STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155383		12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00189218. Complaint IN00189218 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F312. Survey dates: December 29, 30, &31, 2015. Facility number: 000393 Provider number: 155383 AIM number: 100289340 Census bed type: SNF/NF: 75 Total: 75 Census payor type: Medicare: 6 Medicaid : 51 Other: 18 Total: 75 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 5,	F 0000	F000 The creation and submission of this Plan ofCorrection does not constitute an admission by this provider of any conclusionset forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan ofCorrection be considered the Letter of Credible Allegation and requests a DeskReview or Post Survey Review on or after 1/25/2016.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	2016 by 29479.			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review, and interview, the facility failed to ensure residents who were unable to carry out activities of daily living received showers for 2 of 3 residents reviewed for activity of daily living (Residents B and D). Findings include: 1. Resident B's record was reviewed on 12/30/2015 at 9:25 a.m. Resident B had a diagnosis which included, but was not limited to, Alzheimer's disease. A Minimum Data Set (MDS) assessment, dated 10/30/15, indicated Resident B had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 2 out of 15 and required physical assistance from staff for bathing. An Activity of Daily Living (ADLs) care	F 0312	**F312** **What corrective action(s) willbe accomplished for those residents found to have been affected by the deficientpractice?** Residentsgiven showers with appropriate documentation. **How will other residents havingthe potential to be affected by the same deficient practice be identified andwhat corrective action will be taken?** Allresidents have the potential to be affected by this alleged deficient practice. All staff inserviced on shower frequency, refusal of showersand proper documentation of showers. **What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur** All staff inserviced on shower frequency, refusal of showersand proper documentation of showers	01/25/2016

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	plan, dated 9/25/13, indicated Resident B had a functional self care deficit related to impaired cognition. Interventions included staff were to provide full wash up /sponge bath two times per week, partial bath in between, and to refer to shower schedule at the nurse's station for shower days. During an interview on 12/30/15 at 12:25 p.m., Certified Nursing Assistant (CNA) #6 indicated Resident B had not refused showers. She indicated if residents refused showers she reported it to the charge nurse and another staff would re-approach the resident. She indicated Resident C's shower days were Tuesday and Saturdays. During an interview on 12/30/15 at 12:28 p.m., Licensed Practical Nurse (LPN) #5 indicated, Resident B had occasionally refused showers and could not be redirected however, she could not recall the last time that occurred. Shower records dated September 1, 2015 through November 30, 2015, were reviewed with the Administrator on 12/31/15 at 1:30 p.m. The records lacked indication Resident B had been provided a shower during September 2015. The		by 1/25/2016. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** To ensure compliance, theED/Designee is responsible for completing the Shower Compliance tool, whichincludes whether resident refused shower and if nurse notified, weekly for 4weeks and monthly for 6 months. The results of these audits will be reviewed bythe CQI committee overseen by the ED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.	

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	records indicated she had been provided a shower one time in October on 10/27/15. The records indicated she had been provided a shower four times in November on 11/6, 13, 20 and 27, 2015. The records lacked indication she refused showers. 2. Resident D's record was reviewed on 12/30/15 at 10:15 a.m., Resident D had a diagnosis which included, but was not limited to, dementia. A Minimum Data Set (MDS) assessment, dated 12/17/15, indicated Resident C had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15 and required physical assistance from staff for bathing. An Activities of Daily Living (ADL) care plan, dated 3/17/15, indicated Resident D required assistance and/or monitoring for all ADL care including bathing. A self-care deficit care plan, dated 7/31/14, indicated staff was to provide showers twice a week with partial bathing in between. Shower records, dated September 1, 2015 through December 30, 2015, were reviewed with the Administrator on 12/31/15 at 1:30 p.m. The records indicated Resident D had been provided			

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	five showers in September on 9/8,16, 23, 26, and 30, 2015. The records lacked indication Resident D refused showers in September 2015. The records indicated she was provided four showers in October on 10/3, 14, 21, and 10/28/15. The record indicated she refused a shower on 10/24/15. The record indicated she was provided six showers in November on 11/1, 4, 7, 18, 21, and 11/25/15. The record indicated she refused a shower on 11/11/15. The record indicated she was provided a shower three times in December on 12/12, 16, and 23, 2015. The record lacked indication she refused showers. During an interview on 12/30/15 at 12:20 p.m., Certified Nursing Assistant (CNA) #8 indicated Resident D had not refused showers for her. She indicated if residents refused showers the nurse on duty was informed. She indicated her shower days were Wednesdays and Saturdays. During an interview on 12/31/15 at 1:33 p.m., CNA #10 indicated residents who resided on the cottage while the shower was non-functioning were taken to a shower on another unit. She indicated if residents refused showers after several			

