Tamela

continued program participation.

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

11/07/2024

R MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039
NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	X3) DATE SURVEY COMPLETED 10/16/2024
		1000 1	14TH ST	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
conducted by the In accordance with 42  Survey Date: 10/16/ Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Emergency I Hammond-Whiting compliance with En Requirements for M Participating Provid 483.73  The facility has 80 of the survey, the cens	diana Department of Health in CFR 483.73.  2024  0365 55423 87460  Preparedness survey, Care Center was found not in nergency Preparedness dedicare and Medicaid ers and Suppliers, 42 CFR  certified beds. At the time of us was 70.	E 0000		
403.748(d)(1), 416 EP Training Progr.  Based on record reversited to conduct an Emergency Prepared facility must do all detraining in emergency procedures to all neindividuals providing and volunteers, consoles; (ii) Provide entraining at least ann documentation of all training; (iv) Demonstraining; (iv) Demonstraining to the procedure of the provided and training; (iv) Demonstraining procedures are the provided and training; (iv) Demonstraining procedures are the provided and training; (iv) Demonstraining programmers are the provided and training; (iv) Demonstraining programmers are the provided and training; (iv) Demonstraining programmers are the provided and training programmers are the provided and training programmers.	iew and interview, the facility nual training for the dness Program (EPP). The LTC of the following: (i) Initial by preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain I emergency preparedness nestrate staff knowledge of	E 0037	and executed because the provisions of the state and fed 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 health and safety of the reside nor is it of such character to limited.	deral er d er the ents
	PROVIDER OR SUPPLIER ND-WHITING CARE  SUMMARY S (EACH DEFICIENCE REGULATORY OR  An Emergency Prep conducted by the In- accordance with 42  Survey Date: 10/16/ Facility Number: 1002  At this Emergency I Hammond-Whiting compliance with En Requirements for M Participating Provid 483.73  The facility has 80 of the survey, the censure Quality Review com 403.748(d)(1), 416 EP Training Program Emergency Prepared facility must do all of training in emergency procedures to all nev individuals providin and volunteers, cons roles; (ii) Provide er training at least annu documentation of al training; (iv) Demon	PROVIDER OR SUPPLIER  ND-WHITING CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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  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	AND EMPTOY DEFICIENCIES OF CORRECTION    STREET	DENTIFICATION NUMBER 155423  PROVIDER OR SUPPLIER  ND-WHITING CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C IDENTIFYING INFORMATION  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  Alm 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  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 off 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 offices; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of

Any defiency statement 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

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Jones

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

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/16/2024
	ROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	emergency procedu 483.73(d) (1). This all residents in the first Findings include:  Based on record review Director on 10/16/2 a.m., no documentation to demonstrate knowled for review. Based or record review, the Market training is done online program. Showever, the first first first first finding was recompleted training. The only documentate chain regarding star company come out.  This finding was reconference.	res in accordance with 42 CFR deficient practice could affect accility.  The with the Maintenance 4 between 09:25 a.m. and 11:58 tion of annual EPP training and to show staff could edge of the EPP was available in an interview at the time of Maintenance Director stated in person and online via an electric function of the was found during the survey. The was found during the survey. The was found during the survey. The was found the was an email ting the process to have the enance Director during the exit		our capabilities to render adec care. Please accept this plan correction as our credible allegation of compliance that alleged deficiencies have of w correct by the date indicated tremain in compliance with start and federal regulations, the fathas taken or will take the actic set forth in this plan of correct We respectfully request a destreview.  Emergency preparedness train will be provided to all staff. Training will be documented a will include demonstration of sknowledge.  Ongoing Emergency Preparedness training will be initiated for all new employees will be scheduled to take place annually for existing employer a minimum.  Maintenance Director will mor regularly for compliance. Emergency Preparedness Trade Documentation will be review QAPI monthly X 6 months.  Administrator will be responsite to ensure POC implementation completion and ongoing compliance.	the vill be oo te acility ons ion. k  ning and staff  s and be es at hitor aining ed at ble
E 0039 SS=F	403.748(d)(2), 416 EP Testing Requir	5.54(d)(2), 418.113(d)( rements			

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Event ID:

