TAG     REGULATORY OR LSC IDENTIFYING INFORMATION     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     DATE       0000		ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/30/2022	
HAMMOND-WHITING CARE CENTER     WHITING, IN 46394       (x0,1)D     SUMMARY STATEMENT OF DEFICIENCIE     D       TAG     NOTIFIELD ACTORY OR LSC IDENTIFYING INFORMATION     D       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION     D       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION     D       SIGD.00     This visit was for the Investigation of Complaint IN00376073.     F 0000       Complaint IN00376073 - Substantiated.     F 60000     Please reference the enclosed 2567 as "Plan of Correction" for the March 30, 2022 Complaint Survey that was conducted at Hammond Whiling Care Center. 1       Unrelated deficiencies related to the allegations are cited at F677.     Tam respectfully requesting paper compliance for this survey. All educational training materials and completed audits will be provided in Gateway by April 22, 2022.       Facility number: 00355     Provider number: 155423       AIM number: 00357400     Preparation and/or execution of this prepared and/or executed solely because it is required by the provided of the turb facts alleged or conclusion set forth in the statement of deficiencies.       Medicaid: 4.7     Other: 4 Total: 60       These deficiencies reflect State Findings cited in accordance with 410 LAC 16.2-3.1.       Quality review completed on 3/31/22.	NAME OF	PROVIDER OR SUPPLIE	ER				
PREFIX TAG     CALCULATION VIGNEST BEPRECIDED BY FULL REQULATION VIGNEST DEPENDENT IN CONTRACTION REQULATION VIGNEST DEPENDENT IN CONTRACTION DATE     PREFIX TAG     Control Control of the Investigation of Complaint N00376073.     COMPLETION DATE       Pidg. 00     This visit was for the Investigation of Complaint N00376073.     F0000     Please reference the enclosed 2567 as "Plan of Correction" for the March 30, 2022 Complaint Survey that was conducted at Hammond Whiting Care Center. I allegations are cited at F677.     Please reference the enclosed 2567 as "Plan of Correction" for the March 30, 2022 Complaint Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. All educational training materials and completed audits will be provided in Gateway by April 22, 2022.     Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our facility to use in continuing to better the quality of care provided to our facility to use in continuing to better the quality of care provided to our Elders in our community.	HAMMOND-WHITING CARE CENTER						
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Correction, please contact me.						of	
Respectfully,							
					Respectfully,		

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

PRINTED: 04/20/2022

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.

	NT OF DEFICIENCIES OF CORRECTION	· · · · · · · · · · · · · · · · · · ·		ONSTRUCTION	î ź	E SURVEY LETED
	or conduction	155423	B. WING		03/30/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD 14TH ST		
HAMMOND-WHITING CARE CENTER				NG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	COMPLETION DATE
				Verna Meacham, HFA Executive Director		
: 0677 SS=D Bldg. 00	<ul> <li>§483.24(a)(2) A n carry out activitie necessary servic nutrition, groomir hygiene;</li> <li>Based on observat interview, the facili residents received care related to bath reviewed for ADL</li> <li>Finding includes:</li> <li>On 3/30/22 at 10:1 in her bed. She wa appeared greasy.</li> <li>The resident's recoint for the reviewed for ADL appeared greasy.</li> <li>The resident's recoint for the second factor of the secon</li></ul>	4 a.m., Resident D was observed s wearing a gown and her hair ord was reviewed on 3/30/22 at sident was admitted on 2/11/22. d, but were not limited to, <i>y</i> sis on one side of the body) weakness on one side of the cerebral vascular accident, heart	F 0677	This plan of correction is pro- and executed because the provisions of state and feder require it and not because Hammond-Whiting Care Cer agrees with the allegations citations listed. Hammond-W Care Center maintains that alleged deficiencies do not jeopardize the health and sa the residents nor is it of suc character to limit our capab to render adequate care. Pl accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be by the date indicated to rem compliance with state and fi regulations, the facility has or will take the actions set for this plan of correction. We respectfully request a desk <u>F 677- ADL Care Provided for Dependent Residents</u> <i>What Corrective Action with</i>	ral law enter and Vhiting the afety of h lities ease n as correct aain in ederal taken orth in review. <u>for</u>	04/22/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YV4Y11 Facility ID: 000365

