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 00 B. WING	03/30/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00376073. Complaint IN00376073 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Unrelated deficiency is cited. Survey date: March 30, 2022. Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 9 Medicaid: 47 Other: 4 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/31/22.	F 0000	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 Elders in our community. The Plan of Correction submitted on April 18, 2022 serves as our allegation of compliance. Should you have any questions or concerns regarding the Plan of Correction, please contact me. Respectfully,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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			Verna Meacham, HFA Executive Director	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received ADL (activities of daily living) care related to bathing for 1 of 3 residents reviewed for ADL care. (Resident D) Finding includes: On 3/30/22 at 10:14 a.m., Resident D was observed in her bed. She was wearing a gown and her hair appeared greasy. The resident's record was reviewed on 3/30/22 at 11:08 a.m. The resident was admitted on 2/11/22. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral vascular accident, heart failure, and vascular dementia. The Quarterly Minimum Data Set assessment, dated 3/4/22, indicated the resident had severe cognitive deficits, and required extensive two person assistance for bed mobility and transfers. The shower schedule indicated the resident was to receive a bath or shower on Tuesdays and	F 0677	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Hammond-Whiting Care Center agrees with the allegations and citations listed. Hammond-Whiting Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 677**- ADL Care Provided for Dependent Residents ***What Corrective Action will be accomplished for those***	04/22/2022

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	Fridays. The tasks recorded for the past 30 days indicated the resident received a bed bath on 3/18/22. Shower sheets indicated the resident received a bed bath and hair washed on 3/22/22, and another bed bath on 3/25/22. There were no refusals documented. An ADL Care Plan, dated 2/18/22, indicated the resident required assistance of staff to provide a bath or shower as scheduled and as needed. Interview with the Director of Nursing on 3/30/22 at 3:24 p.m., indicated there were no additional shower sheets for the resident. The resident had received a sponge bath on Tuesdays, but it was not documented anywhere. She indicated the resident would frequently refuse care, which was also not documented. This Federal tag relates to Complaint IN00376073. 3.1-38(a)(3)		***residents found to have been affected by this deficient practice:*** 1. Resident D was given a full bed bath per her preference and had her hair washed as well immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An in house audit will be completed by nursing management on residents for the POC charting and completion of shower sheets to assure completed per policy. Any issues will be identified and follow up will be completed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education to the aides, licensed nurses, and SSD for completion of POC/PCC documentation related to refusal of shower/bed bath. Shower sheet to be completed and turned into nurse each shift. MD and POA and/or family to be notified of refusal. Nursing to notify SSD of refusal(s). SSD to ensure care plan is updated to reflect refusal(s). This will be completed by DON/Designee by date of compliance. 2. Any new nursing staff will receive this education during	

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			orientation as well. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Designee will review shower sheets daily 5 times weekly to assure compliance. The shower sheets must be compared to the POC charting to assure they match. Any refusals that are ongoing need to be reported to SSD and SSD will discuss with resident/POA/family. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 4/22/22. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

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	The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,			

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	depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly in isolation rooms, and staff unaware of aerosol generating procedure (AGP) guidelines, for random observations for infection control. (North and South Hall)	F 0880	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	04/22/2022

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	Findings include: 1. On 3/30/22 the following was observed: a. At 9:05 a.m., a staff member was observed in Room 222 on the North hall speaking to the resident at her bedside. The staff member was wearing a surgical mask and no additional PPE. Signage on the door indicated the resident was on Contact and Droplet precautions. PPE required to enter the room included an N95 (respirator) mask, gown, eye protection and gloves. There was an isolation cart outside the door with PPE supplies. The staff member exited the room at 9:20 a.m. Interview at that time indicated she was not aware the resident was on isolation, and should have been wearing additional PPE. b. At 10:44 a.m., staff was observed entering Room 109 on the South hall, wearing a surgical mask and a gown. She preceded to change the resident's bedding while the resident was in the bed. Signage on the door indicated the resident was on Contact and Droplet precautions. PPE required to enter the room included an N95 (respirator) mask, gown, eye protection and gloves. There was an isolation cart outside the door with PPE supplies. Interview with CNA 1 upon exiting the room indicated she was unaware she needed additional PPE when entering the room. 2. On 3/30/22 at 1:47 p.m., resident care was observed with CNA 2. The CNA was wearing a surgical mask and entered room 220 on the North hall. She was asked to exit room and was		character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 880**- Infection Prevention/Control ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. There were no negative outcomes for any residents. CNA# 1 and CNA# 2 were educated immediately. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Clinical nursing is continuing to make observational rounds ongoing to assure compliance. No other issues have been noted at this time. Any issues identified will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be	

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	questioned about the signage on the door. There was a sign on the door that indicate AGP (aerosol generating procedure) was in use. The sign indicated the door should be closed during a procedure and for one hour after. If entering the room during and within one hour after, additional PPE was required. The COVID-19 Infection Control Guidance in Long-term Care Facilities, updated on 2/8/22, indicated: ..."Aerosol Generating Procedures (AGPs)... When possible, a private room is preferred with AGPs with the door shut for the duration of the procedure including 1 hour after the procedure ends... Staff providing direct care within six feet of the resident while AGP is in progress should wear full PPE including N95 mask and eye protection for all types of scenarios...." Interview with CNA 2 at that time, indicated she was not aware of the AGP guidelines. 3.1-18(b)(1)(A)		provided by Nursing Management to all nursing staff r/t the appropriate use of personal protective equipment (PPE) during aerosol generating procedures (AGP) by date of compliance. 2. Competency checks will be completed by date of compliance for donning and doffing the appropriate personal protective equipment (PPE) to be used during an aerosol generating procedure (AGP). Education will be provided during orientation for new hires. 3. The DPOC implemented by facility with oversight by Kara Dawson, QSource consultant. ***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. Clinical managers will observe staff entering/exiting resident rooms during/after an aerosol generating procedure (AGP) 3 times weekly x 3 months, then 2 times weekly x 3 months rotating 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 need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a	

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