Q6M521

Facility ID: 000365

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
			,	DISTRUCTION	` '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155423	B. WING		10/16/2024	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 14TH ST		
		CENTER				
HAIVIIVIÜİ	ND-WHITING CARE	CENTER	VVIIII	NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
Bldg						
	Based on record rev	view and interview, the facility	E 0039	This plan of correction is prepared	ared 11/15/2024	
	failed to conduct ex	ercises to test the emergency		and executed because the		
	plan at least twice p	er year, including		provisions of the state and fed	eral	
		drills using the emergency		law require it and not because		
		C facility must do the		Hammond-Whiting Care Cent		
	following:	-		agrees with the allegations an		
	_	annual full-scale exercise that		citations listed.		
	is community-based			Hammond-Whiting Care Center	er	
		ity-based exercise is not		maintains that the alleged		
		an annual individual,		deficiencies do not jeopardize	the	
	facility-based funct			health and safety of the reside		
	-	y experiences an actual natural		nor is it of such character to lir		
		gency that requires activation		our capabilities to render adec		
	-	lan, the LTC facility is exempt		care. Please accept this plan	•	
		ext required full-scale in a		correction as our credible		
		r individual, facility-based		allegation of compliance that t	ha	
	-	l exercise for 1 year following		alleged deficiencies have of w		
	the onset of the actu	-		correct by the date indicated to		
		itional exercise that may		remain in compliance with state		
	1 1	imited to the following:		•		
	a. A second full-sca	_		and federal regulations, the fa	- I	
		r an individual, facility-based				
	functional exercise.	-		set forth in this plan of correcti	l l	
	b. A mock disaster			We respectfully request a design	K	
		<i>'</i>		review.		
	_	se or workshop that is led by a				
		des a group discussion, using				
		y-relevant emergency scenario,		A		
	_	n statements, directed		A second disaster drill will be		
		red questions designed to		conducted in the facility and		
	challenge an emerg			documented. Going forward,		
		C facility's response to and		Drills will be scheduled/condu	ctea	
		ation of all drills, tabletop		per year per regulation.		
	·	gency events, and revise the		Documentation of drills will be		
	-	gency plan, as needed in		maintained.		
		CFR 483.73(d)(2). This				
	deficient practice co	ould affect all occupants.		Maintenance Director will mon		
				regularly to ensure compliance	Э.	
	Findings include:					

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Event ID:

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Facility ID: 000365

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	. BUILDING COM		COMPL	ETED
		155423	B. WI	NG		10/16/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				IATH ST		
HAMMON	ND-WHITING CARE	CENTER			HITING, IN 46394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view with the Maintenance			Results of the disaster drill will	be	
		4 between 09:25 a.m. and 11:58			presented at QAPI each montl	١X	
		n for a facility-based elopement			6 months for analysis and to		
	-	however no second exercise of			ensure compliance.		
	_	d at the time of the survey.					
		at the time of observation, the			Administrator will be responsib	ole	
		or acknowledged the lack of			for POC implementation,		
		further stated that they were			completion and ongoing		
		documentation could be or if			compliance.		
	there was any documentation. He further stated						
		have happened at the facility					
	which could have been used as an exercise,						
	however they weren't able to say if the						
	documentation for i	t had been completed.					
	The finding was discussed with the Maintenance						
	Director and Execut	tive Director at exit conference.					
E 0041	, ,	(e), 485.542(e), 485.62					
SS=F Bldg	Hospital CAH and	LTC Emergency Power					
	Based on record rev	riew and interview, the facility	E 00	)41	This plan of correction is prepa	ared	11/15/2024
	failed to implement	the emergency power system			and executed because the		
	requirements found	in the Health Care Facilities			provisions of the state and fed	eral	
		nd Life Safety Code in			law require it and not because		
		CFR 483.73(e)(2). This			Hammond-Whiting Care Cente	er e	
	deficient practice co	ould affect all occupants.			agrees with the allegations and citations listed.	d	
	Findings include:				Hammond-Whiting Care Cente	er .	
	Based on record rev	riew with the Maintenance			maintains that the alleged deficiencies do not jeopardize	the	
		4 between 09:25 a.m. and 11:58			health and safety of the reside		
		acked monthly load and			nor is it of such character to lir		
		ting, along with a 36-month			our capabilities to render adeq		
	-	by LSC and NFPA 110. Based			care. Please accept this plan		
	•	time of record review, the			correction as our credible	٠.	
		or stated the generator was			allegation of compliance that the	he	
	missing some of the				alleged deficiencies have of w		
		1			correct by the date indicated to		
	The findings were re	eviewed with the Executive			remain in compliance with stat		

