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	09/16/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, record review and interview, the facility failed to ensure a resident's right to participate in her care related to not being informed on the medication she received during medication pass for 1 of 7 residents observed for medication administration. (Resident E)Finding includes:During medication administration on 9/15/25 at 9:22 a.m., RN 1 prepared the powdered medication Lokelma (given for high potassium level) in water for Resident E. RN 1 handed the resident the medication and the resident was gagging on the mixture and indicated how bad it tasted and did not want to finish it. RN1 instructed to drink the rest of the medication. RN 1 did not educate or inform Resident E what the medication was or why it was important to drink it all.During medication administration on 9/16/25 at 9:28 a.m., LPN 1 prepared the powdered medication Lokelma for Resident E. LPN 1 handed the medication to the resident and did not inform her what the medicine was for. The resident struggled to drink the medication fully and was starting to cry due to the poor taste. LPN 1 added more water to the mixture and instructed her to try and finish the medication drink.During an interview at the time, LPN 1 indicated the resident did not like the way it tasted and would ask for more water.Resident E's record was reviewed on 9/15/25 at 9:28 a.m. Diagnoses included, but were not limited to, high blood pressure, diabetes, and Bell's palsy.The admission Minimum Data Set (MDS) assessment, dated 5/29/25, indicated the resident was moderately impaired for daily decision making.A Physician's Order, dated 8/27/25, indicated to administer 1 packet of Lokelma once a day for high potassium.During an interview on 9/16/25 at 10:11 a.m., the Assistant Director of Nursing (ADON) indicated she would expect the nurses and qualified medication aides to inform the residents what medication they were receiving before they administered the medication.The current and revised Administration of Medications policy, provided by the Nursing Consultant as current on 9/16/25 at 10:09 a.m., indicated staff were responsible for adhering to the 10 rights of medication administration. Which included, . j. Right Education and Information. Provide enough knowledge to the resident of what drug he/she would be taking.This citation relates to Intake 2581285.3.1-3(n)(2)(3)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with ADLs (activities of daily living) related to bathing for 1of 3 residents reviewed for ADLs. (Resident D)Finding includes:On 9/15/25 at 3:33 p.m., Resident D was observed playing bingo. The resident's hair had a greasy appearance.Resident D's record was reviewed on 9/16/25 at 11:05 a.m. The diagnoses included, but were not limited to, heart failure, kidney disease, anxiety, and diabetes.The admission Minimum Data Set (MDS) assessment, dated 7/23/25, indicated the resident was moderately impaired with daily decision. The resident required partial to moderate assistant with toileting.A Care Plan, dated 7/23/25, indicated the resident required assistance with ADLs (activities of daily living) and needed therapy services. Intervention was to assist the resident with ADLs as needed.Showers Sheets indicated the resident had not received a bath/shower on the following dates:8/19/258/20/258/21/258/22/258/23/258/24/258/25/258/26/258/27/25There were no documented refusals for the above dates.During an interview on 9/16/25 at 12:33 p.m., the ADON indicated the resident had a caregiver and she would give her baths when she came. She understood the bath/showers should have been documented.This citation relates to Intake 2581285.3.1-38(2)(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review, and interview, the facility failed to administer medications as ordered related to antibiotic and antianxiety medication for 1 of 3 residents reviewed for medication administration. (Residents B)Finding includes:Resident B's record was reviewed on 9/15/25 AT 10:15 a.m. The diagnoses included, but were not limited to, paraplegia, osteomyelitis (bone and muscle infection), anxiety, hypertension (high blood pressure), muscle weakness, and ulcerative colitis (inflamed bowel).The admission Minimum Data Set (MDS) assessment, dated 7/14/25, indicated the resident was cognitively intact and received an antibiotic and antianxiety medication.A Physician's Order, dated 7/8/25, indicated to administer alprazolam 1 milligram (MG) my mouth at bedtime for anxiety.A Physician's Order, dated 7/11/25, indicated to administer Vancomycin (antibiotic) 1.25 grams intravenously two times a day for a wound infection related to osteomyelitis.The 7/2025 Medication Administration Record (MAR), indicated the following medications were not signed out as being administered:Vancomycin was not signed out as given on 7/9/2025 for the morning and evening dose.Vancomycin was not signed out as given on 7/10/2025 for the morning and evening dose. Alprazolam was not signed out as given on 7/8, 7/9, 7/10, 7/11, 7/14, 7/15, 7/17 and 7/18/2025.During an interview on 9/25/25 at 1:22 p.m., the Assistant Director of Nursing (ADON) indicated discharge paperwork was sent with the resident to the facility but they did not receive the After Visit Summary (AVS). The vancomycin was not listed on the discharge paperwork, and she had called the hospital twice trying to get the AVS sent over . The next day they were able to reach someone to get wound treatment orders, and they were going to fax the AVS to the facility. They never received the fax, and she understood she should have followed up. The resident had complained to staff that she was supposed to be on antibiotics, and they reached out to the physician at that time. At 1:57 p.m., she indicated she had admitted the resident and should have verified with the doctor the resident's antibiotic orders since she came to the facility with a diagnosis of osteomyelitis and without an AVS. She understood this resulted in a delay in treatment and 4 missed doses of Vancomycin. At 2:52 p.m., the ADON indicated she contacted the pharmacy, and they indicated they were waiting on a prescription for Resident C's alprazolam, and the medication was not filled because they never had a prescription. She indicated she asked nursing if they knew why she did not receive her anxiety medication, and they did not have an answer.This citation relates to Intake 2560578.3. 1-37(a)