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	10/16/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/16/2024 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Emergency Preparedness survey, Hammond-Whiting Care Center was found not 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 70. Quality Review completed on 10/18/24	E 0000		
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of	E 0037	This plan of correction is prepared and executed because the provisions of the 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	11/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamela	Jones	11/07/2024

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 -- B. WING	10/16/2024

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
	emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of record review, the Maintenance Director stated that training is done in person and online via an online program. She further stated that staff had received fire training from an organization earlier in the year, however no documentation for the completed training was found during the survey. The only documentation provided was an email chain regarding starting the process to have the company come out. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have of 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. Emergency preparedness training will be provided to all staff. Training will be documented and will include demonstration of staff knowledge. Ongoing Emergency Preparedness training will be initiated for all new employees and will be scheduled to take place annually for existing employees at a minimum. Maintenance Director will monitor regularly for compliance. Emergency Preparedness Training Documentation will be reviewed at QAPI monthly X 6 months. Administrator will be responsible to ensure POC implementation, completion and ongoing compliance.	
E 0039 SS=F	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements			

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	10/16/2024

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. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include:	E 0039	This plan of correction is prepared and executed because the provisions of the 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 of 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. A second disaster drill will be conducted in the facility and documented. Going forward, 2 Drills will be scheduled/conducted per year per regulation. Documentation of drills will be maintained. Maintenance Director will monitor regularly to ensure compliance.	11/15/2024

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	10/16/2024

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
	Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., documentation for a facility-based elopement drill was provided, however no second exercise of choice was produced at the time of the survey. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of documentation and further stated that they were unaware where the documentation could be or if there was any documentation. He further stated that certain events have happened at the facility which could have been used as an exercise, however they weren't able to say if the documentation for it had been completed. The finding was discussed with the Maintenance Director and Executive Director at exit conference.		Results of the disaster drill will be presented at QAPI each month X 6 months for analysis and to ensure compliance. Administrator will be responsible for POC implementation, completion and ongoing compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., the generator lacked monthly load and weekly exercise testing, along with a 36-month exercise all required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the Executive	E 0041	This plan of correction is prepared and executed because the provisions of the 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 of will be correct by the date indicated to remain in compliance with state	11/15/2024

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	10/16/2024

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
	Director and Maintenance Director at the exit conference.		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. Generator monthly load testing and weekly exercise testing will be conducted per regulation. Documentation of testing will be maintained. Maintenance Director will audit records regularly to ensure ongoing compliance. MD will further bring records to QAPI meeting monthly X 6 months for review and analysis. Administrator will be responsible to ensure POC implementation, completion and ongoing compliance.	
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 483.70(a). Survey Date: 10/16/2024 Facility Number: 000365	K 0000		

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	10/16/2024

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
	Provider Number: 155423 AIM Number: 100287460 At this Life Safety Code survey, 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 70 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 10/18/24			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements	K 0300	This plan of correction is prepared and executed because the provisions of the 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	11/15/2024

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	10/16/2024

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
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., no documentation for all battery-smoke detectors in the facility was located during the survey. During a tour of the facility between 1:09 p.m. and 2:12 p.m., all resident rooms had one hardwire smoke detector and one battery smoke detector. When looking at manufacturer instructions for the battery smoke detector, it stated that the smoke detectors required weekly testing. Based on interview at the time of observation and record review, the Maintenance Director confirmed the missing documentation and further stated that the battery smoke detectors were supposedly installed due to other regulations, but they have not done the testing for them. The finding was discussed with Maintenance Director and Executive Director at exit conference. 3.1-19(b)		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 of 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. The battery-smoke detectors in the facility have been tested and have been placed on a schedule to test every Monday. Maintenance Director/Designee with be responsible for weekly testing and documentation of testing. Testing logs will be brought to monthly QAPI meeting for review and analysis X 6 months to ensure ongoing compliance. Administrator will be responsible to ensure POC implementation, completion and ongoing compliance.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems to assure that it had accurate time and date information in accordance with the requirements	K 0345	This plan of correction is prepared and executed because the provisions of the state and federal law require it and not because	11/15/2024

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	10/16/2024

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
	of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 10/16/24 at 1:39 p.m. during a tour of the facility with the Maintenance Director, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 07/16/24 at 3:24 p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and further stated that the control panel had been recently replaced, so it should have been reflecting the accurate date and time. This finding was reviewed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		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 of 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. Fire alarm control panel has been reset to the correct date and time. Maintenance Director and Fire Alarm Vendor will review regularly, to include power outages and any maintenance to the panel, to ensure ongoing compliance. Maintenance Director will bring audits to QAPI meeting monthly X 6 months for review and analysis. Administrator will be responsible for POC implementation, completion and ongoing compliance.	