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

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
		155423	B. WING		10/16/2024	
	PROVIDER OR SUPPLIED		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
140		enance Director at the exit	140	and federal regulations, the fathas taken or will take the action set forth in this plan of correct. We respectfully request a destreview.  Generator monthly load testing and weekly exercise testing we have conducted par regulation.	cility ons ion. k	
				be conducted per regulation. Documentation of testing will is maintained.  Maintenance Director will audirecords 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.	or or	
K 0000 Bldg. 01	ALIC C.C. C.		W 0000			
	Licensure Survey v	Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0000			
	Survey Date: 10/16	5/2024				
	Facility Number: 0	00365				

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 $Q6M521 \qquad {\tt Facility \, ID:} \quad 000365$ 

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155423	B. WING		10/16/2024
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Provider Number: 1	55423			
	AIM Number: 1002	287460			
	compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one story facility Type V (111) constructions on the story facility of the series with hard wired smore resident rooms and has a capacity of 80 time of this survey.  All areas where resident rooms and the survey of the survey.	Care Center was found not in equirements for Participation in 42 CFR Subpart 483.70(a), re and the 2012 edition of the etion Association (NFPA) 101, eSC), Chapter 19, Existing ancies and 410 IAC 16.2.  The equirements for Participation in the corridors, in common areas. The facility and had a census of 70 at the edidents have customary access the facility has one detached			
K 0300 SS=F	NFPA 101				
SS=F Bldg. 01	Protection - Other				
Diag. 01	Based on record rev	view, interview, and	K 0300	This plan of correction is prepared	ared 11/15/2024
		ility failed to ensure		and executed because the	-1/10/2021
		he preventative maintenance		provisions of the state and fed	
	-	operated smoke alarms in		law require it and not because	
		complete. NFPA 101 in ing life safety features obvious		Hammond-Whiting Care Cent	
		required by the Code, shall be		agrees with the allegations an citations listed.	a
	-	72, 29.10 Maintenance and		Hammond-Whiting Care Cent	er
		equipment shall be maintained		maintains that the alleged	
	and tested in accord	lance with the manufacturer's		deficiencies do not jeopardize	
	published instructio	ons and per the requirements		health and safety of the reside	ents

