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	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Healthcare Center	8201 W Washington St Indianapolis, IN 46231

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and homelike environment for 7 of 7 residents who had observed concerns (Residents 40, 10, 12, 5, 47, 20, and 51).Findings include:1. On 8/6/25 at 10:10 a.m., Resident 40's call light was observed out of reach, wrapped on top of the bedside dresser. The cord was visibly dirty with stains and built-up debris under peeling tape. On 8/8/25 at 10:00 a.m., Resident 40's call light remained out of reach, hung over the call box on the wall. The cord remained dirty. On 8/11/25 at 9:31 a.m., Resident 40's call light was observed hung out of reach on the call box, the cord remained dirty. On 8/12/25 at 10:25 a.m., Resident 40's call light remained out of reach and rested on the floor. The yellow tape was still peeling and there was stuck on debris. There were several gnats flying around his head and in the bathroom. 2. On 8/6/25 at 10:29 a.m., Resident 10's fall mattress on the floor beside his bed was observed dirty, stained, and had visible food crumbs and other unidentifiable substances on it. The wall beside his bed was dirty with visible stains and smears. On follow up observations on 8/7/25 and 8/8/25, Resident 10's wall and fall mattress remained dirty. On 8/8/25 at 10:44 a.m., Resident 12's bed was stripped of linen, the mattress surface was observed to be peeling with a large central stain, and discoloration around the edges. The wall beside the bed was streaked with stains. On multiple observations as timestamped above, Resident 40's bedside table was observed to have a dirty and stained surface, the legs of the table were also visibly dirty with unidentifiable clumps and streaks of debris. On 8/6/25 at 12:01 p.m., 8/7/25 at 9:09 a.m., and 8/8/25 at 10:48 a.m., Resident 5's Tube Feeding pole was observed. The equipment was broken as evidence by missing a rolling wheel on one of the legs, which caused the pole to lean to one side and wobbled. There was no metal shine on the length of the pole as it was streaked, stained and clumped with unidentifiable debris. Resident 5's bed frame was observed to have spilled and dried clumps of feeding. There were several gnats flying throughout her room during these observations. 3. On 8/6/25 at 10:12 a.m., Resident 47's fitted bed sheet was observed to be worn thin, the material sheer enough to see the mattress details under the sheet. Some areas were streaked thin enough that small holes had developed. On 8/6/25 at 11:41 a.m., Resident 20's bed was observed. There was a folded blanket in the middle of the bed, but the edges were frayed and tattered. During an interview on 8/6/25 at 11:46 a.m., Resident 51 indicated they were always out of linen, especially fitted sheets, and the linen they had were worn and dingy. 4. On 8/6/25 at 10:18 a.m., room [ROOM NUMBER]'s bathroom had a non-skid tape strip that had completely detached from the floor and was curled on the floor at the base of the toilet. The grab rail was covered in yellow tape with smeared feces visible on the tape. A strong odor was present. On 8/7/2025 at 10:06 a.m., room [ROOM NUMBER]'s bathroom was observed. The non-skid tape remained peeled and curled on the floor and the smeared stain of feces still on the yellow tape of the grab bar. On 8/8/25 at 10:41 a.m., room [ROOM NUMBER]'s bathroom remained uncleaned. The peeled and curled non-skid strip remained on the floor and the grab bar wrapped in yellow tape remained visibly stained. 5. On 8/06/25 at 10:49 a.m., Resident 5's tube feeding and hydration kangaroo bags were left uncapped and open to the air. There were several gnats observed flying (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through the room. On 8/6/25 at 12:03 p.m., the 300-hall meal cart was [NAME] to the floor. Beverages had not been pre-prepared and were poured while on the hall. The cups of milk and juices were not covered after they were filled and placed on trays, and there were several gnats flying through the hallway. On 8/11/25 at 9:31 a.m., several, more than 5, gnats were observed on the rim of a milk cup left on Resident 40's bedside table. There were several cups uncovered as the gnats continued to fly around the cups, the resident's head, and the bedside table. On 8/11/25 at 2:15 p.m., an environmental tour was conducted with the Regional Director of Clinical Services (RDCS). Resident 40, Resident 5, Resident 10, and the bathroom for room [ROOM NUMBER] were visited. The RDCS indicated the areas of concern would be addressed. On 8/11/25 at 2:00 p.m., the RDCS indicated there was no policy for a Clean/Comfortable/Homelike Environment, but indicated the residents had the right to live in healthy, clean, and comfortable environments. At that time, she provided a copy of current, but undated, facility policy for Resident's rights titled, Your Rights and Protections as a Nursing Home Resident. The policy indicated, .at a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. you have the right to be treated with dignity and respect. 