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	connected. At 5:00	p.m., the resident was resting			practice:		
	on the couch in the	lobby. Her tube feeding was			1 Resident 19 had	no	
	not connected.				negative outcomes. MD and F	OA	
					notified of tube feeding hung a		
	On 11/30/23 at 10:3	30 a.m. and 1:14 p.m., the			wrong time. Orders received to		
		red in the hallway in her			tube feeding d/t resident	.,,	
		be feeding was not connected			consuming meals orally.		
	at those times.				2 Resident 33 had	no	
	at these times.				negative outcomes. MD notifie		
	The record for Resi	dent 19 was reviewed on			with no new orders received.		
		n. Diagnoses included, but			How other residents having	the	
	_	Atrial Fibrillation (A Fib -			potential to be affected by th		
	· ·	nm), gastrostomy status (an			same deficient practice will l		
	-	omach from the abdominal wall			identified and what corrective		
		of food), anemia, and			action will be taken:	-	
		ehavior disturbance.			1 Residents with tu	ho	
	dementia without by	chavior disturbance.			feeding orders have been aud		
	The Significant Cha	ange Minimum Data Set (MDS)			to assure orders in place for	iteu	
	-	/7/23, indicated the resident			specific times for infusion per	MD	
	· ·	paired for daily decision making			order. Nursing Management	טועו	
		ensive assistance for eating.			observed these residents for		
	She also received a	_			appropriate times of infusion v	vith	
	mechanically altere						
	inechanically aftere	u uict.			no other issues noted by date	OI	
	A Dhygiaian's Orda	r, dated 11/14/23, indicated the			compliance. What measures and what		
	-	eive a tube feeding of Jevity 1.2					
					systemic changes will be ma	iae	
		per hour, times 18 hours via			to ensure that the deficient		
		0 a.m. and off at 4:00 a.m. May			practice doesn't recur:		
	substitute with Gluc	cerna 1.2.			1 Nursing		
	T. 1 14 4 3	AT C 10 12/1/22			Management will educate lice	nsea	
		Nurse Consultant on 12/1/23 at			nursing staff on infusing tube		
		the Physician discontinued the			feeding per MD order, flushing		
	_	on 11/30/23 due to the resident			giving medications per policy l	эу	
	was eating an oral d	liet and gaining weight.			date of compliance.		
					2 Competencies wi		
		:24 p.m., QMA 1 was observed			be completed on licensed Nur	٠ ١	
		omy tube (an opening into the			on med administration, flushes		
		bdominal wall for the			and assuring following MD ord	lers	
		d) medication for Resident 33.			for Tube feedings.		
	The QMA crushed	a 1 milligram (mg) tablet of			3 New licensed		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155423	B. W	ING		12/01/	/2023
NAME OF A	DROWNER OF GUIDE TEL		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C			14TH ST		
HAMMO	ND-WHITING CAR	E CENTER	_	WHITING, IN 46394			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		-anxiety medication) and			nursing staff will not work until this		
	proceeded to the re-	sident's room.			education and a competency	IS	
	11 4 4	1 4 0 4			completed.		
		esident's room, the QMA			How the corrective action w	111	
	-	am with approximately 15			be monitored to ensure the		
		urified water. The resident was			deficient practice will not re	cur,	
	seated in her wheelchair at that time. The QMA proceeded to lift the resident's shirt and untie the				i.e., what quality assurance	_	
	proceeded to lift the resident's shirt and until the tubing. The tubing was tied in a loose knot. She				program will be put in place.		
	then placed the syringe into the port and				1 DON and/or	h =	
	administered the medication. After she was done				Designee will observe and/or		
	giving the medication, she flushed the tube with			staff verbalize appropriate flushing,			
	15 ml's of water. The QMA did not check for tube				medication administration, and infusion of tube feedings 3 times		
					weekly x 3 months, then 2 tim		
	placement or flush the tubing prior to giving the medication.				weekly x 3 months to assure		
	inedication.				compliance. This will be rotated on		
	Intervious with the	Nurse Consultant on 12/1/23 at			shifts. Audits will be presented to		
		g-tube placement should have					
		to giving the medication and		QAPI x 6 months then QAPI will			
	_	or to giving the Lorazepam.			determine the need for further audits.		
	the tube mushed pm	or to giving the Lorazepain.			The results of the	000	
	The facility policy	titled "Medication			reviews will be discussed at the		
		Enteral Access Device [EAD]",			monthly facility Quality Assura		
		e Regional Vice President of			Committee meeting monthly for		
		0/23 at 4:04 p.m. The policy			total of 3 months and then	o, u	
		ministration of feedings, fluids,			quarterly thereafter once		
		ugh the EAD until correct			compliance is at 100%.		
		onfirmed and prior to			Frequency and duration of rev	/iews	
		cation, stop the feeding and			will be increased as needed, i		
	_	at least 15 ml of purified water			compliance is below 100%.		
	using a 35 ml or lar				Compliance date: 12.14.23. T	he	
					Administrator at		
	3.1-44(a)(2)				Hammond-Whiting Care Cent	er is	
					responsible in ensuring		
					compliance in this Plan of		
					Correction.		
F 0695	483.25(i)						
SS=D	Respiratory/Trach	eostomy Care and					
Blda, 00	Suctioning						l

