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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/18/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 02/02/2024 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Life Safety Code PSR, Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 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 68 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 02/06/24	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 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 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nellie Alexander	RN RDCS	02/20/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
Bldg. 01	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 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 02/02/24 between 10:55 a.m. and 11:24 a.m. during a tour of the facility with the Maintenance Director and Maintenance Technician #1, the set of smoke barrier doors between the main lobby and the north hall corridor did not close completely due to the coordinating device not working properly. When both doors closed, the coordinator would not effectively work and prevented both doors from properly closing which left a gap approximately one inch. Based on interview at the time of	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. No residents were affected. 2. SafeCare repaired the set of smoke barrier doors between the main lobby and the north hall corridor. ***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 February 6, 2023, the Maintenance Assistant inspected all smoke barrier doors with no issues noted. ***What measures and what systemic changes will be made to ensure that the deficient***	03/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
	observation, the Maintenance Director, and Maintenance Technician #1 both stated that they were unsure why the device is not working properly as it has been adjusted many times. He further stated that he is having someone from a sister facility coming to take a look at the coordinator to get further assistance in fixing the issue. This finding was reviewed with the Maintenance Director, Regional Director, and Executive Director at the exit conference. This deficiency was cited on 12/18/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		***practice doesn't recur:*** 1. Maintenance staff will receive education by the Executive Director and/or designee related to smoke barrier door policy to ensure understanding and importance of K374 by March 9, 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 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 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: 3/9/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0920 SS=D	NFPA 101 Electrical Equipment - Power Cords and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
Bldg. 01	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 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 Technician #1 on 02/02/24	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 February 2, 2024 the Executive Director 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***	03/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
	between 10:55 a.m. and 11:24 a.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 Technician #1 agreed that the fridge was still plugged into the power strip. He further stated that he assumed that the original issue was an extension cord but thought it had been already plugged into the wall. Upon further investigation, the Maintenance Director confirmed that the fridge had originally been plugged into the wall after the first time it was noticed in a power strip and had no clue as to why it was replugged into a power strip. Findings were discussed with the Maintenance Director, Regional Director, and Executive Director at exit conference. This deficiency was cited on 12/18/23. The facility failed to implement a systemic plan of correction to prevent recurrence 3.1-19(b)		***same deficient practice will be identified and what corrective action will be taken:*** 1. A full facility audit was completed on February 2, 2024 with any identified deficiencies addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Facility staff will be receive education by the Executive Director and/or designee related to power strips to ensure understanding and importance on K920 by March 9, 2024. 2. On February 5, 2024, residents and responsible parties received notification 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	02/02/2024

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
			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: 3/9/2024. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	