If continuation sheet Page 2 of 9

	NT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 03/30/2022	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETIO	
TAG	Fridays. The tasks recorded the resident receiv Shower sheets ind bed bath and hair y bed bath on 3/25/2 documented. An ADL Care Play resident required a bath or shower as Interview with the at 3:24 p.m., indic shower sheets for received a sponge not documented an resident would fre also not document	A LSC IDENTIFYING INFORMATION I for the past 30 days indicated ed a bed bath on 3/18/22. icated the resident received a washed on 3/22/22, and another 22. There were no refusals n, dated 2/18/22, indicated the assistance of staff to provide a scheduled and as needed. Director of Nursing on 3/30/22 ated there were no additional the resident. The resident had bath on Tuesdays, but it was nywhere. She indicated the quently refuse care, which was red. elates to Complaint IN00376073.	TAG	residents found to have be affected by this deficient practice: 1. Resident D was ge a full bed bath per her prefer and had her hair washed as immediately. How other residents havin potential to be affected by same deficient practice wit identified and what correct action will be taken: 1. An in house audi be completed by nursing management on residents ff POC charting and completies shower sheets to assure completed per policy. Any is will be identified and follow be completed. What measures and what systemic changes will be to ensure that the deficient practice doesn't recur: 1. Education to the aides, licensed nurses, and for completion of POC/PCC documentation related to re shower/bed bath. Shower s be completed and turned in nurse each shift. MD and P and/or family to be notified refusal. Nursing to notify SS refusal(s). SSD to ensure ca plan is updated to reflect refusal(s). This will be comp by DON/Designee by date of compliance. 2. Any new nursing will receive this education d	given erence s well of the fill be trive it will for the on of ssues up will made at SSD fusal of heet to to OA of SD of are oleted of staff	

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u> co		DATE SURVEY COMPLETED 03/30/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP	COD		
HAMMO	ND-WHITING CAF	RECENTER		NG, IN 46394			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
IAU	REGULATORI C	R LSC IDENTIFTING INFORMATION	IAU	orientation as well.		DATE	
				How the corrective a be monitored to ensu- deficient practice will i.e., what quality ass program will be put if 1. DON/Desig review shower sheets times weekly to assur compliance. The show must be compared to charting to assure the Any refusals that are on need to be reported to SSD will discuss with resident/POA/family. be presented to QAPI and QAPI will determing for further audits. 2. The results reviews will be discuss monthly facility Quality Committee meeting m total of 3 months and quarterly thereafter or compliance is at 100% Frequency and duration will be increased as n compliance date: 4/22 Administrator at Hammond-Whiting Ca responsible in ensuring compliance in this Plat Correction.	ure the II not recur, surance in place: gnee will a daily 5 re wer sheets the POC ey match. ongoing o SSD and Audits will I x 6 months ine the need a of these sed at the y Assurance nonthly for a then nce %. on of reviews needed, if 100%. 2/22. The are Center is ng		
<sup>-</sup> 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4 Infection Prevent §483.80 Infectior	tion & Control					

PRINTED: 04/20/2022 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	· /		ORRECTION IDENTIFICATION NUMBER A. BUILDING 00			СОМ	e survey pleted <b>)/2022</b>	
	PROVIDER OR SUPPLIEF		1000 11	ADDRESS, CITY, STATE, ZIP 14TH ST IG, IN 46394	COD				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID			(X5)			
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETIO			
TAG	,	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE			
	The facility must e infection prevention designed to provide comfortable environ the development a communicable dist §483.80(a) Infection program. The facility must e prevention and co- must include, at a elements: §483.80(a)(1) A st identifying, reporti- controlling infection diseases for all re- visitors, and other services under a co- based upon the fa- conducted accord following accepted §483.80(a)(2) Wri and procedures for include, but are no (i) A system of sun identify possible c- infections before t- persons in the fac- (ii) When and to w communicable dis- be reported; (iii) Standard and precautions to be of infections; (iv)When and how	establish and maintain an on and control program de a safe, sanitary and comment and to help prevent and transmission of eeases and infections. on prevention and control establish an infection ntrol program (IPCP) that minimum, the following ystem for preventing, ng, investigating, and ns and communicable sidents, staff, volunteers, individuals providing contractual arrangement cility assessment ing to §483.70(e) and d national standards; tten standards, policies, or the program, which must ot limited to: veillance designed to ommunicable diseases or hey can spread to other				DATE			

