STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155383	B. W	ING		11/12/2015	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			/ WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER			IAPOLIS, IN 46231		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was fo	or the Investigation of	F 00	000	The creation and submission of		
	Complaint IN00	0185787.			this Plan ofCorrection does not		
	•				constitute an admission by this		
	Complaint INOC	0185787 - Substantiated.			provider of any conclusionset forth in the statement of		
	*	eficiencies related to the			deficiencies, or of any violation	n of	
					regulation. This provider	. 01	
	_	eited at F 223, F 225, and			respectfully requests that the		
	F 226.				2567 Plan ofCorrection be		
					considered the Letter of Credil	ble	
	Survey dates: November 10, 12, 2015				Allegation and requests a		
	J	, ,			DeskReview or Post Survey		
	Facility number	: 000393			Review on or after 12/8/15.		
	Provider number						
	AIM number:	100289340					
	Census bed type	·					
		81					
		81					
	Total.	01					
	Census payor ty	rpe:					
	Medicare:	4					
		55					
	Other:	22					
	Total:	81					
	10tal.	01					
	Sample:	3					
	Sumpio.	S					
	These deficience	ies reflect state findings					
		nce with 410 IAC					
	16.2-3.1.						
	10.2-3.1.						
	Quality review	completed 11/13/15 by					

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

TITLE

000393

(X6) DATE

Any defiency statement 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í			î î	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE B. WING 11/12/204			
		155383	B. W.	NG		11/12/	2015
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	29479.						
F 0223 SS=D Bldg. 00	483.13(b), 483.13(free From ABU SECLUSION The resident has to verbal, sexual, phycorporal punishment seclusion. The facility must in sexual, or physical punishment, or inverbal Based on record the facility failed abuse residents be together on a resimaking derogator for 2 of 3 resider allegations (Resimallegations (Resimallegations)	the right to be free from ysical, and mental abuse, ent, and involuntary of use verbal, mental, I abuse, corporal voluntary seclusion. review and interview, I to ensure staff did not by tying the wheels ident's wheelchair and rry remarks to a resident ats reviewed for abuse dents B and C). : ortable Incidents were 10/15 at 11:15 a.m. An 1/1/15, indicated the ted an allegation of g Resident B's wheels being tied cility's investigation cident did occur.	F 02	223	What corrective action(s) will accomplished for those residents found to have been affected by the deficientpractice? Nurseand CNA involved in incidents terminated. How will other residents havingthe potential to be affected by the same deficient practice be identifie andwhat corrective action will be taken? Allresidents have the potential to be affected by this alleged deficient practice. All staff inserviced on abuse, negliand Elder Justice on11/3/2015. What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur Staffinserviced on abuse neglect and Elder Justice on 11/3/2015. All newstaff will be inserviced on abuse, neglect a Elder Justice in generalorienta by 12/8/15. How the correctivaction(s) will be monitored to	d III lie lect lect lect lect lect lect lect lec	12/08/2015

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

Event ID:

G80G11 Facility ID: 000393

If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155383	B. W	ING		11/12/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER			APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	arterly Minimum Data			ensure the deficient practice		
	Set Assessment, dated 10/28/15,				will not recur, i.e., whatqualit assurance program will be p	-	
	indicated Reside	ent B was severely			into place To ensure	ut	
	cognitively impa	nired, and was actively			compliance, theED/Designee i	s	
	involved in prop	elling his w/c.			responsible for completing the		
					Abuse Prohibition		
	During an interv	iew with Housekeeper			andInvestigation tool, which		
	#3 on 11/12/15 a	at 11:30 a.m., she			includes for all allegations of abuse for allresidents, intervie	w	
		29/15 about 4:00 a.m.,			with staff, interview with reside		
		ng laundry to the East			interview with any witnesses,		
	Hall and noted Resident B in front of the				including family/visitors, and		
		in his wheel chair (w/c)			notificationfamily/responsible		
		Housekeeper #3			party, weekly for 4 weeks and monthly for 6 months. Theresu	ılte	
		approached Resident B it			of these audits will be reviewed		
		lanket had fallen off his			by the CQI committee overseen		
		as preventing the wheels		by theED. If threshold of 95% is not achieved an action plan will			
		moving. She indicated as			II		
		chair she realized the			be developedto ensure compliance.		
					compilance.		
		tied together to prevent					
		n moving around in his					
		ed she untied him and					
		room, and she told LPN					
		nd and what she did.					
	•	indicated the nurse said					
	"ok". Housekee	per #3 indicated as she					
	was walking thro	ough the lobby, the nurse					
	and CNA were g	giggling.					
	During an interes	iew with Resident C on					
		0 p.m., she indicated she					
		ent B with his w/c wheels					
	tied together.						
	2. An incident, d	lated 10/22/15, indicated					