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	10/16/2024

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 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., there were no monthly gauge & valve inspections for the wet sprinkler system for the month of August 2024. Furthermore, the following weekly inspections were missing for the dry sprinkler system: a) January 4th-10th of 2024 b) June 26th-July18th of 2024 c) July 22nd-September 13th of 2024. Based on interview at the time of record review, the Maintenance Director confirmed that the inspections were not recorded due to having limited maintenance staff and no director which	K 0353	This plan of correction is prepared and executed because the provisions of the 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 of 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. Monthly Gauge & Valve inspections will be completed going forward for the wet sprinkler system. Weekly inspections will be completed for the dry sprinkler system. Maintenance Director will be responsible to regularly audit the	11/15/2024

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	10/16/2024

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
	left inspections not done. The finding was discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		inspections to ensure compliance. Maintenance Director will bring these inspection audits to monthly QAPI meetings X 6 months for review and analysis. Administrator will be responsible for POC implementation, completion and ongoing compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 20 resident room doors to the 200-Hall would completely resist the passage of smoke. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment for the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted.	K 0363	This plan of correction is prepared and executed because the provisions of the 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 of 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.	11/15/2024

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	10/16/2024

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
	Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or flames in window assemblies. This deficient practice could affect approximately 20 residents, as well as staff and visitors. Findings include: Based on observation on 10/16/24 between 1:09 p.m. and 2:12 p.m. during a tour of the facility with the Maintenance Director, the door to resident room 217 had a circular penetration measuring approximately 1/2 inches in diameter was located above the door handle which went completely through the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door penetration and further stated he was unaware that the penetration was in the door. The finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		Resident Room Door 217 will be repaired or replaced. Maintenance Director will audit doors randomly and regularly for compliance. These audits will be brought to monthly QAPI meetings X 6 months for review and analysis. Administrator will be responsible for POC implementation, completion and ongoing compliance.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the	K 0712	This plan of correction is prepared and executed because the provisions of the state and federal law require it and not because Hammond-Whiting Care Center agrees with the allegations and	11/15/2024

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	10/16/2024

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
	signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., the following shifts were missing documentation of a completed fire drill: a) A third shift fire drill in the second quarter of 2024. b) A second and third shift fire drill in the third quarter of 2024. Based on interview at the time of record review, the Maintenance Director acknowledged that there were missing fire drills and further stated that at one point in time, the facility had no director for maintenance which would have been around the time of the missing fire drills. This finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 3.1-51(c)		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 of 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. Fire Drills will be conducted at least quarterly on each shift. Maintenance Director will be responsible for conducting these fire drills. Drills will be documented. Fire Drill documentation will be presented at monthly QAPI meetings X 6 months for review and analysis. Administrator will be responsible for POC implementation, completion and ongoing compliance.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors			

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	10/16/2024

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
	Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/16/24 between 1:09 p.m. and 2:02 p.m., there was one rolling fire doors/windows between the kitchen and dining hall. The tag on the rolling fire door indicated the last annual test was performed in April of 2024, however the tag did not indicate that the door had passed or failed inspection. Based on interview at the time of observation, the Maintenance Director agreed that there was a lack of documentation and further stated that he would have to contact the inspection company to obtain the report as he did not know if there was any paperwork for the rolling door. The finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0761	This plan of correction is prepared and executed because the provisions of the 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 of 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. Rolling fire door between kitchen and dining room inspection report from 4/11/2-24 was located. Inspection passed. Inspection report is attached	11/15/2024

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	10/16/2024

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 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of 12 months and weekly inspection for 14 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., no documentation was available for the months of March 2024 and June 2024-August 2024 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log showed the following weeks were missing weekly generator inspection: a) April 5th-April 30th 2024 b) June 26th-July 18th 2024 c) July 18th-September 12th 2024 Based on interview at the time of record review,	K 0918	This plan of correction is prepared and executed because the provisions of the 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 of 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. A 4 hour run test will be conducted for the emergency generator. The Maintenance Director will conduct the test and will document. This 4 hour test result will be presented at QAPI meeting subsequent to the test for review and analysis. Testing will be placed on schedule	11/15/2024

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	10/16/2024

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
	the Maintenance Director acknowledged the lack of documentation and further stated that there had been previous issues with retaining maintenance personnel and stated they were without a maintenance director during a part of those times. The finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: During record review with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., documentation of a four hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation and further stated that he was		to complete and document every 36 months under available load. Administrator will be responsible for POC implementation, completion and ongoing compliance.	

