	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2022	
	PROVIDER OR SUPPLIE		8201 \	ADDRESS, CITY, STATE, ZIP CODE WWASHINGTON ST NAPOLIS, IN 46231		
(X4) ID PREFIX TAG 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION	
Bldg	conducted by the I in accordance with Survey Date: 05/2 Facility Number: Provider Number: 10 At this Emergency Washington Healt substantial compli Preparedness Requ Medicaid Participa 42 CFR 483.73. The facility has 91 the survey, the cer	25/22 000393 155383 0289340 7 Preparedness survey, heare Center was found in ance with Emergency uirements for Medicare and ating Providers and Suppliers, certified beds. At the time of	E 0000	The submission of this plane correction does not indicate admission by Washington Healthcare that the findings allegations contained herein an accurate and true representation of the quality care provided to the resident this facility. This facility recognizes its obligation to provide legally and medically necessary care and service safe environment to its resid in an economic and safe ma The facility herby maintains substantial compliance with requirements of participation skilled health care facilities. this end, this plan of correcti shall serve as the credible allegation of compliance with state and federal requirement governing the management facility. It is thus submitted a matter of statue only. *This facility respectfully req from the Department a desk review for paper compliance facility will provide additional information as needed to ide compliance including audit to receipts for items corrected a or pictures of before and after corrections.	an and are of ts of ts of ts of ts of ts in the ents inner. it is a uests a true ts a true	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 06/10/2022

Any define cystatement 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.

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/25/2022	
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
E 0035 SS=C Bldg	§483.73(c)(8); §4 *[For LTC Faciliti [(c) The LTC faci maintain an eme communication p Federal, State an reviewed and up communication p following:] *[For ICF/IIDs at [(c) The ICF/IIDs at [(c) The ICF/IID r an emergency pr plan that complie local laws and m at least every 2 y plan must include (8) A method for the emergency p determined is ap clients] and their Based on record re facility failed to er preparedness plan sharing informatio that the facility hat with residents and representatives in 2 483.75(c)(8). This affect all occupant Findings include: Based on record re	Sharing Plan with Patients 183.475(c)(8) es at §483.73(c):] lity must develop and rgency preparedness lan that complies with nd local laws and must be dated at least annually. The lan must include all of the §483.475(c):] must develop and maintain eparedness communication as with Federal, State and ust be reviewed and updated rears. The communication a all of the following:] sharing information from lan, that the facility has propriate, with residents [or families or representatives. eview and interview, the asure the emergency (EPP) includes a method for n from the emergency plan is determined is appropriate their families or accordance with 42 CFR deficient practice could	E 00	35	The facility will ensure this requirement is met through th following actions. POTENTIAL TO BE AFFECT All residents, family members visitors have the potential to b impacted by this alleged defic practice, however none were. CORRECTIVE ACTIONS COMPLETED: On June 6, 2022 the Executiv Director posted in common ar of facility a notice to residents	ED: and e ient e e	06/10/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12:50 p.m., the Emergency Preparedness Binder family members and visitors that provided did not address a method for sharing the emergency preparedness plan information contained within the EPP Binder that is available for review upon the facility deems appropriate with clients, their request to the Executive Director. families or representatives. Based on interview MEASURES TO PREVENT at the time of records review, the Administrator **REOCCURENCE:** telephoned the corporate office and was told that the documentation provided is what they have The Activity Director will also always used. Documentation provided addresses review 06/2022 in Resident Council and yearly thereafter that how and when the facility would contact families and representatives in the event of an emergency. EPP is available for review upon request to the Executive Director. but did not declare when, where and how residents, families or representatives could view Signage will be maintained with the EPP documentation the facility deemed isdh postings. appropriate if they so decided. The provided HOW THE CORRECTIVE documentation only suggested they call the facility if they had questions. ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT The finding was reviewed with the acknowledged PRACTICE WILL NOT RECUR by the fill-in Maintenance Supervisor at the time The Executive Director will insure of discovery and again at the exit conference that continued posting will be with the Executive Director and fill-in maintained in visible area. If there are any issues with posting, they Maintenance Supervisor present at 4:30 p.m. will be addressed and resolved immediately. The issues will then be brought to the Quality Assurance Committee at that time. If needed and Action Plan will be recommended and then monitored by the Executive Director. K 0000 Bldg. 01 A Life Safety Code Recertification and State The submission of this plan of K 0000 Licensure Survey was conducted by the Indiana correction does not indicate an Department of Health in accordance with 42 admission by Washington CFR 483.90(a). Healthcare that the findings and allegations contained herein are Survey Date: 05/25/22 an accurate and true FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6L21 Facility ID: 000393 If continuation sheet Page 3 of 30

PRINTED: 06/10/2022 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) representation of the quality of Facility Number: 000393 care provided to the residents of this facility. This facility Provider Number: 155383 AIM Number: 100289340 recognizes its obligation to provide legally and medically At this Life Safety Code survey, Washington necessary care and service in a Healthcare Center was found not in compliance safe environment to its residents with Requirements for Participation in in an economic and safe manner. Medicare/Medicaid, 42 CFR Subpart 483.90(a), The facility herby maintains it is in substantial compliance with the Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) requirements of participation for skilled health care facilities. To 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC this end, this plan of correction 16.2. shall serve as the credible allegation of compliance with all This one-story facility was determined to be of state and federal requirements Type V (111) construction and fully sprinklered. governing the management of this facility. It is thus submitted as a The facility has a fire alarm system with smoke detection in the corridors and in all areas open to matter of statue only. the corridor. The facility has battery operated *This facility respectfully requests smoke detectors in all resident sleeping rooms. The facility has a capacity of 91 and had a census from the Department a desk of 43 at the time of this visit. review for paper compliance. The facility will provide additional information as needed to identify All areas where residents have customary access compliance including audit tools, were sprinklered. The facility has one detached building for storage of supplies which was not receipts for items corrected and sprinklered. or pictures of before and after corrections. Quality Review completed on 05/31/22 K 0222 **NFPA 101** SS=E Egress Doors Bldg. 01 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

requires the use of a tool or key from the egress side unless using one of the following

CLINICAL NEEDS OR SECURITY THREAT

special locking arrangements:

TQ6L21

Facility ID: 000393

If continuation sheet

Page 4 of 30

PRINTED: 06/10/2022 FORM APPROVED

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
	155383		B. WING	<u></u>	05/25/2022
NAME OF	PROVIDER OR SUPPLI	- P	STREE	T ADDRESS, CITY, STATE, ZIP	CODE
TURNE OF	I KO VIDEK OK SOTTEL		8201	W WASHINGTON ST	
WASHIN	IGTON HEALTHC	ARE CENTER	INDIA	NAPOLIS, IN 46231	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION (X5
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLE
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	LOCKING				
		ocking arrangements for the			
		needs of the patient are			
		ocking device shall be			
		h door and provisions shall			
		rapid removal of occupants			
		ol of locks; keying of all			
	-	rried by staff at all times; or			
		le means available to the			
	staff at all times.				
		2.2.2.6, 19.2.2.2.5.1,			
	19.2.2.2.6				
	SPECIAL NEED				
	ARRANGEMEN				
		ocking arrangements for the			
		he patient are used, all of			
		ecurity Locking requirements			
	-	addition, the locks must be			
		nat fail safely so as to			
		s of power to the device; the			
		ted by a supervised			
		ler system and the locked			
		ed by a complete smoke			
	-	n (or is constantly monitored			
		ocation within the locked			
		the sprinkler and detection			
	-	inged to unlock the doors			
	upon activation.	2 2 2 5 2 TIA 12 4			
	DELAYED-EGR	2.2.2.5.2, TIA 12-4			
	ARRANGEMEN				
		delayed-egress locking			
		d in accordance with			
		e permitted on door			
		ing low and ordinary hazard			
		ings protected throughout by			
		pervised automatic fire			
		or an approved, supervised			
	automatic sprink				
	18.2.2.2.4, 19.2.				
	1	-			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 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 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 K 0222 It is the policy of this facility to 06/10/2022 insure doors within a required failed to ensure all means of egress were readily accessible for residents without a clinical means of egress shall not be diagnosis requiring specialized security equipped with a latch or lock that measures. Doors within a required means of requires the use o a tool, key or code from the earess side unless egress shall not be equipped with a latch or lock otherwise permitted to meet set that requires the use of a tool or key from the egress side unless otherwise permitted by LSC standards. 19.2.2.2.4. Door-locking arrangements shall be POTENTIAL TO BE AFFECTED: permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Residents. staff and visitors have the potential to be impacted by Findings include: this alleged deficient practice, however none were. Based on observations and interview during a CORRECTIVE ACTIONS tour of the facility with the Executive Director COMPLETED: and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the exit door On October 6. 2022 the Executive at the main entrance was marked as a facility exit, Director posted the correct code was magnetically locked and could be opened by at the exit door to exit the facility at the main entrance. On October entering a four digit code but the code was not posted at the exit. 6. 2022 the Executive Director in-serviced the Maintenance FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6L21 Facility ID: 000393 If continuation sheet Page 6 of 30

PRINTED:

06/10/2022

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155383	(X2) MULTIPLE CC A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 05/25/2022
	PROVIDER OR SUPPLIE		8201 W	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN 46231	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O The finding was re by the fill in Maint of discovery and a with the Executive	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) viewed with the acknowledged enance Supervisor at the time gain at the exit conference Director and fill in rvisor present at 4:30 p.m.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Director on the requirement that all exit doors must have the correct code posted to meet th standards and that monthly inspections are completed on a egress doors to assure exit cod are posted. If the maintenance director fails to comply with the points of the in-service further education and or progressive discipline as needed will be completed. MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/of designee will review the codes all exit doors throughout the facility 1x monthly x's 12 month insure the correct codes are posted as part of the facilities preventative maintenance progressive	or for ns to
				and document those inspection results as appropriate. If any issues are discovered, they wil addressed and resolved immediately. The maintenance supervisor will review with the Executive Director the inspecti results. HOW THE CORRECTIVE ACTIONS WILL BE MONITOR TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUP The Executive Director will mo adherence to the Preventative Maintenance schedule and validate the "Preventative Maintenance Egress Doors" 1>	n II be e on RED R nitor

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	JILDING	onstruction <u>01</u>	(X3) DATE SURV COMPLETED	
		155383	B. WI	NG		05/2	5/2022
NAME OF	PROVIDER OR SUPPLIE	P		STREET	ADDRESS, CITY, STATE, ZIP O	CODE	
					V WASHINGTON ST		
WASHIN	IGTON HEALTHC	ARE CENTER		INDIAN	NAPOLIS, IN 46231		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COI	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					monthly x's 12 months		
					of the audit will be pre		
					the Executive Director		
					review in the monthly		
					meeting. Frequency a		
					of the audits will be ad	-	
					needed or recommend	ded by the	
					QA team.		
(0321	NFPA 101						
SS=E	Hazardous Areas	s - Enclosure					
Bldg. 01	Hazardous Areas						
Blag. 01		s are protected by a fire					
		hour fire resistance rating					
	-	e rated doors) or an					
		tinguishing system in					
		8.7.1 or 19.3.5.9. When the					
		atic fire extinguishing system					
		ne areas shall be separated					
		es by smoke resisting					
		ors in accordance with 8.4.					
	Doors shall be se						
		g and permitted to have					
		-applied protective plates					
	that do not excee	ed 48 inches from the bottom					
	of the door.						
	Describe the floo	or and zone locations of					
	hazardous areas	that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9	9					
		• · · · • • · · ·					
	Area	Automatic Sprinkler					
	Separation	N/A					
		el-Fired Heater Rooms					
		ger than 100 square feet)					
		enance, and Paint Shops					
		Rooms (exceeding 64					
	gallons)	5					
	e. Trash Collection						
	(exceeding 64 ga						

PRINTED: 06/10/2022 FORM APPROVED

(X5)

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility K 0321 It is the intent of this facility to 06/10/2022 failed to ensure all hazardous area doors, such as assure that all hazardous rooms storage rooms, were provided with properly are equipped with a self-closing device or self-closing hinges. working self-closing devices. This deficient practice could affect more than 10 residents, as Hazardous rooms are designated well as staff and visitors. as such. POTETIAL TO BE AFFECTED: Findings include: Residents. staff and visitors have Based on observations and interview during a the potential to be impacted by tour of the facility with the Executive Director this alleged deficient practice, however none were. These rooms and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the following were on a closed secured unit that was noted: did not occupy any residents. CORRECTIVE ACTIONS A) Room 210, greater than 50 square feet, COMPLETED: contained a number of combustible items, such as, paper, plastic, and more than 50 cardboard On 6/6/22 The Executive Director in-serviced the Maintenance and boxes. The room not equipped with a self-closing device or self-closing hinges. Housekeeping Supervisor/designee on the requirements for storage and B) Room 211, greater than 50 square feet, had cardboard boxes and various Christmas using only designated storage decorations stored inside the room. The room areas. not equipped with a self-closing device or A) Room 210, room was self-closing hinges. organized and some items dispersed to proper storage C) Room 212, greater than 50 square feet, had areas. covid test supplies and cardboard boxes. The B) Room 211. all cardboard boxes room not equipped with a self-closing device or and various Christmas self-closing hinges. decorations were removed from the room. The room is now set up

> D) Room 201, greater than 50 square feet, contained boxes and mattresses. The room not equipped with a self-closing device or self-closing hinges.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TQ6L21

Facility ID: 000393

for a resident.