3.1-19(f)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review, the facility failed to ensure proper oral hygiene was provided and maintained for a dependent resident (Resident 5) and failed to ensure a resident preference for facial hair was maintained (Resident 49) for 2 of 4 residents reviewed for Activities of Daily Living.Findings include:1.On 8/6/25 at 10:49 a.m., Resident 5 was observed. She laid in her bed and had a Tube Feeding hung and running. Her lips were dry and cracked, there was a pasty/frosty build-up around her lips and gums. On 8/6/25 at 12:02 p.m., Resident 5's was observed. Her lips remained dry and cracked, and there was a thick build-up of pasty drying secretions. There was an uncovered cup of blue liquid and an oral sponge left on her bedside table. There were two gnats on the rim of the cup. On 8/7/25 at 9:09 a.m., Resident 5 was observed. Her lips were dry and cracked, and a thick layer of pasty secretions rimmed her lips and gums. Her teeth were also observed to have built up plaque/tarter. On 8/8/25 at 10:17 AM Resident 5 was observed. Her mouth remained in need of oral care as evidence by dry cracked lips and a buildup of frothy, pasty secretions. During an interview on 8/8/25 at 1:47 p.m., Certified Nursing Aide (CNA) 6 indicated they did not like to use a toothbrush for Resident 5 because it caused his gums to bleed. Instead, they used an oral swab dipped in mouthwash to clean out her mouth. On 8/8/25 at 1:31 p.m., Resident 5's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, cerebral palsy, severe intellectual disabilities and Down Syndrome. She required the use of a gastrostomy tube (G-tube) and had a physician's order not to receive anything by mouth (NPO). Resident 5 had a comprehensive care plan, initiated 1/15/24, which indicated, she .has likely cavity teeth and is at risk for further impairment due to NPO status. Interventions for this plan of care included, but were not limited to, assist resident with oral care, dental consult as indicated, observe and document: red/bleeding gums, lesions, loose teeth, symptoms of pain, and notify MD. Resident 5 had a dental exam on 4/28/25. The exam notes indicated, Tissues are red and inflamed. Heavy plaque, poor oral hygiene. Oral Hygiene Instructions: Brush 2x/daily. Generalized worn teeth. Dry mouth noted. Resident 5 had a dental exam on 5/28/25. The exam notes indicated, moderate plaque, heavy build up and severe gingivitis along gumline. Staff needs to try and use brush along gumline for as long as patient will allow due to bleeding/gingivitis present with severe build up. The record lacked documentation that oral care had been completed, if the resident was cooperative or refused, and/or attempts were made to brush her teeth. On 8/8/25 at 2:04 p.m., the Regional Director of Clinical Services (RDCS) indicated there was no specific policy for oral care but provided a list of tasks for a.m. routine cares which should be (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed by the CNAs for each resident as applicable. The AM care included, but were not limited to, .step 7. Assist resident with oral hygiene. 2. On 8/6/25 at 10:25 a.m. Resident 49 was observed as he lay in bed resting. He appeared to be unkempt; his beard and hair appeared to be overgrown. Resident 49 indicated several times he was very upset that he hadn't been shaved or had a haircut in over two weeks. He indicated he normally kept his face clean shaven. On 8/11/25 at 10:43 a.m. Resident 49 was observed as he lay in bed resting with his eyes closed. The resident's hair and beard did not appear to have been trimmed at that time. On 8/12/25 at 10:32 a.m. Resident 49 was observed as he sat in a chair waiting for a doctor's appointment. His hair and beard had not been trimmed at this time. On 8/12/25 at 9:40 a.m. Resident 49's medical record was reviewed. He was a long-term care resident residing on the memory care unit whose diagnoses included but were not limited to dementia and osteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage and the underlying bone in a joint.). Resident 49's last Brief Interview for Mental Status (BIMS) (A cognitive