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet

Page 3 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET					
		155383	B. W	ING		11/12/	/2015
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	ΓE	(X5) COMPLETION DATE
	abuse concerning	tigated an allegation of g a nurse making rks to Resident C.					
	The record for Resident C was reviewed on 11/10/15 at 2:05 p.m. Her diagnoses included, but were not limited to, anxiety, and bipolar disorder.						
	A Quarterly Minimum Data Set Assessment, dated 9/9/15, indicated Resident C was cognitively intact.						
	night she had asl and LPN #1 had only one on the Resident C indic crying, and LPN whining and cry wasn't the only of Resident C indic feelings. She als she had gone to table there and L couldn't because lights on. When the light couldn't LPN #1 had told rules." When ask rule, Resident C	iew with Resident C on 0 p.m., she indicated one ked to go to the bathroom told her "she wasn't the unit who needed help." atted she had started "#1 told her to "stop ing like a baby, that she one who had a hard life." atted this had hurt her to indicated another night the lounge to color at the LPN #1 had told her she she couldn't have the Resident C asked why to be on, she indicated ther "because it was the ked if it was a facility was told it was her (LPN he was told to go back to					
	her room.	Č					

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet

Page 4 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		A. BUILDING B. WING	<u>00</u>	COMPLETED 11/12/2015				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	had heard someth mouth she never a nurse say. She said to Resident it, she wasn't goi tonight." Resider Minimum Data S 9/30/15, indicate intact. A current facility and last revised i Prohibition, and provided by the I Nursing Services a.m. The policy i willful infliction confinement, inti with resulting ph mental anguish individual's actio inadvertent or ac Abuseimproper restraintsVerb.	Set Assessment, dated d she was cognitively policy, dated 2/2010 n 7/2015, titled "Abuse Investigation" was DNS (Director of o) on 11/10/15 at 10:00 ndicated: "Abuse is the of injury, unreasonable midation or punishment ysical harm or pain, or .Willful - the n was deliberate [not cidental]Physical						
	and last revised 2 "Restrictive Dev	policy, dated 6/2013 2/2013, titled ices" was provided by Facility Administrator)						

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

Event ID:

G80G11 Facility ID: 000393

If continuation sheet Page 5 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CO. A. BUILDING B. WING	00	COMPLETED		
	155383		ADDRESS, CITY, STATE, ZIP CODE	11/12/2015		
	PROVIDER OR SUPPLIER GTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0225 SS=D Bldg. 00	on 11/10/15 at 11:10 a.m. The policy indicated: "It is the policy of [name of corporation] to prohibit the use of restrictive devicesfor the purpose of discipline or convenienceDefinition: A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body" This federal tag relates to Complaint IN00185787. 3.1-27(a) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source					

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet

Page 6 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPLE	
		155383	B. W	ING		11/12/2	2015
NAME OF F	PROVIDER OR SUPPLIER	.	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					/ WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER		INDIAN	IAPOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		tion of resident property		TAG	Dia relation (DATE
	are reported imme						
		ne facility and to other					
		ance with State law					
	through established procedures (including to the State survey and certification agency).						
		nave evidence that all					
	alleged violations	0 ,					
		must prevent further hile the investigation is in					
	progress.	Tille the investigation is in					
	p. eg. eee.						
	The results of all investigations must be						
	reported to the ad						
		sentative and to other ance with State law					
	(including to the S						
	certification agend	cy) within 5 working days of					
		f the alleged violation is					
	verified appropriation be taken.	te corrective action must					
		review and interview,	F 0	225	What corrective action(s) wil	lbe	12/08/2015
	the facility failed				accomplished for those		12,00,2015
	1	orted awareness of an			residents found to have been	n	
	1	use to the administrator			affected by thedeficient		
		nts reviewed for abuse			practice? Nurse and CNA terminated. Housekeeper		
	allegations (Res				suspended and educated		
	unogations (ICCs)	idom Dj.			onreporting abuse immediatel	y to	
	Findings include	<u>.</u>			Executive Director. How will		
	i mamga merude	. .			other residents havingthe		
	The facility Reportable Incidents were reviewed on 11/10/15 at 11:15 a.m. An incident, dated 11/1/15, indicated the facility investigated an allegation of abuse concerning Resident B's wheelchair (w/c) wheels being tied				potential to be affected by the same deficient practice be	ie	
					identified andwhat corrective	,	
					action will be taken? All		
					residents have the potential to		
					affected bythe alleged deficier		
					practice. All staff inserviced o reportingabuse and neglect or		
	` '	•			11/3/2015. What measures w		
	wgemer. The fac	cility's investigation			be put intoplace or what	-	

