STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155423	A. BUILDING -- B. WING	12/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/18/2023 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Emergency Preparedness survey, Hammond-Whiting Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 67. Quality Review completed on 12/19/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/18/2023 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Life Safety Code survey,	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Ready	Regional Vice President	12/30/2023

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

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	Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and in common areas. The facility has a capacity of 80 and had a census of 67 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage. Quality Review completed on 12/19/23		to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet 1 of 3 service corridors clear width requirement exception per 19.2.3.4(1). LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice	K 0232	**K232 – Aisle, Corridor, or Ramp Width** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***	01/15/2024

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	could affect staff only. Findings include: Based on observation with the Maintenance Director on 12/18/23 between 12:27 p.m. and 1:33 p.m., the service corridor contained approximately five house keeping carts, one linen cart and other miscellaneous carts that took up approximately half the corridor. When measured at its narrowest point, the corridor width, with the numerous carts, was approximately 38 inches. Based on interview at the time of observation, the Maintenance Director stated that all of the carts are stored in the corridor until late in the day when they are put away. The Maintenance Director confirmed during observation that the clear corridor width was less than 44 inches. Findings were discussed with the Maintenance Director and Interim Administrator at exit conference. 3.1-19(b)		1. On December 18, 2023, the Maintenance Director removed all carts from the service corridor. 2. No residents were immediately affected by this deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. No other residents were immediately affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Facility staff will be re-educated by the Executive Director and/or designee by January 15, 2024 on proper storage of carts and maintaining at least a four foot wide clearance to evacuate the facility. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct audits of service corridor area(s) 5x per week for 4 weeks, then 1x per week for 2 months, and then monthly for 3 months until 100% compliance is achieved. Any issues identified will be immediately addressed 2. The results of these reviews	

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			will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain 1 of 6 Exit Discharges in accordance with NFPA 101 Section 7.7 as required by Section 19.2.7. Section 7.7.1.1 state that the exit discharge shall be of the required width and size to provide all occupants with a safe access to a public way. This deficient practice could affect approximately 20 residents and staff in the North Hall. Findings include: Based on observation with the Maintenance	K 0271	**K271 – Discharge from Exits** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. On December 18, 2023, the Maintenance Director immediately notified the car owner and the car was moved from blocking the exit/fire lane and parked in an appropriate location. ***How other residents having the***	01/15/2024

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	Director on 12/18/23 during a tour of the facility from 12:27 p.m. to 1:33 p.m., the Exit Discharge from the North Hall was blocked by a passenger car. The car was parked in front of the emergency ext gate that had a sign indicating it was a fire lane. Based on interview at the time of observation, the Maintenance Director agreed that the gate was blocked by a car and the exit discharge was blocked. The Maintenance Director had the car owner notified and the car was moved from blocking the exit and parked in a parking space prior to survey exit. This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. 3.1-19(b)		***potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. On December 18, 2023, the Maintenance Director inspected all other exits and fire lane(s) to ensure they were free of obstruction. No other issues were identified via this inspection. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Facility staff will be re-educated by the Executive Director and/or designee by January 15, 2024 on maintaining the exit discharges and fire lane(s) are free of obstruction. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct audits of exit discharges/fire lane(s) 5x per week for 4 weeks, then 1x per week for 2 months, and then monthly for 3 months until 100% compliance is achieved. Any issues identified will be immediately addressed 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	

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			compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview, the facility failed to maintain 1 of 1 kitchen commercial cooking equipment in accordance with NFPA 96, Standard for	K 0324	**K324 – Cooking Facilities** ***What Corrective Action will be accomplished for those residents found to have been***	01/15/2024

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	Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) as required by NFPA 101, Life Safety Code (2012), Section 9.2.3. NFPA 96, Section 10.2.6 states that automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A 2009 Edition, Standard for Wet Chemical Extinguishing Systems where applicable. NFPA 17A, 2009 Edition, at 7.3.3.2 states, where semiannual maintenance of any wet chemical containers or system components reveals conditions such as, but not limited to, corrosion or pitting in excess of the manufacturer's limits; structural damage or fire damage; or repairs by soldering, welding, or brazing, the affected part(s) shall be replaced or hydrostatically tested in accordance with the recommendations of the manufacturer or the listing agency. This deficient practice could affect approximately 12 residents and staff who use the main dining area. Findings include: Based on record review with the Maintenance Director on 12/18/23 between 08:41 a.m. and 12:27 p.m., The Kitchen Suppression System Inspection dated 10/10/23 stated that the "Hood system tank is showing significant amounts of rust." Based on an interview at the time of record review, the Maintenance Director stated that he was aware of the issue and stated the inspection company reported to the facility that there was no hinderance with the operation of the system, however no documentation was available to demonstrate the corrosion was not in excess of manufacturer's limits or the hood system tank had been hydrostatically tested. During a tour of the facility between 12:27 p.m. and 1:33 p.m., visible rust was noted on the underside of the		***affected by this deficient practice:*** 1. Safecare replaced rusted hood system tank on 12/20/2023 per facility leadership's request. 2. Although, statement was provided by vendor that the system was thoroughly tested on 10/10/2023 and is working properly and the documented rust is not affecting the functionality of the system at this time. The tank has a pressure gauge that is inspected on frequent basis to make sure no pressure is lost – see enclosed. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. No other residents were affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Maintenance staff educated on ensuring inspection reports fully document if any recommendations reflect a hindrance or not with the operation of system and/or equipment. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Found to be 100% compliant. Facility will continue to	

