| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155423 | A. Building<br>B. Wing | 02/11/2026 |

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

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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 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>Based on observation, record review, and interview, the facility failed to provide therapy or treatment for a resident with post-stroke hemiplegia resulting in a loss of range of motion to the affected hand for 1 of 2 residents reviewed for range of motion. (Resident 15)Finding includes:During random observations on 2/5/26 at 9:56 a.m., 2/6/26 at 1:03 p.m., and 2/9/26 at 10:00 a.m., Resident 15's left hand remained in a fist position. The knuckles on his left hand appeared larger than on his right. No visible intervention was observed for the left hand. During an observation of care on 2/9/26 at 10:41 a.m., the resident grabbed and pulled non-purposefully with his right hand when turned on his left side. When turned to his right side, minimal movement of his left arm was observed, and his left hand remained in a fist. At that time, CNA 2 indicated the resident did not really move his left hand or use his left arm. The resident's record was reviewed on 2/9/26 at 11:39 a.m. Diagnoses included, but were not limited to, hemiplegia (one-sided weakness or paralysis) of the left side after a stroke, and dementia. The End of PPS Part A Stay Minimum Data Set (MDS) assessment, dated 10/26/25, indicated the resident was not cognitively intact and was dependent in activities of daily living (ADLs). A Care Plan, dated 8/5/25, indicated the resident had a stroke. The goal was that the resident would be free from complications from a stroke, including contractures. Interventions included observing and reporting changes including weakness. A Care Plan, revised 8/5/25, indicated the resident had an alteration in his neurological status. The goal was that the resident would maintain status and quality of life within limitations imposed by neurological deficits. Interventions included physical therapy and occupational therapy to evaluate and treat as ordered. An Occupational Therapy Evaluation and Plan of Treatment dated 8/5/25, indicated the resident was totally dependent in ADLs and transfers. The evaluation of the resident's upper extremity (arm) ROM and strength were coded as Other (pt [patient] unable to follow simple one step commands for formal assessment; pt resistive at time of assessment).A Rehabilitation Services Screening Tool, dated 1/12/26, indicated the resident was not appropriate for skilled therapy at that time. The screening tool did not include the resident's hemiplegia or a range of motion (ROM) assessment. During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated she did not know if there were any interventions in place for the resident's hand, but she would check with therapy. In an evaluation, dated 2/10/26 at 11:52 a.m., Occupational Therapist (OT) 1 indicated the resident had arm mild hypertonicity (an abnormal increase in muscle tone, resulting in stiffness, rigidity, and reduced mobility caused by central nervous system damage, often linked to conditions like a stroke) throughout four of his fingers. OT 1 recommended therapy three times a week to trial a splint/palm guard. During an interview on 2/11/26 at 10:00 a.m., OT 1 indicated the last time the resident was on service, at the end of 2025, it was only for evaluation for a new chair. She indicated she thought the resident was using both hands at that time. She indicated normally nursing staff would inform them if there was a change in the resident's ROM, or they (therapist) would jump in if they observed it. She indicated during her assessment on 2/10/26, the resident did not follow commands, but through attempting passive ROM, she observed stiffness to his left fingers. She cleaned his hand and was trialing him with a palm guard. 3.1-42(a)(2) |

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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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to ensure a clean and sanitary kitchen was maintained related to food containers and boxes stored on the floor of walk ins, refrigerated food open to air and heavy debris build up on equipment for 1 of 1 kitchen observed. (Main Kitchen) This had the potential to affect 62 residents who received meals prepared from the kitchen.Findings include:On 2/5/26 at 8:50 a.m., the initial kitchen tour was completed with the Head Cook. The following was observed:a. In the portable walk-in refrigerator there were two loose containers of beef broth on the floor, There was a box of tortilla shells and two other food boxes sitting on the floor. There was a bag of biscuits open to air and discolored on the tops.b. In the portable walk-in freezer, there were no shelves. All food boxes were stacked in 22 stacks on the floor. c. The dishwasher had a heavy buildup of crumbs and debris.During an interview at the time of the kitchen tour, the Head [NAME] indicated food was not supposed to be stored on the floor, the biscuits should be thrown away, and the dishwasher was in need of cleaning.3.1-21(i)(3) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>Based on record review and interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment was accurate related to hospice services, diet, and medications for 4 of 19 residents whose MDS assessments were reviewed. (Residents 3, 18, 11, and 2)Findings include:1. The record for Resident 3 was reviewed on 2/9/26 at 1:30 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), Alzheimer's disease, heart failure, dementia, chronic kidney disease, stroke, peg tube (a tube that was inserted directly into the stomach for nutrition), and anxiety disorder.<br><br>A Physician's Order, dated 11/26/25, indicated admit to hospice services.<br><br>A hospice admission document, dated 12/1/25, indicated the resident was admitted to hospice.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 12/8/25, indicated the resident was not cognitively intact for daily decision making and received 51% or more of cubic centimeters (cc) a day of enteral feeding through the peg tube. Hospice services while a resident was not checked.