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	approaches the nurse was informed. During an interview on 12/31/15 at 1:35 p.m., the Administrator indicated the facility did not have a policy regarding frequency of showers however, all residents were provided two showers a week unless otherwise indicated in their plan of care. She indicated if residents continued to refuse showers the nurse should have assessed the reasons why and adjusted the plan of care accordingly. 3.1-38(3)(b)(2)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to identify and accurately assess skin impairment as a pressure ulcer and failed	F 0314	**What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Resident's care plan updated with new	01/25/2016

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	to ensure pressure reducing interventions were evaluated and revised when a resident developed a pressure ulcer for 1 of 2 residents reviewed for alteration in skin integrity that had developed within the facility (Resident C). Finding includes: During an interview on 12/29/15 at 2:09 p.m., Unit Manager #1 indicated Resident C was incontinent and had alterations in his skin integrity. During an observation on 12/30/15 at 1:25 p.m., with Licensed Practical Nurse (LPN) #2 and LPN #3 present, Resident C's skin was observed. LPN #2 and #3 positioned Resident C on his left side. Resident C was observed to have three areas in a triangular pattern approximately two inches apart located on his posterior upper right thigh. Wound #1 was observed to have a bright red wound bed with proximated edges and no drainage. Wound #2 and #3 were observed with bright pink, intact skin. During the observation LPN #2 obtained measurements and indicated wound #1 measured 2.3 cm (centimeters) length (L) X 1.0 cm width (W) X "less than" 0.1 cm depth. (D). LPN #2 indicated wounds #2 and #3 had "just closed."		preventivemeasures in place, including hourly check and repositioning. Resident seen by urology for continuedleaking from catheter. **How will other residents havingthe potential to be affected by the same deficient practice be identified andwhat corrective action will be taken?**All residents have the potential to be affected bythe alleged deficient practice. All nursing staff inserviced onskin assessment, documentation and preventive measures to keep wounds fromdeveloping by 1/25/16. **What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?** All nursing staff inserviced onskin assessment, documentation and preventive measures to keep wounds fromdeveloping by 1/25/16. All residents will receive weeklyskin assessments by 1/25/16. Interventions will be reviewedweekly for all residents with wounds by 1/25/16. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** To ensure compliance, the DNS/Designee is responsiblefor completing the Wound/Skin tool weekly for 4 weeks and monthly for 6 months.The results of these audits will be reviewed by the CQI committee	

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	Resident C's record was reviewed on 12/30/15 at 9:00 a.m. Resident C had diagnosis which included, but were not limited to, overflow incontinence-persistent, spina bifida with hydrocephalus, male genital organ disorders, neuromuscular dysfunction of bladder, and acquired absence of unspecified leg above the knee-bilateral. An admission assessment, dated 6/20/14 at 4:26 p.m., indicated Resident C was admitted to the facility with a stage 3 pressure ulcer which measured 8.5 (L), 8.0 (W), 0.2 (D) located on his "posterior right thigh." The record indicated scarring was noted on his buttocks from "old" decubitis. A wound skin evaluation report dated, September 9, 2014, indicated the wound was resolved. An initial Minimum Data Assessment (MDS) assessment, dated 6/27/14 indicated Resident C was admitted with a stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) and was at risk for developing pressure ulcers. A Minimum Data Assessment (MDS)		overseen bythe ED. If threshold of 95% is not achieved an action plan will bedeveloped to ensure compliance.	

