STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48383 Based on observation, record review, and interview, the facility failed to ensure a wound treatment was completed and heels were floated as ordered for 2 of 3 residents reviewed for pressure-related skin conditions. (Residents B and C) Findings include: 1. On 5/5/25 at 11:59 a.m., Resident B was observed lying in bed on her right side. The resident's heels were resting on the bed, not off-loaded, and she had wounds on her left lateral and medial foot. During an interview at the time, the wound nurse indicated the resident did not have an order for off-loading boots but she would call the doctor today to get an order. She indicated the resident's heels were off-loaded the last time she was in the room. The record for Resident B was reviewed on 5/5/25 at 10:48 a.m. Diagnoses included, but were not limited to, dementia, anorexia, tube feeding support, and lymphedema (swelling in arms or legs). The Quarterly Minimum Data Set (MDS) assessment, dated 2/19/25, indicated the resident was cognitively impaired for daily decision making, dependent for all activities of daily living (ADL's) and was at risk for developing a pressure ulcer. A Physician's Order, dated 4/29/25, indicated to off-load heels while in bed as tolerated and confirm every shift. During an interview on 5/6/25 at 2:11 p.m., the Executive Director indicated she understood the concern and had no additional information to provide. 2. On 5/5/25 at 9:37 a.m., Resident C was observed lying in bed awake. The resident's dressing was checked with the wound nurse and there was no dressing in place covering the resident's sacral wound. The wound was pink, the size of a golf ball, and open to air. The resident's heels were lying flat on the bed and were not off-loaded. During an interview at the time, the Wound Nurse indicated she would put a dressing on the wound right away. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 10:38 a.m., the resident was observed in bed with 2 blankets covering her, she was lying on her back and crying she was cold. When the blankets were removed to observe the wound treatment, the resident's feet were lying flat on the bed. The Wound Nurse began the wound treatment, the resident's brief was opened and a new pad was placed underneath the resident. Hand hygiene was performed and a new set of gloves was donned. The wound nurse did not have a gown on and she began cutting the collagen dressing package open. She was stopped and asked if the resident was in Enhanced Barrier Precautions (EBP). There was an EBP sign observed on the resident's door. During an interview at the time, the Wound Nurse indicated she had forgotten to put on a gown. The record for Resident C was reviewed on 5/5/25 at 10:01 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), dementia, high blood pressure, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of the lower extremities and used a wheelchair. The resident required partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene. The resident required substantial/maximum assistance with lower body dressing and shower/ bathing. The resident required dependent care with toileting and putting on footwear. The resident was at risk for pressure ulcers and injuries. A Care Plan, dated 3/5/25, indicated the resident was at risk for unavoidable pressure injury development related to decline of skin integrity. Interventions were to administer treatments as ordered, provide weekly skin checks, assist with turning and repositioning, and educate on causative factors and measures to prevent skin injury. A Physician's Order, dated 4/2/25, indicated to offload heels while in bed as tolerated and confirm every shift. A Physician's Order, dated 5/2/25, indicated to cleanse the Sacrum with normal saline, pat dry, apply collagen to the wound bed, and cover with a dry dressing. The dressing was to be changed every day shift on Monday, Wednesday and Friday and as needed. During an interview on 5/5/25 at 10:31 a.m., the Executive Director indicated she understood Resident C should have had a dressing on her wound and the resident's heels should have been offloaded. No additional information was provided. This citation relates to Complaint IN00458244. 3.1-40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48383 Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to conflicting orders for wound treatments for 1 of 3 residents reviewed for pressure. (Resident D) Finding includes: On 5/5/25 at 11:01 a.m., Resident D was observed during a wound treatment. During the wound treatment, the wound nurse went to apply aquacell alginate to the wound bed. The current physician's order called for xerofoam to be placed on the wound bed. During an interview at the time, the nurse indicated she had confirmed the orders with the physician and the 12/20/24 order for xerofoam was the correct order to use going forward. She would delete the aquacell treatment order to ensure the correct order was used. The record for Resident D was reviewed on 5/5/25 at 10:55 p.m. Diagnoses included, but were not limited to, anemia (low iron), dysphagia (difficulty swallowing), and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/14/25, indicated Resident D was moderately impaired for daily decision making. The resident required dependent care for toileting, shower/bathing, upper body dressing, and lower body dressing. A Care Plan, dated 4/16/25, indicated the resident had pressure ulcers to the left buttock and right buttock related to dehydration, immobility, anemia, and incontinence. Interventions were to, administer treatments as ordered, place in EBP, and assess wounds weekly. A Physician's Order, dated 12/20/24, indicated to cleanse the right buttock with normal saline/wound cleanser, pat dry with sterile gauze, apply skin prep to the surrounding skin, apply Aquacel AG (alginate) to the wound bed, and secure with dry dressing. Change the dressing every 3 days and as needed (PRN) for soilage/dislodgement. A Physician's Order, dated 2/4/25, indicated to cleanse the right upper buttock with normal saline/wound cleanser, pat dry with sterile gauze, apply skin prep to the peri wound, apply Xerofoam Gauze to the wound bed, and cover with a border gauze dressing. Change the dressing every 3 days and PRN for soilage/dislodgement. The 5/2025 Treatment Administration Record (TAR) indicated both right buttock treatment orders were signed out as being completed. The treatment order from 12/20/24 was signed out as completed on 5/3/25 and 5/5/25. The treatment order from 2/4/25 was signed out as completed on 5/2/25. During an interview on 5/5/25 at 3:00 p.m., the Executive Director indicated she understood the concern and had no further information to provide. 3.1-50(a)(1) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-50(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48383 Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (Wound Nurse) when providing care during a wound treatment for resident who was in Enhanced Barrier Precautions (EBP) for 1 of 3 residents observed for pressure ulcer care. (Resident C) Finding includes: On 5/5/25 at 10:38 a.m., Resident C was observed in bed with 2 blankets covering her. She was lying on her back and crying she was cold. When the blankets were removed to observe the wound treatment, the resident's feet were lying flat on the bed. The Wound Nurse began the wound treatment, the resident's brief was opened and a new pad was placed underneath the resident. Hand hygiene was performed, and a new set of gloves were donned. The wound nurse did not have a gown on, and she began cutting the collagen dressing packet open. She was stopped and asked if the resident was in Enhanced Barrier Precautions. There was an EBP sign observed on the resident's door. During an interview at the time, the Wound Nurse indicated she had forgotten to put on a gown. The record for Resident C was reviewed on 5/5/25 at 10:01 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), dementia, high blood pressure, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of the lower extremities and used a wheelchair. The resident required partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene. The resident required substantial/maximum assistance with lower body dressing and shower/ bathing. The resident required dependent care with toileting and putting on footwear. The resident was at risk for pressure ulcers and injuries. A Physician's Order, dated 5/2/25, indicated to cleanse the Sacrum with normal saline, pat dry, apply collagen to wound bed, and cover with dry dressing. The dressing was to be changed every day shift on Monday, Wednesday, and Friday and as needed. Current CDC guidance for EBP in nursing homes, dated 7/12/22 and titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrugresistant Organisms (MDROs) indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated . Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressing During an interview on 5/6/25 at 1:11 p.m., the Infection Prevention (IP) nurse indicated their policy indicated EBP precautions were up to the discretion of the facility and their policy for EBP indicated if the wound could be covered and was not secreting drainage, then it did not need to be in EBP precautions. She understood regulation standards and had no further information to provide. 3.1-18(b)