<br><br>During an interview with on 2/10/26 at 9:11 a.m., the MDS Coordinator indicated hospice services should have been checked while a resident.<br><br>2. The record for Resident 18 was reviewed on 2/9/26 9:30 a.m. Diagnoses included, but were not limited to, heart failure, end stage renal disease, dialysis, heart disease, anemia, and anxiety.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/25, indicated the resident was cognitively intact for daily decision making and was not on a therapeutic diet.<br><br>A Physician's readmission Order, dated 12/9/25, indicated regular diet with no oranges, orange juice, bananas, potatoes, tomatoes, no salt packets, and diet condiments.<br><br>During an interview on 2/10/26 at 9:11 a.m., the MDS Coordinator indicated a therapeutic diet should have been checked on the MDS assessment.<br><br>3. The record for Resident 11 was reviewed on 2/9/26 at 7:54 a.m. Diagnoses included, but were not limited to, stroke, heart failure, anxiety, major depressive disorder, psychosis, and dementia without behaviors.<br><br>A Physician's Order, dated 1/14/26, indicated to discontinue Buspirone (an anti-anxiety medication) 10 milligrams (mg) one tablet twice a day.<br><br>The 1/23/26 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and in the last seven days received an anti-anxiety medication.<br><br>During an interview on 2/10/26 at 9:11 a.m., the MDS Coordinator indicated the anti-anxiety medication was coded inaccurately.<br><br>4. Resident 2's record was reviewed on 2/'9/26 at 2:01 p.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation and right and left below the knee amputation.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A Physician's Order, dated 6/13/25, indicated hydrocodone-acetaminophen 5/325 milligrams (an opioid pain medication) one tablet every eight hours for pain.<br><br>The Annual MDS assessment, dated 12/5/25, did not indicate the resident used opioid medications.<br><br>During an interview on 2/10/26 at 9:11 a.m., the MDS Coordinator indicated she would correct the discrepancies.<br><br>3.1-31(i) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident who was risk for elopement had their wander guard pendant (personal exit door alarm) checked for functioning at least daily for 1 of 1 resident reviewed for elopement. (Resident 9) The facility also failed to ensure hot water temperatures were below 120 degrees Fahrenheit on 1 of 2 units. (The North Unit) Findings include:1. During a random observation on 2/6/26 at 1:06 p.m., Resident 9 was observed sitting in a wheelchair at the nursing station with his legs crossed. At that time a wander guard was observed around the resident's ankle. The record for Resident 9 was reviewed on 2/9/26 at 11:43 a.m. Diagnoses included but were not limited to, intracranial loss of consciousness, fracture of the occipital lobe, altered mental status, mental disorder, obsessive compulsive disorder, high blood pressure, major depressive disorder, and history of falls. A Physician's Order, dated 6/5/25, indicated wander guard to right ankle for exit seeking behaviors. Check for placement every shift. A Care Plan, revised on 9/17/25, indicated the resident was at risk for elopement and had a history of attempts to leave the facility unattended. The approaches were to check wander guard every shift per order and replace per expiration date and as needed. The 11/28/25 Minimum Data Set (MDS) assessment indicated the resident was moderately intact for daily decision making, had no wandering issues, but had some physical behaviors during the assessment period. An Elopement Risk Evaluation, dated 1/27/26, indicated the resident had a history of elopement, and wandered aimlessly without purpose. There was no documentation in the clinical record that ensured the function of the wander guard was checked daily. During an interview on 2/9/26 at 1:12 p.m., LPN 1 indicated she visually checked the wander guard for placement by looking at the resident's ankle to see if it was there. She did not use any type of device to ensure it was functioning. She said she thought maintenance checked the wander guard but was unsure and she did not know if it was documented or not. During an interview on 2/9/26 at 1:20 p.m., the Maintenance Director indicated he does not check the wander guard for function once it was placed on the resident. He only checked it for function prior to placement. During an interview on 2/9/26 at 1:25 p.m., LPN 1 indicated she found the wander guard device to check the function in the bottom of the medication cart but it had a dead battery inside. She changed the battery and checked the wander guard and it did light up that it was working. She indicated she had not done that before and did not realize there was a device to check the wander guard. During an interview on 2/10/26 at 1:55 p.m., the Director of Nursing (DON) indicated they would follow the general manufacturer's guidelines for the wander guard function. The facility had no policy for checking the function of the wander guard. She indicated she would have thought maintenance would have been in charge of doing that. During an interview on 2/10/26, the DON brought in the guidelines for checking the function of the wander guard and indicated it should have been checked with a specific device to make sure it was working. The current and undated Transmitter Testing guidelines, provided by the Director of Nursing on 2/10/26 at 3:00 p.m., indicated You must test all wander management transmitters prior to use. It is recommended that you test your patient locking security transmitters on a regular basis to ensure proper operation. 