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE A. BUILDING B. WING	construction 01	COMPL	(X3) DATE SURVEY COMPLETED 10/16/2024	
NAME OF F	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COD 114TH ST			
HAMMOI	ND-WHITING CARE	E CENTER		ΓING, IN 46394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	COMPLETION	
TAG		A 72, 14.2.1.1 Inspection,	TAG	nor is it of such character to	limit	DATE	
	•	nance programs shall satisfy		our capabilities to render ad			
		this Code and conform to the		care. Please accept this pla	-		
		turer's published instructions.		correction as our credible	11 01		
		ice could affect all residents,		allegation of compliance tha	t the		
	staff, and visitors.	,		alleged deficiencies have of			
	,			correct by the date indicated			
	Findings include:			remain in compliance with s			
				and federal regulations, the	facility		
	Based on record rev	riew with the Maintenance		has taken or will take the ac	tions		
	Director on 10/16/2	4 between 09:25 a.m. and 11:58		set forth in this plan of corre	ction.		
		ation for all battery-smoke		We respectfully request a de	∍sk		
		lity was located during the		review.			
		ur of the facility between 1:09					
		all resident rooms had one		The battery-smoke detector			
		ector and one battery smoke		the facility have been tested			
		king at manufacturer		have been placed on a sche			
		battery smoke detector, it		test every Monday. Mainter	iance		
		te detectors required weekly		Director/Designee with be			
	_	terview at the time of		responsible for weekly testir	ig and		
		ord review, the Maintenance		documentation of testing.			
		the missing documentation at the battery smoke		Tastina lana will be buswalat	4		
		osedly installed due to other		Testing logs will be brought monthly QAPI meeting for re			
		y have not done the testing		and analysis X 6 months to			
	for them.	y have not done the testing		ongoing compliance.	5113u16		
				ongoing compilation.			
	The finding was dis	cussed with Maintenance		Administrator will be respon	sible		
	Director and Execu	tive Director at exit conference.		to ensure POC implementat			
				completion and ongoing			
	3.1-19(b)			compliance.			
IX 0045	NEDA 404						
K 0345 SS=C	NFPA 101	. Tosting and					
Bldg. 01	Fire Alarm Systen Maintenance	i - resung and					
Diag. 01		on and interview, the facility	K 0345	This plan of correction is pre	nared	11/15/2024	
		of 1 fire alarm systems to	N 0343	and executed because the	pareu	11/13/2024	
		curate time and date		provisions of the state and f	ederal		
		rdance with the requirements		law require it and not becau			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  10/16/2024
	PROVIDER OR SUPPLIER ND-WHITING CARE CENTER	1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, 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 APPROPRIA 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 health and safety of the residenor is it of such character to limour capabilities to render adectore. Please accept this plan correction as our credible allegation of compliance that the alleged deficiencies have of word correct by the date indicated to remain in compliance with staff and federal regulations, the fact has taken or will take the actions set forth in this plan of corrections.  Fire alarm control panel has be reset to the correct date and time. Alarm Vendor will review regulation to include power outages and maintenance to the panel, to ensure ongoing compliance.  Maintenance Director will bring audits to QAPI meeting month 6 months for review and analy Administrator will be responsible for POC implementation, completion and ongoing compliance.	er d er the ents mit quate of he ill be colecility ens on. k een me. elarly, any

