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	05/06/2025

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 IN00458244. Complaint IN00458244 - Federal/state deficiencies related to the allegations are cited at F686. Unrelated deficiencies are cited. Survey dates: May 5 and 6, 2025 Facility number: 000365 Provider number: 155423 AIM number: 100287460 Census Bed Type: SNF: 67 Total: 67 Census Payor Type: Medicare: 7 Medicaid: 57 Other: 3 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/12/25.	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a wound treatment was completed and heels were floated as ordered for 2 of 3 residents reviewed for	F 0686	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	06/03/2025

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

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	pressure-related skin conditions. (Residents B and C) Findings include: 1. On 5/5/25 at 11:59 a.m., Resident B was observed lying in bed on her right side. The resident's heels were resting on the bed, not off-loaded, and she had wounds on her left lateral and medial foot. During an interview at the time, the wound nurse indicated the resident did not have an order for off-loading boots but she would call the doctor today to get an order. She indicated the resident's heels were off-loaded the last time she was in the room. The record for Resident B was reviewed on 5/5/25 at 10:48 a.m. Diagnoses included, but were not limited to, dementia, anorexia, tube feeding support, and lymphedema (swelling in arms or legs). The Quarterly Minimum Data Set (MDS) assessment, dated 2/19/25, indicated the resident was cognitively impaired for daily decision making, dependent for all activities of daily living (ADL's) and was at risk for developing a pressure ulcer. A Physician's Order, dated 4/29/25, indicated to off-load heels while in bed as tolerated and confirm every shift. During an interview on 5/6/25 at 2:11 p.m., the Executive Director indicated she understood the concern and had no additional information to provide.		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 686** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident B had her heels uploaded immediately and Resident C had her wound tx completed and her dressing in place immediately as well as her feet being off loaded. ***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 audit was completed of	

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	2. On 5/5/25 at 9:37 a.m., Resident C was observed lying in bed awake. The resident's dressing was checked with the wound nurse and there was no dressing in place covering the resident's sacral wound. The wound was pink, the size of a golf ball, and open to air. The resident's heels were lying flat on the bed and were not off-loaded. During an interview at the time, the Wound Nurse indicated she would put a dressing on the wound right away. On 5/5/25 at 10:38 a.m., the resident was observed in bed with 2 blankets covering her, she was lying on her back and crying she was cold. When the blankets were removed to observe the wound treatment, the resident's feet were lying flat on the bed. The Wound Nurse began the wound treatment, the resident's brief was opened and a new pad was placed underneath the resident. Hand hygiene was performed and a new set of gloves was donned. The wound nurse did not have a gown on and she began cutting the collagen dressing package open. She was stopped and asked if the resident was in Enhanced Barrier Precautions (EBP). There was an EBP sign observed on the resident's door. During an interview at the time, the Wound Nurse indicated she had forgotten to put on a gown. The record for Resident C was reviewed on 5/5/25 at 10:01 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), dementia, high blood pressure, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident		residents at risk for skin breakdown and their interventions by nursing management by date of compliance. Residents had their orders validated, care plan reviewed and observed to ensure interventions are in place. Any issues noted will be corrected immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by the wound nurse to the nursing department by date of compliance. This education will include to ensure pressure reduction interventions are in place and maintained through the shift. This education will also include the aides are to report to their nurse immediately if a resident has a dressing off and the nurse will perform tx and replace dressing immediately. This education will be completed annually, upon hire and as needed. No nursing staff will work beyond date of compliance without this education being complete. Repeated occurrence will result in progressive discipline up to and including termination. ***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. The wound nurse will observe 5	

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	was severely impaired for daily decision making. The resident had impairment on both sides of the lower extremities and used a wheelchair. The resident required partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene. The resident required substantial/maximum assistance with lower body dressing and shower/ bathing. The resident required dependent care with toileting and putting on footwear. The resident was at risk for pressure ulcers and injuries. A Care Plan, dated 3/5/25, indicated the resident was at risk for unavoidable pressure injury development related to decline of skin integrity. Interventions were to administer treatments as ordered, provide weekly skin checks, assist with turning and repositioning, and educate on causative factors and measures to prevent skin injury. A Physician's Order, dated 4/2/25, indicated to offload heels while in bed as tolerated and confirm every shift. A Physician's Order, dated 5/2/25, indicated to cleanse the Sacrum with normal saline, pat dry, apply collagen to the wound bed, and cover with a dry dressing. The dressing was to be changed every day shift on Monday, Wednesday and Friday and as needed. During an interview on 5/5/25 at 10:31 a.m., the Executive Director indicated she understood Resident C should have had a dressing on her wound and the resident's heels should have been offloaded. No additional information was provided. This citation relates to Complaint IN00458244.		residents daily Monday thru Friday and the weekend manager will observe on weekends x 3 months then 3 residents daily x 3 months to ensure compliance. 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: June 3rd, 2025. The Administrator at Hammond-Whiting Care Center is responsible in ensuring compliance in this Plan of Correction.	