2. During random observations on the North Unit, the hot water temperatures in resident rooms were too hot in the following rooms:a. The hot water in room [ROOM NUMBER] was checked on 2/5/26 at 11:07 a.m. and was too hot for a hand to hold under. There were two residents who shared the bathroom.The hot water was checked on 2/11/26 at 9:20 a.m., and was 118 degrees Fahrenheit.b. The hot water in room [ROOM NUMBER] was checked on 2/6/26 at 9:20 a.m. by the Maintenence Director and registered 130 degrees Fahrenheit. There were four residents who shared the bathroom. The hot water was checked on 2/6/26 at 10:30 a.m. and was 113 degrees Fahrenheit.c. The hot water in room [ROOM NUMBER] was checked on 2/6/26 at 9:23 a.m. by the Maintenence Director and registered 125 degrees Fahrenheit. There were four residents<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | who used the bathroom.The hot water was checked on 2/6/26 at 10:30 a.m. and was 113 degrees Fahrenheit.d. The hot water in room [ROOM NUMBER] was checked on 2/6/26 at 9:25 a.m.by the Maintenence Director and registered 124 degrees Fahrenheit. There were four residents who shared the bathroom. During an interview at that time on 2/6/26, the Maintenance Director indicated the boiler was set at 130 degrees Fahrenheit. The facility had issues with the circulating pump a couple of days prior and the water was too cold and he had that fixed right away. He indicated he was going to set the boiler at 120 degrees Fahrenheit and recheck the water temperatures every hour. The hot water was rechecked on 2/6/26 at 10:30 a.m. and was 112 degrees Fahrenheit.3.1-45(a)2 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure enteral feedings were infusing and administered as ordered by the physician, water flush bags were labeled and dated when hung, placement of the peg tube (a tube directly inserted into the stomach for nutrition) was checked prior to the administration of medication, and water flushes were not plunged via the peg tube for 5 of 5 residents reviewed for tube feeding. (Residents 3, 74, 76, 15, and 33)Findings include: 1. During a random observation on 2/6/26 at 8:45 a.m., Resident 3 was observed in bed and the enteral feeding was infusing at 60 cubic centimeters (cc) into the peg tube. At that time, there was a water flush bag hanging on the pole that was not dated or labeled.<br><br>On 2/9/26 at 8:36 a.m. and 9:00 a.m., the resident was observed in bed and the enteral feeding was infusing at 60 cc per hour into the peg tube.<br><br>On 2/9/26 at 12:50 p.m., the tube feeding was turned off.<br><br>On 2/10/26 at 8:30 a.m., the enteral tube feeding was turned off and the water flush bag was not labeled or dated.<br><br>The record for Resident 3 was reviewed on 2/9/26 at 1:30 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), Alzheimer's disease, chronic kidney disease, stroke, and peg tube (a tube that was inserted directly into the stomach for nutrition).<br><br>A Physician's Order, dated 10/15/25, indicated Jevity (enteral feeding) 1.2 at 60 cc per hour times 20 hours for a total of 1200 cc. Flush with 125 cc of purified water every six hours. On at 12:00 p.m., and off at 8:00a.m.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 12/8/25, indicated the resident was not cognitively intact for daily decision making and received 51% or more of cubic centimeters (cc) a day of enteral feeding through the peg tube.<br><br>A Care Plan, revised on 12/19/25, indicated the resident required a tube feeding. The approaches indicated the resident was dependent with tube feeding and water flushes and to see physician orders for current feeding orders.<br><br>During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing indicated the enteral feeding should be infusing according to physician orders. The water bags should be changed every 24 hours and the bag should be dated and labeled when hung.<br><br>2. During a random observation on 2/6/26 at 1:05 p.m., Resident 74 was observed in bed. At that time, and enteral feeding was infusing into the peg tube. The water flush bag hanging on the pole was not labeled or dated.<br><br>The record for Resident 74 was reviewed on 2/6/26 at 2:20 p.m. Diagnoses included, but were not limited to, paraplegia, peg tube (a tube inserted directly into the stomach for nutrition), severe calorie protein malnutrition, and dysphagia (difficulty swallowing). The resident was admitted to the facility on [DATE].<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The admission Minimum Data Set (MDS) assessment was still in progress.<br><br>A Physician's Order, dated 1/29/26, indicated enteral tube feeding of Glucerna 1.2 at 45 cubic centimeters (cc) per hour times 24 hours via pump for a total amount of 1080 cc, and flush with 145 cc of purified water every four hours.<br><br>A Care Plan, dated 1/30/26, indicated the resident required a tube feeding.<br><br>During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing (DON) indicated the water bag should be labeled and dated when hung and was to be changed every 24 hours.<br><br>3. On 2/5/26 at 12:05 p.m., Resident 76 was observed lying in his bed. There was a container of tube feeding hanging on pole that was not currently being infused, The resident indicated it was supposed to be for twelve hours a day from 6:00 p.m. to 6 a.m. and it didn't get turned on until 10:00 p.m. the previous night.<br><br>The resident's record was reviewed on 2/6/26 at 2:50 p.m. Diagnoses included, but were not limited to, muscular dystrophy, functional quadriplegia and gastrostomy (feeding tube). The resident was admitted to the facility on [DATE].<br><br>A Physician's Order, dated 1/29/26, indicated the tube feeding should be administered at 100 milliliters (ml) an hour for twelve hours a day.<br><br>The Brief Interview for Mental Status, dated 1/30/26, indicated the resident was cognitively intact.<br><br>The February 2026 Treatment Administration Record indicated enteral feeding every shift at 100 ml an hour for twelve hours for a total amount of 1200 ml. There was no specified time for the feeding to be turned on or off. The tube feeding was signed out as turned on during the evening shift and turned off during the midnight shift.<br><br>During an interview on 2/6/26 at 1:30 p.m., the DON was made aware there were no times specified for the tube feeding administration, she indicated she would get it corrected.<br><br>During an observation of medication administration via a PEG tube on 2/5/26 at 4:21 p.m., LPN 2 crushed each of Resident 76's medications and diluted them with water. Prior to administration, LPN 2 instilled an air bolus into the tube. He did not use his stethoscope to verify tube placement and he did not check residual. He flushed the tube with water prior to administration, in between each medication, and after the medications were given. He used the syringe to plunge in the last of the water flush instead of infusing via gravity.