PRINTED: 12/28/2023

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155423	A. BU B. WI	ILDING NG	00	COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER			1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG IN 46394		
	ı		WHITING, 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)	ATE	(X5) COMPLETION DATE
F 0000							
Bldg. 00		Recertification and State	F 00	00	December, 14, 2023		
		This visit included the mplaints IN00417083 and			Brenda Buroker, Director of Long-Term Care Indiana State Department of		
	related to the allega	7083 - Federal/state deficiencies ations are cited at F677.			Public Health 2 North Meridian St. Indianapolis, IN 46204		
	Complaint IN00417 the allegations are of	7627 - No deficiencies related to cited.			Dear Ms. Buroker,		
	Survey dates: Nove December 1, 2023	ember 27, 28, 29, 30, and			Please reference the enclosed CMS 2567 as "Plan of Correct for the December 01, 2023		
	Facility number: 0 Provider number: 1 AIM number: 1002	155423			Recertification and State Licensure with Complaint (IN004172627, IN00417083) Survey that was conducted at		
	Census Bed Type: SNF/NF: 69				Hammond Whiting Care Cent	er.	
	Total: 69 Census Payor Type Medicare: 7 Medicaid: 51 Other: 11 Total: 69	:			Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth fact alleged or conclusion set forth the statement of deficiencies. This plan of correction is prep	ot ment ots in	
					and/or executed solely because		

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

These deficiencies reflect State Findings cited in

accordance with 410 IAC 16.2-3.1. v

Quality review completed on 12/6/23.

is required by the provision of the

dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our

Federal and State Laws. This facility appreciated the time and

TITLE

community.

(X6) DATE

Mark Thompson **Executive Director** 12/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	F OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVEI OMB NO. 0938-039	
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIEF		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	N
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must it resident; consult we physician; and no her authority, the when there is- (A) An accident in results in injury ar requiring physicia (B) A significant of physical, mental,	Injury/Decline/Room, etc.) otification of Changes. mmediately inform the with the resident's tify, consistent with his or resident representative(s) volving the resident which and has the potential for		The Plan of Correction submit on December 14, 2023 serves our allegation of compliance. We are requesting a desk revi of this Plan of Correction. Should you have any question concerns regarding the Plan of Correction, please contact me Respectfully, Mark Thompson, HFA Executive Director	ew or f	

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psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST WHITING, IN 46394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	of treatment); or (D) A decision to the resident from the fine \$483.15(c)(1)(ii). (ii) When making the ground of the fine \$483.15(c)(2) is the ground of the ground of the fine \$483.15(c)(2) is the ground of the ground	ast also promptly notify the esident representative, if som or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Instructory and periodically ess (mailing and email) and					
	facility that is a co defined in §483.5) admission agreem configuration, inclu that comprise the and must specify the	uding the various locations composite distinct part, the policies that apply to ween its different locations					
	Based on record rev failed to promptly n medication changes	view and interview, the facility notify the resident's family of for 2 of 2 residents reviewed hange. (Residents 23 and B)	F 0580	This plan of correction is preparand executed because the provisions of state and federal require it and not because Hammond-Whiting Care Centeragrees with the allegations and citations listed. Hammond-Wh	law er d		

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Event ID:

 $XXWZ11 \quad \text{Facility ID:} \quad 000365$

If continuation sheet

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12/28/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. During a phone interview with Resident 23's Care Center maintains that the responsible party on 11/27/23 at 1:18 p.m., she alleged deficiencies do not indicated she was not always made aware of her jeopardize the health and safety of brother's medication changes. the residents nor is it of such character to limit our capabilities The record for Resident 23 was reviewed on to render adequate care. Please 11/29/23 at 9:59 a.m. The resident was admitted to accept this plan of correction as the facility on 9/5/23. Diagnoses included, but our credible allegation of were not limited to, lung, liver and bladder cancer, compliance that the alleged epilepsy, high blood pressure, and major deficiencies have or will be correct depressive disorder. by the date indicated to remain in compliance with state and federal The Admission Minimum Data Set (MDS) regulations, the facility has taken assessment, dated 9/11/23, indicated the resident or will take the actions set forth in was not cognitively intact and needed extensive this plan of correction. We assistance with 1 person physical assist for bed respectfully request a desk review. mobility and transfers. In the last 7 days, the resident received an anti-anxiety medication 6 **F 580-** Notify of Changes times. What Corrective Action will be accomplished for those A Nurses' Note, dated 11/10/23 at 1:25 a.m., residents found to have been indicated the resident was observed having a affected by this deficient seizure that lasted 3 minutes. The Hospice Nurse practice: was notified and indicated someone would be out Resident number 23 to assess the resident. and resident B had no negative outcomes. The resident's A Nurses' Note, dated 11/10/23 at 10:01 a.m., responsible party have been indicated the Hospice Nurse arrived to the facility notified of medication for the follow up regarding the seizure. She had changes. new Physician's Orders for the resident to start on How other residents having the Keppra 1000 milligrams (mg) and Lamotrigine 200 potential to be affected by the mg daily (both were medications to treat seizures). same deficient practice will be identified and what corrective A Nurses' Note, dated 11/15/23 at 12:26 p.m., action will be taken: indicated the Hospice Nurse was in the facility All residents who and had a new a order for Lorazepam (an have a medication change have

anti-anxiety medication) 1 milliliter (ml) at bed time.

Physician's Orders, dated 11/10/23, indicated

Lamotrigine oral tablet 200 mg, give 1 tablet by

the potential to be affected.

responsible parties of residents

who have had a recent medication

The physician and

If continuation sheet

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155423	B. WING		12/01/2023
					ı
NAME OF F	PROVIDER OR SUPPLIER	Ł		ET ADDRESS, CITY, STATE, ZIP COD	
) 114TH ST	
HAMMOI	ND-WHITING CARE	E CENTER	WHI	TING, 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 APPROPRI DEFICIENCY)	DATE DATE
IAG		day and Keppra oral tablet 1000	IAG	shange have been notified	DATE
				change have been notified.	
	mg, give I tablet by	mouth two times a day.			
	P1 1 1 0 1	1 . 111/15/00 : 1: 1		What measures and what	_
	1 -	dated 11/15/23, indicated		systemic changes will be m	ade
		oral concentrate 2 mg/ml, give		to ensure that the deficient	
		edtime for agitation and		practice doesn't recur:	
	_	oral concentrate 2 mg/ml, give		1 DON/designee w	vill
	0.5 ml by mouth thr	ree times a day for anxiety.		provide education to licensed	
				nursing staff on the notification	on
	There was no docur	mentation the resident's		process to the responsible pa	arty
	responsible party w	as notified of the new		and physician when a resider	nt has
	medication orders.			a medication change. Educat	• • • • • • • • • • • • • • • • • • •
				will be completed by date of	
	Interview with the N	Nurse Consultant on 11/30/23		compliance.	
		ated the resident's family		2 All new licensed	
		re been notified of the change		nursing staff will receive this	
		y had thought hospice was		education prior to working.	
		y, however, they had no			.:11
		rove they were informing the		How the corrective action w	''''
	_	rove they were informing the		be monitored to ensure the	
	family.			deficient practice will not re	
	2.5	'4 P '1 (P)		i.e., what quality assurance	
	_	ew with Resident B's spouse		program will be put in place	
		a.m., they indicated the facility		1 DON/designee v	
	was not always call	•		review 24/72 hour report 5 tin	nes a
	medications were or	rdered.		week x's 6 months to ensure	
				responsible party notification	has
		dent B was reviewed on		been made for residents iden	tified
	_	n. Diagnoses included, but were		to have medication change.	
		bolic encephalopathy, protein		2 Results will be	
	calorie malnutrition	, stroke, Atrial Fibrillation (A		presented to QAPI x 6 month	s
	Fib - irregular heart	rhythm), pacemaker, anemia,		and QAPI will determine the i	need
	high blood pressure	, and alcohol dependence.		for further audits.	
		-		3 The results of the	ese
	The 10/23/23 Media	care 5 day Minimum Data Set		reviews will be discussed at t	
		indicated the resident was not		monthly facility Quality Assur	
	1 1	The resident received an		Committee meeting monthly	
		ntiplatelet medication.		total of 3 months and then	
	and and and an	implatore medication.		quarterly thereafter once	
	A Nursas! Note dat	red 10/19/23 at 10:29 a.m.,		_ ·	
	A muises more, dar	cu 10/17/23 dt 10.27 d.III.,	1	compliance is at 100%.	

indicated the resident's spouse gave verbal

Frequency and duration of reviews

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155423	B. WING		12/01/2023
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY 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
	consent for the reside antipsychotic medic bedtime. The reside the use of the medic notified if there were the use of the medic A Nurses' Note, dat indicated a Pharmac received and the Phrecommendation to Reduction) the Que 12.5 mg at bed time. Physician's Orders, Quetiapine 25 mg g bedtime. There was no docur spouse had been no	dent to have Quetiapine (an eation) 25 milligrams (mg) at ent's spouse was made aware of eation and wanted to be re any adverse reactions from eation. Led 11/8/23 at 12:52 p.m., ety recommendation was expected the GDR (Gradual Dose estiapine 25 mg at bed time to eation. Led 11/8/23, indicated give 0.5 tablet by mouth at ementation the resident's tified of the reduction.		will be increased as needed, it compliance is below 100%. Compliance date: 12/29/23. To Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction.	ne e
	at 3:15 p.m., indica	Nurse Consultant on 11/30/23 ted the resident's family should of the medication change.			
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation interview, the faciliaresidents received a daily living (ADL's	ed for Dependent Residents esident who is unable to sof daily living receives the est to maintain good g, and personal and oral on, record review, and ty failed to ensure dependent essistance with activities of) related to shaving and esidents reviewed for ADL's.	F 0677	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Center	law