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPI	LETED
		155423	B. WI	NG		12/01	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	<			14TH ST		
HAMMO	ND-WHITING CARI	E CENTER		WHITIN	NG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DETERMET)		DATE
	,,,,	ratory care, including e and tracheal suctioning.					
	1	e and tracheal suctioning. 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,						
		ls and preferences, and					
	483.65 of this subpart.						
		on, record review, and	F 06	595	This plan of correction is prep	ared	12/29/2023
	interview, the facili	ty failed to ensure oxygen was			and executed because the		
	at the correct flow i	rate for 1 of 2 residents			provisions of state and federa	l law	
	reviewed for oxygen. (Resident 2)				require it and not because		
					Hammond-Whiting Care Cent	er	
	Finding includes:				agrees with the allegations an	d	
					citations listed. Hammond-Wh	iting	
		2 p.m., Resident 2 was seated in			Care Center maintains that the	е	
		from the nurses' station. The			alleged deficiencies do not		
		ng oxygen by the way of a			jeopardize the health and safe	ety of	
		portable oxygen tank was set			the residents nor is it of such		
		p.m., the resident was in her			character to limit our capabiliti		
	_	ng. She was holding the nasal			to render adequate care. Plea		
	cannula in her hand	ls.			accept this plan of correction	as	
	On 11/20/22 -+ 0.29	0 a m and 11.20 a 41			our credible allegation of		
		8 a.m. and 11:28 a.m., the room in bed sleeping. The			compliance that the alleged	rroot	
		nula was not in place and the			deficiencies have or will be co		
		or was set at 2 liters. At 12:10			by the date indicated to remai compliance with state and fed		
		as in use and the concentrator			regulations, the facility has take		
	was set at 2 liters.	as in ase and the concentrator			or will take the actions set fort		
	Set at 2 incis.				this plan of correction. We		
	On 11/30/23 at 10:3	38 a.m., the resident was			respectfully request a desk re	view.	
		m in bed. The resident's					
		and the oxygen concentrator			F 695- Respiratory/Tracheosto	omy	
	was set at 2 liters.				Care and Suctioning		
					What Corrective Action will	be	
	The record for Resi	dent 2 was reviewed on			accomplished for those		
	11/29/23 at 10:42 a	.m. Diagnoses included, but			residents found to have been	n	
		COPD (chronic obstructive			affected by this deficient		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155423		B. WING 12/01/2023			2023		
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			14TH ST		
HAMMON	ND-WHITING CARE	E CENTER			NG, IN 46394		
			1		· 	1	OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	1 2	, Alzheimer's late onset,			practice:	_	
	_	tion, Atrial Fibrillation (A Fib -			1 Resident 2 had no	0	
	irregular heart rhyth hemiplegia/hemipa				negative outcomes. MD was	. 02	
) following a stroke.			notified on inaccurate liter flow		
	weakiiess/pararysis/) following a stroke.			sats were taken immediately was no issues noted and O2 liter fl		
	The Significant Cha	ange Minimum Data Set (MDS)			adjusted to ordered liter flow	UWS	
	_	0/31/23, indicated the resident			immediately.		
		paired for daily decision making			How other residents having	the	
		ng oxygen while a resident of			potential to be affected by the		
	the facility.	ing on Jean white a resident of			same deficient practice will l		
	the facility.				identified and what corrective		
	The current Care Pl	an indicated the resident had			action will be taken:		
		status related to COPD and			1 An Audit was		
		eart failure). Interventions			completed on residents in hou	ise	
		not limited to, apply oxygen as			with current 02 orders to assu		
	ordered.				orders accurate and clinical te		
					observed liter flow being		
	A Physician's Order	r, dated 3/15/23 and listed as			administered per order. No oth	ner	
	-	ember 2023 Physician's Order			issues have been identified. A		
		I the resident was to receive			completed by nursing		
	-	ontinuously per nasal cannula.			management by date of		
					compliance.		
	Interview with the I	Nurse Consultant on 11/30/23			What measures and what		
	at 2:44 p.m., indicat	ted the resident's oxygen			systemic changes will be ma	ade	
	concentrator should	have been set at 3 liters.			to ensure that the deficient		
					practice doesn't recur:		
	3.1-47(a)(6)				1 DON and/or		
					designee have educated licen	sed	
					nursing staff and certified aide	es to	
					observe liter flow on residents		
					using 02 and assure liter flow		
					accurate per order. This will be		
					completed by date of complian		
					How the corrective action wi	ill	
					be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance		
					program will be put in place:	;	
					1 DON/Nursing		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		A. BU	A. BUILDING <u>00</u>			COMPLETED	
		B. WING			12/01/2023		
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			14TH ST		
HAMMON	ND-WHITING CAR	E CENTER			NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					management will observe 5		
					residents daily Monday throug		
					Friday x 8 weeks, then 3 resid		
					daily Monday through Friday x	8 8	
					weeks, then 2 residents daily Monday through Friday x 8 we	oko	
					to assure compliance. Audits		
					be presented to QAPI x 6 mor		
					and then QAPI will determine		
					need for further audits. Any no		
					issues will be addressed		
					immediately.		
					2 The results of the	se	
					reviews will be discussed at th	ie	
					monthly facility Quality Assura	nce	
					Committee meeting monthly for	or a	
					total of 3 months and then		
					quarterly thereafter once		
					compliance is at 100%.		
					Frequency and duration of rev	riews	
					will be increased as needed, i	f	
					compliance is below 100%.		
					Compliance date: 12.29.23. T	he	
					Administrator at		
					Hammond-Whiting Care Cent	er is	
					responsible in ensuring		
					compliance in this Plan of		
					Correction.		
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00	§483.25(I) Dialysi	is.					
	,,,	ensure that residents who					
		eceive such services,					
		ofessional standards of					
	· ·	prehensive person-centered					
	•	e residents' goals and					
	preferences.	-					
	Based on record re	view and interview, the facility a post dialysis assessment for 1	F 06	98	This plan of correction is prepared and executed because the	ared	12/29/2023

