STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155383	A. BUILDING -- B. WING	06/13/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/13/23 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Emergency Preparedness survey, Washington Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 91 certified beds. At the time of the survey, the census was 57. Quality Review conducted on 06/14/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/13/23 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this Life Safety Code survey, Washington	K 0000	The submission of this plan of correction does not indicate an admission by Washington Healthcare that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of this facility. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Blevins	Executive Director	06/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 91 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building for storage of supplies which was not sprinklered. Quality Review conducted on 06/14/23		care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. *This facility respectfully requests from the Department a desk review for paper compliance. The facility will provide additional information as needed to identify compliance including audit tools, receipts for items corrected and or pictures of before and after corrections.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 entry / exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 36 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:05 a.m. to 2:26 p.m. on 06/13/23, the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a five-digit code, however, the code posted was not correct: a. The main entry / exit door b. The employee entry / exit door c. The Southeast entry / exit door Based on interview at the time of the observations, the Maintenance Director, as well as the facility signage, alleged the facility exits were secured and marked as exits. Furthermore, it was posted that the doors could be opened by entering a five-digit code. The code posted was	K 0222	**K222 Egress Doors** It is the intent of this facility to ensure the means of egress are readily accessible for residents without a clinical diagnosis requiring specialized security measures. POTENTIAL TO BE AFFECTED: Residents, staff, and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: Maintenance Director programed the door codes as 3 digits at the main entry/exit door, the employee entry/exit door, and the Southeast entry/exit door. The Maintenance Director posted the correct code at the main entry/exit door, the employee entry/exit door, and the Southeast entry/exit	06/28/2023

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	posted as * mm/dd for the five-digit code, (the * key + m - month digit #1, + m - month digit #2 / + d - day digit number #1, + d - day digit #2) but when activated, the door keypad only needed to have the * mm/d entered and the door unlocked. When asked why the code was not just posted as just a four-digit code the Maintenance Director advised that he was told by his Regional Supervisor to list it as a five-digit code and post it at the doors as such. During the exit conference with the facility Executive Director and the Maintenance Director at 2:10 p.m. on 06/13/22, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		door. The Maintenance Director was educated on the requirement to ensure means of egress are readily accessible. MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/or designee will review the codes for all exit doors throughout the facility 1x monthly x's 12 months to ensure the correct codes are posted as part of the facilities preventative maintenance program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The maintenance supervisor will review with the Executive Director the inspection results. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED: The Executive Director will monitor adherence to the Preventative Maintenance schedule and validate the "Preventative Maintenance Egress Doors" 1x monthly x's 12 months. The results of the audit will be	

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			presented by the Executive Director monthly for review in the monthly QAPI meeting.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was installed in accordance with 19.3.4.1. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches. This deficient practice could affect staff and up to 15 residents, 4 staff and 2 visitors in the smoke compartment. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 12:55 p.m.	K 0341	**K341 Fire Alarm System - Installation** It is the intent of this facility to ensure that smoke detectors are not located in a direct airflow or closer than 36 inches. POTENTIAL TO BE AFFECTED: Residents, staff, and visitors have the potential to be impacted by this alleged deficient practice,	06/28/2023

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	on 06/13/23, the main entry lobby had a smoke detector approximately 24 inches from an air duct. Based on interview at the time of the observation, the Maintenance Director acknowledged the aforementioned condition and stated that he would have the smoke detector moved as soon as he could schedule his vendor to come in and do so. During the exit conference with the facility Executive Director and the Maintenance Director at 2:10 p.m. on 06/13/22, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		however none were. CORRECTIVE ACTION COMPLETED: The main entry lobby smoke detector was moved beyond 36 inches from an air duct. The maintenance director did an inspection of all other smoke detectors to ensure they met this requirement. MEASURES TO PREVENT REOCCURENCE: The Maintenance Director will measure any newly installed smoke detectors to ensure they are beyond 36 inches. HOW THE CORRECTIVE ACTION WILL BE MONITORED: The Maintenance Director will complete a visual/manual inspection of smoke detectors quarterly. The Ed will review the audit tool and present it to the QAPI team quarterly.	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 power strips used for office equipment was firmly secured. NFPA 70, National Electric Code, 2011 Edition, Article 110.13 Mounting and Cooling of Equipment states electrical equipment shall be firmly secured to the surface on which it is mounted. Wooden plugs driven into holes in masonry, concrete, plaster, or similar materials shall not be used. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the nurse's station by Room 215. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 12:55 p.m. on 06/13/23, office equipment was plugged into a power strip which was dangling above the floor in the Activities Office and was not secured. Based on interview at the time of the observations, the Maintenance Director agreed the power strip was not placed on the floor or firmly secured in any way. During the exit conference with the facility	K 0511	**K511 Utilities – Gas and Electric** It is the intent of this facility to ensure that all power strips used for office equipment are firmly secured. POTENTIAL TO BE AFFECTED: Residents, staff, and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTION COMPLETED: The power strip was removed from the Activities Office.	06/28/2023