(Residents B and C)

agrees with the allegations and

CTATEMEN	T OF DEFICIENCIES	NATURE OF THE PROPERTY OF THE	(2/2) 1/	III TIDI E CO	NCTRICTION	OVA) DATE	CLIDATEN
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155423	B. W	ING		12/01/	/2023
NAME OF F	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SOLLEE	•			14TH ST		
IOMMAH	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
					citations listed. Hammond-Wh	iting	
	Findings include:				Care Center maintains that the	Э	
				alleged deficiencies do not			
	 During an interv 	riew with Resident B's spouse			jeopardize the health and safe	ty of	
	on 11/28/23 at 9:38	a.m., they indicated they did			the residents nor is it of such		
	not think the reside	nt was receiving a shower at			character to limit our capabiliti	es	
	least 2 times a weel	ζ.			to render adequate care. Plea	se	
					accept this plan of correction a	as	
	The record for Resi	dent B was reviewed on			our credible allegation of		
	11/28/23 at 1:25 p.i	n. Diagnoses included, but were			compliance that the alleged		
	not limited to, meta	bolic encephalopathy, protein			deficiencies have or will be co	rrect	
calorie malnutrition, stroke, Atrial Fibrillation (A				by the date indicated to remai	n in		
	Fib - irregular heart rhythm), pacemaker, anemia,				compliance with state and fed		
	high blood pressure, and alcohol dependence.				regulations, the facility has tak		
					or will take the actions set fort		
	The 10/23/23 Medi	care 5 day Minimum Data Set			this plan of correction. We		
		indicated the resident was not			respectfully request a desk rev	view.	
	cognitively intact.	The resident needed some help			F 677- ADL Care Provided for		
	and partial assistance	ce from another person to			Dependent Residents	-	
	complete bathing, d	lressing, using the toilet, and			What Corrective Action will I	be	
	walking.				accomplished for those		
					residents found to have been	n	
	The Care Plan, revi	sed on 9/22/23, indicated the			affected by this deficient		
	resident had an AD	L self-care performance deficit.			practice:		
					1 Resident B was		
	The resident receive	ed a shower or bed bath 2			offered/given a shower		
	times a week from	9/21/23 to 11/26/23 except for			immediately. No negative	ļ	
	the weeks of 10/22,	10/29, and 11/5/23, where only			outcomes noted.	ļ	
	1 shower was docum	mented as being given.			2 Resident C was		
					shaven. No negative outcome	s	
	Interview with the	Nurse Consultant on 12/1/23 at			noted.		
	9:15 a.m., indicated	the resident was to receive at			How other residents having	the	
	least 2 showers a w	eek.			potential to be affected by th	ie	
					same deficient practice will l	be	
	2. On 11/27/23 at 1	1:25 a.m., on 11/28/23 at 9:45			identified and what corrective	'e	
	a.m., 1:21 p.m., and	l 2:50 p.m., Resident C was			action will be taken:	ļ	
		white facial hair on their			1 An in house audit	,	
	cheeks, chin and ne	ck area.			will be completed by nursing	ļ	
					management on residents for	the	
	The record for Resi	dent C was reviewed on			POC charting and completion	of	

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039				B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. WI	NG		12/01/	/2023
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP COD 1000 114TH ST			
		CENTER		l			
ПАММО	ND-WHITING CARE	ECENTER		VVIIIIN	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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	11/29/23 at 11:56 a	.m. The resident was admitted to			shower sheets to assure		
	the facility on 5/10/	23. Diagnoses included, but			completed per policy. Any issu	ies	
	were not limited to,	fracture of left femur, dementia			will be identified and follow up	will	
	without behaviors, Parkinson's disease, cellulitis				be completed.		
	of the right lower li	mb, dermatitis, history of			What measures and what		
	falling, difficulty w	alking, and high blood			systemic changes will be ma	ide	
	pressure.				to ensure that the deficient		
					practice doesn't recur:		
	The 9/30/23 Quarte	rly Minimum Data Set (MDS)			1 Education to the		
	assessment indicated the resident was not				aides, licensed nurses, and SS	SD	
	cognitively intact and needed extensive assist				for completion of POC/PCC		
	with 2 person physical assist for bed mobility and				documentation related to shav	ring	
		ent needed extensive assist			and refusal of shower/bed bath	•	
	with 1 person physi	cal assist for personal			Shower sheet to be completed	i	
	hygiene.	•			and turned into nurse each shi		
	1 75				MD and POA and/or family to		
	The Care Plan, revi	sed on 11/25/23, indicated the			notified of refusal. Nursing to r		
		L self-care performance deficit			SSD of refusal(s). SSD to ensu	•	
	related to dementia.	-			care plan is updated to reflect		
					refusal(s). This will be complet		
	There was no Care	Plan indicating the resident			by DON/Designee by date of		
	refused care.	C			compliance.		
					2 Any new nursing		
	The resident's show	ver schedule was on			staff will receive this education	1	
	Wednesdays and Sa	aturdays.			during orientation as well.		
		•					
	The resident receive	ed a bed bath on 11/28/23 and			How the corrective action will	II .	
	the removal of facia	al hair was blank.			be monitored to ensure the		
					deficient practice will not red	cur,	
	Interview with the I	Director of Nursing on 11/30/23			i.e., what quality assurance	ŕ	
		ated she had no additional			program will be put in place:		
		ng the resident being			1 DON/Designee w		
	unshaven.	-			review shower sheets daily 5		
					times weekly to assure		
	This citation relates	to Complaint IN00417083.			compliance. Any refusals that	are	
		•			ongoing need to be reported to		
	3.1-38(a)(2)(A)				SSD and SSD will discuss with		
	3.1-38(a)(3)(D)				resident/POA/family. Audits wi		

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be presented to QAPI x 6 months and QAPI will determine the need