<br><br>During an interview on 2/11/26 at 1:54 p.m., the DON indicated PEG tube placement should be verified by checking residual before medications are administered, and flushes should be given by gravity, not by plunging with a syringe.<br><br>The policy, Medication Administration via Enteral Access Device (EAD), was received from the DON on 2/11/26 and indicated, .6. Avoid administration of feeding, fluids or medications through the EAD until correct position has been confirmed<br><br>4. During a random observation on 2/5/26 at 9:54 a.m., a tube feeding water flush bag was hanging on<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | a pole connected to Resident 15's feeding tube. The bag was dated 2/3/26.<br><br>During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated the water flush bags for tube feedings should be changed every 24 hours.<br><br>5. The record for Resident 33 was reviewed on 2/6/26 at 1:18 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness on one side of the body) following a stroke and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living.<br><br>A Physician's Order, dated 2/4/26, indicated Glucerna (a liquid tube feeding formula) three times a day, one can, flush with 15 ml (milliliters) of purified water before and after feeding, hold if meal (oral intake) is 50% or more.<br><br>The February, 2026 Medication Administration Record (MAR) indicated the following:<br><br>2/4/26 dinner intake 75%, no tube feeding given2/5/26 breakfast and lunch intakes 75%, no tube feeding given; dinner X, refused tube feeding2/6/26 breakfast and lunch intakes 75%, no tube feeding given; dinner 75%, no tube feeding given2/7/26 breakfast intake 75%, lunch and dinner 100%, no tube feeding given2/8/26 breakfast & lunch intake 100%, dinner 75%, no tube feeding given2/9/26 breakfast intake 0, lunch 75%, no tube feeding given<br><br>The meal consumptions documented by the CNAs indicated the following:2/4/26 0-25% breakfast and lunch; 51-75% dinner2/5/26 breakfast 51-75%, lunch and dinner 0-25%2/6/26 breakfast and lunch 26-50%, dinner 76-100%2/7/26 breakfast 51-75%, lunch 0-25%, dinner 26-50%2/8/26 breakfast, lunch and dinner 0-25% 2/9/26 breakfast 26-50%<br><br>During an interview on 2/9/26 at 9:38 a.m., RN 2 indicated she never gave the resident a tube feeding because it started at 6:00 p.m., and she worked day shift. The way she understood the order was that if the resident ate less than 50% of her meals throughout the day, she would get one can of Glucerna through her feeding tube at 6 p.m. When asked how the nurse knows how much the resident ate, RN 2 indicated she did not know how they figured that out.<br><br>During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated the nurse should administer one can of Glucerna via the feeding tube, for each meal time when the resident consumed less than 50% of her meal. When informed of the findings, the DON indicated she did not know why there was such a discrepancy between the CNA and the nurse documented meal intakes, but that she was going to look into it.<br><br>3.1-44(a)(2) |

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

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to keep the resident's environment clean and in good repair related to marred walls, gouged bathroom door frames, dirty ceiling vents, dirty tube feeding poles, dirty floor registers, and no toilet paper holders in bathrooms for 2 of 2 units. (The South and North units)Findings include: During the Environmental Tour on 2/11/26 at 9:10 a.m., with the Maintenance Director the following was observed:South Unit:a. room [ROOM NUMBER] - there was no toilet paper holder in the bathroom and the floor register was observed with a dried substance. There were 2 residents who resided in the room and four residents who shared the bathroom.b. room [ROOM NUMBER] - the floor vent was observed with dried substance on it. There were two residents who resided in the room.c. room [ROOM NUMBER] - there was no toilet paper holder in the bathroom. There were three residents who shared the bathroom.d. room [ROOM NUMBER] - the wall by the floor register was dirty as well as the floor register. The bathroom walls were marred. There were two residents who resided in the room and three residents who shared the bathroom.North Unit:a. room [ROOM NUMBER] - the floor behind the bed was dirty and the baseboard was pulling away from the wall. The bathroom ceiling vent was dusty. There was one resident who resided in the room and used the bathroom.b. room [ROOM NUMBER] - the bathroom door frame was gouged. There were three residents who used the bathroom. c. room [ROOM NUMBER] - there was no toilet paper holder in the bathroom. The pedestal sink was loose and pulling away from the wall. The walls were marred in the bathroom. The tube feeding pole by bed two was dirty with dried feeding noted on the base of the pole. The wall and floor behind the pump had dried tube feeding spillage noted. There were two residents who resided in the room, and three residents who used the bathroom.d. room [ROOM NUMBER] - the bathroom room walls and door frame were gouged and marred. There were four residents who used the bathroom.During an interview on 2/11/26 at 9:30 a.m., the Maintenance Director indicated all of the above were in need of cleaning and/or repair. 3.1-19(f) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, record review and interview, the facility failed to maintain a resident's dignity related to wearing a hospital gown during the day and posting of swallowing precautions/instructions in residents' rooms for 3 of 4 residents reviewed for dignity. (Residents 15, 33 and 42)Findings include:1. During random observations on 2/5/26 at 9:54 a.m., 2/9/26 at 10:31 a.m., and 2/9/26 at 3:33 p.m., Resident 15 was wearing a hospital gown during the day. The resident's record was reviewed on 2/9/26 at 11:39 a.m. Diagnoses included, but were not limited to, hemiplegia (one-sided weakness or paralysis) of the left side after a stroke, and dementia. The End of PPS Part A Stay Minimum Data Set (MDS) assessment, dated 10/26/25, indicated the resident was not cognitively intact and was dependent in activities of daily living (ADLs). The resident's care plan did not indicate the resident had a preference of wearing a hospital gown. During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) was informed of the finding and offered no additional information. 