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	tool, dated 11/14/15, indicated Resident C was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, was incontinent of bowel and bladder, and required extensive assistance of two staff for toilet use, personal hygiene, and bed mobility. . An admission assessment, dated 6/20/14 at 4:26 p.m., indicated Resident C was admitted to the facility with a stage 3 pressure ulcer which measured 8.5 (L), 8.0 (W), 0.2 (D) located on his "posterior right thigh." The record indicated scarring was noted on his buttocks from "old" decubitis. A wound skin evaluation report dated, September 9, 2014, indicated the wound was resolved. Resident C's care plans were reviewed on 12/30/15 at 10:00 a.m. A skin care plan, originally dated 6/23/14, and last reviewed on 11/20/15, indicated Resident C was at risk for skin breakdown or further skin break down due to a history of wounds, impaired mobility, incontinence, heart disease, and open areas on his buttocks. A goal indicated he would be free from skin breakdown. Interventions were implemented on the following dates: 8/22/14 -side rails, 6/23/14- assess and document skin condition weekly and as needed, 6/23/14-encourage him to eat greater than			

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	50 percent, 6/23/14- incontinent care as needed using peri wash and moisture barrier, 6/23/14-pressure reducing /redistribution cushion in chair/wheelchair, 6/23/14 pressure reducing/redistribution mattress on bed, 6/23/14 preventative treatment as ordered, 6/23/14-turn and reposition at least every two hours. The care plan lacked indication interventions had been evaluated and/or revised to reduce the risk of skin break down. A nurse's note, dated 1/28/15 at 1:59 a.m., indicated Resident C developed two areas of "excoriation" located on his "right posterior thigh." Wound #1 measured 1 cm x 1 cm and wound #2 measured 1 cm x 1 cm. A MDS, dated 5/26/15, indicated Resident C was at at risk for developing pressure ulcers A nurse's note, dated 7/22/15 at 4:43 p.m., indicated Resident C developed a new area of skin alteration identified as "moisture associated skin damage." The area was located on his right posterior thigh/buttock and measured 2.0 cm (L) x 2.0 cm (W) x less than 0.1 cm (D). An event report, dated 9/9/15, indicated Resident C continued to have moisture associated skin damage described as an			

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	"open area" which measured 0.5 cm (L) x 0.5 cm (W) x less than 0.1 cm (D) located on his right posterior thigh. The note indicated Resident C had difficulty with incontinence and urinary frequency. A wound skin evaluation report, dated 9/16/15, indicated this wound was resolved. A MDS, dated 8/25/15, indicated Resident C was at risk for developing pressure ulcers. A MDS, dated, 11/1/15, indicated Resident C was at risk for developing pressure ulcers. A nurse's note, dated 11/14/15 at 11:25 p.m., indicated Resident C developed a "small wound" located in the "button [sic]." The record lacked indication of wound measurements. A nurse's note, dated 11/18/15 at 11:22 p.m., indicated Resident C had an open area located on his right buttock. The record lacked indication of wound measurements. An Inter-Disciplinary Team (IDT) note, dated 11/18/15, indicated Resident C developed a "new skin tear" on his right buttock. The record lacked indication of wound measurements.			

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	A nurse's note, dated 11/25/15 at 10:48 p.m., indicated Resident C had "two" open areas on his right posterior thigh. The record lacked indication of wound measurements. A nurse's note, dated 11/29/15 at 1:28 p.m., indicated Resident C had three open to his right buttock with a "small amount of blood" noted. The note indicated the treatment to his right buttock had been changed. The record lacked indication of wound measurements. A nurse's note, dated 11/30/15 at 6:15 p.m., indicated Resident C had three open areas to his right buttock. The record lacked indication of wound measurements. A document provided by the Director of Nursing on 12/31/15 at 12:30 p.m., indicated Resident C's had two wounds on his right buttock. The document indicated measurements were taken on the following dates: a. 12/2/15, Wound #1 measured "2.5 x 1.5 x 0.1" and Wound #2 measured "2.0 x 1.0 x 0.1." b. 12/8/15, Wound #1 measured "2.5 x 1.5 x 0.1" and Wound #2 measured "2.0 x 1.0 x 0.1." c. 12/16/15, Wound #1 measured "2.0 x			