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F 0842 SS=D Bldg. 00	3.1-40 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to conflicting orders for wound treatments for 1 of 3 residents reviewed for pressure. (Resident D) Finding includes: On 5/5/25 at 11:01 a.m., Resident D was observed during a wound treatment. During the wound treatment, the wound nurse went to apply aquacell alginate to the wound bed. The current physician's order called for xerofoam to be placed on the wound bed. During an interview at the time, the nurse indicated she had confirmed the orders with the physician and the 12/20/24 order for xerofoam was the correct order to use going forward. She would delete the aquacell treatment order to ensure the correct order was used. The record for Resident D was reviewed on 5/5/25 at 10:55 p.m. Diagnoses included, but were not limited to, anemia (low iron), dysphagia (difficulty swallowing), and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/14/25, indicated Resident D was moderately impaired for daily decision making. The resident required dependent care for toileting, shower/bathing, upper body dressing,	F 0842	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 842** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident D had no negative outcomes and the treatment was clarified with the MD. The TX for	06/03/2025

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	and lower body dressing. A Care Plan, dated 4/16/25, indicated the resident had pressure ulcers to the left buttock and right buttock related to dehydration, immobility, anemia, and incontinence. Interventions were to, administer treatments as ordered, place in EBP, and assess wounds weekly. A Physician's Order, dated 12/20/24, indicated to cleanse the right buttock with normal saline/wound cleanser, pat dry with sterile gauze, apply skin prep to the surrounding skin, apply Aquacel AG (alginate) to the wound bed, and secure with dry dressing. Change the dressing every 3 days and as needed (PRN) for soilage/dislodgement. A Physician's Order, dated 2/4/25, indicated to cleanse the right upper buttock with normal saline/wound cleanser, pat dry with sterile gauze, apply skin prep to the peri wound, apply Xerofoam Gauze to the wound bed, and cover with a border gauze dressing. Change the dressing every 3 days and PRN for soilage/dislodgement. The 5/2025 Treatment Administration Record (TAR) indicated both right buttock treatment orders were signed out as being completed. The treatment order from 12/20/24 was signed out as completed on 5/3/25 and 5/5/25. The treatment order from 2/4/25 was signed out as completed on 5/2/25. During an interview on 5/5/25 at 3:00 p.m., the Executive Director indicated she understood the concern and had no further information to provide.		the Aquacell was discontinued ***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 on resident with wound treatment orders to ensure correct and no more than 1 treatment is in place for each wound by the wound nurse by date of compliance. Any discrepancies noted 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 completed to the wound nurse by the RDCS on the appropriate protocol when writing wound treatment orders. This education is to include to review of all current treatment orders and discontinue if a new order is written. This education will then be completed by the wound nurse/SDC to licensed nursing as well by date of compliance. This education will be completed upon hire, at least annually and as needed. No licensed nurses will work past date of compliance with out this education completed. Repeated occurrences will lead to progressive discipline up to and including termination.	

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	3.1-50(a)(1) 3.1-50(a)(2)		***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. New orders will be reviewed by the clinical team Monday through Friday in the morning meeting. Any new treatment orders will be validated at that time that the old treatment order has been discontinued ongoing to ensure compliance. 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: June 3rd, 2025. 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 Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (Wound Nurse) when providing care during a wound treatment for resident who was in Enhanced Barrier Precautions (EBP) for 1 of 3 residents observed for pressure ulcer care.	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	06/03/2025

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	(Resident C) Finding includes: On 5/5/25 at 10:38 a.m., Resident C was observed in bed with 2 blankets covering her. She was lying on her back and crying she was cold. When the blankets were removed to observe the wound treatment, the resident's feet were lying flat on the bed. The Wound Nurse began the wound treatment, the resident's brief was opened and a new pad was placed underneath the resident. Hand hygiene was performed, and a new set of gloves were donned. The wound nurse did not have a gown on, and she began cutting the collagen dressing packet open. She was stopped and asked if the resident was in Enhanced Barrier Precautions. There was an EBP sign observed on the resident's door. During an interview at the time, the Wound Nurse indicated she had forgotten to put on a gown. The record for Resident C was reviewed on 5/5/25 at 10:01 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), dementia, high blood pressure, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of the lower extremities and used a wheelchair. The resident required partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene. The resident required substantial/maximum assistance with lower body dressing and shower/ bathing. The resident required dependent care with toileting and putting		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 880 ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident C had no negative outcomes. The wound nurse was educated immediately by the IP on EHP. ***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 was completed on residents with EHP. Random observations have been completed by the IP on the wound nurse to ensure all EBP is being	

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	on footwear. The resident was at risk for pressure ulcers and injuries. A Physician's Order, dated 5/2/25, indicated to cleanse the Sacrum with normal saline, pat dry, apply collagen to wound bed, and cover with dry dressing. The dressing was to be changed every day shift on Monday, Wednesday, and Friday and as needed. Current CDC guidance for EBP in nursing homes, dated 7/12/22 and titled "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrugresistant Organisms (MDROs)" indicated the following: "... Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated ... Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing · Bathing/showering · Transferring · Providing hygiene · Changing linens · Changing briefs or assisting with toileting · Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator · Wound care: any skin opening requiring a dressing ...." During an interview on 5/6/25 at 1:11 p.m., the Infection Prevention (IP) nurse indicated their		followed. No other concerns were noted. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Staff will be re in-serviced on EBP and the protocol and policy. No staff will work past date of compliance with out this education being completed. This education will be completed upon hire, annually, and as needed. Repeated occurrences will result in progressive discipline up to and including termination. ***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. The IP will observe 5 staff members weekly x 3 months and then 3 staff members weekly x 3 months on donning EHP PPE to ensure compliance. 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: June 3rd, 2025. The Administrator at Hammond-Whiting Care Center is responsible in ensuring	

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	policy indicated EBP precautions were up to the discretion of the facility and their policy for EBP indicated if the wound could be covered and was not secreting drainage, then it did not need to be in EBP precautions. She understood regulation standards and had no further information to provide. 3.1-18(b)		compliance in this Plan of Correction.	