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet Page 7 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155383	B. W	ING		11/12/	′2015
				CEDEFE	ADDRESS COMMUNICATE STREET, ST		
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
14/4 01 1151	OTON 115 A1 THOA	DE OENTED			WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER		INDIAN	APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	concluded the in	cident did occur.			systemic changes you will		
					make to ensure that the		
	The incident dat	ted 11/1/15 indicated the			deficientpractice does not		
	The incident, dated 11/1/15, indicated the actual incident occurred on 10/29/15 at				recur? All staff inserviced on		
					reporting abuse and neglector	1	
	4:30 a.m. The report indicated				11/3/2015. All newstaff will be		
	Housekeeper #3 had found Resident B				inserviced on reporting abuse		
	with the wheels	of his wheel chair tied			neglect in general orientationb	У	
	together, she had	d untied him and reported			12/8/15. How the corrective		
		luty. The facility's			action(s)will be monitored to		
		licated the nurse (LPN			ensure the deficient practice will not recur, i.e., whatqualit		
					assurance program will be p	-	
	1	had been suspended			into place To ensure	ut	
	during the invest	tigation. Housekeeper #3			compliance, theED/Designee i	9	
	had been suspen	ded during the			responsible for completing the		
	investigation for	not reporting the			Abuse Prohibition		
	incident to the ac				andInvestigation tool, which		
	immediately.				includes for all allegations of		
	miniculatory.				abuse for allresidents, intervie	w	
					with staff, interview with reside	ent,	
	1	iew on 11/12/15 at 10:15			interview with any witnesses,		
	a.m., the Admini	istrator indicated she had			including family/visitors, and		
	asked Housekee	per #3 why she had not			notificationfamily/responsible		
	reported the inci	dent to her			party, weekly for 4 weeks and monthly for 6 months. Theresu	ulto	
	_	The Administrator			of these audits will be reviewe		
	, ,	keeper #3 had thought it			by the CQI committee oversee	-	
					by theED. If threshold of 95%		
	_	she had told the nurse on			not achieved an action plan wi		
	duty (LPN #1).				be developedto ensure		
					compliance.		
	A current facility	y policy, dated 2/2010					
	and last revised	7/2015, titled "Abuse					
	Prohibition, Rep	· · · · · · · · · · · · · · · · · · ·					
		as provided by the DNS					
	(Director of Nursing Services) on						
		0 a.m. The policy					
	indicated: "Polic	y/Procedure:3.					
	Employees whet	her direct care, contract					

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ILTIPLE CO ILDING	nstruction 00	(X3) DATE (COMPL			
		155383	B. WI	NG		11/12/	2015	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST					
WASHIN	GTON HEALTHCAR	RE CENTER	INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 APPROPRIAT DEFICIENCY)	HOULD BE COMP		
	or consultants recon abuse during operiodically during education. The transport abuse4. families are education to report allow and/or complaint retribution5. A must be reported Director immedia	ng ongoing inservice raining will include: a. abuse b. To whom to Residents and their rated as to whom and regations, incidents, s without fear of all abuse allegations to the Executive						
F 0226 SS=D Bldg. 00	ETC POLICIES The facility must d written policies and mistreatment, negi residents and misa property. Based on record the facility failed policies and proc abuse and immed allegation of abu	review and interview, to implement its redures for preventing diately reporting an se of residents for 2 of 3 red for allegations of	F 02	26	What corrective action(s) will accomplished for those residents found to have been affected by thedeficient practice? Nurse and CNA terminated. Housekeeper suspended and educated onreporting abuse immediately	1	12/08/2015	