C) Room 212 all covid test

supplies and cardboard boxes were removed from the room. The

If continuation sheet

Page 9 of 30

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 05/25/2022	
NAME OF PROVIDER OR SUPPLIER		8201 V	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST			
	IGTON HEALTHC			NAPOLIS, IN 46231		(71.5)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COM	(X5) IPLETION DATE
< 0353 SS=E Bldg. 01	The finding was re by the fill in Main of discovery and a with the Executive Maintenance Supe 3.1-19(b) NFPA 101 Sprinkler System Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testi Water-based Fire Records of syste inspection and te	 a. Maintenance and Testing b. Maintenance and Testing c. Maintenance and Testing ler and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of e. Protection Systems. em design, maintenance, asting are maintained in a and readily available. 		room is now set up for a resid D) Room 201, all contained by and mattresses were removed from the room. The room is no set up for a resident. MEASURES TO PREVENT REOCCURRENCE: Executive Director/or designe do a daily inspection of secure unit 5's week x's 30 days, then weekly x's 4 weeks then 1 x weekly x's 8 weeks HOW THE CORRECTIVE ACTIONS WILL BE MONITOU TO ENSURE THE DEFICIEN PRACTICE WILL NOT RECU The Executive Director will forward the inspection results the Quality Assurance Team monthly The results of the aud will be presented by the Exect Director for review in the mon QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA tear	ent. pxes d bw e will ed n 2x RED T R to dit utive thly d	

PRINTED: FORM APPROVED

06/10/2022

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the K 0353 It is the intent of this facility that 06/10/2022 Sprinkler System- Maintenance facility failed to maintain the ceiling construction throughout the facility. The ceiling and Testing Automatic sprinkler traps hot air and gases around the sprinkler and and system are inspected, tested and maintained in accordance cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 NFPA 25 and assure that all states the distance between the sprinkler sprinkler heads are not covered deflector and the ceiling above shall be selected with foreign material in based on the type of sprinkler and the type of accordance with LSC 9.7.5 and construction. This deficient practice could 5.2.1.1.1 affect 4 residents and 3 staff. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have Findings include: the potential to be impacted by Based on observations and interview during a this alleged deficient practice, tour of the facility with the Executive Director however none were. and fill in Maintenance Supervisor 05/25/22 CORRECTIVE ACTIONS between 12:50 p.m. and 3:30 p.m., in the COMPLETED: common area in the LTC side, there were a 1-inch unsealed gaps around the sprinkler heads. On 6/10/22 the sprinkler head This condition could delay the activation of the found in common area on the ltc sprinklers. Based on interview at the time of side was re-secured to close gap observation, the Maintenance Supervisor agreed between the head and ceiling. On 6/10/22 the sprinkler heads in there were unsealed gaps in the ceiling around the sprinkler head. the laundry area were inspected and cleaned by the the The finding was reviewed with the acknowledged Maintenance Director. by the fill in Maintenance Supervisor at the time MEASURES TO PREVENT of discovery and again at the exit conference **REOCCURRENCE:** with the Executive Director and fill in FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6L21 Facility ID: 000393 If continuation sheet Page 11 of 30

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATIO		IDENTIFICATION NUMBER: 155383	B. WING		completed 05/25/2022
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER		8201 V	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST NAPOLIS, IN 46231		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC
TAG K 0355 SS=E Bldg. 01	Maintenance Super 2. Based on observe facility failed to ere not loaded or cove accordance with L edition, at 5.2.1.1.7 signs of leakage; si foreign materials, p shall be installed in up-right, pendent, 5.2.1.1.2 any sprin the following shall Corrosion (3) Physi in the glass bulb he Loading (6) Paintis sprinkler manufact could affect staff a area. Findings include: Based on observati tour of the facility and fill in Mainten between 12:50 p.m heads in the laundar showed signs of lo The finding was ree by the fill in Mainten of discovery and a with the Executive	viewed with the acknowledged enance Supervisor at the time gain at the exit conference Director and fill in rvisor present at 4:30 p.m.	TAG	Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of the sprinkler hea and system visual inspections. Maintenance Director or design will do a visual inspection of all sprinkler heads to include couplings to ensure that the devices are free from dust and secured with no gap from ceilin to sprinkler 3x's week x's 4 wee then 1x weekly x 8 weeks then monthly x's 9 months HOW THE CORRECTIVE ACTIONS WILL BE MONITOR! TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The inspection results will be presented to the Quality Assurance Team monthly by the Executive Director. Frequency and duration of the audits will bu adjusted as needed or recommended by the QA team upon review.	ads ee ng ks 1x ED e