screening tool used to assess cognitive function, primarily in nursing homes and long-term care facilities) score was 8 out of 12 which indicated moderate cognitive impairment. A progress note, dated 8/2/25 at 7:57 p.m., indicated Resident 49 required assistance of one staff member for Activities of Daily Living (ADL). During an interview on 8/12/25 at 1:20 p.m., Regional Director of Clinical Services (RDCS) indicated she knew his preference was to be clean shaven and she had offered to shave him herself and had other staff offer, but he only wanted a professional barber or beautician to shave him and cut his hair. She and the Executive Director (ED) both agreed that they could get Resident 49 to a barber, there isn't a beautician in the facility at this time, but they could attempt to take him to a sister facility or a barber shop or have a beautician from a sister facility come to shave him. The record lacked documentation related to arranging to take Resident 49 to a barber or beautician as of 8/12/25 at 1:20 p.m. On 8/8/25 at 2:04 p.m., the RDCS indicated there was no specific policy for oral care but provided a list of tasks for a.m. routine cares which should be completed by the CNAs for each Resident as applicable. The AM care included, but was not limited to, .8. Shave resident, if needed or requested. 3.1-38(a)(3)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide appropriate, person centered programing, and treatment plans to attain or maintain the highest practical level of psychosocial well-being for 1 of 5 residents (Resident 11) reviewed for behavioral health concerns.Findings include:On 8/6/25 at 10:50 a.m. Resident 11 was observed as she lay in bed watching her roommate's tv and resting. There was no tv on her side of the room. Resident 11 indicated she arrived at the facility about 5 months ago and hadn't had any problems so far. She appeared to have a flat affect (a severe reduction in the outward expression of emotion) and a low mood.On 8/7/25 at 9:45 a.m. the memory care unit dining room was observed. There were three residents at a table with the Dementia Care Facilitator watching a cooking show on a tablet and two residents sitting on the couch watching TV. This was not the scheduled activity.On 8/7/25 at 12:01 p.m. Resident 11 was observed in bed resting with her eyes closed.On 8/7/25 at 12:15 p.m. Resident 11 came out to the dining room for lunch. On 8/7/25 at 12:45 p.m. Resident 11 went back to her room after lunch.On 8/8/25 at 10:42 a.m. the memory care dining room was observed. There were six residents listening to soothing music and having a snack.On 8/8/25 at 11:00 a.m. the Memory Care Facilitator began playing a trivia game with the residents. This was not the scheduled activity.On 8/8/25 at 11:28 a.m. Resident 11's medical record was reviewed. She was a long-term care resident residing on the memory care unit whose diagnoses included but were not limited to Schizophrenia and history of a traumatic brain injury.A progress note, dated 3/25/25 at 4:35 p.m., indicated Resident 11 was admitted to the facility in a long-term care bed due to a fall.A progress note, dated 3/27/25 at 1:58 p.m., indicated Resident 11 attempted to leave the facility. She indicated a family member was at the front door to pick her up, but no one was there for her.A provider note, dated 4/10/25 at 7:06 a.m., indicated Resident 11 reported her mood had improved and she felt less sad, depressed, and anxious.A progress note, dated 4/11/25 at 12:33 a.m., indicated Resident 11 had packed her bags and requested to leave. The writer of the note explained the resident could not leave and the resident understood and did not try to leave.A behavioral note, dated 4/17/25 at 3:44 p.m., indicated Resident 11 was experiencing delusions and hallucinations. The intervention attempted was to assist the resident in calling her daughter, which was successful.A Medicare charting note, dated 4/21/25 at 10:28 p.m., resident was tearful at times but was easily redirected.A provider note, dated 4/24/25 at 6:33 a.m., indicated Resident 11 wanted to leave the facility, but there had been no elopement attempts.A progress note, dated 5/27/25 at 9:47 p.m., indicated Resident 11 was having delusional thoughts and hallucinations, but she was easily redirected back to her room.A progress note, dated 6/5/25 at 4:36 p.m., indicated Resident 11 was seen walking the halls, appeared to be tearful, and had many questions but was easily redirected.A progress note, dated 6/11/25 at 2:09 p.m., indicated Resident 11 started packing her clothes and taking them to the front door stating her brother was outside waiting for