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/01/2023
	PROVIDER 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
				for further audits. 2 The results of the reviews will be discussed at the monthly facility Quality Assurated Committee meeting monthly footal of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, it compliance is below 100%. Compliance date: 12/29/23. The Administrator at the Hammond-Whiting Care Cental responsible in ensuring compliance in this Plan of Correction.	ne ance or a views f
F 0684 SS=E Bldg. 00	applies to all treat facility residents. I comprehensive as facility must ensur treatment and car professional stand comprehensive peand the residents'	a fundamental principle that ment and care provided to Based on the seessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan, choices.	F 0.004	This plan of compating is proper	12/20/2022
	interview, the facili bruising, scratches, were assessed and r reviewed for skin of The facility also fai checks were comple	on, record review, and ty failed to ensure areas of sutures, and glued lacerations nonitored for 3 of 4 residents onditions non-pressure related. led to ensure neurological eted as well as fall follow-up 2 of 3 residents reviewed for 19, 23, B, and C)	F 0684	This plan of correction is prep and executed because the provisions of state and federal require it and not because Hammond-Whiting Care Cent agrees with the allegations ar citations listed. Hammond-Wh Care Center maintains that the alleged deficiencies do not jeopardize the health and safe	I law eer nd niting e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155423	B. WI	NG	12/01/2023		
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			14TH ST		
НАММО	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				the residents nor is it of such		
	1 0 11/07/02	10.53 P. 11.43			character to limit our capabiliti		
		1. On 11/27/23 at 10:53 a.m., Resident 2 was			to render adequate care. Plea		
	observed with scattered areas of reddish/purple discoloration to her bilateral forearms.				accept this plan of correction	as	
	discoloration to her	r bilateral forearms.			our credible allegation of		
	Om 11/29/22 -4-10	15 a m the coeffee 1 £			compliance that the alleged		
		45 a.m., the scattered areas of ined to the resident's bilateral			deficiencies have or will be co		
	forearms.	ined to the resident's bilateral			by the date indicated to remai		
	lorearms.				compliance with state and fed		
	On 11/20/22 at 0.2	9 a.m. the regident was			regulations, the facility has take or will take the actions set fort		
	On 11/29/23 at 9:38 a.m., the resident was observed in her room in bed. A new area of dark					.11 111	
	purple bruising was observed on the top of the				this plan of correction. We respectfully request a desk re	viow	
	resident's left hand and wrist area.				l respectibily request a desk re	view.	
	resident s left hand	and wrist area.			F 684- Quality of Care		
	The record for Res	ident 2 was reviewed on			What Corrective Action will	be	
		a.m. Diagnoses included, but			accomplished for those		
		, Alzheimer's late onset,			residents found to have bee	n	
		ation, Atrial Fibrillation (A Fib -			affected by this deficient		
	irregular heart rhyt				practice:		
	hemiplegia/hemipa				1 Resident # 2 had		
	weakness/paralysis) following a stroke.			skin assessment completed a	nd	
		-			orders obtained immediately a		
	The Significant Ch	ange Minimum Data Set (MDS)			put in place to monitor bruisin		
	assessment, dated	10/31/23, indicated the resident			until resolved. Family was not	-	
	was cognitively im	paired for daily decision			No negative outcomes noted.		
	_	ent had received an antiplatelet			2 Resident # 19 ha	d	
	_	the last 7 days of the			skin assessment completed a	nd	
	assessment referen	ce period.			orders obtained immediately a	and	
					put in place to monitor bruising	-	
	· · · · · ·	S assessment, dated 9/30/23,			until resolved. Family was not		
		ent required extensive assist			No negative outcomes noted.		
		and she was totally dependent			3 Resident #23 had	d no	
	on staff for transfer	rs.			negative outcomes noted.		
					4 Resident B had n	10	
		3/9/21 and revised on 10/26/23,			negative outcomes noted.		
	indicated the reside				5 Resident C had s		
		ated to long term use of Aspirin			assessment completed and tx		
	and Plavix (an anti	platelet medication).			orders obtained and put in pla	ice.	
	1		- 1		Resident C had no negative		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED
		155423	B. WI	NG		12/01/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			14TH ST	
НАММО	ND-WHITING CAR	E CENTER			IG, IN 46394	
TIAWWO	TO-WITHING CAR			VVIIIII		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	,	, dated 9/5/23, indicated to			outcomes noted.	
		the bilateral forearms every			How other residents having	
		nd monitor for signs and			potential to be affected by t	
		ling including black tarry			same deficient practice will	
		ms, bruising, and nose bleed			identified and what correcti	ve
	_	ulant use every shift.			action will be taken:	
		gns and symptoms were			1 In house audit	
	present and "-" if n	ot present.			completed with head to toe sl	
					assessments to assure any s	kin
		23 Physician's Order Summary			issues are identified and	
		ne resident received Aspirin 81			addressed by nursing	
	milligrams (mg) daily and Plavix 75 mg daily.				management by date of	
					compliance. Any new orders	
		ntegrity form, dated 11/28/23,			received will be put on TX and	
	indicated no areas	of bruising were identified.			med sheet, care plan and kar	
					updated. Any issues identified	d will
		mentation related to the new			be addressed.	
	areas of discolorati	on on 11/29/23.			What measures and what	
					systemic changes will be m	ade
		cation Administration Record			to ensure that the deficient	
		there were no anticoagulant			practice doesn't recur:	
	_	t for all 3 shifts 11/20 through			1 Education will be	•
	11/28/23.				completed to licensed and	
					certified nursing staff to assur	
		Nurse Consultant on 11/30/23			any skin issue or abnormal fir	_
	_	ated the areas of bruising should			needs reported and documen	ited in
		l and monitored. She also			the clinical record, MD and	
		toe skin assessment would be			Responsible party need notifi	
	completed for the r	resident.			and care plan and Kardex to	
	0 0 11/0=/00	10.00			updated to reflect new orders	
		12:03 p.m., Resident 19 was			and/or include any new	
		ding purple bruise to her left			interventions by Nursing	
	forearm.				management by date of	
	0 11/20/22 : 12	20 4 31 4			compliance. New licensed or	,,,
		30 a.m., the resident was			certified nursing employees w	
		ding purple bruise to her right			receive this education prior to	
	forearm.				working.	
					How the corrective action w	rill
		ident 19 was reviewed on			be monitored to ensure the	
	11/28/23 at 2:50 p.	 m. Diagnoses included, but 			deficient practice will not re	cur,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155423	B. WIN	NG		12/01/	/2023
			<u> </u>		_		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	\TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	were not limited to	, Atrial Fibrillation (A Fib -			i.e., what quality assurance		
	irregular heart rhyt	hm), gastrostomy (an opening			program will be put in place	:	
		into the stomach from the abdominal wall for the			1 DON/Designee w		
	introduction of foo	d), anemia, and dementia			review 24/72 hour report 5 tim		
	without behavior d	without behavior disturbance.			weekly to ensure treatment or		
					are obtained and in place for a		
	The Significant Change Minimum Data Set (MDS)				skin issues and care plan is	,	
	_	assessment, dated 9/7/23, indicated the resident			updated x 6 months. Audits w	ill be	
	was cognitively im	paired for daily decision making			presented to QAPI x 6 months		
		stensive assist with bed			and QAPI will determine need		
	_	also totally dependent for			further audits. Competencies		
	-	dent had received an			be completed by date of		
	anticoagulant (bloc	od thinner) 7 times during the			compliance on aides and nurs	es	
	assessment reference period.				for the appropriate protocol fo		
					assessments and accurate fol		
	A Care Plan, dated	9/8/23, indicated the resident			through and documentation by	y	
	had an occlusive D	VT (deep vein thrombosis -			Nursing Management.	<u> </u>	
	blood clot) in the le	eft axilla (armpit) area.			2 The results of the	ese	
	Interventions inclu	ded, but were not limited to,			reviews will be discussed at th	ne	
	observe and report	as needed (PRN) any signs			monthly facility Quality Assura	ance	
	and symptoms of I	OVT complications: pulmonary			Committee meeting monthly for	or a	
	embolism (sudden	onset of chest pain and			total of 3 months and then		
	difficulty breathing	g (dyspnea)), restlessness,			quarterly thereafter once		
	anxiety, cough, pal	pitations, nausea, vomiting,			compliance is at 100%.		
	syncope (fainting),	and abnormal bleeding and			Frequency and duration of rev	/iews	
	bruising related to	anticogulant use.			will be increased as needed, i	f	
					compliance is below 100%.		
	The November 202	23 Physician's Order Summary			Compliance date: 12/29/23. T	he	
		e resident received Aspirin 81			Administrator at		
	milligrams (mg) da	ily and Eliquis (an			Hammond-Whiting Care Cent	er is	
	anticoagulant) 2.5	mg twice a day. Monitor for			responsible in ensuring		
	signs and symptom	s of bleeding including black			compliance in this Plan of		
	-	ng gums, bruising, and nose			Correction.		
		icoagulant use every shift.					
		gns and symptoms were					
	present and "-" if n	ot present.					
		23 Medication Administration					
		icated no anticoagulant side					
	effects were presen	t for all 3 shifts 11/20 through					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155423	B. WI	NG		12/01	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			4TH ST		
HAMMOI	ND-WHITING CARE	E CENTER		WHITIN	G, IN 46394		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
	11/28/23.						
	The Weekly Skin Ir	ntegrity form, dated 11/23/23,					
		nt's skin was intact. There					
		ion related to the bruising on					
	the forearms.	E					
		Nurse Consultant on 11/30/23					
	· -	ted the resident's bruises					
		ssessed and monitored. 3. On					
		.m., Resident 23 was observed					
	_	f his bed with a bandaid on					
	his forehead.						
	The manand for Desi	dent 23 was reviewed on					
		n. The resident was admitted to					
		3. Diagnoses included, but					
	I -	lung, liver and bladder cancer,					
		d pressure, and major					
	depressive disorder.	-					
	1						
	The Admission Mir	nimum Data Set (MDS)					
	· ·	/11/23, indicated the resident					
		intact and needed extensive					
	_	erson physical assist for bed					
	I -	ers. In the last 7 days the					
		anti-anxiety medication 6					
		ssant medication 2 times, and					
	_	on 6 times. The resident had no					
		cility and 2 or more prior to					
	admission.						
	The Care Plan revi	sed on 11/20/23, indicated the					
	resident was at risk						
	- STACIL WAS ALTISK						
	A Nurses' Note, dat	ed 9/22/23 at 11:00 a.m.,					
		tive Director informed the					
	nurse the resident w	vas laying on the floor in the					
		ay. The resident was assessed					
	and no new injuries	were noted.					

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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DA'	(X3) DATE SURVEY COMPLETED 12/01/2023		
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION There was no fall follow up assessment or documentation after the fall. A Neurological Observation was initiated on 9/22/23 at 1:48 p.m., but not completed. A Nurses' Note, dated 10/31/23 at 2:57 p.m., indicated the resident was found on the floor in the hallway. They were assessed and had no apparent injuries. There was no fall follow up assessment or documentation after the fall. Nurses' Notes, dated 11/19/23 at 2:25 p.m., indicated the resident was found on the floor in front of the nurses' station. A skin tear was observed to the forehead. A Neurological Observation was initiated on 11/19/23 but not completed to its entirety. There was no fall follow up assessment or documentation after the fall. A Neurological Observation was initiated on 11/19/23 but not completed to its entirety. There was no fall follow up assessment or documentation after the fall. A Nurses' Note, dated 11/25/23 at 3:55 a.m., indicated the resident was found on the floor by the bed and there was blood noted from the eye brow. The resident was sent to the emergency room for treatment. A Nurses' Note, dated 11/25/23 at 11:39 a.m.,				1000 1	14TH ST	COD			
documentation after the fall. A Neurological Observation was initiated on 9/22/23 at 1:48 p.m., but not completed. A Nurses' Note, dated 10/31/23 at 2:57 p.m., indicated the resident was observed on the floor in the hallway. They were assessed and had no apparent injuries. There was no fall follow up assessment or documentation after the fall. Nurses' Notes, dated 11/19/23 at 2:25 p.m., indicated the resident was found on the floor in front of the nurses' station. A skin tear was observed to the forehead. A Neurological Observation was initiated on 11/19/23 but not completed to its entirety. There was no fall follow up assessment or documentation after the fall. A Nurses' Note, dated 11/25/23 at 3:55 a.m., indicated the resident was found on the floor by the bed and there was blood noted from the eye brow. The resident was sent to the emergency room for treatment. A Nurses' Note, dated 11/25/23 at 11:39 a.m.,	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETION		
hospital. The hospital nurse informed the facility the resident received 4 sutures to the forehead and they should be removed in 10 days. A Neurological Observation was initiated on		There was no fall for documentation after A Neurological Obs 9/22/23 at 1:48 p.m. A Nurses' Note, dat indicated the reside in the hallway. The apparent injuries. There was no fall for documentation after Nurses' Notes, date indicated the reside front of the nurses' observed to the force A Neurological Obs 11/19/23 but not coomount to the treatment of the bed and there we brow. The resident room for treatment. A Nurses' Note, date indicated the resident room for treatment. A Nurses' Note, date indicated the resident room for treatment.	bollow up assessment or rethe fall. servation was initiated on, but not completed. sed 10/31/23 at 2:57 p.m., nt was observed on the floor by were assessed and had no sollow up assessment or rethe fall. d 11/19/23 at 2:25 p.m., nt was found on the floor in station. A skin tear was schead. servation was initiated on empleted to its entirety. bollow up assessment or rethe fall. sed 11/25/23 at 3:55 a.m., nt was found on the floor by has blood noted from the eye was sent to the emergency sed 11/25/23 at 11:39 a.m., nt would be returning from the tal nurse informed the facility d 4 sutures to the forehead removed in 10 days.						