PRINTED: 06/10/2022

FORM APPROVED

OMB NO. 0938-0391

PRINTED: 06/10/2022 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155383	r í	ILDING	DNSTRUCTION 01	COMP	e survey leted 5/2022
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER		8201 W WASH		ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN 46231	VASHINGTON ST		
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION
	-				CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	
TAG	Portable fire extin installed, inspecte accordance with N Portable Fire Extin 18.3.5.12, 19.3.5. Based on observati failed to inspect all the facility each mo Portable Fire Extin states fire extinguis manually or by mea system at a minimu Section 7.2.2 states electronic monitori include a check of a (1) Location in des (2) No obstruction (3) Pressure gauge operable range or p (4) Fullness determ for self expelling-ty cartridge-operated (5) Condition of tir and nozzle for whe (6) Indicator for no using pushto-test p Section 7.2.4.1 stat inspections shall ke extinguishers inspe require corrective a requires where at le inspections are con inspections shall be attached to the fire	12, NFPA 10 on and interview, the facility portable fire extinguishers in onth. NFPA 10, Standard for guishers, Section 7.2.1.2 hers shall be inspected either ans of an electronic device / im of 30-day intervals. periodic inspection or ng of fire extinguishers shall at least the following items: ignated place to access or visibility reading or indicator in the osition ined by weighing or hefting ype extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, eled extinguishers nrechargeable extinguishers	К 0	355	It is the intent of this facility the fire extinguishers have the arrinspection completed and mainspections completed and documented monthly. POTENTIAL TO BE AFFECT Residents, staff and visitors he the potential to be impacted to this alleged deficient practice however none were. CORRECTIVE ACTIONS COMPLETED: The fire extinguisher in the courtyard was removed and we not be replaced d/t this is not smoking area any longer and facility is non smoking. The cooking grill in this area was relocated to unattached picni area by employee parking lot MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of monthly manu- fire extinguisher inspections. Maintenance Director or desi will do a visual/manual inspec- of all fire extinguishers 1x motions.	nat all nnual anual TED: nave by will a c c c c c c	DATE 06/10/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	СОМ	PLETED	
		155383	B. WING		05/2	5/2022	
			STREET	ADDRESS, CITY, STATE, ZIP CO	DE		
NAME OF I	PROVIDER OR SUPPLIE	R	8201 \	W WASHINGTON ST			
WASHIN	GTON HEALTHCA	ARE CENTER	INDIA	NAPOLIS, IN 46231			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROMINED'S DI AN OF CODDI	CTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PROPRIATE	DATE	
	be kept to demons	trate that at least the last 12		results with facility map	locations		
	monthly inspection	ns have been performed. This		of all extinguishers give	n to the		
	deficient practice of	could affect 8 residents and 4		Executive Director for re	eview.		
	staff in the courtya	rd.					
				HOW THE CORRECTIV			
	Findings include:			ACTIONS WILL BE MO			
				TO ENSURE THE DEFI			
		ions and interview during a		PRACTICE WILL NOT F			
		with the Executive Director		The Executive director v			
		ance Supervisor 05/25/22		the audit tool and then p			
		h. and 3:30 p.m., the monthly		audit tool with the inspe			
	·	ion tag on the ABC fire		the Quality Assurance T			
		ed in the courtyard lacked			nonthly. Frequency and duration		
		tion of recent monthly inspections or of the audits will be ac		-			
		e September of 2019. The		needed or recommende	d by the		
		lity is now Whitlock, the		QA team.			
	-	d Nelbud which the facility					
		uple years. The fill in					
		rvisor stated that this					
		een missed by the contractor					
	and by the facility	since 9/19.					
	The finding was re	viewed with the acknowledged					
		tenance Supervisor at the time					
	of discovery and a	gain at the exit conference					
	with the Executive	Director and fill in					
	Maintenance Supe	rvisor present at 4:30 p.m.					
	3.1-19(b)						
< 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
U -	Doors protectina	corridor openings in other					
		closures of vertical					
		or hazardous areas resist					
		moke and are made of 1 3/4					
		d core wood or other					
	material capable	of resisting fire for at least					
		s in fully sprinklered smoke					
	1	- ·		1		1	

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 05/25/2022	
	PROVIDER OR SUPPLIE		8201	TADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST NAPOLIS, IN 46231		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETI	
	passage of smok to rooms contain combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or cor Clearance betwe covering is not et doors complying if provided with a the door closed w applied. There is closing of the doo release when the are permitted. Not unlimited height a meeting 19.3.6.3 frames shall be la other materials ir unless the smoke sprinklered. Fixe are allowed per 8 compartments th area or fire resist window assemble 19.3.6.3, 42 CFR 483, and 485 Show in REMAR fire protection rate devices, etc. 1. Based on observe facility failed to er impediment to clo frame and would re-	erials have positive latching latches are prohibited by These requirements do not spaces that do not contain nbustible material. en bottom of door and floor acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is no impediment to the ors. Hold open devices that door is pushed or pulled onrated protective plates of are permitted. Dutch doors 6 are permitted. Door abeled and made of steel or a compliance with 8.3, a compartment is d fire window assemblies a.3. In sprinklered ere are no restrictions in ance of glass or frames in	K 0363	It is the intent of this facility the corridor doors have no impediment to closing and la into the door frame and no o passages that would impede ability to resist the passage of smoke.	ntching pen e the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS, IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Findings include: POTENTIAL TO BE AFFECTED: Residents, staff and visitors have Based on observations and interview during a tour of the facility with the Executive Director the potential to be impacted by this alleged deficient practice, and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the following however none were. corridor doors failed to latch positively into CORRECTIVE ACTIONS their respective door frames: a) The Nourishment Pantry Door on the LTC COMPLETED: side, equipped with a self-closing device. a) The Nourishment Pantry Door b) The Housekeeping room on the LTC side, on the LTC side is equipped with a self-closing device. This device equipped with a self-closing device. c) The bathing shower rooms on the (1) LTC was adjusted to allow full closure and (2) the Therapy side, equipped with a of door to allow a complete latch. self-closing device. b) The Housekeeping room on the d) Storage room by the nurse's station on the LTC side equipped with a LTC side, equipped with a self-closing device. self-closing device. This device e) The Mechanical room across from the was adjusted to allow full closure conference room on the LTC side, equipped with of door to allow a complete latch. a self-closing device. c) The bathing shower room on the (1)LTC and (2)the Therapy The finding was reviewed with the acknowledged Side, is equipped with a self by the fill in Maintenance Supervisor at the time closing device. This device was of discovery and again at the exit conference adjusted to allow full closure of with the Executive Director and fill in door to allow a complete latch. Maintenance Supervisor present at 4:30 p.m. d) The Storage room by the nurses station on the LTC side is 2. Based on observation and interview, the equipped with a self-closing device. This device was adjusted facility failed to ensure all corridor doors would resist the passage of smoke. This deficient to allow full closure of door to practice could affect 15 residents in the dining allow a complete latch. e) The Mechanical room across area. from the conference room on the LTC side, equipped with a self Findings include: closing device. This device was Based on observations and interview during a adjusted to allow full closure of tour of the facility with the Executive Director door to allow a complete latch. 2. Kitchen door into memory care and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the kitchen dining area holes that penetrated

FORM CMS-2567(02-99) Previous Versions Obsolete

door into the memory care dining area had holes

Event ID:

TQ6L21 Facility I

Facility ID: 000393

If continuation sheet

completely through the door have

Page 16 of 30

PRINTED:

06/10/2022

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/25/2022	
NAME OF PROVIDER OR SUPPLIER		8201 V	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O which penetrated o approximately ½ i passage of smoke. The finding was ro by the fill in Main of discovery and a with the Executive	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) completely through the door, nch and would not resist the		NAPOLIS, IN 46231 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) been filled with fire caulk. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement of responsibility is assure that all corridor doors no impediment to closing and latching into the door frame to allow resistance of smoke of passage of smoke. Maintenan Director or designee will do a visual/manual inspection of a closing doors 1x weekly x's 3 months then 1x monthly x's 9 months with the inspection re given to the Executive Director review. HOW THE CORRECTIVE ACTIONS WILL BE MONITO TO ENSURE THE DEFICIEN PRACTICE WILL NOT RECU The Executive director will re the audit tool and then presen audit tool with the inspections the Quality Assurance Team monthly. Frequency and dura of the audits will be adjusted needed or recommended by QA team.	to have bave bave bave bave bave bave bave b
SS=E Bldg. 01	Barrie	uilding Spaces - Smoke uilding Spaces - Smoke tion			