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 $XXWZ11 \quad \ \ {\rm Facility\ ID:} \quad \ 000365$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of 1 resident reviewed for dialysis. (Resident 25) provisions of state and federal law require it and not because Finding includes: Hammond-Whiting Care Center agrees with the allegations and Resident 25's record was reviewed on 11/28/23 at citations listed. Hammond-Whiting 2:39 p.m. Diagnoses included, but were not limited Care Center maintains that the to, heart failure, hypertension (high blood alleged deficiencies do not pressure), end stage renal disease (renal failure), jeopardize the health and safety of diabetes, malnutrition, and dependent on renal the residents nor is if of such dialysis. character to limit our capabilities to render adequate care. Please The 11/3/23 Quarterly Minimum Data Set (MDS) accept this plan of correction as assessment indicated the resident was cognitively our credible allegation of intact for daily decision making. compliance that the alleged deficiencies have or will be correct A Care Plan, dated 11/13/23, indicated the resident by the date indicated to remain in received hemodialysis related to renal failure and compliance with state and federal had an arteriovenous (AV) fistula (dialysis access regulations, the facility has taken site). Interventions included, but were not limited or will take the actions set forth in to, observe for bleeding at dialysis access site, this plan of correction. We obtain dry weights from dialysis center, assess respectfully request a desk review. shunt site for bruit and thrill, and encourage the resident to go for scheduled dialysis F 698 - Dialysis appointments on Monday, Wednesday, and Friday each week. What Corrective Action will be accomplished for those A Physician's Order, dated 9/12/23, indicated the residents found to have been resident was a dialysis patient and received affected by this deficient dialysis on Monday, Wednesday, and Friday at a practice: dialysis center. Resident # 25: No negative outcomes noted. Orders The Dialysis Communication binder included updated to include supplementary communication forms that had information for the documentation for post dialysis facility to fill out prior to the resident going to the assessment. dialysis center and upon return from the dialysis How other residents having the center. The information included vital signs, bruit potential to be affected by the and thrill was assessed, medication sent to same deficient practice be dialysis center, medication received prior to identified and what corrective dialysis, and other pertinent information (lunch or action will be taken: snack sent with resident, comments, or concerns). All residents who receive