2. During random observations on 2/5/26 at 10:15 a.m., 2/6/26 at 1:10 p.m., and 2/9/26 at 3:03 p.m., a sign was posted above Resident 33's bed that stated, PATIENT IS A SILENT ASPIRATOR. The record for Resident 33 was reviewed on 2/6/26 at 1:18 p.m. Diagnoses included, but were not limited to, hemiplegia following a stroke.The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/26, indicated the resident had severe cognitive impairment and was dependent in ADLs. During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated the speech therapist must have put up signs in the resident's room, but she was not aware they were there. 3. During random observations on 2/5/26 at 10:33 a.m. and 2/9/26 at 9:50 a.m., a sign indicating the she was a silent aspirator and a page of individualized swallowing instructions were posted on the wall next to Resident 42's bed. The resident's record was reviewed on 2/9/26 at 2:21 PM . Diagnoses included, but were not limited to, dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, indicated the resident was cognitively intact for daily decision making. During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated the speech therapist must have put up signs in the resident's room, but she was not aware they were there. 3.1-3(t) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on record review and interview, the facility failed to provide timely notification of changes to the physician related to complaint of a cough for 1 of 2 residents reviewed for respiratory care (Resident 63) and a change in respiratory status for 1 of 1 resident reviewed for change in condition. (Resident 15)Findings include:1.On 2/5/26 at 10:21 a.m., Resident 63 was observed in his room. He indicated he had a cough and had requested cough medicine but was told by nursing that he didn't have an order for any the previous day.<br><br>The resident's record was reviewed on 2/10/26 at 10:36 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia and muscle weakness.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 1/9/26, indicated the resident was cognitively intact.<br><br>A Behavior Note, dated 1/26/26, indicated the resident had requested some cough syrup. The writer indicated he did not have an order for cough syrup and if he was having a cough or feeling congested the writer would contact the physician for an order. The resident became agitated and was redirected. There was no indication in the note the resident had been assessed for a cough or the physician had been notified.<br><br>A Health Status Note, dated 2/9/26, indicated the resident had complained of a cough. The resident was assessed, the physician was notified and an order was received for Robitussin as needed for cough.<br><br>During an interview on 2/11/26 at 9:51 a.m., the Director of Nursing was made aware of the delay in physician notification and order for cough syrup. She indicated she would look into it, but no further information was provided.<br><br>2. The record for Resident 15 was reviewed on 2/9/26 at 11:39 a.m. Diagnoses included, but were not limited to, hemiplegia (one-sided weakness or paralysis) of left side after a stroke, dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (COPD).<br><br>The End of PPS Part A Stay Minimum Data Set (MDS) assessment, dated 10/26/25, indicated the resident was not cognitively intact and was dependent in ADLs.<br><br>A Care Plan, initiated 10/9/25, indicated the resident was at risk for rehospitalization. Interventions included that the staff was to provide timely communication to the physician or nurse practitioner regarding any change in the resident's condition.<br><br>In a Progress Note, dated 12/13/25 at 10:31 p.m., the nurse indicated they were called to the resident's room by a co-worker, who informed them that the resident didn't look well. The nurse indicated the resident was not responding to verbal stimuli and had shallow breathing. At that time, the resident's blood pressure was 75/66, and his oxygen saturation was 85%. The nurse administrated oxygen at 5 lpm (liters per minute) per nasal cannula. After 20 minutes, the resident's blood pressure was 94/60 and his oxygen saturation was 93%. The nurse indicated she would keep resident on the oxygen at 5 lpm and monitor throughout their shift.<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The record lacked documentation that the physician was informed of the change in the resident's status.<br><br>In a Progress Note, dated 12/14/25 at 1:30 a.m., the nurse indicated the resident was resting quietly, aroused to verbal stimuli, and had an oxygen saturation of 98%.<br><br>A Progress Note, dated 12/14/25 at 6:00 a.m., indicated the resident was not responding to verbal stimuli or tactile stimuli. His oxygen saturation level was 83% with oxygen being administered at 5 lpm per nasal cannula. An ambulance was called, and the resident was sent out to the hospital.<br><br>During an interview on 2/10/26 at 9:35 a.m., the Director of Nursing (DON) indicated the nurse should have notified the physician immediately of the change in the resident's status.<br><br>A policy titled, Changes in Resident's Condition or Status, received from the DON as current on 2/10/26, indicated, . A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is . A significant change in the resident's physical, mental, or psychosocial status.