PRINTED: 06/10/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 155383 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. It is the intent of this facility that Based on observation and interview, the facility K 0372 06/10/2022 failed to ensure unsealed holes in 1 of 1 ceiling roof/ceiling of a smoke barrier assembly, shall be protected by a smoke barriers were protected to maintain the smoke resistance of the ceiling smoke barrier. system or material capable of LSC Section 19.3.7.5 requires smoke barriers to restricting the movement of be constructed in accordance with LSC Section smoke. 8.5 and shall have a minimum $\frac{1}{2}$ hour fire POTENTIAL TO BE AFFECTED: resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside Residents, staff and visitors have wall to an outside wall, from a floor to a floor, or the potential to be impacted by from a smoke barrier to a smoke barrier, or by this alleged deficient practice, however none were. use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, CORRECTIVE ACTIONS pipes, tubes, vents, wires, and similar items to COMPLETED: The ceiling in the accommodate electrical, mechanical, plumbing, corridor near the entrance to the and communications systems that pass through a wall, floor, or floor/ceiling assembly memory care unit had a ceiling constructed as a smoke barrier, or through the tile placed to cover the access ceiling membrane of the roof/ceiling of a smoke point to the attic. barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect MEASURES TO PREVENT staff and at least 20 residents near the entrance **REOCCURRENCE:** to the memory care unit. Maintenance Supervisor was in-serviced on 6/9/22 by the Findings include: Executive Director on the requirement of smoke barrier assembly Maintenance Director or Based on observations and interview during a tour of the facility with the Executive Director designee will do a visual/manual FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6L21 Facility ID: 000393 If continuation sheet Page 18 of 30

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	A. BUILDING <u>01</u> COM		(X3) DATE SURVEY COMPLETED 05/25/2022
	PROVIDER OR SUPPLIE		8201 V	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST JAPOLIS, IN 46231	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLE DAT
	between 12:50 p.m the corridor near th care unit a hole ap appeared to be an of The finding was re- by the fill in Maint of discovery and a with the Executive	ance Supervisor 05/25/22 h. and 3:30 p.m., the ceiling in he entrance to the memory proximately 24 X 24 Inches. It unfilled attic access point. eviewed with the acknowledged tenance Supervisor at the time gain at the exit conference • Director and fill in rvisor present at 4:30 p.m.		inspection of ceilings throughout all corridors 1x monthly x's 12 months with the inspection resigned given to the Executive Director HOW THE CORRECTIVE ACTIONS WILL BE MONITOR TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUP The results of the audit will be presented by the Executive Director for review in the month QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team	sults RED - R hly
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that Nonrated protect are permitted. Do fixed fire window are self-closing o require latching, swing in the direc opening provides 32 inches for swi 19.3.7.6, 19.3.7.8 Based on observat failed to ensure all would restrict the t	uilding Spaces - Smoke uilding Spaces - Smoke barriers are 1-3/4-inch thick bac-core doors or of resists fire for 20 minutes. ive plates of unlimited height bors are permitted to have assemblies per 8.5. Doors r automatic-closing, do not and are not required to beton of egress travel. Door a minimum clear width of nging or horizontal doors. 3, 19.3.7.9 ion and interview, the facility sets of smoke barrier doors movement of smoke for at LSC 19.3.7.8 requires doors in	K 0374	It is the intent of this facility tha smoke barrier will restrict the movement of smoke for at leas min an shall close the opening	st 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155383	A. BUILDING <u>01</u> B. WING		- 05/25/2022	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	JR	8201 V	V WASHINGTON ST		
WASHIN	GTON HEALTHCA	ARE CENTER	INDIAN	NAPOLIS, IN 46231		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE	
	smoke barriers sha	Ill comply with LSC Section		leaving only the minimum		
	8.5.4. LSC 8.5.4.1	requires doors in smoke		clearance necessary for prope	er	
	barrier shall close	the opening leaving only the		operation.		
	minimum clearanc	e necessary for proper				
	operation. This de	eficient practice could affect		POTENTIAL TO BE AFFECTI	ED:	
	12 residents and 6			Residents, staff and visitors ha	ave	
				the potential to be impacted by	y	
	Findings include:			this alleged deficient practice,		
				however none were.		
	Based on observat	ions and interview during a				
		with the Executive Director		CORRECTIVE ACTIONS		
		ance Supervisor 05/25/22		COMPLETED:		
		n. and 3:30 p.m., the set of		The smoke barrier doors near		
		rier doors near room 312 did		room 312 was adjusted so that	ıt	
		ely and latch. Based on		when released the doors woul		
	_	he time of observations, the		close completely and latch.		
		r acknowledged these smoke				
		ot close completely and latch.		MEASURES TO PREVENT		
		1 5		REOCCURRENCE:		
	The finding was re	eviewed with the acknowledged		Maintenance Supervisor was		
		tenance Supervisor at the time		in-serviced on 6/9/22 by the		
		gain at the exit conference		Executive Director on the		
		Director and fill in		requirement of responsibility to	o	
		rvisor present at 4:30 p.m.		assure all doors are checked		
	1	1 1		are a smoke barrier and will		
	3.1-19(b)			restrict the movement of smok	æ	
				for at least 20 min and shall cl	ose	
				the opening leaving only the		
				minimum clearance necessary	/ for	
				proper operation. Maintenand		
				Director or designee will do a	-	
				visual/manual inspection of all		
				smoke barrier corridor doors 1		
				weekly x's 3 months then 1 tin	ne	
				monthly x's 9 months with the		
				inspection results given to the		
				Executive Director for review.		
				HOW THE CORRECTIVE		
				ACTIONS WILL BE MONITOR	KED	