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Q6M521

Facility ID: 000365

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			(X3) DATE COMPL	LETED			
		155423	B. WI	NG		10/16	/2024
	PROVIDER OR SUPPLIER		•	1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353 SS=F Bldg. 01	Based on record reversities failed to maintain 2 accordance with LS automatic sprinkler and maintained in a Standard for the Instance of Was yetems. NFPA 25 indicates the require testing. NFPA 25, 5 pipe sprinkler system and gauges on dry sinspected weekly to pressure is being mastates valves should valves secured lock shall be permitted to deficient practice consistency. Findings include:  Based on record reversity Director on 10/16/2 a.m., there were no inspections for the word month of August 20 weekly inspections sprinkler system:  a) January 4th-10th b) June 26th-July18 c) July 22nd-Septem Based on interview the Maintenance Diinspections were no	th of 2024	K 0.	353	This plan of correction is prepared executed because the provisions of the state and fed law require it and not because Hammond-Whiting Care Centragrees with the allegations and citations listed.  Hammond-Whiting Care Centragrees with the alleged deficiencies do not jeopardize health and safety of the resident nor is it of such character to linguary capabilities to render adectorate. Please accept this plan correction as our credible allegation of compliance that the alleged deficiencies have of worrect by the date indicated to remain in compliance with state and federal regulations, the fathas taken or will take the actions set forth in this plan of correct we respectfully request a destreview.  Monthly Gauge & Valve inspections will be completed going forward for the wet spring system. Weekly inspections will be completed for the dry spring system.  Maintenance Director will be responsible to regularly audit to the state of the dry spring system.	leral eer d er the ents mit quate of the cillity ons ion. k	11/15/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVE		SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPL	COMPLETED	
		155423	B. WI	B. WING 10/16/2		/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	t			IATH ST			
HAMMON	ND-WHITING CARE	- CENTER			IG, IN 46394			
1 17 (IVIIVIOI	10-11111110 07111			**********				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	left inspections not	done.			inspections to ensure			
					compliance.			
	_	cussed with the Executive						
		enance Director at exit			Maintenance Director will bring	-		
	conference.				these inspection audits to mor	-		
	2.1.10/4)				QAPI meetings X 6 months for	Ĩ		
	3.1-19(b)				review and analysis.			
					Administrator will be reen eneith	ala.		
					Administrator will be responsible for POC implementation,	ле		
					completion and ongoing			
					compliance.			
					Compliance.			
K 0363	NFPA 101							
SS=E	Corridor - Doors							
Bldg. 01								
	Based on observation	on and interview, the facility	K 0	363	This plan of correction is prepa	ared	11/15/2024	
	failed to ensure 1 of	f 20 resident room doors to the			and executed because the			
	200-Hall would con	npletely resist the passage of			provisions of the state and fed	eral		
	smoke. Doors prote	cting corridor openings in			law require it and not because	!		
	other than required	enclosures of vertical			Hammond-Whiting Care Cente	er		
		nazardous areas resist the			agrees with the allegations an	d		
		nd are made of 1 3/4 inch			citations listed.			
		vood or other material capable			Hammond-Whiting Care Cente	er		
	_	at least 20 minutes. Doors in			maintains that the alleged			
		noke compartments are only			deficiencies do not jeopardize			
	•	e passage of smoke. Corridor			health and safety of the reside			
		rooms containing flammable or			nor is it of such character to lir			
		als have positive latching			our capabilities to render adec			
		tches are prohibited by CMS			care. Please accept this plan	of		
		equirements do not apply to			correction as our credible	l		
		t do not contain flammable or			allegation of compliance that t			
		al. Clearance between bottom			alleged deficiencies have of w			
		overing is not exceeding 1 inch.			correct by the date indicated to			
		aplying with 7.2.1.9 are ded with a device capable of			remain in compliance with state			
		-			and federal regulations, the far has taken or will take the action			
		osed when a force of 5 lbf is impediment for the closing of						
		on devices that release when			set forth in this plan of correcti			
		or pulled are permitted.			We respectfully request a desi	X		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		<u>01</u>	COMPL	
		155423	B. WING	B. WING		10/16/	2024
	ROVIDER OR SUPPLIER		1	1000 11	DDRESS, CITY, STATE, ZIP COD 4TH ST G, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	Т	CAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	I E	DATE
	Nonrated protective are permitted. Duted permitted. Door frame of steel or other manualess the smoke confirmed fire window and In sprinklered comprestrictions in area of flames in window and practice could affect as well as staff and and Findings include:  Based on observation p.m. and 2:12 p.m. the Maintenance Direction of the Maint	e plates of unlimited height h doors meeting 19.3.6.3.6 are mes shall be labeled and made terials in compliance with 8.3, ompartment is sprinklered. assemblies are allowed per 8.3. cartments there are no or fire resistance of glass or ssemblies. This deficient t approximately 20 residents,			Resident Room Door 217 will repaired or replaced.  Maintenance Director will audit doors randomly and regularly 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.	t for o	
	acknowledged the d stated he was unawa the door.	door penetration and further are that the penetration was in scussed with the Maintenance tive Director at exit conference.					
	(=)						
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						
	failed to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (r	view and interview, the facility re drills on each shift for 2 of 4 1.6 states drills shall be on each shift to familiarize nurses, interns, maintenance inistrative staff) with the	K 0712	2	This plan of correction is preparand executed because the provisions of the state and fed law require it and not because Hammond-Whiting Care Center agrees with the allegations and	eral er	11/15/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/16/2024
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	signals and emerger varied conditions. Tall staff and residen Findings include:  Based on record rev Director on 10/16/2 a.m., the following documentation of a a) A third shift fire a 2024.  b) A second and third quarter of 2024. Based on interview the Maintenance Dithere were missing that at one point in a director for mainten around the time of the signal of the	riew with the Maintenance 4 between 09:25 a.m. and 11:58	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD DEPICIENCY)  citations listed. Hammond-Whiting Care Cermaintains that the alleged deficiencies do not jeopardizhealth and safety of the residence of	e the dents imit equate in of the will be to ate acility ions stion. sk
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Insp	pection & Testing - Doors			