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	1.5 x 0.1" and Wound #2 measured "1.9 x 1.0 x 0.1." d. 12/23/15, Wound #1 measured "1.8 x 1.3 x 0.1" and Wound #2 measured "1.5 x 1.0 x 0.1." e. 12/30/15, Wound #1 measured 2.3 x 1.0 x less than 0.1" and Wound #2 had "resolved." A progress note, dated 12/31/15, indicated, "...Reason for visit: skin assessment/supra pubic catheter issues. History of present illness: ...with newly placed supra pubic catheter. Pt has had recent issues with catheter causing leaking from catheter site and penis. Pt (patient) has been reluctant to get out of bed due to leakage issues. Pt has been wearing brief to prevent wetting clothes. Pt has a pending appointment with urology on 1/4/16 to address leakage issues. In mean time, pt has developed a moisture type skin issue on right upper thigh from persistent wetness and use of brief. There are 3 small areas, all very superficial. 2 appear closed but fragile, one is open with no tunneling, undermining or signs of infections. Measurements for open area are 0.4 x 0.1... Treatment and plan: non-pressure ulcer of right thigh, limited to break down of skin secondary to current need of brief while newly placed supra pubic catheter issues are being resolved. pt has			

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	had poorly draining catheter that has required flushing q (every) shift to promote drainage from catheter. urine has been leaking from both site and penis, pt is reluctant to get up in chair while leakage is an issue and has been needing to wear brief... Area to right upper thigh has developed and is moisture related. 3 areas, all very superficial. one open, 2 closed...." During an interview on 12/30/15 at 9:39 a.m., Resident C indicated "long waits" for incontinent care. He indicated at times at night he would wait over an "hour." During an interview on 12/30/15 at 1:25 p.m., with LPN #2 and LPN #3 present, LPN #2 indicated Resident C had a "pressure" area because he was unable to move and he was incontinent. She indicated they "rotated" him and "checked and changed" him every two hours. She indicated he had issues with his catheter leaking. During an interview on 12/31/15 at 10:41 a.m., the Director of Nurses (DON) indicated Resident C admitted to the facility with a stage three pressure ulcer to his right posterior thigh. She indicated they "healed" the pressure ulcer but he had recurrent open areas to the same area.			

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	She indicated he acquired a stage three "level" moisture related ulcer while in the facility. She indicated the current area was incontinence related skin break down and not a pressure ulcer. She indicated she was out of the country when the area was first noted and measurements were not obtained until she returned. She indicated he was incontinent on admission and eventually required a catheter due to bladder dysfunction. She indicated once the catheter was placed they had difficulty with it leaking. She indicated his catheter had been leaking on and off for "at least a couple of months." She indicated they had scheduled him for an appointment to have a supra pubic catheter placed but in the mean time his skin broke down. She indicated the supra pubic catheter was placed a few weeks ago and it leaked as well. She indicated he was scheduled to see a urologist in a few weeks. She indicated he was at risk for pressure and moisture related skin breakdown due to his impaired mobility, incontinence, history of wounds. She indicated they had him on standard interventions implemented for anyone at risk for skin breakdown such as a turning and repositioning schedule, pressure redistribution devices, and check and change every two hours or as needed. She indicated other than monitoring his catheter and ensuring			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/31/2015
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231	

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	appointments to address the leaking catheter, interventions had not been evaluated/revised to ensure he did not develop moisture related skin break down due to increased moisture. She further indicated the current interventions were not effective and stated, "that's why he broke down." During an interview on 12/31/15 at 2:03 p.m., with the Administrator, the Nurse Practitioner, and the DON present, the DON indicated she called his wound a stage three because "you don't downsize wounds." She indicated she classified it as a "stage three" based on her knowledge of wounds and because it had "depth." She indicated until 12/31/15, a physician, nurse practitioner, or wound specialist had not assessed the wound. She indicated because Resident C was cognitively alert and oriented and was able to utilize his call light interventions were not implemented to minimize the moisture due to the catheter leaking. A skin management program policy, identified by the Director of Nursing as current on 12/31/15 at 1:17 p.m., indicated, "...It is the policy of American Senior Communities to assess each resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually, and with			

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	155383		12/31/2015

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	significant change... A head to toe assessment will be completed by a licensed nurse upon admission/readmission and weekly... A plan of care will be initiated to include resident specific risk factors with appropriate interventions. Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place. A care plan will be developed specific to the resident's needs including prevention interventions. Direct care givers will be notified of the resident; specific prevention interventions...." This Federal tag relates to Complaint IN00189218. 3.1-40(a)(2)			