<br><br>3.1-5(a)(2) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and interview, the facility failed to ensure interventions were attempted prior to administering PRN (as needed) anti-anxiety medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 2)Finding includes: The record for Resident 2 was reviewed on 2/9/26 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart failure and right and left below the knee amputation. The Annual Minimum Data Set assessment, dated 12/5/25, indicated the resident had moderate cognitive deficits.A Physician's Order, dated 1/20/26, indicated to give lorazepam (an anti-anxiety medication) 0.5 milligrams every 12 hours as needed for anxiety for 14 days. A Behavior Care Plan, revised on 7/29/25, indicated the resident had behaviors of yelling, exit seeking, and being aggressive. Interventions included, but were not limited to, engage calmly in conversation, guide away from source of distress, assess for needs and document attempted interventions. The January 2026 Medication Administration Record indicated the resident received lorazepam on 1/22, 1/24 and 1/29/26. There were no interventions documented prior to giving the medication. During an interview on 2/10/26 at 1:55 p.m., the Director of Nursing indicated there were no interventions documented prior to giving the medication.3.1-3(w) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on record review and interview, the facility failed to ensure a resident and/or their responsible party were sent the facility's bed-hold policy and State approved transfer form before and upon transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 70)Finding includes: Resident 70's closed record was reviewed on 2/11/26 at 12:57 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure and atrial fibrillation.The admission Minimum Data Set assessment, dated 11/26/25, indicated the resident was cognitively intact.A Health Status Note, dated 12/3/25 at 3:59 a.m., indicated the resident had called 911 and reported difficulty breathing. Emergency Services arrived and she was transported to the hospital. She returned to the facility later that morning with no new orders. A Health Status Note, dated 12/3/25 at 3:45 p.m., indicated the resident had called 911 again complaining of pain and shortness of breath. Emergency Services arrived and transported her to the hospital. She was admitted to the hospital at that time.There was no indication the bed hold policy or State approved transfer form had been provided to the resident or the resident's responsible party for either of the hospital transfers that day.During an interview on 2/11/26 at 2:25 p.m., the Director of Nursing indicated there were no transfer or bed hold policies provided.3.1-12(a)(6)(A)(ii)3.1-12(a)(6)(A)(iii)3.1-12(a)(25)(A) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, record review, and interview, the facility failed to ensure the care plan reflected the resident's current care needs and choices related to maintaining a bed in high position and indwelling catheter maintenance and care for 1 of 3 residents reviewed for accidents (Resident 33) and 1 of 2 residents reviewed for catheters (Resident 37).Findings include:1. During a random observation on 2/5/26 at 10:20 a.m., Resident 33 was observed lying in a diagonal position with both of her legs hanging off of side of bed. She indicated she was unable to move her legs back into the bed. The bed was in a high position. On 2/5/26 at 12:46 p.m., 2/6/26 at 1:14 p.m., and 2/9/26 at 9:57 a.m. and 3:02 p.m., the resident was observed lying in her bed, which was in a high position. The record for Resident 33 was reviewed on 2/6/26 at 1:18 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness on one side of the body) following a stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living and transfers. A care plan, revised on 7/30/25, indicated the resident had an actual fall and was at risk for falling. Interventions included to anticipate and meet the resident's needs, and to keep the call light in reach. There was no care plan indicating the resident had a preference for keeping the bed in a high position.During an interview on 2/10/26 at 2:30 p.m., the Director of Nursing (DON) indicated the bed was in a high position due to the resident's preference, but they did not have a care plan for it. 2. During a random observation on 2/5/26 at 10:51 a.m., Resident 37 was observed resting in his bed. There was a urine collection bag hanging from his bedframe. At that time, the resident indicated he had an indwelling urinary catheter. The record for Resident 37 was reviewed on 2/10/26 at 2:27 p.m Diagnoses included, but were not limited to, congestive heart failure (CHF) and chronic kidney disease.A Progress Note, dated 1/21/26, indicated an indwelling urinary catheter was inserted in the resident.The record lacked a care plan related to the indwelling catheter.During an interview on 2/11/26 at 9:35 a.m., the Director of Nursing (DON) indicated they should have a care plan in place for the resident related to the indwelling catheter. 3.1-35(a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on record review and interview, the facility failed to invite and hold care planning conferences for residents and/or their family members. The facility also failed to update care plans related to medications for 3 of 19 residents whose care plans were reviewed. (Residents 6, 11, and 13)Findings include:1. During an interview on 2/5/26 at 10:33 a.m., Resident 6 indicated she has not been invited to a care conference.<br><br>The record for Resident 6 was reviewed on 2/6/26 at 1:09 p.m. Diagnoses included, but were not limited to, heart failure, heart disease, chronic kidney disease, and depression.<br><br>The 12/17/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making.<br><br>A Psychosocial Note, dated 3/27/25 at 10:30 a.m., indicated the IDT (interdisciplinary team) met with the resident for a quarterly care plan meeting.<br><br>There were no other care plan meetings in the clinical record.<br><br>During an interview on 2/10/26 at 9:20 a.m., the Administrator indicated the facility was without a Social Service Director (SSD) for a couple of months. The current SSD had been there for about two months. They were aware care planning conferences were missed.<br><br>2. During an interview on 2/5/26 at 11:06 a.m., Resident 11 indicated she does not recall going to a care plan meeting.<br><br>The record for Resident 11 was reviewed on 2/9/26 at 7:54 a.m. Diagnoses included, but were not limited to, stroke, heart failure, anxiety, major depressive disorder, psychosis, and dementia without behaviors.<br><br>The 1/23/26 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and in the last seven days received an anti-anxiety medication.<br><br>Psychosocial Progress Notes, dated 4/10/25, 12/12/25 and 1/8/26, indicated the IDT met with the resident for a quarterly care plan conference.<br><br>There were no documented care plan conferences between 4/10/25 and 12/12/25.