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	suppression tank. The issue was also noted on the suppression report dated 04/11/23. Findings were discussed with the Maintenance Director and Interim Administrator at exit conference. 3.1-19(b)		review all documentation to ensure any inspections completed are properly filed, reviewed, and recommendations are followed up as deemed necessary. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			

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	Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect approximately 20 residents and staff in two smoke compartments. Findings include: Based on observation on 12/18/23 between 12:27 p.m. and 1:33 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors between the main lobby and the north hall corridor did not close completely due to a door getting caught on a metal rabbet. The door set did not have a coordinating device, and when the doors were tested, the rabbet plate got caught on the other door which hindered the doors from closing and latching properly. Based on interview at the time of observation, the Maintenance Director confirmed the smoke doors did not latch and stated they have been having issues with the door set closing and latching because the self-closer's need to be adjusted more than normal. He further acknowledged no coordinating device was installed to prevent the This finding was reviewed with the Maintenance Director and Interim Administrator at the exit conference. 3.1-19(b)	K 0374	**K374 – Subdivision of Building Spaces - Smoke Barrier** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Coordinating device will be ordered and installed on the set of smoke barrier doors leading to north unit from front lobby on or prior to January 15, 2024. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. On December 18, 2023, the Maintenance Director inspected all other smoke barrier doors with no issues noted. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Maintenance staff will be re-educated by the Executive Director and/or designee by January 15, 2024 on K374. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct audits of the smoke barrier doors 1x per week for 3 months, then 1x per month for 3 months until 100% compliance is achieved. Any	01/15/2024

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			issues identified will be immediately addressed 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be	K 0511	**K511 – Utilities - Gas and Electric** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Executive Director notified the utility company and letter of reliability will be received by January 15, 2024.	01/15/2024

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	used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director between 12:27 a.m. and 1:33 p.m. on 12/18/23, the fuel source for the emergency generator was natural gas. Additionally, based on interview, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. This finding was confirmed by the Maintenance Director at the time of discovery. The Interim Administrator further stated that he was unaware if the facility had a letter and had been in contact with the gas company to get the process started for a letter. This finding was reviewed with the Maintenance Director and Interim Administrator at the exit conference. 3.1-19(b)		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All residents have the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Maintenance staff will be re-educated by the Executive Director and/or designee to ensure understanding and importance of proper documentation on K511 by January 15, 2024 . ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will review facility documentation related to Life Safety Code monthly to ensure appropriate documentation is in place. Any issues identified will be immediately addressed 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%.	

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			Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits.			

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	155423	A. BUILDING 01 B. WING	12/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure the transfer time to the alternate power source on the monthly load tests for 12 of the past 12 months was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 12/18/23 between 08:46 a.m. and 12:16 p.m., the Generator Log Sheets showed the generator transfer time from normal power to emergency power took more than 10 seconds. Also, no documentation was provided to show a process was provided to annually confirm this capability for the life safety and critical branches. Based on interview at the time of record review, the Maintenance Director indicated the transfer time took more than 10 seconds and stated no documentation was available to show a process to annually confirm the capability for the life safety branch. The Finding was reviewed with the Maintenance Director and the interim Administrator during the exit conference. 3.1-19(b)	K 0918	**K918 – Electrical Systems - Essential Electric System** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Vendor is scheduled to inspect, test, and service generator by January 15, 2024 to ensure capable of supplying service within 10 seconds. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All other residents, staff, and visitors have the potential to be affected by deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Maintenance staff educated on tag K918 by Executive Director and/or designee prior to January 15, 2024. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will review TELS	01/15/2024

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			1x per week for 4 weeks, then 1x per monthly for 2 months, and then monthly for 3 months to ensure testing of emergency systems are appropriately tested until 100% compliance is achieved. Any issues identified will be immediately addressed 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE			

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	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately two residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/18/23 between 12:27 p.m. and 1:33 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in resident room 109. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned issue and stated they were unaware that the fridge was plugged into the power strip. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0920	**K920 – Utilities - Gas and Electric** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. On December 18, 2023, the Maintenance Director appropriately plugged the refrigerator directly into the wall outlet and removed the power strip from resident room 109. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. A full facility audit will be completed prior to January 15, 2024 with any identified to be immediately addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Facility staff will be	01/15/2024

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			re-educated by the Executive Director and/or designee to ensure understanding and importance on K920 by January 15, 2024. 2. In addition, residents and responsible parties will receive educational material related to not bringing in electrical equipment without maintenance department's inspecting prior to use. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Executive Director and/or designee will conduct audits of resident rooms 5x per week for 4 weeks, then 1x per week for 2 months, and then monthly for 3 months until 100% compliance is achieved. Any issues identified will be immediately addressed 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/15/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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