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF T	DOMDED OF GUIDN TER		<u> </u>	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIER ND-WHITING CARE			14TH ST NG, IN 46394	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
140	Based on observation failed to maintain a fire door in accordance requires any device condition, arrangement other feature is required provision of this Consystem, condition, a protection, or other maintained unless the	on and interview, the facility nnual testing of 1 of 1 rolling nce of NFPA 80. LSC 4.5.8 , equipment, system, nent, level of protection, or any nired for compliance with the ode, such device, equipment, narrangement, level of feature shall thereafter be the Code exempts such A 80 5.2.1 requires fire door inspected and tested not less a written record of the signed and kept for inspection efficient practice could affect all ning room.  on during a tour of the facility the Director on 10/16/24 and 2:02 p.m., there was one indows between the kitchen the tag on the rolling fire door mulal test was performed in ever the tag did not indicate assed or failed inspection. at the time of observation, the tor agreed that there was a lack and further stated that he would inspection company to obtain not know if there was any	K 0761	This plan of correction is prepared and executed because the provisions of the state and fed 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 health and safety of the resident nor is it of such character to limpur capabilities to render adectorate. Please accept this plan correction as our credible allegation of compliance that the alleged deficiencies have of we correct by the date indicated to remain in compliance with state and federal regulations, the fact has taken or will take the action set forth in this plan of correction we respectfully request a descreview.  Rolling fire door between kitch and dining room inspection reform 4/11/2-24 was located. Inspection passed. Inspection report is attached	ared 11/15/2024 leral ere derid er the ents mit quate of the cill be o te cility ons ion. k
	3.1-19(b)				

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  10/16/2024
	PROVIDER OR SUPPLIER		1000 1	CADDRESS, CITY, STATE, ZIP COD 114TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F	NFPA 101 Electrical Systems	s - Essential Electric Syste			
Bldg. 01	1. Based on record of facility failed to mate of monthly generated months and weekly Chapter 6.4.4.1.1.4(monthly testing of the emergency electrical with NFPA 110, the Standby Powers System and Standby Powers System and Standby Powers System and Standby Power Supply System appurtenant composition weekly and exercised at least or 30 minutes. Section Power Supply System appurtenant composition weekly and exercised NFPA 99 requires a performance, exercing generator to be regulated for inspection by the jurisdiction. This doccupants.  Findings include:  Based on record rever Director on 10/16/2 a.m., no documental months of March 20/2024 to show the generator at least or 30 minutes. Also, the	review and interview, the intain a complete written record or load testing for 4 of 12 inspection for 14 of 52 weeks.  (a) of 2012 NFPA 99 requires the generator serving the all system to be in accordance as Standard for Emergency and Stems, Chapter 8. NFPA 110 Il generator sets in service to be the monthly, for a minimum of 8.4.1 requires an Emergency tem (EPSS) including all ments, shall be inspected and monthly. Chapter 6.4.4.2 of a written record of inspection, using period, and repairs for the alarly maintained and available the authority having efficient practice could affect all rew with the Maintenance 4 between 09:25 a.m. and 11:58 tion was available for the 1024 and June 2024-August temerator set in service was the monthly, for a minimum of the generator weekly inspection towing weeks were missing spection: 0th 2024	K 0918	This plan of correction is prepared and executed because the provisions of the state and fed law require it and not because Hammond-Whiting Care Centragrees with the allegations and citations listed.  Hammond-Whiting Care Centragrees with the alleged deficiencies do not jeopardize health and safety of the reside nor is it of such character to limpur capabilities to render adectorare. Please accept this plan correction as our credible allegation of compliance that it alleged deficiencies have of worrect by the date indicated to remain in compliance with state and federal regulations, the factor has taken or will take the action set forth in this plan of corrections we respectfully request a desireview.  A 4 hour run test will be conducted for the emergency generator. The Maintenance Director will conduct the test a will document.  This 4 hour test result will be presented at QAPI meeting subsequent to the test for review and applying and app	eral er d er the ents mit quate of he ill be o te cility ons ion. k
	c) July 18th-Septem			and analysis.  Testing will be placed on sche	dule