XXWZ11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE dialysis have the potential to be The Dialysis Post Communication sheets were not affected. filled out on 10/2/23, 10/20/23, 10/23/23, 10/27/23, What measures and what 10/30/23, 11/1/23, 11/3/23, 11/6/23, 11/10/23, systemic changes will be made 11/13/23, 11/15/23, 11/17/23, 11/20/23, and to ensure that the deficient 11/25/23. practice doesn't recur: Education provided A facility policy titled, "Hemodialysis Offsite to licensed nursing staff regarding Policy", reviewed on 8/23/23 and identified as completion of post-dialysis current, indicated ..."1. Obtain vital signs of assessment by date of resident upon return from dialysis and complete compliance. Pre/Post Dialysis Communication Form"... All newly hired licensed nursing staff will receive Interview with the Regional Vice President of this education during orientation. Operations on 11/30/23 at 10:50 a.m., indicated the How the corrective action will post dialysis sheet was not being filled out be monitored to ensure the consistently. deficient practice will not recur, i.e., what quality 3.1-37(a) 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

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XXWZ11 Fa

Facility ID: 000365

compliance in this Plan of

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Correction. F 0791 483.55(b)(1)-(5) SS=D Routine/Emergency Dental Srvcs in NFs Bldg. 00 §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;

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§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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155423	B. W	ING		12/01/	2023
	POLITICE OF STATE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			14TH ST		
HAMMO	ND-WHITING CARE	E CENTER		WHITIN	NG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ordance with facility policy					
	to be the facility's	responsibility; and					
	8483 55(b)(5) Mus	st assist residents who are					
	- ' ' ' '	o participate to apply for					
	_	dental services as an					
		expense under the State					
	plan.						
		on, record review, and	F 0'	791	This plan of correction is prep	oared	12/29/2023
		ty failed to ensure residents			and executed because the		
		ntal services for 1 of 4			provisions of state and federa	al law	
		for dental services. (Resident			require it and not because		
	31)				Hammond-Whiting Care Cen		
	Einding includes				agrees with the allegations at		
	Finding includes:				citations listed. Hammond-W Care Center maintains that the	•	
	On 11/27/23 at 3.50	p.m., Resident 31 was			alleged deficiencies do not	IC	
		in bed watching television. At			jeopardize the health and saf	ety of	
		ent indicated she had asked to			the residents nor is it of such	•	
	i i	was told she was put on the			character to limit our capabili		
	list "months ago" by	_			to render adequate care. Plea		
					accept this plan of correction	as	
		dent 31 was reviewed on			our credible allegation of		
		n. The resident was admitted on			compliance that the alleged		
	_	s included, but were not limited			deficiencies have or will be co		
		orillation (abnormal heart			by the date indicated to rema		
	• •	re, hypertension (high blood			compliance with state and fed		
		dementia, hemiplegia, anxiety,			regulations, the facility has ta		
	and depression.				or will take the actions set for this plan of correction. We	ul III	
	The 9/1/23 Annual	Minimum Data Set (MDS)			respectfully request a desk re	eview	
	assessment, indicate						
		or daily decision making.			F 791- Routine_Emergency [Dental	
		-			Srvcs in NFs		
