

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

PRINTED: 03/18/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155423</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/15/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HAMMOND-WHITING CARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 114TH ST</b> <b>WHITING, IN 46394</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A 2nd Post Survey Revisit (PSR) was conducted for the 1st PSR survey that was conducted on 02/02/24 for the Life Safety Code survey conducted on 12/18/23 by the Indiana Department of Health in accordance to 42 CFR 483.90(a)</p> <p>Survey Date: 03/15/2024</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>At this Life Safety Code PSR, Hammond-Whiting Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and in common areas. The facility has a capacity of 80 and had a census of 65 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage.</p> <p>Quality Review completed on 03/15/24</p>			{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.