her. The resident was redirected back to her room.A progress note, dated 6/19/25 at 1:32 p.m., indicated Resident 11 was moved to the memory care unit.A progress note, dated 6/19/25 at 9:10 p.m., indicated Resident 11 was in her room crying and talking loudly, a staff member went in and the resident calmed down but after the staff member left the resident began crying again. The note indicated the resident asked repeatedly to go to the main lobby door so that her family can be let into the building, the staff member told the resident that if her family was here, they would be directed to the memory care unit. The resident did not like that answer, she yelled and went back to her room.A behavior note, dated 6/21/25 at 12:23 p.m., indicated Resident 11 had an episode of tearfulness and hallucinations. The note indicated the resident was able to talk to her daughter on the phone and that calmed her down.A progress note dated 7/2/25 at 9:07 a.m. indicated Resident 11 became upset after she requested to go outside of the unit for activities and to play bingo and have (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	snacks with everyone else when the Activities Director was on the unit. The note indicated the resident was offered activities on the unit but the resident refused.A progress note, dated 7/29/25 at 11:51 a.m., indicated Resident 11 had a visit from her ex-boyfriend and some family members.A behavioral IDT note, dated 7/30/25 at 10:34 a.m., indicated Resident 11 was stating her daughter was at the facility to pick her up. The resident stated staff can't see her daughter. Resident 11 started yelling out loudly, crying and banging on the door to be let out. The immediate intervention was to offer snacks and drinks to the resident, but the resident refused. Staff also assisted the resident in calling her daughter, which was successful. The preventative intervention was to redirect the resident to activities like watching tv and assist in calling her daughter when time permits.A provider note, dated 7/31/25 at 6:54 a.m., indicated Resident 11 was adjusting to the memory care unit fair. The provider indicated Resident 11 complained of feeling anxious.A progress note dated 8/3/25 at 5:49 p.m. indicated Resident 11 was seen banging on the exit door repeatedly.A preferences for customary routine and activities assessment dated [DATE] indicated Resident answered the question, . While you are in this facility how important is it to you to be able to use the phone in private? ., with somewhat important.Resident 11's activity log for July was reviewed. Activities were logged three times that month.Resident 11's activity log for August was reviewed. Activities had been offered 8 times so far.On 8/5/25 at 10:08 a.m. Resident 11 was invited to do popsicle stick crafting, the resident refused.On 8/7/25 at 11:19 a.m. Resident 11 was invited to bake chocolate chip cookies, the resident refused.On 8/7/25 at 11:27 a.m. Resident 11 was invited to chair yoga, the resident refused.On 8/7/25 at 11:35 a.m. Resident 11 was invited to a ted-talk and morning discussion, the resident refused.On 8/7/25 at 11:53 a.m. Resident 11 was invited to play a ball toss game, the resident refused.On 8/11/25 at 11:38 a.m. Resident 11 was invited to go outside and get some fresh air, the resident refused.During an interview on 8/11/25 at 10:43 a.m., Resident 11 indicated she liked it much better out in the long-term care section of the facility. She indicated she felt like all she did was lay in bed because there weren't many activities on the memory care unit that interested her. Resident 11 indicated she used to be able to make private phone calls from her room when she was in the long-term care side but now, she can only make calls from the front desk.On 8/12/25 at 11:45 a.m. the Social Services Director (SSD) provided a current facility policy titled, Activities, dated 1/06. This policy indicated, . it is the policy of this facility to provide for an ongoing program of activities designed to meet the interest and the physical, mental and psychosocial well-being of each resident in accordance with the comprehensive assessment.3.1-373.1-43