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11/25/23 at 5:06 a.m., however, it was incomplete.

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 $XXWZ11 \quad \text{Facility ID:} \quad 000365$

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUI		INSTRUCTION 00	(X3) DATE COMPI	
		155423	B. WIN			12/01	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
HAMMOI	ND-WHITING CAR	E CENTER			IG, IN 46394		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	REFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
TAG	There was no fall f sutures after the reshospital. Interview with the at 11:50 a.m., indicated the documented ever was no documentar resident's injury and back with from the 4. The record for I 11/28/23 at 1:25 p. not limited to, meticalorie malnutrition Fib - irregular hear high blood pressure. The 10/23/23 Med (MDS) assessment cognitively intact, and partial assistant complete bathing, walking. The resid and antiplatelet med. A Nurses' Note, daindicated the reside	R LSC IDENTIFYING INFORMATION follow up or assessment of the sident returned from the Nurse Consultant on 11/30/23 cated follow up after a fall should ery shift for 72 hours. There tion or assessments of the d the 4 sutures when he came hospital on 11/25/26. Resident B was reviewed on m. Diagnoses included, but were abolic encephalopathy, protein n., stroke, Atrial Fibrillation (A trhythm), pacemaker, anemia, e, and alcohol dependence. icare 5 day Minimum Data Set indicated the resident was not The resident needed some help ace from another person to dressing, using the toilet, and ent received an antipsychotic				AIE	DATE
	The Physician and	responsible party were made were received to obtain an					
	· ·	side of the abdomen. At 10:09					
	a.m., the resident s	tarted yelling for help and					
		re pain to the right abdomen. made aware and orders were					
	-	e resident to the hospital.					
		dmitted to the hospital with (inflamed gallbladder).					

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155423	B. WI	NG		12/01/	/2023
				CED DET.	A DDD EGG CVTV GT ATE JID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
		CENTED			14TH ST		
HAIVIIVIOI	ND-WHITING CARE	ECENTER		WHITIN	IG, 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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9/27/23, indicated the checked at the time signs that were door	tion Assessment, dated here were no current vital signs of the status change. The vital umented all had the date of					
	9/27/23 and the time of 4:14 a.m.						
		ed 11/2/23 at 10:12 a.m., nt fell and hit their head.					
		ed 11/3/23 at 2:27 a.m., nt's steri strips were dry and					
	fall. There was no f documentation and the resident was ser	ological observations after the fall follow up assessment or there was no documentation at out to the hospital after the assessment of the forehead					
	at 11:50 a.m., indica	Nurse Consultant on 11/30/23 ated follow up after a fall should ry shift for 72 hours.					
	at 3:15 p.m., indicates steri strips on their sent out to the emer was glued. There we laceration after it has	Nurse Consultant on 11/30/23 ted the resident did not have forehead. The resident was regency room and the laceration as no monitoring of the appened and there was no eurological checks or e fall.					
	observed to the oute foot. The resident w	245 a.m., fresh blood was er sock of Resident C's left vas also observed with a large brown bruise to the right side eabbed abrasions.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. Wl	NG		12/01/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		1000 11	I4TH ST		
HAMMO	ND-WHITING CARE	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1 p.m., and 2:50 p.m., the					
		red in bed. Both of their feet					
	were laying directly						
	-	ided. The resident did not					
		r foot, but was observed with					
	-	legs. A white bandage could uter ankle with no date on it.					
	be seen to the left o	ater affice with no date on it.					
	On 11/29/23 at 2·25	5 p.m., the resident was					
		both of their feet were not					
		ided. At 2:28 p.m., QMA 1 was					
		e resident's plain white socks					
		hat time, there was a white					
		e left outer ankle with no date					
	and a white bandage	e noted to the right lower leg					
	with no date on it.						
		A 1 at that time, indicated she					
	was unaware the res	sident had any open areas.					
	Interview with LPN	I 1 on 11/29/23 at 2:33 p.m.,					
	indicated she was n	ot made aware the resident					
	had any open areas.						
	The record for Resi	dent C was reviewed on					
	11/29/23 at 11:56 a	.m. The resident was admitted to					
	the facility on 5/10/	23. Diagnoses included, but					
	were not limited to,	fracture of the left femur,					
		ehaviors, Parkinson's disease,					
	_	t lower limb, dermatitis, history					
		walking, and high blood					
	pressure.						
	The 9/30/22 Ougests	rly Minimum Data Set (MDS)					
		ed the resident was not					
		nd needed extensive assist					
		cal assist for bed mobility and					
		ent needed extensive assist					
		cal assist for personal hygiene					
		Falls with no injury since the					
	and had 2 of more i	and then no injury since the					

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r i i		l í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	00	COMPL	
		155423	B. WIN	IG		12/01/	2023
	PROVIDER OR SUPPLIER			1000 11	DDRESS, CITY, STATE, ZIP COD 4TH ST G, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	last assessment.						
	Physician's Orders, offload heels while There were no order the areas on the ank documentation in N regarding any type of conditions to the an A Weekly Skin Inter 11/28/23 at 2:51 p.r. was not intact and the laceration and faded was no documentation right lower leg. Interview with LPN indicated she assess lower leg open area like it was a blister and measured 1 cen						
	at 11:50 a.m., indicaskin and the open are scratching. The order while in bed was gowords "as tolerated" order or documentatological 11/29/23. A Change of Conditatological 9:22 a.m., indicator fractured hip. The reference of the conditatological order or an area of the conditatological order o	Nurse Consultant on 11/30/23 ated the resident scratched their reas were a result of er for the heels to be offloaded oing to be changed to add the '. There was no treatment tion of the open areas prior to tion Evaluation dated 7/29/23 ated the resident had a fall post esident was sent to the d had X-rays to determine fractures or a dislocation.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023	
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR A Neurological Obs	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Servation was initiated on	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	incomplete and not	, however, they were fully documented. ollow up or assessment			
	indicated the reside the floor next to the head and had a lace Physician was notif to send the resident	ed 11/14/23 at 7:09 p.m., nt was observed face down on bed. The resident hit their ration to the right eye. The fied and orders were obtained to the hospital.			
	There was no assess injuries.	sment of the resident's			
	indicated the bruising	ed 11/17/23 at 11:14 a.m., and and swelling remained to be laceration was observed with			
	was identified as be	the first time the laceration ing a glued closure. There was tion, assessment or lued closure.			
	at 11:50 a.m., indicate documented ever was no documentate	Nurse Consultant on 11/30/23 ated follow up after a fall should ry shift for 72 hours. There ion or assessment of the I glued laceration after the fall			
		rent 4/7/22 "Fall y, provided by the Regional perations indicated the			

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PRINTED: 12/28/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB I	NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE A. BUILDING B. WING	construction 00	COMPLET	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIER		1000	et address, city, state, zip coi) 114TH ST TING, IN 46394	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
IAC	Lippincott Procedur "even if the residen has sustained only a frequency of monite and respirations for directed by your fac status, as directed b	res for fall management were t shows no signs of distress or minor injuries, increase the bring of blood pressure, pulse, the next 72 hours or as cility Monitor neurologic by your facility. Notify the mote any changes from	TAU			DATE
F 0685 SS=D Bldg. 00	§483.25(a) Vision To ensure that restreatment and assisted vision and hearing if necessary, assisted §483.25(a)(1) In necessary, assisted and from the of specializing in the hearing impairment professional special vision or hearing a Based on record restrailed to ensure resi	sidents receive proper istive devices to maintain g abilities, the facility must, st the resident- making appointments, and arranging for transportation fice of a practitioner treatment of vision or nt or the office of a alizing in the provision of assistive devices. View and interview, the facility dents had access to receive	F 0685	This plan of correction is and executed because t		12/29/2023
	services for impaire reviewed for vision and 18) Findings include: 1. On 11/27/23 at 3 observed in her roo	and hearing. (Residents 31 was m watching television. The he wore glasses and she		provisions of state and for require it and not because Hammond-Whiting Care agrees with the allegatio citations listed. Hammond Care Center maintains the alleged deficiencies do repopardize the health and the residents nor is it of the state of the sta	ederal law se Center ons and od-Whiting hat the not d safety of	