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/30/2022	
	PROVIDER OR SUPPLIE		1000	tt address, city, state, zip ( 114TH ST TNG, IN 46394	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	organism involve (B) A requirement the least restriction under the circumstant must prohibit emcommunicable di lesions from direct their food, if direct disease; and (vi)The hand hyg followed by staff contact. §483.80(a)(4) A stant incidents identified and the corrective facility. §483.80(e) Linem Personnel must he transport linens as of infection. §483.80(f) Annual The facility will co its IPCP and upd necessary. Based on observat interview, the facili control guidelines including those sp and/or contain CO protective equipment isolation rooms, and generating proced	At that the isolation should be ve possible for the resident stances. ances under which the facility ployees with a sease or infected skin ct contact with residents or ct contact will transmit the iene procedures to be involved in direct resident system for recording ed under the facility's IPCP e actions taken by the s. handle, store, process, and so as to prevent the spread	F 0880	This plan of correction and executed because provisions of state and require it and not beca Hammond-Whiting Ca agrees with the allega citations listed. Hamm Care Center maintains alleged deficiencies do jeopardize the health a the residents nor is it of	e the d federal law ause are Center tions and oond-Whiting s that the o not and safety of	04/22/202	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CON	STRUCTION	•	<b>HB NO. 0938-039</b> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD		00	î /	LETED
IND FLAI	OF CORRECTION	155423	B. WING		00		)/2022
		133423	D. WING			03/30	J/2022
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP COD		
				000 114			
НАММО	ND-WHITING CAF	RECENTER	V	VHITING	G, IN 46394		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	Findings include:				character to limit our capabiliti		
					to render adequate care. Plea		
	1. On 3/30/22 the	following was observed:			accept this plan of correction a	as	
					our credible allegation of		
		staff member was observed in			compliance that the alleged		
		North hall speaking to the			deficiencies have or will be co		
		side. The staff member was			by the date indicated to remain		
	wearing a surgical	mask and no additional PPE.			compliance with state and fed		
				regulations, the facility has tak			
	Signage on the do			or will take the actions set fort	h in		
	Contact and Dropl			this plan of correction. We			
		luded an N95 (respirator) mask,			respectfully request a desk rev	view.	
		on and gloves. There was an					
	isolation cart outsi	de the door with PPE supplies.			<u>F 880-</u> Infection Prevention/Co What Corrective Action will		
	The staff member	exited the room at 9:20 a.m.			accomplished for those		
		me indicated she was not aware			residents found to have been	n	
	the resident was or	n isolation, and should have			affected by this deficient		
	been wearing addi	tional PPE.			practice:		
					1. There were no neg		
		taff was observed entering			outcomes for any residents. C		
		South hall, wearing a surgical			1 and CNA# 2 were educated		
	-	She preceded to change the			immediately.		
	-	while the resident was in the			How other residents having		
	bed.				potential to be affected by th		
	C' 1 1	· · · · · · · · · · ·			same deficient practice will I		
	00	or indicated the resident was on			identified and what correctiv	'e	
	-	et precautions. PPE required to			action will be taken:		
		luded an N95 (respirator) mask,			1. Clinical nursing is	nol	
		on and gloves. There was an de the door with PPE supplies.			continuing to make observatio	nai	
		ac the door with FFE supplies.			rounds ongoing to assure		
	Interview with CN	IA 1 upon exiting the room			compliance. No other issues h been noted at this time. Any	ave	
	indicated she was			issues identified will be addres	has		
	PPE when entering				immediately.	3000	
		5 110 100111.			What measures and what		
	2 On 3/30/22 at 1	:47 p.m., resident care was			systemic changes will be ma	ado	
		A 2. The CNA was wearing a			to ensure that the deficient		
		entered room 220 on the North			practice doesn't recur:		
	hall. She was aske				1. Education will be		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/30/2022
	PROVIDER OR SUPPLIE		1000 1 <sup>2</sup>	address, city, state, zip cod 14TH ST IG, IN 46394	
HAMMO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C questioned about t There was a sign of (aerosol generatin sign indicated the procedure and for room during and w PPE was required. The COVID-19 In Long-term Care F indicated:"Aero (AGPs) When p preferred with AG duration of the pro the procedure end within six feet of t progress should w and eye protection	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION the signage on the door. on the door that indicate AGP g procedure) was in use. The door should be closed during a one hour after. If entering the within one hour after, additional	WHITIN ID PREFIX TAG	NG, IN 46394 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) provided by Nursing Managen to all nursing staff r/t the appropriate use of personal protective equipment (PPE) du aerosol generating procedures: (AGP) by date of compliance. 2. Competency check will be completed by date of compliance for donning and du the appropriate personal prote- equipment (PPE) to be used during an aerosol generating procedure (AGP). Education w be provided during orientation new hires. 3. The DPOC implementer by facility with oversight by Ka Dawson, QSource consultant How the corrective action with be monitored to ensure the deficient practice will not rece i.e., what quality assurance program will be put in places 1. Clinical managers	nent uring s s offing octive vill for ed ara :: ill cur,
				<ul> <li>observe staff entering/exiting resident rooms during/after an aerosol generating procedure (AGP) 3 times weekly x 3 monther 2 times weekly x 3 monther 2 times weekly x 3 monther otating shifts to assure compliance. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the monther for further audits.</li> <li>The results of these reviews will be discussed at the monthly facility Quality Assure Committee meeting monthly facility Quality for the formation of the formati</li></ul>	nths, ns need e ne nce

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YV4Y11 Facility ID: 000365

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	F OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155423		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2022	
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
				total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of re will be increased as needed, compliance is below 100%. Compliance date: 4/22/22. Th Administrator at Hammond-Whiting Care Cen responsible in ensuring compliance in this Plan of Correction.	if ne	

4Y11 Facility ID: 000365

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