AND PLAN OF O NAME OF PRO' WASHINGT (X4) ID PREFIX TAG K 0511 N SS=E U Bldg. 01 U E cd	OVIDER OR SUPPLIEF FON HEALTHCA SUMMARY S (EACH DEFICIEN	RE CENTER TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	î /	JILDING NG STREET J 8201 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST JAPOLIS, IN 46231 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	Rew the o on	LETED
NAME OF PRO WASHINGT (X4) ID PREFIX TAG K 0511 N SS=E U Bldg. 01 U E	VVIDER OR SUPPLIER FON HEALTHCA SUMMARY S (EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	155383 RE CENTER TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		NG STREET 2 8201 W INDIAN ID PREFIX	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST JAPOLIS, IN 46231 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	05/25/ E R ew the o on s	(X5) COMPLETION
WASHINGT (X4) ID PREFIX TAG K 0511 N SS=E U Bldg. 01 U E cd	TON HEALTHCA SUMMARY S (EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	RE CENTER TATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)		STREET A 8201 W INDIAN ID PREFIX	VWASHINGTON ST IAPOLIS, IN 46231 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	E R ew the o on S	(X5) COMPLETION
WASHINGT (X4) ID PREFIX TAG (X4) ID PREFIX SS=E U Bldg. 01 E c	TON HEALTHCA SUMMARY S (EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	RE CENTER TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)		8201 W INDIAN ID PREFIX	VWASHINGTON ST IAPOLIS, IN 46231 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	COMPLETION
(X4) ID PREFIX TAG K 0511 N SS=E U Bldg. 01 U E cd	SUMMARY S (EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)		INDIAN ID PREFIX	APOLIS, IN 46231 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	COMPLETION
(X4) ID PREFIX TAG X 0511 N SS=E U Bldg. 01 U E c	SUMMARY S (EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revise the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	COMPLETION
C 0511 N SS=E U Bldg. 01 U E	(EACH DEFICIEN REGULATORY OR NFPA 101 Jtilities - Gas and Jtilities - Gas and	CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)		PREFIX	reach corrective action should be cross-referenced to the appropriation DEFICIENCY TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revise the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	COMPLETION
C 0511 N SS=E U Bldg. 01 U E	NFPA 101 Jtilities - Gas and Jtilities - Gas and	ELSC IDENTIFYING INFORMATION)			reach corrective action should be cross-referenced to the appropriation DEFICIENCY TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revise the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	
< 0511 N SS=E U Bldg. 01 U E	NFPA 101 Jtilities - Gas and Jtilities - Gas and	l Electric I Electric		TAG	TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	DATE
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			PRACTICE WILL NOT RECUR The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	R ew the o on	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			The Executive director will revie the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	ew the o on	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			the audit tool and then present audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	the o on	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	o on S	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	o on S	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	on S	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the	S	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			needed or recommended by the		
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			-	e	
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric			QA team.		
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric					
SS=E U Bldg. 01 U E	Jtilities - Gas and Jtilities - Gas and	Electric					
Bldg. 01 U	Jtilities - Gas and	Electric					1
E							
c	Equipment using g	and an unlated was minima					
	•	PA 54, National Fuel Gas					
		riring and equipment					
	-	PA 70, National Electric					
	-	stallations can continue in					
	service provided r						
	8.5.1.1, 19.5.1.1						
		ation and interview, the	K 0	511	It is the intent of this facility that		06/10/202
	•	sure all electrical panels in			electrical panels in the corridors		
		secured from non-authorized			are secured from non-authorize	ed	
-		0, 2011 edition states 230.62 service equipment shall be			personnel and all electrical	_	
	e .	ed in 230.62(A) or guarded as			junction boxes in the facility are maintained in a safe operating	5	
	specified in 230.62	· · · ·			condition.		
-	*	(D). gized parts shall be enclosed					
`		t be exposed to accidental			POTENTIAL TO BE AFFECTE	٦·	
	•	guarded as in 230.62(B).			Residents, staff and visitors ha		
		gized parts that are not			the potential to be impacted by		
		istalled on a switchboard,			this alleged deficient practice,		
		rol board and guarded in			however none were.		
-		0.18 and 110.27. Where					
		guarded as provided in			CORRECTIVE ACTIONS		
		A)(2), a means for locking or			COMPLETED:		
		ding access to energized parts			(1)The 2 electrical panels near	the	
		This deficient practice could			nurse's station on the LTC side		
	affect staff and 30 r	-			hall are now locked		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		ILDING	DNSTRUCTION 01	(X3) DATE S COMPLI 05/25/2	ETED
	PROVIDER OR SUPPLIE		8201 W	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN 46231	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
TAG	Findings include: Based on observati tour of the facility and fill in Mainten- between 12:50 p.m electrical panels ne LTC side hall were (2) one electrical p care hall was not lo The finding was re by the fill in Maint of discovery and ag with the Executive Maintenance Super 2. Based on observ ensure all electrical were maintained in LSC 19.5.1.1 requi Section 9.1. LSC 9 and equipment to c National Electrical Edition, Article 314 boxes shall be prov with the box and st use. Where used, r the grounding requi deficient practice c residents in the 100 Findings include: Based on observati tour of the facility and fill in Mainten- between 12:50 p.m	viewed with the acknowledged enance Supervisor at the time gain at the exit conference Director and fill in visor present at 4:30 p.m. ation, the facility failed to I junction boxes in the facility a safe operating condition. res utilities comply with 0.1.2 requires electrical wiring omply with NFPA 70, Code. NFPA 70, 2011 4.28(3) (c) states junction rided with covers compatible uitable for the conditions of netal covers shall comply with irements of 250.110. This ould affect 4 staff and 14 0 hall and soiled utility area.	TAG	 (2) The electrical panel in the memory care hall is now locked (1) The electrical junction box above the ceiling by the flores lights on the 100 hall have beer re-secured. (2) The electrical junction box the soiled utility area on the Rehab side near the water inluhas had a cover placed and is now not exposing the electrication wiring. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 6/9/22 by the Executive Director on the requirement that all electrical panels in the corridors are secured from non-authorized personnel and that all electrication. Maintenance Director or designee will do a visual/manual inspection of al electrical panels and junction boxes in facility areas to assut they are secured 1x weekly x' months then 1 time monthly x months with the inspection regiven to the Executive Director or the requirement that all panels and junction boxes in facility areas to assut they are secured 1x weekly x' months then 1 time monthly x months with the inspection regiven to the Executive Director preview. 	ed es accent en in et s al et s al re g tor l re s s ults r for RED T R	DATE
		poxes above the ceiling by the		The Executive director will rev		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T