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	10/16/2024

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
	unaware if the facility had a 36-month exercise for the generator documented. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure 3 of 3 power cord daisy chained together were not used as a substitute for fixed wiring. 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. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect 2 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on 10/16/24 between 1:09 p.m. and 2:02 p.m., in the Executive Director's office contained three power strips and each of those power strips were plugged into and powering each other. The power strips were also used to power electronics and computer equipment. Based on interview at the time of observation, the Maintenance Director acknowledged the daisy chained power strips and further stated he was unaware when the power strips were plugged into each other.	K 0920	This plan of correction is prepared and executed because the provisions of the 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 of 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. Power strip cords in the E. D.'s office have been unplugged from each other and are now properly	11/15/2024

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	10/16/2024

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
	The finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 flexible cords was installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 10/16/24 between 1:09 p.m. and 2:02 p.m., the Executive Director office contained three power strips daisy chained together. The second of the three daisy chained power strips was dangling at a high height unsecured. Based on interview at the time of observation, the Maintenance Director acknowledged the dangling power strip and further stated that the office is going to go under remodel, so the daisy chain could have been created by the floor repair personnel to get it off the floor. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		plugged in. The extension cord in the Activities office has also been removed. All staff will be educated regarding inappropriate use of power cords. Maintenance Director will conduct this education for all staff. Maintenance Director will conduct regular safety audits via safety committee to include extension cords and daisy-chained power strips. Appropriate disciplinary action will be taken for employees engaging in any non-compliance. Audits will be presented at monthly QAPI meetings X 6 months for review and analysis. Administrator will be responsible for POC implementation, completion and ongoing compliance.	

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	10/16/2024

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
	3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. 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 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/16/24 between 1:09 p.m. and 2:12 p.m., within the Activities office within the 100-Hall, across from the nurses desk, contained an extension cord used to power a phone charger and a power strip. Based on interview at the time of observation, the Maintenance Director acknowledged that there was an extension cord used for permanent use. The finding was reviewed with the Maintenance Director and the Executive Director during the exit conference. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location had proper separation in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect approximately 12	K 0927	This plan of correction is prepared and executed because the provisions of the 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	11/15/2024

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	10/16/2024

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
	residents and staff. Findings include: Based on observation with the Maintenance Director on 10/16/24 between 09:25 a.m. and 11:58 a.m., while sitting in the front office area adjacent to the front lobby, a loud audible noise was heard coming from near the front waiting area. The Maintenance Director and the surveyor both went to investigate and discovered an employee had entered the oxygen transfilling/storage room to transfill a portable oxygen machine. When the staff member was transfilling, they had pulled out the liquid oxygen container out of the room half-way exposing it to the corridor and started to transfill with the door also propped open. Based on interview at the time of observation, the Maintenance Director acknowledged that the staff member was transfilling with the door propped open. The finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is		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 of 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. Oxygen storage area has been reorganized to safely accommodate tanks, equipment and personnel to stand and perform transfilling as needed. All nursing staff will be educated on proper storage and filling techniques for O2 to include keeping door closed while transfilling O2. Education will be documented and will include demonstration of staff knowledge. O2 transfilling will be reviewed during monthly safety meeting to include a random staff demonstration for safety committee to audit. Results of the audit will be presented at monthly QAPI X 6 months for review and analysis. Administrator will be responsible for POC implementation,	

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	10/16/2024

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
	sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/16/24 between 1:09 p.m. and 2:02 p.m., the oxygen storage/transfer room contained liquid oxygen tanks, oxygen cylinders, and other oxygen supplies completely filling the room. This condition does not leave enough room for a person transfilling oxygen inside the room with the door closed. Based on interview at the time of observation, the Maintenance Director stated staff can not completely fit inside the room to properly transfill oxygen concentrators and would have to prop open the door. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		completion and ongoing compliance.	