<br><br>A Care Plan, last revised on 11/10/25, indicated the resident was on pain medication therapy and had a prescribed opioid for pain.<br><br>A Physician's Order, dated 1/14/26, indicated to discontinue Hydrocodone (an opioid medication).<br><br>During an interview on 2/10/26 at 9:20 a.m., the Administrator indicated the facility was without a Social Service Director (SSD) for a couple of months. The current SSD has been here for about two months. They were aware care planning conferences were missed.<br><br>During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing indicated the care plan was<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | outdated.<br><br>3. Resident 13's record was reviewed on 2/9/26 at 9:17 a.m. Diagnoses included, but not limited to, functional quadriplegia, cirrhosis of the liver and vascular dementia.<br><br>The resident's medication list did not include any diuretics.<br><br>A Care Plan, dated 11/7/25, indicated the resident was on diuretic therapy. Interventions included, but were not limited to, administer medications as ordered, monitor for side effects and monitor for weight changes.<br><br>During an interview on 2/9/26 at 10:53 a.m., RN 2 indicated the physician had discontinued the diuretics.<br><br>During an interview on 2/10/26 at 9:25 a.m., the Director of Nursing was made aware the care plan for diuretics was still in place. No additional information was provided.<br><br>3.1-35(d)(2)(B) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, record review and interview, the facility failed to ensure a resident who needed assistance with ADL's (Activities of Daily Living) received help related to oral care and washing of hair for 1 of 3 residents reviewed for ADL's. (Resident 6)Finding includes: During an interview on 2/5/26 at 10:30 a.m., Resident 6 indicated her hair was not washed every week and staff do not set her up to brush her teeth. At that time, the resident's hair was unkempt. During an interview on 2/9/26 at 9:35 a.m., the resident indicated CNA 1 got her up and dressed, however, she did not set her up to brush her teeth or provide oral care. She also indicated her hair had not been washed recently. The record for Resident 6 was reviewed on 2/6/26 at 1:09 p.m. Diagnoses included, but were not limited to, heart failure, heart disease, chronic kidney disease, and depression. The 12/17/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident needed set up assistance with oral care and partial/moderate assist with personal hygiene. A Care Plan, revised on 9/11/25, indicated the resident needed assistance with ADL's. The approaches were to encourage the resident to participate in tasks as tolerated. The shower sheets, indicated the resident received a bed bath on 1/8, 1/12, 1/15, 1/19, 1/26, 1/29, and 2/5/26. The resident's hair was only washed on 1/26/26. During an interview on 2/9/26 at 10:25 a.m., CNA 1 indicated she provided morning care for the resident today and did not set her up to brush her teeth or assist her with oral care. During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing had no additional information to provide. 3.1-38(a)(3)(B)3.1-38(a)(3)(C) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, record review and interview, the facility failed to ensure a skin rash was assessed and monitored for 1 of 2 residents reviewed for non-pressure related skin conditions, and blood pressure medications were administered as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. (Residents 18 and 37)Findings include: 1. During an interview on 2/5/26 at 12:10 p.m., Resident 18 indicated he had a red area on the left side of his neck that had been there for about two months. He had told nursing staff and nurses at dialysis but still has not had any treatment for it. At that time, there was a red circular area on the side of his neck. He indicated it was starting to itch.<br><br>On 2/9/26 at 12:45 p.m., RN 1 was asked to perform a skin assessment to the resident's neck area. At that time, she observed the red and raised area to the left side of his neck.<br><br>During an interview at that time, RN 1 indicated she was unaware of the skin rash and was not provided any information during the end of shift report she had received in the morning. She indicated when a new skin condition was observed, it would be assessed and the doctor would be notified for a treatment.<br><br>The record for Resident 18 was reviewed on 2/9/26 9:30 a.m. Diagnoses included, but were not limited to, heart failure, end stage renal disease, dialysis, heart disease, anemia, and anxiety.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/25, indicated the resident was cognitively intact daily decision making. The resident had no skin concerns.<br><br>There were no physician orders for any type of cream or ointment to the area on his neck.<br><br>The Weekly Skin Assessments, dated 11/2, 11/13, 11/20, 11/27, 12/10, 12/17, 12/24, 12/31/25, 1/7, 1/14, 1/21, 1/28, and 2/4/26, indicated the resident's skin was intact and there was no documentation regarding any redness to the left side of his neck.<br><br>There was no documentation in nursing progress notes from 10/2026 until 2/2026 regarding the reddened area to the left side of the neck.<br><br>A Physician's Order, dated 2/9/26, indicated Triamcinolone Acetonide Ointment 0.1%, apply to left anterior neck topically two times a day for rash for seven days.<br><br>During an interview on on 2/10/26 at 9:20 a.m., the Director of Nursing (DON) had no additional information to provide.<br><br>2. The record for Resident 37 was reviewed on 2/10/26 at 2:27 p.m Diagnoses included, but were not limited to, congestive heart failure (CHF) and chronic kidney disease.<br><br>A Physician's Order, dated 1/14/26, indicated metoprolol succinate (a medication for heart failure and high blood pressure) one time a day for CHF, hold if SBP (top number of a blood pressure reading) was under 100.<br><br>The January 2026 Medication Administration Record (MAR) indicated the following: 1/3/26 BP (blood pressure) 86/56, metoprolol was given; 1/5/26 BP 85/65, metoprolol was given; 1/8/16 BP 90/53, (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<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hammond-Whiting Care Center | 1000 114th St<br>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.