TQ6L21 Facility

Facility ID: 000393

If continuation sheet P

Page 22 of 30

 PRINTED:
 06/10/2022

 FORM APPROVED

 OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155383	(X2) MULTIPLE (A. BUILDING B. WING	LDING <u>01</u> IG		(X3) DATE SURVEY COMPLETED 05/25/2022	
	PROVIDER OR SUPPLIE		8201	T ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST			
	IGTON HEALTHC			NAPOLIS, IN 46231			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COM	(X5) IPLETION DATE	
K 0712 SS=F Bldg. 01	florescent lights or electrical junction on the Rehab side contain a cover and The finding was re by the fill in Main of discovery and a with the Executive Maintenance Supe 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire Drills Fire drills include alarm signal and fire conditions. Fi expected and un- varying condition shift. The staff is and is aware that routine. Where co 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through	the transmission of a fire simulation of emergency re drills are held at expected times under s, at least quarterly on each familiar with procedures c drills are conducted between D AM, a coded the transmission of a fire simulation of established transmission of a fire simulation of emergency re drills are held at expected times under s, at least quarterly on each familiar with procedures the transmission of a fire simulation of established trills are conducted between D AM, a coded the transmission of 19.7.1.7 view and interview, the	K 0712	the audit tool and then presen audit tool with the inspections the Quality Assurance Team monthly. Frequency and durat of the audits will be adjusted a needed or recommended by the QA team.	t the to tion as he	10/202	
	documented orient 2 of 4 quarters. LS be conducted quar	ation training on each shift for C 19.7.1.6 states drills shall terly on each shift to		documented orientation trainin on each shift all 4 quarters.			
	maintenance engin with the signals an under varied condi temporary waiver	personnel (nurses, interns, eers, and administrative staff) d emergency action required tions. QSO-20-31 1135 states in lieu of a physical fire		POTENTIAL TO BE AFFECTI All residents have potential to affected by this alleged deficie practice, however none were.	be		
		l orientation training program nt fire plan, which considers		CORRECTIVE ACTIONS COMPLETED: All staff was			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COMPLETED 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS, IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) current facility conditions, is acceptable. The in-serviced on fire drills and training will instruct employees, including Maintenance Supervisor was in-serviced on 6/9/22 by the existing, new or temporary employees, on their Executive Director on the current duties, life safety procedures and the fire protection devices in their assigned area. This requirement for fire drills, logging deficient practice affects all occupants. drill into tels and assuring a in-service log is signed by all staff Findings include: participating. Based on record review and interview with the Executive Director and fill in Maintenance MEASURES TO PREVENT Supervisor on 05/25/22 between 10:00 a.m. and **REOCCURRENCE:** 12:50 p.m., the following shifts were missing Maintenance Director or documentation of a completed fire drill or designee will run fire drills 1x per shift per month and log drill into documented orientation training: a) Third Shift first quarter 2022. tels. The Director will also assure b) First and Third Shifts, Third quarter of 2021. that In-service sheets are signed by all participating employee. The finding was reviewed with the acknowledged These sheets will then be given to by the fill in Maintenance Supervisor at the time the Executive Director for review. of discovery and again at the exit conference with the Executive Director and fill in HOW THE CORRECTIVE Maintenance Supervisor present at 4:30 p.m. ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR 3.1-19(b) The Executive director will review 3.1-51(c) the audit tool and then present the audit tool with the inspections to the Quality Assurance Team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team. K 0741 **NFPA 101** SS=E **Smoking Regulations** Bldg. 01 **Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TQ6L21

Facility ID: 000393

0393 If c

If continuation sheet

Page 24 of 30

PRINTED: 06/10/2022 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDI				OMB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u>01</u>	COMPLETED
		155383	B. WING		05/25/2022
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	
WASHIN	IGTON HEALTHC	ARE CENTER		W WASHINGTON ST ANAPOLIS, IN 46231	
(X4) ID	1	STATEMENT OF DEFICIENCIES		1	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION	
TAG	,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC DATE
IAU		· · · · · · · · · · · · · · · · · · ·	IAG		DAIL
	.,	I be prohibited in any room,			
		ment where flammable			
		ble gases, or oxygen is used			
		any other hazardous			
		h area shall be posted with			
		O SMOKING or shall be			
		nternational symbol for no			
	smoking.				
		occupancies where			
		pited and signs are			
		ed at all major entrances,			
		with language that prohibits			
	smoking shall no	t be required.			
	(3) Smoking by p	atients classified as not			
	responsible shall	be prohibited.			
	(4) The requirem	ent of 18.7.4(3) shall not			
	apply where the	patient is under direct			
	supervision.				
	(5) Ashtrays of n	oncombustible material and			
	safe design shall	be provided in all areas			
	where smoking is	-			
	-	ers with self-closing cover			
		h ashtrays can be emptied			
		vailable to all areas where			
	smoking is permi				
	18.7.4, 19.7.4				
		ion, records review, and	K 0741	It is the intent of this facility to	06/08/20
		lity failed enforce 1 of 1	12 0 / 11	follow the facility smoke free	00/00/20
		vies. This deficient practice		policy.	
		f around the shelter area.		F 5110 J .	
		areana the shorter area.		POTENTIAL TO BE AFFECTE	: _П .
	Findings include:			All residents, visitors and staff	
	i munigs menude.			have potential to be affected b	
	Based on chargest	ions and interview during a		this alleged deficient practice,	y
		ions and interview during a			
		with the Executive Director		however none were.	
		ance Supervisor 05/25/22			
		n. and 3:30 p.m., smoking on		CORRECTIVE ACTIONS	
		ent due to at least 25 cigarette		COMPLETED: All staff was	
		nelter area outside. Based on		in-serviced on smoke free polic	cy.
	1	smoking policy stated			