		r, dated 2/2/23, indicated the			What Corrective Action will	be	
		Dental, Podiatry, Audiology,			accomplished for those		
	and Optometry care	e as needed.			residents found to have been	en	
					affected by this deficient		
		mentation the resident had			practice:		
	seen a dentist since	admission.			1 Resident # 31 is		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY LETED 1/2023	
	PROVIDER OR SUPPLIE		1000 1	ADDRESS, CITY, STATE, ZIP COI 14TH ST NG, IN 46394)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
	Interview with the Operations on 11/2 resident had not see the facility and and Interview with the 12/1/23 at 12:45 p.	Regional Vice President of 9/23 at 3:17 p.m., indicated the en the dentist since being at I was put on the list today. Social Service Director on m., indicated she couldn't recall ting to see the dentist.		scheduled to be seen by services at next visit in D No negative outcomes new thow other residents has potential to be affected same deficient practice identified and what correction will be taken: 1 All residents the potential to be affected 2 In house authorized for all resident ensure residents have reappointments to be seen provider. Any issues idented be addressed. What measures and whom systemic changes will be to ensure that the deficient practice doesn't recur: 1 Education whom completed to SSD to ensure identis have routine does services by date of completed to SSD to ensure identified be monitored to ensure deficient practice will not i.e., what quality assurate program will be put in put	pecember. oted. oving the by the evill be rective shave ed. dit to be ts to buttine by dental attified will et be made ient iiill be sure all ental bliance. on will ethe ot recur, ance blace: besignee sions to ment smonths, bns/week e conths need for of these	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE C		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155423	A. BUILDING B. WING	00	COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST		
HAMMO	ND-WHITING CARI	E CENTER	WHITI	NG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/S §483.90(i) Other In The facility must provided the sanitary, and compresidents, staff and Based on observation failed to ensure the clean and in good provided to marred door frames missing toilet bolts, baseboards, missing conditioner, and was multi resident room and South Units) Findings include: During the Environ Environmental Direct the following was contact the following	canitary/Comfortable Environ Environmental Conditions provide a safe, functional, fortable environment for d the public. on and interview, the facility residents' environment was epair related to marred walls, s, discolored floors, rusted and dirty and broken floor g pieces from an air ash basins not contained in a a on 2 of 2 units. (The North	F 0921	monthly facility Quality Assurated Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, it compliance is below 100%. Compliance date: 12.29.23. The Administrator at Hammond-Whiting Care Centaresponsible in ensuring compliance in this Plan of Correction. This plan of correction is prepand executed because the provisions of state and federarequire it and not because Hammond-Whiting Care Centagrees with the allegations and citations listed. Hammond-Who Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleataccept this plan of correction and our credible allegation of compliance that the alleged	riews f he er is l law er d itting e ety of les se as	12/29/2023
	1. South Hall			deficiencies have or will be co	rrect	

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a. Room 102 - The door frame was observed to be