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

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       01       COMPLETED         B. WING       10/16/2024		ETED		
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	the Maintenance Di	R LSC IDENTIFYING INFORMATION rector acknowledged the lack		TAG	to complete and document even	•	DATE
	had been previous i	nd further stated that there ssues with retaining			36 months under available loa		
	maintenance personnel and stated they were without a maintenance director during a part of those times.				Administrator will be responsible for POC implementation, completion and ongoing compliance.		
		viewed with the Maintenance tive Director during the exit			·		
	3.1-19(b)						
	facility failed to ma Standby System in Standard for Emerg Systems, Section 8. Health Care Facility NFPA 110 Section Emergency Power to once within every trassigned class is grapermitted to termin NFPA 99 Section 6. Type 2 essential elesshall be classified at generator sets. This affect all building of	review and interview, the intain 1 of 1 Emergency Power accordance with NFPA 110, gency and Standby Power 4.9, as required by NFPA 99 its Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least three years. Where the eater than 4 hours, it shall be attended the test after 4 hours. 4.1.1.6.1 states that Type 1 and extrical system power sources to Type 10, Class X, Level 1 is deficient practice could occupants.					
	Director on 10/16/2 a.m., documentatio emergency generate months was not pro- interview at the tim Maintenance Direct	ew with the Maintenance 44 between 09:25 a.m. and 11:58 on of a four hour run test for the per conducted within the last 36 evided for review. Based on the e of record review, the tor acknowledged the lack of further stated that he was					

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	NT OF DEFICIENCIES OF CORRECTION	TOWITING CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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)		(X3) DATE SURVEY  COMPLETED  10/16/2024	
	PROVIDER OR SUPPLIER		1000 1	14TH ST	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
IAU	unaware if the facil the generator docum This finding was re	ity had a 36-month exercise for nented.  viewed with the Executive	TAU		DATE
K 0920 SS=E Bldg. 01	Extens 1. Based on observation failed to ensure 3 of together were not unwiring. NFPA-70/2 specifically permitticables shall not be usefixed wiring. Articlichains, because the strip) is now acting wiring of a structural affect 2 staff and an residents.  Findings include:  Based on observation with the Maintenan Director on 10/16/2 p.m., in the Execution three power strips a were plugged into a power strips were a and computer equip	ent - Power Cords and ation and interview, the facility f 3 power cord daisy chained sed as a substitute for fixed 011, 400.8 state unless ed in 400.7 flexible cords and used for (1) as a substitute for e 400.8 (1) prohibits daisy first extension cord (or power as a substitute for the fixed e. This deficient practice could a unknown number of  on during a tour of the facility ce Director and Executive de between 1:09 p.m. and 2:02 ve Director's office contained and each of those power strips and powering each other. The lso used to power electronics oment. Based on interview at	K 0920	This plan of correction is prepared and executed because the provisions of the state and fed law require it and not because Hammond-Whiting Care Centeragrees with the allegations and citations listed.  Hammond-Whiting Care Centermaintains that the alleged deficiencies do not jeopardize health and safety of the reside nor is it of such character to limour capabilities to render adequate. Please accept this plan correction as our credible allegation of compliance that the alleged deficiencies have of with correct by the date indicated to remain in compliance with state and federal regulations, the fact has taken or will take the actionset forth in this plan of corrections.	eral er d er the ents mit juate of he ill be co de collity ens on.
	acknowledged the d	tion, the Maintenance Director daisy chained power strips and as unaware when the power into each other.		Power strip cords in the E. D.'s office have been unplugged from each other and are now prope	om