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needed new glasses. At that time, the resident

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character to limit our capabilities

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		155423	B. W	ING		12/01	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	8			14TH ST		
HAMMO	ND-WHITING CAR	E CENTER			NG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and asked multiple times to be			to render adequate care. Plea		
	placed on the list to	see an eye doctor.			accept this plan of correction	as	
	The record for Resident 31 was reviewed on				our credible allegation of		
	The record for Resident 31 was reviewed on				compliance that the alleged		
	11/28/23 at 1:59 p.m. The resident was admitted to				deficiencies have or will be co		
	the facility on 11/18/21. Diagnoses included, but				by the date indicated to remai		
	·	anemia, atrial fibrillation			compliance with state and fed		
	(abnormal heart rhy				regulations, the facility has tal		
		blood pressure), diabetes,			or will take the actions set fort	th in	
	dementia, hemipleg	gia, anxiety, and depression.			this plan of correction. We		
	TTI 0/1/00 4 1	N. (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1			respectfully request a desk re	view.	
		Minimum Data Set (MDS)			-		
	assessment, indicate				F 685- Treatment/Devices to		
		or daily decision making and			Maintain Hearing/Vision	_	
	had no vision impar	irment or corrective lens.			What Corrective Action will	be	
		1.10000			accomplished for those		
		r, dated 2/2/23, indicated the			residents found to have bee	n	
	-	Dental, Podiatry, Audiology,			affected by this deficient		
	and Optometry care	e as needed.			practice:		
					1 Resident # 31 is		
		mentation the resident had			scheduled to be seen by visio		
	seen an eye doctor	since admission.			services at next visit in Decen		
	T	D ' 177' D '1 / C			No negative outcomes noted.		
		Regional Vice President of			2 Resident # 18 is		
	_	9/23 at 3:17 p.m., indicated the			scheduled to be seen by visio		
		en the eye doctor since being			services at next visit in Decen	nper.	
	1	vas put on the list today to be			No negative outcomes noted.	41	
	seen.				How other residents having		
	Interview 11 41 4	Social Service Director on			potential to be affected by the		
					same deficient practice will		
		m., indicated the resident had			identified and what corrective	/e	
		ctor since arriving to the			action will be taken:	_	
	facility in 2021.				1 All residents have	=	
	2 On 11/20/22 at 1	0:05 a.m. Resident 18 was			the potential to be affected.	ho	
					2 In house audit to	ne	
		m. At that time, the resident			completed for all residents to		
		l cataract surgery. He had t at last month's resident			ensure residents have routine		
	•	i ai iast monin s resident			appointments to be seen by	201105	
	council meeting.				vision/hearing provider. Any is	ssues	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W			12/01/	
						,	
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
					14TH ST		
IOMMAH	ND-WHITING CARE	E CENTER		WHITIN	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	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The record for Resi	dent 18 was reviewed on			What measures and what		
	11/28/23 at 2:14 p.r	n. The resident was admitted to			systemic changes will be ma	ade	
	the facility on 12/19	9/22. Diagnoses included, but			to ensure that the deficient		
	were not limited to,	heart failure, hypertension			practice doesn't recur:		
	(high blood pressure	e), hemiplegia (muscle			1 Education will be	:	
	weakness), asthma,	and cellulitis (infection) in the			completed to SSD to ensure a	all	
	right and left leg.				residents have routine		
	inglie and rote reg.				vision/hearing services by dat	te of	
	The 9/13/23 Quarte	rly Minimum Data Set (MDS)			compliance.		
	assessment, indicate	•			How the corrective action w	ill	
	cognitively intact for daily decision making and				be monitored to ensure the		
	had corrective lens.				deficient practice will not re	cur	
	nad corrective iens.				i.e., what quality assurance	our,	
	A Physician's Order, dated 7/28/23, indicated the				program will be put in place		
	resident may have Dental, Podiatry, Audiology,				1 ED and/or Design		
	and Optometry care				will review all new admissions		
	una optomeny care	, us needed.			ensure consent/appointment	3 10	
	There was no Care	Plan for impaired vision.			completed/scheduled x 3 mor	nthe	
	There was no care	run for impuned vision.			then will audit 2 admissions/w		
	There was no docur	nentation the resident had			x 3 months. Audits will be	, con	
	seen an eye doctor s				presented to QAPI x 6 months	s	
					and QAPI will determine need		
	A History and Phys	ical (H&P), dated and signed			further audits.	1 101	
		7/28/23, indicated the resident			2 The results of the	920	
	had a premature left				reviews will be discussed at the		
	nad a prematare ier	t cyc cataract.			monthly facility Quality Assura		
	Interview with the I	Regional Vice President of					
		9/23 at 3:17 p.m., indicated			Committee meeting monthly f	u a	
	_	ments to provide, Resident 18			total of 3 months and then		
		e doctor, and no appointment			quarterly thereafter once		
					compliance is at 100%.		
	was made prior to to	oday.			Frequency and duration of rev		
	2.1.20(.)(1)				will be increased as needed, i	IT	
	3.1-39(a)(1)				compliance is below 100%.		
					Compliance date: 12.29.23. T	ne	
					Administrator at		
					Hammond-Whiting Care Cent	ter is	
					responsible in ensuring		
					compliance in this Plan of		
					Correction.		
					1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. WI	NG		12/01	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			14TH ST		
HAMMON	ND-WHITING CARE	CENTER	_		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
F 0686	483.25(b)(1)(i)(ii)						
SS=D		Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin Ir						
	§483.25(b)(1) Pre						
		prehensive assessment of					
		ility must ensure that-					
		ives care, consistent with					
		lards of practice, to prevent					
		nd does not develop nless the individual's clinical					
	•	trates that they were					
	unavoidable; and	uales that they were					
		pressure ulcers receives					
		ent and services, consistent					
	_	standards of practice, to					
		prevent infection and prevent					
	new ulcers from d	·					
		on, record review, and	F 06	686	This plan of correction is prepare	ared	12/29/2023
	interview, the facili	ty failed to ensure pressure			and executed because the		
	reducing measures	were in use for a resident with			provisions of state and federal	l law	
	a deep tissue injury	(DTI) for 1 of 1 resident			require it and not because		
	reviewed for pressu	re ulcers. (Resident 2)			Hammond-Whiting Care Cente	er	
					agrees with the allegations an	d	
	Finding includes:				citations listed. Hammond-Wh	iting	
					Care Center maintains that the	е	
		3 p.m., Resident 2 was observed			alleged deficiencies do not		
	in her room in bed.	No heel protectors were in use			jeopardize the health and safe	ty of	
	at that time.				the residents nor is it of such		
					character to limit our capabiliti		
		3 a.m. and 11:28 a.m., the			to render adequate care. Plea		
		red in her room in bed. The			accept this plan of correction a	as	
		k on her right foot and her			our credible allegation of		
	foot was resting on foot was resting on	a pillow. The resident's left			compliance that the alleged	rraat	
	1001 was resung on	me mauress.			deficiencies have or will be co		
	The record for Resi	dent 2 was reviewed on			by the date indicated to remain compliance with state and fed		
		.m. Diagnoses included, but			regulations, the facility has tak		
		Alzheimer's late onset,			or will take the actions set fort		
		tion Atrial Fibrillation (A Fib.			this plan of correction We		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE irregular heart rhythm), and respectfully request a desk review. hemiplegia/hemiparesis (muscle F686 Treatment/Services to weakness/paralysis) following a stroke. prevent/heal pressure ulcer What Corrective Action will be The Significant Change Minimum Data Set (MDS) accomplished for those assessment, dated 10/31/23, indicated the resident residents found to have been was cognitively impaired for daily decision affected by this deficient making. The resident also had one deep tissue practice: injury (purple or maroon localized area or Res #2 immediately had discolored intact skin due to damage of heels offloaded. Orders and care underlying soft tissue from pressure and/or plan updated. No negative shear). outcomes noted. How other residents having the The Quarterly MDS assessment, dated 9/30/23, potential to be affected by the indicated the resident required extensive assist same deficient practice will be with bed mobility and she was totally dependent identified and what corrective on staff for transfers. action will be taken: Audit completed on all A Care Plan, dated 10/26/23, indicated the resident current residents with skin had a DTI (deep tissue injury) to her right heel. integrity impairment/at risk for skin Interventions included, but were not limited to, integrity impairment to ensure heel boots to be applied while in bed. pressure reducing measures are in place by date of compliance. A Physician's Order, dated 9/5/23 and listed as What measures and what current on the November 2023 Physician's Order systemic changes will be made Summary, indicated the resident's heels were to be to ensure that the deficient off loaded when in bed. practice doesn't recur: DON and/or designee to Interview with the Regional Vice President of provide education to all staff r/t Operations and the Director of Nursing (DON) on pressure reducing measures by 12/1/23 at 1:09 p.m., indicated both heels should date of compliance. have been off loaded while in bed or the heel All newly hired staff will boots should have been in use. receive this education during orientation, prior to providing 3.1-40(a)(2)resident care. How the corrective action will be monitored to ensure the deficient practice will not recur,

i.e., what quality assurance program will be put in place:

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

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/01/2023
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				1 DON and/or designee to complete observations at ran times 5 times a week for 2 months, then 3 times a week months, then 1 time a week for months. Any issues identified be immediately addressed by DON/designee. 2 The results of these revivill be discussed at the mont facility Quality Assurance Committee meeting monthly total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance is below 100%. Compliance date: 12/29/23. Administrator at Hammond-Whiting Care Centersponsible in ensuring compliance in this Plan of Correction.	for 2 for 2 for 2 f will f the fiews hly for a eviews if
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and or resident's comprel facility must ensur §483.25(g)(4) A re to eat enough alor fed by enteral met	stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a mensive assessment, the e that a resident- esident who has been able he or with assistance is not hods unless the resident's emonstrates that enteral			

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155423	B. W	NG		12/01	/2023
				_	_		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
					14TH ST		
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	IG, IN 46394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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)	16	DATE
	consented to by the	ne resident; and					
	§483.25(a)(5) A re	esident who is fed by enteral					
		ne appropriate treatment					
	and services to restore, if possible, oral eating skills and to prevent complications of						
	_	cluding but not limited to					
	_	onia, diarrhea, vomiting,					
	dehydration, meta	abolic abnormalities, and					
	nasal-pharyngeal	ulcers.			This plan of correction is prepared		
	Based on observation	on, record review, and	F 00	593			12/14/2023
	interview, the facili	ty failed to ensure a tube	1 0055		and executed because the		
	feeding was infusin	g at the correct time. The			provisions of state and federal	law	
	facility also failed t	o ensure tube feeding			require it and not because		
	placement was che	cked and a water flush was			Hammond-Whiting Care Cente	er	
	completed prior to	administering gastrostomy			agrees with the allegations and	d	
	tube (an opening in	to the stomach from the			citations listed. Hammond-Wh	iting	
	abdominal wall for	the introduction of food)			Care Center maintains that the	Э	
	medications for 2 o	f 2 residents reviewed for tube			alleged deficiencies do not		
	feeding. (Residents	s 19 and 33)			jeopardize the health and safe	ty of	
					the residents nor is it of such		
	Findings include:				character to limit our capabilitie	es	
					to render adequate care. Pleas	se	
		12:03 p.m., Resident 19 was			accept this plan of correction a	as	
		ing room eating lunch. Her			our credible allegation of		
	tube feeding was no	ot infusing at that time.			compliance that the alleged		
					deficiencies have or will be co	rrect	
		17 a.m., 1:38 p.m., and 3:19 p.m.,			by the date indicated to remain		
		served in her wheelchair			compliance with state and fede		
		lity. Her tube feeding was not			regulations, the facility has tak		
	infusing nor connec	eted to the gastrostomy tube.			or will take the actions set fortl	h in	
	0.44/00/25				this plan of correction. We		
		39 a.m., the resident was being			respectfully request a desk rev	/iew.	
	^	allway by a staff member, her					
	_	ot connected. At 11:28 a.m.,			F 693- Tube Feeding		
		he side of her bed. Again, the			Management/Restore eating s		
		ot connected. A tube feeding			What Corrective Action will k	oe	
		I next to the resident's bed. At			accomplished for those	_	
	_	dent was in the dining room			residents found to have been	า	
	eating lunch. Her t	ube feeding was not			affected by this deficient		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155423	B. W	B. WING			12/01/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			14TH ST			
наммо	ND-WHITING CAR	E CENTER			NG, IN 46394			
TIAWWO	ND-WHITING CAR	E CENTER		VVIIIIIV	NG, IN 40394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		p.m., the resident was resting			practice:			
	on the couch in the	lobby. Her tube feeding was			1 Resident 19 had	no		
	not connected.				negative outcomes. MD and F	POA		
					notified of tube feeding hung a	at		
		30 a.m. and 1:14 p.m., the			wrong time. Orders received t	o d/c		
	resident was observ	ved in the hallway in her			tube feeding d/t resident			
	wheelchair. Her tu	be feeding was not connected			consuming meals orally.			
	at those times.				2 Resident 33 had			
					negative outcomes. MD notifie	ed		
		ident 19 was reviewed on			with no new orders received.			
	_	m. Diagnoses included, but			How other residents having	the		
		, Atrial Fibrillation (A Fib -			potential to be affected by the	ne		
		hm), gastrostomy status (an			same deficient practice will	be		
		omach from the abdominal wall			identified and what corrective	⁄e		
		n of food), anemia, and			action will be taken:			
	dementia without b	behavior disturbance.			1 Residents with tu	be		
					feeding orders have been aud	lited		
	_	ange Minimum Data Set (MDS)			to assure orders in place for			
		9/7/23, indicated the resident			specific times for infusion per	MD		
		paired for daily decision making			order. Nursing Management			
		ensive assistance for eating.			observed these residents for			
		tube feeding and a			appropriate times of infusion v			
	mechanically altered	ed diet.			no other issues noted by date	of		
					compliance.			
		er, dated 11/14/23, indicated the			What measures and what			
		eive a tube feeding of Jevity 1.2			systemic changes will be ma	ade		
	· ·	l) per hour, times 18 hours via			to ensure that the deficient			
	1	00 a.m. and off at 4:00 a.m. May			practice doesn't recur:			
	substitute with Glu	cerna 1.2.			1 Nursing			
	l				Management will educate lice	nsed		
		Nurse Consultant on 12/1/23 at			nursing staff on infusing tube			
		d the Physician discontinued the			feeding per MD order, flushing	-		
	_	on 11/30/23 due to the resident			giving medications per policy	by		
	was eating an oral	diet and gaining weight.			date of compliance.			
	2 0 11/20/22	124 014 1 1			2 Competencies wi			
		1:24 p.m., QMA 1 was observed			be completed on licensed Nur	-		
		tomy tube (an opening into the			on med administration, flushe			
		bdominal wall for the			and assuring following MD ord	ders		
		d) medication for Resident 33.			for Tube feedings.			
	The QMA crushed	a 1 milligram (mg) tablet of	1		3 New licensed		I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00		ESURVEY LETED 1/2023	
	PROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COL 114TH ST NG, IN 46394)	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR Lorazepam (an anti- proceeded to the res Upon entering the re diluted the Lorazepa milliliters (ml) of pt seated in her wheele proceeded to lift the tubing. The tubing then placed the syrit administered the me giving the medication 15 ml's of water. To placement or flush to medication. Interview with the N 8:55 a.m., indicated been checked prior the tube flushed prior The facility policy to Administration via 1 was provided by the Operations on 11/30 indicated, avoid adr or medications throuposition had been ca administering medic	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION -anxiety medication) and sident's room. esident's room, the QMA am with approximately 15 arified water. The resident was chair at that time. The QMA e resident's shirt and untie the was tied in a loose knot. She nge into the port and edication. After she was done on, she flushed the tube with the QMA did not check for tube the tubing prior to giving the Nurse Consultant on 12/1/23 at g-tube placement should have to giving the medication and for to giving the Lorazepam. itled, "Medication Enteral Access Device [EAD]", the Regional Vice President of 10/23 at 4:04 p.m. The policy ministration of feedings, fluids, sugh the EAD until correct onfirmed and prior to cation, stop the feeding and at least 15 ml of purified water	WHITII ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY) nursing staff will not work education and a compete completed. How the corrective actions to monitored to ensure deficient practice will not i.e., what quality assurate program will be put in put 1 DON and/or Designee will observe an staff verbalize appropriate medication administration infusion of tube feedings weekly x 3 months, then weekly x 3 months to assure compliance. This will be pressed as the shifts. Audits will be pressed as need to monthly facility Quality A Committee meeting monitoral of 3 months and the quarterly thereafter once compliance is at 100%. Frequency and duration will be increased as need compliance is below 100 Compliance date: 12.14.2 Administrator at Hammond-Whiting Care responsible in ensuring compliance in this Plan of the property of the plan	c until this ency is con will the of recur, ence olace: ad/or have the flushing, in, and times 2 times sure rotated on ented to API will urther of these d at the ssurance thly for a en of reviews ded, if %. 23. The Center is	(XS) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Trach Suctioning	eostomy Care and		Correction.		