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by the date indicated to remain in

compliance with state and federal

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETI	ED
155423		B. WING 12/01/20		23			
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8					
	LIAMMOND WILLIAM CARE CENTED				14TH ST		
HAMMOND-WHITING CARE CENTER				WHITIN	NG, IN 46394		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	marred and there w	as adhered dirt behind the base			regulations, the facility has tak	(en	
	of the door. One res	sident resided in the room and			or will take the actions set fort		
	two residents shared	d the bathroom.			this plan of correction. We		
					respectfully request a desk rev	view.	
	b. Room 104 - The	bathroom walls were observed					
	to be marred and th	e toilet bolts were missing and			<u>F 921-</u>		
	rusted. There were	two residents who resided in			Safe/Functional/Sanitary/Com	forta	
	the room and four r	esidents who shared the			ble Environment		
	bathroom.				What Corrective Action will I	be	
					accomplished for those		
	c. Room 106 - The	bathroom walls was observed			residents found to have been	n	
	to be marred, the ba	seboard near bed one was			affected by this deficient		
	broken, and the air	conditioner was missing			practice:		
	pieces. There were	two residents residing in the			1 The marred walls		
	room.				and door frames were repaired	d in	
					rooms 102, 104, 106, 212, 214	4,	
	2. North Hall				221, 222, and 223. The floor t		
					the bathrooms of rooms 223 a		
	a. Room 212 - The	bathroom door frame was			221 were cleaned. All wash ba	asins	
	observed to be man	red and there was adhered dirt			were placed in trash and new	were	
	on the floor. Two p	lastic wash basins were			obtained and covered in		
	observed on the cou	inter and not contained. There			appropriate plastic bag with		
	were two residents	who resided in the room and			resident's name. The toilet bo	lts	
	four residents who	shared the bathroom.			were replaced in room 104. The	ne	
					baseboard repaired in rooms	106,	
	b. Room 214 - The	door frame was observed to be			214, and 222. The AC in room	106	
	marred and chipped	l. The base board was peeling			was repaired.		
	from the wall in bet	ween the two beds. There were			How other residents having	the	
	two residents who r	resided in the room and four			potential to be affected by th	ne	
	residents who share	d the bathroom.			same deficient practice will l	be	
					identified and what corrective	re	
	c. Room 221 - The	floor beneath the toilet bowel			action will be taken:		
	was observed to be	discolored. The door frame			1 Other residents h	ad	
	was gouged. There	were two residents who			the potential to be affected by	this	
	resided in the room	and four residents who shared			deficient practice.		
	the bathroom.				What measures and what		
					systemic changes will be ma	ade	
	d. Room 222 - The	bathroom door frame was			to ensure that the deficient		
	observed to be man	red and missing a baseboard.			practice doesn't recur:		
	The walls in the roo	om were marred. There were			1 Environmental		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
0		esided in the room and four		rounds have been completed maintenance department and has been put into place to add	by plan
	was observed to be was gouged. The was	floor beneath the toilet bowel discolored. The door frame alls in the room were marred.		marred walls, discolored floor in bathrooms, wash basins, to bolts, baseboard, and AC unit	tiles pilet
	and four residents w	dents who resided in the room tho shared the bathroom.		or prior to 12/29/23. 2 The Maintenance Director and/or designee will	
		on 12/1/23 at 10:18 a.m., the actor indicated all of the above uning and/or repair.		include identified areas in the current preventive maintenan program and conduct routine resident room rounds accordi	ce
	3.1-19(f)			the facility policy. How the corrective action w be monitored to ensure the	
				deficient practice will not re 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 ne months to ensure the residen environment is in good repair	ťs
				marred walls, discolored floor in bathrooms, wash basins, to bolts, baseboard, and AC unit	tiles pilet
				Any concerns identified will be addressed immediately. Audit will be presented to QAPI x 6	e
				months then QAPI will determ the need for further audits. 2 The results of the	
				reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly f	ance
				total of 3 months and then quarterly thereafter once compliance is at 100%.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2023

FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		IDENTIFICATION NUMBER	ĺ	ILDING	INSTRUCTION 00	(X3) DATE COMPL 12/01/	ETED
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
					Frequency and duration of rev will be increased as needed, if compliance is below 100%. Compliance date: 12/29/23. The Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.	ne	

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