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet

Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155383	B. W	ING		11/12/	2015
NAME OF A			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		8201 W	/ WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER		INDIANAPOLIS, IN 46231			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		ı	DATE
	F: 1:				Executive Director. How will other residents havingthe		
	Findings include	:			potential to be affected by the	ne	
					same deficient practice be		
	The facility Reportable Incidents were				identified andwhat corrective	е	
	reviewed on 11/10/15 at 11:15 a.m. An				action will be taken?		
	incident, dated 11/1/15, indicated the				Allresidents have the potentia	I to	
	facility investigated an allegation of				be affected by this alleged		
	abuse concerning Resident B's				deficientpractice. All staff inserviced on reportingabuse	and	
	wheelchair (w/c) wheels being tied				neglect on 11/3/2015. What	and	
	together. The facility's investigation				measures will be put intopla	ce	
	concluded the incident did occur.				or what systemic changes y	ou	
					will make to ensure that the		
	1 The record for	r Resident B was			deficientpractice does not		
		10/15 at 10:30 a.m. His			recur All staff inserviced on		
		led, but were not limited			reportingabuse and neglect of 11/3/2015. All newstaff will be		
		h delusions, anxiety, and			inserviced on reporting abuse		
	-	•			neglect in general orientation		
	-	arterly Minimum Data			12/8/15. How the corrective		
	Set Assessment,				action(s)will be monitored to		
		ent B was severely			ensure the deficient practice		
		aired, and was actively			will not recur, i.e., whatquali	•	
	involved in prop	elling his w/c.			assurance program will be p into place To ensure	ut	
					compliance, theED/Designee	is	
	During an interv	riew with Housekeeper			responsible for completing the		
	#3 on 11/12/15 a	at 11:30 a.m., she			Abuse Prohibition		
	indicated on 10/2	29/15 about 4:00 a.m.,			andInvestigation tool, which		
	she was deliveri	ng laundry to the East			includes for all allegations of abuse for allresidents, intervie	NA/	
	Hall and noted F	Resident B in front of the			with staff, interview with residence		
	linen room door	in his wheel chair (w/c)			interview with any witnesses,	,	
		Housekeeper #3			including family/visitors, and		
	indicated as she approached Resident B it looked like his blanket had fallen off his shoulders and was preventing the wheels				notificationfamily/responsible		
					party, weekly for 4 weeks and		
					monthly for 6 months. Theres of these audits will be reviewed		
		moving. She indicated as			by the CQI committee overse		
		chair she realized the			by theED. If threshold of 95%		
	she reached the	chan she realized the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155383	B. W	ING		11/12/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C			WASHINGTON ST		
WASHIN	GTON HEALTHCA	RE CENTER			APOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wheels had been	tied together to prevent			not achieved an action plan wi	II	
	the resident from moving around in his				be developedto ensure		
	w/c. She indicated she untied him and				compliance.		
	took him to his r	oom, and she told LPN					
		nd and what she did.					
		indicated the nurse said					
	_	per #3 indicated as she					
		•					
		ough the lobby, the nurse					
	and CNA were g	giggling.					
	During on intern	riew with Resident C on					
	-						
		0 p.m., she indicated she					
		ent B with his w/c wheels					
	tied together.						
	2 An incident d	lated 10/22/15, indicated					
	· ·	stigated an allegation of					
		g a nurse making					
	derogatory rema	rks to Resident C.					
	The record for R	Resident C was reviewed					
		:05 p.m. Her diagnoses					
		ere not limited to, anxiety,					
	and bipolar disor	, , ,					
	and orporar also	IUCI.					
	A Quarterly Mir	nimum Data Set					
	1	ed 9/9/15, indicated					
	-	cognitively intact.					
	Resident C was	cognitivery intact.					
	During an interv	riew with Resident C on					
	_	0 p.m., she indicated one					
		ked to go to the bathroom					
	_	told her "she wasn't the					
	omy one on the	unit who needed help."					

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

Event ID:

G80G11 Facility ID: 000393

If continuation sheet Page 11 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE COMPI 11/12				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE		
	crying, and LPN whining and cry wasn't the only of Resident C indiction feelings. She also she had gone to table there and I couldn't because lights on. When the light couldn't LPN #1 had told rules." When ask rule, Resident C #1's) rule, and she her room. During an interv 11/12/15 at 10:0 had heard somet mouth she never a nurse say. She said to Resident it, she wasn't goit tonight." Reside: Minimum Data S 9/30/15, indicate intact.	Set Assessment, dated and she was cognitively						
	and last revised Prohibition, and provided by the	y policy, dated 2/2010 in 7/2015, titled "Abuse Investigation" was DNS (Director of s) on 11/10/15 at 10:00						

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

Event ID:

G80G11 Facility ID: 000393

If continuation sheet Page 12 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/12/2015			
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	willful infliction confinement, int with resulting phemental anguish individual's actional inadvertent or act Abuseimproper estraints Verband/or speaking tones." A current facility and last revised 2 "Restrictive Development on 11/10/15 at 1 indicated: "It is to corporation] to prestrictive device discipline or comphysical restrain manual method of device, material adjacent to the resindividual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restricts freedom access to one's beautiful and individual cannot restrict to the restricts freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and individual cannot restrict freedom access to one's beautiful and	on was deliberate [not secidental]Physical r use of al Abusescolding to them in harsh voice y policy, dated 6/2013 2/2013, titled ices" was provided by Facility Administrator) 1:10 a.m. The policy he policy of [name of brohibit the use of esfor the purpose of venienceDefinition: A t is defined as any or physical or mechanical or equipment attached or esident's body that the t remove easily which a of movement or normal						

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

Event ID:

G80G11

Facility ID: 000393

If continuation sheet

Page 13 of 14

PRINTED: 12/14/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/12/2015			
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: G80G11

Facility ID: 000393

If continuation sheet

Page 14 of 14