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

Event ID:

 $XXWZ11 \quad \text{Facility ID:} \quad 000365$

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>00</u>		COMPLETED	
		155423	B. WI	NG	_	12/01/2023	
	PROVIDER OR SUPPLIER			1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST NG, IN 46394	•	
HAIVIIVIOI		EGENTER		VVITITIV			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		ratory care, including e and tracheal suctioning.					
		e and trachear suctioning. ensure that a resident who					
	needs respiratory						
		e and tracheal suctioning,					
	_	care, consistent with					
	1 '	dards of practice, the					
	comprehensive pe	erson-centered care plan,					
		ls and preferences, and					
	483.65 of this sub	•					
		on, record review, and	F 06	595	This plan of correction is prep	ared	12/29/2023
		ty failed to ensure oxygen was			and executed because the		
		rate for 1 of 2 residents			provisions of state and federa	l law	
	reviewed for oxyge	n. (Resident 2)			require it and not because		
	Finding includes:				Hammond-Whiting Care Cent agrees with the allegations an		
	r manig merades.				citations listed. Hammond-Wh		
	On 11/28/23 at 1:42	2 p.m., Resident 2 was seated in			Care Center maintains that the	•	
		from the nurses' station. The			alleged deficiencies do not	_	
	-	ng oxygen by the way of a			jeopardize the health and safe	ety of	
	nasal cannula. The	portable oxygen tank was set			the residents nor is it of such	•	
	at 2 liters. At 3:38	p.m., the resident was in her			character to limit our capabiliti	es	
	room in bed sleepin	ng. She was holding the nasal			to render adequate care. Plea	se	
	cannula in her hand	ls.			accept this plan of correction	as	
					our credible allegation of		
		8 a.m. and 11:28 a.m., the			compliance that the alleged		
		room in bed sleeping. The			deficiencies have or will be co		
		nula was not in place and the			by the date indicated to remai		
		or was set at 2 liters. At 12:10			compliance with state and fed		
	was set at 2 liters.	as in use and the concentrator			regulations, the facility has take or will take the actions set fort		
	was set at 2 mers.				this plan of correction. We	11 111	
	On 11/30/23 at 10:3	38 a.m., the resident was			respectfully request a desk re	view.	
		m in bed. The resident's					
		and the oxygen concentrator			F 695- Respiratory/Tracheosto	omy	
	was set at 2 liters.				Care and Suctioning		
					What Corrective Action will	be	
		dent 2 was reviewed on			accomplished for those		
		.m. Diagnoses included, but			residents found to have been	n	
	were not limited to,	COPD (chronic obstructive			affected by this deficient		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155423		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ;	(X3) DATE SURVEY COMPLETED 12/01/2023	
	PROVIDER OR SUPPLIEI		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	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	pulmonary disease)), Alzheimer's late onset,		practice:	
	dementia with agita	ation, Atrial Fibrillation (A Fib -		1 Resident 2 had no	
	irregular heart rhytl	hm), and		negative outcomes. MD was	
	hemiplegia/hemipa	resis (muscle		notified on inaccurate liter flow.	O2
	weakness/paralysis) following a stroke.		sats were taken immediately wi	th
				no issues noted and O2 liter flo	ws
		ange Minimum Data Set (MDS)		adjusted to ordered liter flow	
		10/31/23, indicated the resident		immediately.	
		paired for daily decision making		How other residents having the	
		ing oxygen while a resident of		potential to be affected by the	
the facility.			same deficient practice will be		
				identified and what corrective	•
		lan indicated the resident had		action will be taken:	
		status related to COPD and		1 An Audit was	
		eart failure). Interventions		completed on residents in hous	
		not limited to, apply oxygen as		with current 02 orders to assure	
	ordered.			orders accurate and clinical tea	ım
	A DI COLO	1 4 12/15/22 11: 4 1		observed liter flow being	
	1	er, dated 3/15/23 and listed as		administered per order. No other	
		ember 2023 Physician's Order d the resident was to receive		issues have been identified. Au	all
	-	ontinuously per nasal cannula.		completed by nursing	
	oxygen at 5 mers e	ontinuousty per nasar camiura.		management by date of compliance.	
	Interview with the	Nurse Consultant on 11/30/23		What measures and what	
		ated the resident's oxygen		systemic changes will be mad	10
	_	d have been set at 3 liters.		to ensure that the deficient	,
		2		practice doesn't recur:	
	3.1-47(a)(6)			1 DON and/or	
				designee have educated licens	ed
				nursing staff and certified aides	
				observe liter flow on residents	
				using 02 and assure liter flow is	;
				accurate per order. This will be	
				completed by date of compliand	ce.
				How the corrective action will	
				be monitored to ensure the	
				deficient practice will not recu	ur,
				i.e., what quality assurance	
				program will be put in place:	

DON/Nursing

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

PRINTED: 12/28/2023 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 00	(X3) DATE SURVEY COMPLETED 12/01/2023
	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
				management will observe 5 residents daily Monday through Friday x 8 weeks, then 3 resid daily Monday through Friday x weeks, then 2 residents daily Monday through Friday x 8 we to assure compliance. Audits be presented to QAPI x 6 mor and then QAPI will determine need for further audits. Any no issues will be addressed immediately. 2 The results of the reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed, it compliance date: 12.29.23. The Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.	eents a 8 eeks will oths the oted se ne or a
F 0698 SS=D Bldg. 00	require dialysis red consistent with pro practice, the comp care plan, and the preferences.	nsure that residents who ceive such services, ofessional standards of orehensive person-centered residents' goals and			
		iew and interview, the facility post dialysis assessment for 1	F 0698	This plan of correction is prepared and executed because the	ared 12/29/2023

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

Event ID:

XXWZ11 Facility ID: 000365

If continuation sheet Page 31 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155423	B. Wl	ING		12/01/2023	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			14TH ST		
⊔∆ММ∩N	ND-WHITING CARE	E CENTER			IG, IN 46394		
TIAMMOI	ND-WITHING OAK			VVIIIII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of 1 resident review	ved for dialysis. (Resident 25)			provisions of state and federal	law	
					require it and not because		
	Finding includes:				Hammond-Whiting Care Cente		
	D 11 . 25	1 11/20/22			agrees with the allegations and		
		d was reviewed on 11/28/23 at			citations listed. Hammond-Wh	•	
		es included, but were not limited			Care Center maintains that the	9	
		pertension (high blood			alleged deficiencies do not	44	
		e renal disease (renal failure),			jeopardize the health and safe	ty of	
	dialysis.	on, and dependent on renal			the residents nor is if of such		
	dialysis.				character to limit our capabilities		
	The 11/3/23 Quarte	erly Minimum Data Set (MDS)			to render adequate care. Plea accept this plan of correction a		
		ed the resident was cognitively			our credible allegation of	15	
	intact for daily deci				compliance that the alleged		
	intact for daily acci	sion making.			deficiencies have or will be co	rrect	
	A Care Plan, dated	11/13/23, indicated the resident			by the date indicated to remain		
		rsis related to renal failure and			compliance with state and fed		
		ıs (AV) fistula (dialysis access			regulations, the facility has tak		
		included, but were not limited			or will take the actions set fort		
	1	ding at dialysis access site,			this plan of correction. We		
	obtain dry weights	from dialysis center, assess			respectfully request a desk rev	/iew.	
	shunt site for bruit a	and thrill, and encourage the					
	resident to go for so	cheduled dialysis			F 698 – Dialysis		
	appointments on M	onday, Wednesday, and					
	Friday each week.				What Corrective Action will be	е	
					accomplished for those		
	•	r, dated 9/12/23, indicated the			residents found to have beer	1	
		vsis patient and received			affected by this deficient		
		y, Wednesday, and Friday at a			practice:		
	dialysis center.				1. Resident # 25: No		
	m p: 1 : ~				negative outcomes noted. Ord		
	· ·	nunication binder included			updated to include supplemen	-	
		ms that had information for the			documentation for post dialysi	S	
		rior to the resident going to the			assessment.		
		upon return from the dialysis			How other residents having t		
		ation included vital signs, bruit			potential to be affected by th	е	
		sed, medication sent to			same deficient practice be	_	
	•	dication received prior to			identified and what correctiv	е	
		pertinent information (lunch or			action will be taken:	\ <u>(</u> 0	
	E SHACK SHOLW/IID PACI					114	

12/28/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE dialysis have the potential to be The Dialysis Post Communication sheets were not affected. filled out on 10/2/23, 10/20/23, 10/23/23, 10/27/23, What measures and what 10/30/23, 11/1/23, 11/3/23, 11/6/23, 11/10/23, systemic changes will be made 11/13/23, 11/15/23, 11/17/23, 11/20/23, and to ensure that the deficient 11/25/23. practice doesn't recur: Education provided A facility policy titled, "Hemodialysis Offsite to licensed nursing staff regarding Policy", reviewed on 8/23/23 and identified as completion of post-dialysis current, indicated ..."1. Obtain vital signs of assessment by date of resident upon return from dialysis and complete compliance. Pre/Post Dialysis Communication Form"... All newly hired licensed nursing staff will receive Interview with the Regional Vice President of this education during orientation. Operations on 11/30/23 at 10:50 a.m., indicated the How the corrective action will post dialysis sheet was not being filled out be monitored to ensure the consistently. deficient practice will not recur, i.e., what quality 3.1-37(a) assurance program will be put in place: 1. DON and/or Designee to audit dialysis communication sheets to ensure post assessment completed 3x/week for 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.