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	Executive Director and the Maintenance Director at 2:10 p.m. on 06/13/22, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		MEASURES TO PREVENT REOCCURENCE: The ED in-serviced the Maintenance Director on 6/13/23 on the requirement that all power strips must be firmly secured. The Maintenance Director will complete a visual/manual inspection of all power strips in facility areas to assure they are firmly secured. 1x weekly x's 3 months then 1x weekly x's 9 months with the inspection results given to the ED for review. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED: The ED will review the audit tool and then present the audit tool with the inspection to the QAPI team monthly.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.			

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	The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 11 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the document titled "Direct Supply - TELS - Conduct a Fire drill" with the Maintenance Director on 06/13/22 at 9:40 a.m., the documentation for the drills for the past eleven of the last twelve months lacked verification of the transmission of the signal for drills. All eleven of the fire drills were marked as "silent drills" as well. Based on interview at the time of record review, the Maintenance Director stated that he did call the monitoring company to take the facility off test but neglected to ask for the verification of the transmission of the fire alarm signal and did not know that the verification was a requirement for fire drills. During the exit conference with the facility Executive Director and the Maintenance Director at 2:10 p.m. on 06/13/22, no additional information or evidence could be provided contrary to this	K 0712	**K712 Fire Drills** It is the intent of this facility to ensure fire drills include the verification of transmission of the fire alarm signal to the monitoring station. POTENTIAL TO BE AFFECTED: Residents, staff, and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTION COMPLETED: The Maintenance Director conducted a fire drill on 6/27/23 and obtained verification of the transmission of the fire alarm signal. All future fire drills will include verification of the transmission of the fire alarm signal.	06/28/2023

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	deficient finding. 3.1-19(b) 3.1-51(c)		MEASURES TO PREVENT REOCCURENCE: Maintenance Director/Designee will run fire drills 1x per shift per month and obtain verification of transmission of the fire alarm signal from the monitoring station. The notice of verification will be provided to the ED for review. HOW THE CORRECTIVE ACTION WILL BE MONITORED: The ED will review the audit tool and then present the audit tool to the QAPI team monthly.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating			

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	the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review, and interview; the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations made with the Maintenance Director during a tour of the facility from 11:23 a.m. to 2:20 p.m. on 06/13/23, the	K 0914	**K914 Electrical Systems – Maintenance and Testing** It is the intent of this facility to ensure all nonhospital-grade electrical receptacles at the resident room locations are tested at least annually. POTENTIAL TO BE AFFECTED: Residents, staff, and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTION COMPLETED: The Maintenance Director completed receptacle retention testing for all resident rooms. Documentation was completed.	06/28/2023

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	facility's 46 resident rooms had roughly 8 electrical receptacles in each room. Based on interview at the time of the observation, the Maintenance Director indicated all of the electrical receptacles in the resident rooms were not hospital-grade and also indicated there was no documentation of a completed receptacle retention testing available for review as of the time of this survey. During the exit conference with the facility Executive Director and the Maintenance Director at 2:10 p.m. on 06/13/22, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		MEASURES TO PREVENT REOCCURRENCE: The Maintenance Director will select receptacles to test quarterly throughout the year until all receptacles have been tested. Documentation will be completed and presented to ED annually. HOW THE CORRECTIVE ACTION WILL BE MONITORED: Documentation will be reviewed by ED and presented to QAPI team annually.	