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE C	ONSTRUCTION	(X3) D.	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155383	A. BUILDING <u>01</u> B. WING		01	COMPLETED 05/25/2022	
				STREET	ADDRESS, CITY, STATE, ZIP C	CODE	
NAME OF	PROVIDER OR SUPPLIE	R			V WASHINGTON ST		
WASHIN	IGTON HEALTHCA	ARE CENTER		INDIAN	NAPOLIS, IN 46231		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	smoking is not allo	owed on the facility's property.					
					MEASURES TO PREV	VENT	
	-	eviewed with the acknowledged			REOCCURRENCE:		
		tenance Supervisor at the time			Maintenance Director	-	
		gain at the exit conference			will walk through parki	-	
		Director and fill in			daily x's 5 days x's 3 n		
Maintenan	Maintenance Supe	rvisor present at 4:30 p.m.			1x weekly x's 9 month		
	2110(1-)				that there is no eviden		
5.1-	3.1-19(b)				or visitors smoking on Any cigarette butts fou		
					addressed and cleane		
					time.	a up at that	
					HOW THE CORRECT	IVE	
					ACTIONS WILL BE M	ONITORED	
					TO ENSURE THE DE	FICIENT	
					PRACTICE WILL NOT	RECUR	
					The Executive director		
					the audit tool and then	-	
					audit tool with the insp		
					the Quality Assurance		
					monthly. Frequency ar		
					of the audits will be ad	-	
					needed or recommend QA team.	led by the	
					QA lean.		
< 0920	NFPA 101						
SS=E	-	nent - Power Cords and					
Bldg. 01	Extens						
•	Electrical Equipm	nent - Power Cords and					
	Extension Cords						
	Power strips in a	patient care vicinity are					
		nponents of movable					
		ed electrical equipment					
		bles that have been					
		alified personnel and meet					
		10.2.3.6. Power strips in					
		vicinity may not be used for					
		., personal electronics),					
	except in long-ter	rm care resident rooms that			1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155383 B. WING 05/25/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTHCARE CENTER INDIANAPOLIS. IN 46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the K 0920 It is the intent of this facility to not 06/10/2022 facility failed to ensure the facility did not used utilize multi-plug adaptors multi-plug adaptors as a substitute for fixed POTENTIAL TO BE AFFECTED: wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, All residents and staff have National Electrical Code. NFPA 70, 2011 potential to be affected by this Edition, Article 400.8 requires that, unless alleged deficient practice, however none were. specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring CORRECTIVE ACTIONS of a structure. This deficient practice affects 4 COMPLETED: All staff was staff. in-serviced on 6/8/22 regarding Findings include: the non-use of multi-plug adaptors. The 2 adaptors found Based on observations and interview during a during LS tour were removed tour of the facility with the Executive Director immediately. and fill in Maintenance Supervisor 05/25/22 between 12:50 p.m. and 3:30 p.m., the (1) MEASURES TO PREVENT maintenance office contained a multi-plug adaptor powering equipment near the corridor REOCCURRENCE: door. And (2) the payroll office contained an Maintenance Director or designee multi-plug adaptor powering various equipment will walk through common areas and offices 1x daily x's 5days x's 3 behind the computer screen. months then 1x weekly x's 9 The finding was reviewed with the acknowledged months to assure that there is no TQ6L21

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 000393

If continuation sheet

Page 27 of 30

PRINTED:

06/10/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 05/25/2022
	PROVIDER OR SUPPLIE		8201 V	ADDRESS, CITY, STATE, ZIP CO V WASHINGTON ST JAPOLIS, IN 46231	DE
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	of discovery and a with the Executive Maintenance Supe 2. Based on observe facility failed to en- used as a substitut power equipment NFPA-70/2011, 40 permitted in 400.7 shall not be used f wiring. This defici 2 staff in the scheo Findings include: Based on observat tour of the facility and fill in Mainten- between 12:50 p.n Schedulers Office to power a dorm st draw equipment). The finding was re- by the fill in Main of discovery and a with the Executive	tenance Supervisor at the time gain at the exit conference e Director and fill in rvisor present at 4:30 p.m. vation and interview, the asure all power strips were not e for fixed wiring to provide with a high current draw. 00.8 state unless specifically flexible cords and cables for (1) as a substitute for fixed ent practice could affect up to hulers office. ions and interview during a with the Executive Director nance Supervisor 05/25/22 h. and 3:30 p.m., in the a power strip was being used tyle refrigerator (high power eviewed with the acknowledged tenance Supervisor at the time gain at the exit conference e Director and fill in rvisor present at 4:30 p.m.		evidence of staff utilizing multi-plug adaptors smo property. Any adaptors f be removed and the staf will be re-educated on n HOW THE CORRECTIV ACTIONS WILL BE MOI TO ENSURE THE DEFI PRACTICE WILL NOT F The Executive director w the audit tool and then p audit tool with the inspec the Quality Assurance T monthly. Frequency and of the audits will be adju needed or recommende QA team.	king on found will ff member on-use. /E NITORED CIENT RECUR vill review resent the ctions to eam duration sted as
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of ox another is in acco Transfilling of Hig	Transfilling Cylinders Transfilling Cylinders ygen from one cylinder to ordance with CGA P-2.5, gh Pressure Gaseous Respiration. Transfilling of			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

 PRINTED:
 06/10/2022

 FORM APPROVED

 OMB NO. 0938-0391

AND PLAN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN 155383 B. WING		NG	<u>01</u>	COMPLETED 05/25/2022		
	PROVIDER OR SUPPLIEF			8201 V	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST JAPOLIS, IN 46231		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE C	(X5) COMPLETIO DATE
	 prohibited in patiet to liquid oxygen concontainers over 50 conditions under a Transfilling to liquid portable containers conditions under a transfilling to liquid portable containers conditions under a transfilling to liquid portable containers conditions under a transfilling to ensure 1 or transfilling to ensure 1 or transfilled to ensure 1 or where oxygen transfilled to ensure 1 or where oxygen transfilled with propie ventilation. NFPA (2) requires oxygen mechanically ventil requires mechanical requires mechanica negative pressure in deficient practice cone smoke compart findings include: Based on observation to the facility of the facility or and fill in Maintena between 12:50 p.m. storage/transfer root oxygen tanks. Ther but it did not appear tested with paper, do to the outside. The finding was reversed by the fill in Maintena of discovery and again with the Executive 	 11.5.2.3.1 (NFPA 99). id oxygen containers or to rs under 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) on and interview, the facility f 1 oxygen storage room ferring takes place, was erly working mechanical .99 2012 edition, 11.5.2.3.1 transfilling rooms to be ated. Section 9.3.7.5.3.1 l exhaust to maintain a the space continuously. This build affect 18 residents in ment. 	К 0	927	It is the intent of this facility to ensure that the oxygen storag room where oxygen transferrin takes place is provided with properly working mechanical ventilation POTENTIAL TO BE AFFECTE All residents and staff have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: Vent in the oxy storage room was replaced wi working one. MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or desig visually inspect the oxygen storage room 1x daily x's 5 da x's 3 months then 1x weekly x months to assure that the ventilation fan is in working or The Maintenance Director will then give these Audit tools to the Executive Director.	e ng ED: /gen ith a ynee ys 's 9 der.	06/10/202

	OF HEALTH AND HU MEDICARE & MEDIC					RM APPROVED 1B NO. 0938-0392
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 05/25/2022		
	ROVIDER OR SUPPLIEI	-	8201	T ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST NAPOLIS, IN 46231		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRC DEFICIENCY)) BE	(X5) COMPLETIO DATE
				HOW THE CORRECTIVE ACTIONS WILL BE MONI TO ENSURE THE DEFICI PRACTICE WILL NOT RE The Executive director will the audit tool and then pre audit tool with the inspection the Quality Assurance Teal monthly. Frequency and di of the audits will be adjusted needed or recommended to QA team.	ENT CUR review sent the ons to um uration ed as	

L21 Facility ID: 000393

0393 If continuation sheet

ation sheet Page 30 of 30