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

Event ID:

XXWZ11

Facility ID: 000365

Administrator at

responsible in ensuring compliance in this Plan of

If continuation sheet

Date of compliance: 12.29.23 The

Hammond-Whiting Care Center is

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PRINTED: 12/28/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155423	B. W	NG		12/01	/2023
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					I4TH ST		
HAMMO	ND-WHITING CARE	- CENTER		WHITIN	IG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY 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
F 0791 SS=D Bldg. 00	§483.55 Dental Soft The facility must a routine and 24-ho §483.55(b) Nursing The facility- §483.55(b)(1) Must outside resource, §483.70(g) of this services to meet to (i) Routine dental covered under the (ii) Emergency de §483.55(b)(2) Must requested, assisted (i) In making appoor (ii) By arranging for the dental service §483.55(b)(3) Must refer residents with for dental services within 3 days, the documentation of resident could still while awaiting der	assist residents in obtaining ur emergency dental care. ag Facilities. ast provide or obtain from an in accordance with part, the following dental he needs of each resident: services (to the extent e State plan); and intal services; ast, if necessary or if the resident-pintments; and or transportation to and from			Correction.		
	those circumstand damage of dentur	est have a policy identifying ces when the loss or es is the facility's may not charge a resident					

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for the loss or damage of dentures

Event ID:

XXWZ11

Facility ID: 000365

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SO			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED 12/01/2023	
		155423	B. W	ING	_		
NAME OF I	DROWIDED OF CUIDDLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				14TH ST		
IOMMAH	ND-WHITING CARE	E CENTER		WHITIN	NG, IN 46394		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ordance with facility policy	+	IAG			DATE
		responsibility; and					
	ĺ	•					
		st assist residents who are					
	1 -	o participate to apply for					
		dental services as an expense under the State					
	plan.	expense under the state					
		on, record review, and	F 0'	791	This plan of correction is prepared	ared	12/29/2023
		ty failed to ensure residents			and executed because the		
		ntal services for 1 of 4			provisions of state and federal	l law	
		for dental services. (Resident			require it and not because		
	31)				Hammond-Whiting Care Cent		
	Finding includes:				agrees with the allegations an		
	Finding includes.				citations listed. Hammond-Wh Care Center maintains that the	•	
	On 11/27/23 at 3:50	p.m., Resident 31 was			alleged deficiencies do not	-	
		in bed watching television. At			jeopardize the health and safe	ety of	
	i i	ent indicated she had asked to			the residents nor is it of such	-	
		was told she was put on the			character to limit our capabiliti		
	list "months ago" by	y social services.			to render adequate care. Plea		
	The record for Resi	dent 31 was reviewed on			accept this plan of correction a our credible allegation of	15	
		m. The resident was admitted on			compliance that the alleged		
	_	s included, but were not limited			deficiencies have or will be co	rrect	
		orillation (abnormal heart			by the date indicated to remain	n in	
		re, hypertension (high blood			compliance with state and fed		
		dementia, hemiplegia, anxiety,			regulations, the facility has tak		
	and depression.				or will take the actions set fort	n in	
	The 9/1/23 Annual	Minimum Data Set (MDS)			this plan of correction. We respectfully request a desk re	view	
	assessment, indicate				100pcolidiny request a desk fe	V 1 C VV .	
	· ·	or daily decision making.			F 791- Routine_Emergency D	ental	
		·			Srvcs in NFs		
	1	r, dated 2/2/23, indicated the			What Corrective Action will I	be	
	l ,	Dental, Podiatry, Audiology,			accomplished for those		
	and Optometry care	e as needed.			residents found to have been	n	
	There was no door	mentation the resident had			affected by this deficient		
	seen a dentist since				practice: 1 Resident # 31 is		
	1		1		. Ιλοσιαστίκ <i>π</i> σ Ι Ιδ		Ī.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPLETED
		155423	B. WIN	G		12/01/2023
				CTREET	A DDDESG CITY CT A TE ZID COD	
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP COD	
	ND WULLTING OAD	C OENTED			14TH ST	
HAMMO	ND-WHITING CAR	E CENTER		WHITIN	NG, IN 46394	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					scheduled to be seen by denta	al
	Interview with the	Regional Vice President of			services at next visit in Decem	ıber.
	Operations on 11/2	9/23 at 3:17 p.m., indicated the			No negative outcomes noted.	
	resident had not see	en the dentist since being at			How other residents having	the
	the facility and and	was put on the list today.			potential to be affected by th	re
					same deficient practice will l	be
	Interview with the	Social Service Director on			identified and what corrective	'e
	12/1/23 at 12:45 p.:	m., indicated she couldn't recall			action will be taken:	
	the resident request	ring to see the dentist.			1 All residents have	;
					the potential to be affected.	
	3.1-24(a)(1)				2 In house audit to	be
					completed for all residents to	
					ensure residents have routine	
					appointments to be seen by de	ental
					provider. Any issues identified	will
					be addressed.	
					What measures and what	
					systemic changes will be ma	ıde
					to ensure that the deficient	
					practice doesn't recur:	
					1 Education will be	
					completed to SSD to ensure a	.11
					residents have routine dental	
					services by date of compliance	
					How the corrective action wi	"
					be monitored to ensure the	
					deficient practice will not red	;ur,
					i.e., what quality assurance	
					program will be put in place:	
					1 ED and/or Design	
					will review all new admissions	IO
					ensure consent/appointment	46-
					completed/scheduled x 3 mon	
					then will audit 2 admissions/w x 3 months. Audits will be	∃GK
					presented to QAPI x 6 months	
					and QAPI will determine need	IUI
					further audits.	00
					2 The results of the	
1					reviews will be discussed at th	e

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Event ID:

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

PRINTED: 12/28/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155423	A. BUILDING B. WING	00	COMPLETED 12/01/2023
	ROVIDER OR SUPPLIER		1000 1	ADDRESS, CITY, STATE, ZIP COD 14TH ST IG, 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
F 0921 SS=E Bldg. 00	§483.90(i) Other E The facility must p sanitary, and comf residents, staff and Based on observation failed to ensure the c clean and in good re marred door frames, missing toilet bolts, baseboards, missing conditioner, and was multi resident room and South Units) Findings include: During the Environm Environmental Dire the following was of	an and interview, the facility residents' environment was apair related to marred walls, discolored floors, rusted and dirty and broken floor pieces from an air sh basins not contained in a on 2 of 2 units. (The North	F 0921	monthly facility Quality Assura Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed, if compliance is below 100%. Compliance date: 12.29.23. The Administrator at Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction. This plan of correction is prepared executed because the provisions of state and federal require it and not because Hammond-Whiting Care Centeresponsible in ensuring compliance in this Plan of Correction. This plan of correction is prepared executed because the provisions of state and federal require it and not because Hammond-Whiting Care Centeres with the allegations and citations listed. Hammond-Whome Care Center maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilities to render adequate care. Plea accept this plan of correction accept the plan of correction acc	iews ine ared 12/29/2023 law er d itting e sty of es se as

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE marred and there was adhered dirt behind the base regulations, the facility has taken of the door. One resident resided in the room and or will take the actions set forth in two residents shared the bathroom. this plan of correction. We respectfully request a desk review. b. Room 104 - The bathroom walls were observed to be marred and the toilet bolts were missing and rusted. There were two residents who resided in Safe/Functional/Sanitary/Comforta the room and four residents who shared the ble Environment bathroom. What Corrective Action will be accomplished for those c. Room 106 - The bathroom walls was observed residents found to have been to be marred, the baseboard near bed one was affected by this deficient practice: broken, and the air conditioner was missing pieces. There were two residents residing in the 1 The marred walls room. and door frames were repaired in rooms 102, 104, 106, 212, 214, 2. North Hall 221, 222, and 223. The floor tile in the bathrooms of rooms 223 and a. Room 212 - The bathroom door frame was 221 were cleaned. All wash basins observed to be marred and there was adhered dirt were placed in trash and new were on the floor. Two plastic wash basins were obtained and covered in observed on the counter and not contained. There appropriate plastic bag with were two residents who resided in the room and resident's name. The toilet bolts four residents who shared the bathroom. were replaced in room 104. The baseboard repaired in rooms 106, b. Room 214 - The door frame was observed to be 214, and 222. The AC in room 106 marred and chipped. The base board was peeling was repaired. from the wall in between the two beds. There were How other residents having the two residents who resided in the room and four potential to be affected by the residents who shared the bathroom. same deficient practice will be identified and what corrective c. Room 221 - The floor beneath the toilet bowel action will be taken: was observed to be discolored. The door frame Other residents had was gouged. There were two residents who the potential to be affected by this resided in the room and four residents who shared deficient practice. the bathroom. What measures and what systemic changes will be made

d. Room 222 - The bathroom door frame was

observed to be marred and missing a baseboard.

The walls in the room were marred. There were

1

to ensure that the deficient

Environmental

practice doesn't recur:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/01/2023 155423 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 114TH ST HAMMOND-WHITING CARE CENTER WHITING, IN 46394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE two residents who resided in the room and four rounds have been completed by residents who shared the bathroom. maintenance department and plan has been put into place to address e. Room 223 - The floor beneath the toilet bowel marred walls, discolored floor tiles was observed to be discolored. The door frame in bathrooms, wash basins, toilet was gouged. The walls in the room were marred. bolts, baseboard, and AC units on There were two residents who resided in the room or prior to 12/29/23. and four residents who shared the bathroom. The Maintenance Director and/or designee will When interviewed on 12/1/23 at 10:18 a.m., the include identified areas in the Environmental Director indicated all of the above current preventive maintenance were in need of cleaning and/or repair. program and conduct routine resident room rounds according to 3.1-19(f)the facility policy. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Maintenance Director and/or designee to conduct resident room observations 5x weekly for next 6 months to ensure the resident's environment is in good repair from marred walls, discolored floor tiles in bathrooms, wash basins, toilet bolts, baseboard, and AC unit. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. The results of these

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reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%.

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155423	(X2) MUI A. BUII B. WIN	LDING	INSTRUCTION 00	(X3) DATE COMPL 12/01/	ETED
	ROVIDER OR SUPPLIER			1000 11	ADDRESS, CITY, STATE, ZIP COD 4TH ST IG, IN 46394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	l	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					Frequency and duration of rev will be increased as needed, if compliance is below 100%. Compliance date: 12/29/23. The Administrator at Hammond-Whiting Care Center responsible in ensuring compliance in this Plan of Correction.	ne	

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