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

FORM APPROVED
OMB NO. 0938-039

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	07/06/2022

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 05/25/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/06/22 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 At this PSR 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 43. Quality Review completed on 07/07/22	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/25/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/06/22 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340	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. This facility recognizes its obligation to provide legally and medically necessary	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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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	At this PSR Life Safety Code survey, Washington 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 43 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 completed on 07/07/22		care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health 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 has provided pictures, videos, invoices showing corrections and audit tools attached as exhibits to coincide with each number. If anything further is needed facility will provide department documentation upon request.	
K 0222 SS=E 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			

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	be made for the rapid removal of occupants by: remote control of locks; keying of all 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.			

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	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 failed to ensure all means of egress 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 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor on 07/06/22 between 9:50 A.M. and 11:15 A.M., the exit door at the main entrance was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code, the code was posted at the exit however it did not open the door. The Maintenance Supervisor stated that the incorrect program code had likely been entered into the keypad. The finding was reviewed with the acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with	K 0222	It is the policy of this facility to insure doors within a required means of egress shall not be equipped with a latch or lock that requires the use o a tool, key or code from the egress side unless otherwise permitted to meet set standards. 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: On July 8, 2022 the Maintenance Director reprogrammed the correct code at the exit door to exit the facility at the main entrance. This Code will be * current 2 digit month and last 2 digit year. *See attached Exhibit K222 1 MEASURES TO PREVENT REOCCURENCE:	07/08/2022

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	the Executive Director and Maintenance Supervisor present. This deficiency was cited on 05/25/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		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 and verify codes work 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 TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive Director will monitor adherence to the Preventative Maintenance schedule and validate the "K 222 Audit Tool" 1x monthly x's 12 months. The results of the audit will be presented by the Executive Director monthly for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team. *See attached Exhibit K222 2	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an			

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	automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) 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 failed to ensure all hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance	K 0321	It is the intent of this facility to assure that all hazardous rooms are equipped with a self-closing device or self-closing hinges. Hazardous rooms are designated as such. POTETIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice,	07/08/2022

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	Supervisor on 07/06/22 between 9:50 A.M. and 11:15 A.M., Room 210, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and more than 50 cardboard boxes. The room was not equipped with a self-closing device or self-closing hinges. The finding was reviewed with the acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. This deficiency was cited on 05/25/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		however none were. These room is on a closed secured unit that did NOT occupy any residents. CORRECTIVE ACTIONS COMPLETED: On 7/8/22 The Maintenance Director installed a self-closing device on door for room 210. MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designee will complete K323 Audit Tool with wkly inspection of secured unit 1x wk x's 12 wks then 1x month x's 6 months to assure door maintains self- closure while being used for storage *See exhibit K321 2 HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive Director will forward the inspection results to the Quality Assurance Team monthly The results of the audit will be presented by the Executive Director for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 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			
	Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 4 residents and 3 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor on 07/06/22 between 9:50 A.M. and 11:15 A.M., in the common area in the LTC side, there were 1-inch unsealed gaps around the sprinkler heads. This condition could delay the activation of the sprinklers. Based on interview at the time of observation, the Maintenance Supervisor agreed there were unsealed gaps in the	K 0353	It is the intent of this facility that Sprinkler System- Maintenance and Testing Automatic sprinkler and system are inspected, tested and maintained in accordance NFPA 25 and assure that all sprinkler heads are not covered with foreign material in accordance with LSC 9.7.5 and 5.2.1.1.1 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: On 7/8/22 Coupling ring was placed around sprinkler head in common area on the LTC side, therefor closing the 1-inch unsealed gap around the sprinkler	07/08/2022

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	ceiling around the sprinkler heads in the common area in the LTC side. The finding was reviewed with the acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. This deficiency was cited on 05/25/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		head. *See exhibit K353 1 MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor was in-serviced on 7/8/22 by the Executive Director on the requirement of audit tools being completed accurately and ensuring corrective action is taken to ensure compliance with LS 2567. * See attached Exhibit K353 3. Maintenance Director or designee will complete Audit Tool K353 and do a visual inspection of all sprinkler heads in each zone to include couplings to ensure that the devices are free from dust and secured with no gap from ceiling to sprinkler 3x's week x's 4 weeks then 1x weekly x 8 weeks then 1x monthly x's 9 months. *See attached Exhibit K353 2 HOW THE CORRECTIVE ACTIONS WILL BE MONITORED 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 be adjusted as needed or recommended by the QA team upon review.	
K 0927 SS=E	NFPA 101 Gas Equipment - Transfilling Cylinders			

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Bldg. 01	Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect 18 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor on 07/06/22 between 9:50 A.M. and 11:15 A.M., the oxygen storage/transfer room contained large liquid oxygen tanks. There was one vent in the room, but it did not appear to be working and when tested with paper, did not appear to be exhausting to the outside. The Maintenance Supervisor stated that it has been determined that the vent is part of the HVAC system and does not operate continuously nor vent to the outside. A new vent with proper termination has been ordered but has not arrived	K 0927	It is the intent of this facility to ensure that the oxygen storage room where oxygen transferring takes place is provided with properly working mechanical ventilation POTENTIAL TO BE AFFECTED: All residents and staff have potential to be affected by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On 7/15/22 Outside contractor installed fan in oxygen room that is continuous and was installed on its own ventilation to exterior of facility through the roof. *See attached exhibit K927 1 and 2 MEASURES TO PREVENT REOCCURRENCE: Maintenance Director or designee	07/15/2022

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	as of the time of this PSR survey. The finding was reviewed with the acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Executive Director and Maintenance Supervisor present. This deficiency was cited on 05/25/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		will complete Audit Tool K 927 to visually inspect the oxygen storage room 1x daily x's 5 days x's 3 months then 1x weekly x's 9 months to assure that the ventilation fan is in working order. The Maintenance Director will then give these Audit tools to the Executive Director. * See attached exhibit K927 3 HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Executive director will review 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.	