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | metoprolol was given; 1/9/26 BP 90/68, metoprolol was given; and 1/10/26 BP 96/65, metoprolol was given.<br><br>A Physician's Order, dated 1/15/26, indicated midodrine (a medication to treat low blood pressure) three times a day, hold if SBP (top number of a blood pressure reading) was over 110.<br><br>The January 2026 Medication Administration Record (MAR) indicated the following: 1/5/26 at 2:00 p.m., BP 120/43, midodrine was given; 1/5/26 at 8:00 p.m., BP 116/46, midodrine was given; 1/7/26 at 2:00 p.m., no blood pressure was documented, no midodrine was given; and 1/10/26 at 2:00 p.m., BP 115/97, metoprolol was given.<br><br>During an interview on 2/11/26 at 9:35 a.m., the DON was informed of the findings and offered no additional information.<br><br>3.1-37(a) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to a dialysis fistula and pressure ulcer treatments for 1 of 1 resident reviewed for dialysis and 1 of 2 residents reviewed for pressure ulcers. (Residents 18 and 74)Findings include:1. During an observation on 2/6/26 at 12:10 p.m., Resident 18 was observed sitting in a wheelchair in his room. At that time, his shirt was off and a perma catheter was observed in his upper chest. He indicated, that was being used for his dialysis treatments. He had never had a fistula, as they were going to do that later. The record for Resident 18 was reviewed on 2/9/26 9:30 a.m. Diagnoses included, but were not limited to, heart failure, end stage renal disease, dialysis, heart disease, anemia, and anxiety.A Physician's Order, dated 7/24/25, indicated dialysis resident, assess bruit/thrill (assessments performed on a dialysis fistula) upon return from dialysis every evening shift every Monday, Wednesday, and Friday. The order was discontinued on 12/4/25.The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/25, indicated the resident was cognitively intact for daily decision making.The Treatment Administration Record (TAR) for the months of 7/2025 through 12/2025 indicated the assessment for the bruit/thrill was signed out as being completed.A Physician's order, dated 1/9/26, indicated dialysis resident, assess bruit/thrill upon return from dialysis every evening shift every Monday, Wednesday, and Friday. The TAR for 1/2026 and 2/2026 indicated indicated the assessment for the bruit/thrill was signed out as being completed.During an interview on 2/9/26 at 12:45 p.m., RN 1, who was taking care of the resident, indicated she was unsure if the resident had a fistula for dialysis, but knew he had a perma catheter.During an interview on 2/10/26 at 1:55 p.m., the Director of Nursing indicated the dialysis orders were batch orders from the physician. She had no additional information to provide. 2. The record for Resident 74 was reviewed on 2/6/26 at 2:20 p.m. Diagnoses included, but were not limited to, paraplegia, severe calorie protein malnutrition, and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on [DATE].The admission Minimum Data Set (MDS) was still in progress.The Treatment Administration Record (TAR) for 2/2026 indicated the following treatments were not signed out as being completed on 2/2/26 and 2/3/26:Bilateral heels and lateral right big toe apply skin prep daily. Left heel and left pinky toe: cleanse with wound wash, pat dry, cover with calcium alginate with silver and cover with border gauze one time a day.Left outer ankle blister: cleanse with wound wash, pat dry, cover with xeroform and cover with border gauze, one time a day. Left thigh and leg: cleanse with wound wash, pat dry, cover with calcium alginate with silver and cover with border gauze, one time a day. Right middle back: cleanse with wound wash, pat dry and cover with xeroform and border gauze daily.Right thigh: cleanse with wound wash, pat dry, cover with calcium alginate with silver and cover with border gauze one time a day. Sacrum/ coccyx: cleanse with wound wash, wet to dry dressing and cover with border gauze one time a day.The Wound Physician assessed the resident on 2/3/26.During an interview on 2/9/26 at 10:05 a.m., the Wound Nurse indicated she did the wound treatments on Mondays, Wednesdays and Fridays when she worked. She also worked on Tuesdays when the Wound Physician made his rounds. The treatments were completed, however, she did not sign them out.During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing had no additional information to provide. 3.1-50(a)(1)3.1-50(a)(2) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff not donning personal protective equipment (PPE) for a resident in enhanced barrier precautions (EBP), an indwelling Foley catheter bag observed on the floor, and the improper storage of personal care equipment during random infection control observations. (Residents 74 and 76)Findings include:1. During random observations on 2/5/26 at 9:49 a.m., 10:19 a.m., and 12:16 p.m., Resident 74 was observed in bed. At those times, the indwelling Foley catheter bag was observed on the floor.<br><br>The record for Resident 74 was reviewed on 2/6/26 at 2:20 p.m. Diagnoses included, but were not limited to, paraplegia and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on [DATE].<br><br>The admission Minimum Data Set (MDS) was still in progress.<br><br>A Physician's Order, dated 1/29/26, indicated Indwelling catheter to straight drainage, size 16 French with a 10 cubic centimeters (cc) bulb.<br><br>During an interview on 2/10/26 at 9:20 a.m., the Director of Nursing (DON) indicated the foley catheter bag should not have been on the floor.<br><br>The current and updated 9/4/25, Indwelling Urinary Catheter Foley Management policy, provided by the DON on 2/9/26 at 3:00 p.m., indicated do not rest the bag on the floor.<br><br>2. During random observations of the bathroom in room [ROOM NUMBER] on 2/5/26 at 10:26 a.m. and on 2/11/26 at 9:20 a.m., there were two pink wash basins observed on the floor and a urinal hanging on the grab bar. All three were not labeled or contained in any bag. There were three residents who shared the bathroom.<br><br>During an interview on 2/11/26 at 1:05 p.m., the Director of Nursing (DON) had no additional information to provide.<br><br>The current 5/1/25 Keeping a Resident's Room in Order policy, provided by the DON on 2/11/26 at 3:13 p.m., indicated Bedpans and urinals must be covered with a plastic bag. Each plastic bag will be marked with the resident's name.<br><br>3. During an observation of medication administration on 2/5/26 at 4:21 p.m., LPN 2 prepared each of Resident 76's medications to be administered via his PEG tube (a feeding tube inserted through the abdomen). At 4:25 p.m., LPN 2 went into the resident's room to wash his hands. He donned gloves and proceeded with medication administration. He did not don a gown to administer the PEG tube medications.<br><br>During an interview on 2/11/26 at 1:54 p.m., the Director of Nursing (DON) indicated a gown should be worn when administering medications via a PEG tube.<br><br>3.1-18(b) |