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  10/16/2024
	PROVIDER OR SUPPLIED		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	<del>-</del>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	scussed with the Maintenance ative Director at exit conference.		plugged in. The extension co	
	3.1-19(b)			removed.	
	failed to ensure 1 o	ation and interview, the facility f 3 flexible cords was installed n a safe manor. NFPA 99,		All staff will be educated regal inappropriate use of power con Maintenance Director will con this education for all staff.	ords.
	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.			Maintenance Director will con regular safety audits via safet committee to include extensio cords and daisy-chained powerstrips.	y on
				Appropriate disciplinary action be taken for employees engagin any non-compliance.	
	Findings include:			Audits will be presented at monthly QAPI meetings X 6 months for review and analys	is.
	Director on 10/16/2 p.m., the Executive power strips daisy of the three daisy of dangling at a high linterview at the tim Maintenance Direct power strip and fur going to go under recould have been compersonnel to get it of			Administrator will be responsi for POC implementation, completion and ongoing compliance.	
	_	eviewed with the Maintenance ative Director during the exit			
	3.1-19(b)				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155423	A. BUILDING B. WING	A. BUILDING <u>01</u> COMPLETED  B. WING 10/16/2024		
		100+20	<u> </u>		10/10/2024	
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
HAMMOND-WHITING CARE CENTER				ING, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	DEI TOLENCT I	DATE	
	3. Based on observa	ation and interview, the facility				
		f 1 flexible cords were not used				
	as a substitute for fi	xed wiring. NFPA-70/2011,				
		pecifically permitted in 400.7				
		ables shall not be used for (1)				
		xed wiring. This deficient				
	practice could affect	t 20 residents and staff.				
	Findings include:					
	Based on observation	on 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					
		thin the 100-Hall, across from				
	the nurses desk, contained an extension cord used to power a phone charger and a power strip.					
		at the time of observation, the				
		or acknowledged that there				
		ord used for permanent use.				
	The finding was rev	viewed with the Maintenance				
	Director and the Ex	ecutive Director during the exit				
	conference.					
	3.1-19(b)					
K 0927	NFPA 101					
SS=E Bldg. 01		Transfilling Cylinders				
-		ation and interview, the facility	K 0927	This plan of correction is prep	ared 11/15/2024	
		f 1 oxygen storage/transfer		and executed because the		
		separation in accordance with		provisions of the state and fed		
		9, Health Care Facilities Code,		law require it and not because		
		on 11.5.2.3.1(1) states, ecur in) A designated area		Hammond-Whiting Care Cent		
		portion of a facility wherein		agrees with the allegations ar citations listed.	lu	
	-	examined, or treated by a fire		Hammond-Whiting Care Cent	er	
	-	e-resistive construction. This		maintains that the alleged		
	deficient practice co	ould affect approximately 12		deficiencies do not jeopardize	the	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155423	B. W			10/16/	
							-
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
			1000 114TH ST				
HAMMOND-WHITING CARE CENTER				WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	residents and staff.				health and safety of the reside	nts	
					nor is it of such character to lir	nit	
	Findings include:				our capabilities to render adec	er adequate	
	Based on observation with the Maintenance				care. Please accept this plan	of	
					correction as our credible		
	Director on 10/16/24 between 09:25 a.m. and 11:58				allegation of compliance that t	he	
	a.m., while sitting in the front office area adjacent				alleged deficiencies have of w		
		a loud audible noise was heard			correct by the date indicated to		
	_	he front waiting area. The			remain in compliance with stat		
	Maintenance Direct	tor and the surveyor both went			and federal regulations, the fa	cility	
	to investigate and d	liscovered an employee had			has taken or will take the actio	ns	
	entered the oxygen	transfilling/storage room to			set forth in this plan of correcti	on.	
	transfill a portable oxygen machine. When the				We respectfully request a desi	k	
	staff member was transfilling, they had pulled out				review.		
	the liquid oxygen container out of the room						
	half-way exposing it to the corridor and started to				Oxygen storage area has been	n	
	transfill with the door also propped open. Based				reorganized to safely		
	on interview at the time of observation, the				accommodate tanks, equipme	nt	
		tor acknowledged that the staff			and personnel to stand and		
	member was transfilling with the door propped				perform transfilling as needed.		
	open.						
					All nursing staff will be educate	ed	
		scussed with the Maintenance			on proper storage and filling		
	Director and Execu	tive Director at exit conference.			techniques for O2 to include		
					keeping door closed while		
	3.1-19(b)				transfilling O2. Education will	be	
					documented and will include		
		ation and interview, the facility			demonstration of staff knowled	dge.	
		nsfilling of oxygen took place					
		ansfilling rooms that are			O2 transfilling will be reviewed		
	-	portion of a facility, NFPA 99			during monthly safety meeting	to	
		.3.1, Transfilling to liquid			include a random staff		
		oir containers or to liquid			demonstration for safety		
	, , ,	ntainers over 344.74 kPa (50			committee to audit. Results of		
	psi) shall include th	_			audit will be presented at mon	-	
		ea separated from any portion			QAPI X 6 months for review a	nd	
	_	n patients are housed,			analysis.		
		d by a fire barrier of 1 hour					
	fire-resistive constr				Administrator will be responsit	ole	
	(2) The area is mechanically ventilated, is				for POC implementation,		

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

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  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.	X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  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.	COMPLETED	
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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)	DATE	

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