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure a vegetarian resident had food variety and options to meet his dietary preferences for 1of 1 resident reviewed for dietary preferences (Resident 43). Findings include:On 8/6/25 at 11:00 a.m. Resident 43 was observed as he sat on his bed. The resident indicated the food the facility provided was terrible. He indicated sometimes he could send the food back and they gave him something else but a lot of times there wasn't anything for them to give him because he was vegetarian. He indicated most days he got either grilled cheese or a peanut butter and jelly sandwich for his entree.On 8/7/25 at 12:17 p.m. lunch trays were observed being passed to residents in the memory care dining room. Resident 43 received two grilled cheese sandwiches and two sides.On 8/12/25 at 9:40 a.m. Resident 43's medical record was reviewed. He was a long-term care resident residing on the memory care unit whose diagnoses included but were not limited to traumatic brain injury (TBI) and depression. His diet order indicated he was on a regular diet and he was a vegetarian.A progress note, dated 4/24/25 at 3:48 p.m., indicated Resident 43's sister talked with the Registered Dietician and indicated the resident had been a vegetarian for 17 to 18 years. She indicated he loved pizza, Asian, Thai, Indian foods, fruit, grains, vegetables, etc. She also indicated he liked meatless products and other faux meat products.On 8/12/25 at 10:44 a.m. the Culinary Director provided meal tickets for Resident 43 from 8/5/25 to 8/12/25.On 8/5/25 Resident 43's entrees for breakfast, lunch, and dinner were scrambled eggs, grilled cheese sandwich, and peanut butter and jelly.On 8/6/25 Resident 43's entrees for breakfast, lunch, and dinner were cheesy eggs, peanut butter and jelly, and pasta with no meat (cheese, noodles, and sauce).On 8/7/25 Resident 43's entrees for breakfast, lunch, and dinner were scrambled eggs, cheese and fruit plate, and kidney beans with onion, celery and tomato sauce.On 8/8/25 Resident 43's entrees for breakfast, lunch, and dinner were scrambled eggs, grilled cheese, and peanut butter with crackers.On 8/9/25 Resident 43's entrees for breakfast, lunch, and dinner were cheesy eggs, peanut butter sandwich, and soup with kidney beans.On 8/10/25 Resident 43's entrees for breakfast, lunch, and dinner were scrambled eggs, cheese and crackers, and bean burrito.On 8/11/25 Resident 43's entrees for breakfast, lunch, and dinner were egg muffin sandwich, grilled cheese, and peanut butter and jelly with tomato soup.On 8/12/25 Resident 43's entrees for breakfast, lunch and dinner were scrambled eggs, peanut butter and celery, and cheese crackers.During an interview on 8/11/25 at 11:15 a.m. LPN 7 indicated Resident 43 is a vegetarian and they were doing the best they could to get him appropriate meals, but there could have been more options for him. 3.1-21(a)(4)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record reviews and interviews, the facility failed to offer the influenza (flu) vaccination to 2 of 5 residents reviewed for the influenza vaccination (Resident 11 and 18). Findings include:1. On 8/11/25 at 1:39 p.m., a record review was completed for Resident 11. She had the following diagnoses which included, but were not limited to, Schizophrenia, asthma, and sleep apnea. Her record lacked a consent to receive the influenza vaccination, and she did not receive the vaccination. 2. On 8/11/25 at 1:44 p.m., a record review was completed for Resident 18. He had the following diagnoses which included, but were not limited to, dementia, type 2 diabetes mellitus, chronic kidney disease, and anxiety. His record lacked a consent to receive the influenza vaccination, and he did not receive the vaccination. On 8/11/25 at 2:00 p.m., during an interview with the Regional Clinical Specialist (RCS), she indicated she could not find the consents or where the residents were administered the vaccinations. A policy titled, Influenza (Flu) Vaccination (Resident) was provided by the RCS on 8/12/25 at 10:55 a.m. It indicated, .Current and newly admitted residents will be offered the influenza vaccine, unless the immunization is contraindicated, or the resident has already been immunized during this times period (unless otherwise recommended by the Centers for Disease Control and prevention (CDC).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to offer a resident the COVID-19 vaccination for 1 of 5 residents reviewed (Resident 15). Findings include:On 8/11/25 at 1:32 p.m., a record review was completed for Resident 15. She had the following diagnoses which included but were not limited to Alzheimer's disease, hypertension, major depression, and anxiety. Her record lacked a consent to administer the COVID-19 vaccinations, and lacked documentation the COVID-19 vaccination was administered.On 8/11/25 at 2:00 p.m., during an interview with the Regional Clinical Specialist (RCS), she indicated she could not find the consent or where the resident was administered the COVID-19 vaccination.A policy titled, Resident COVID-19 Vaccination was provided by the RCS on 8/12/25 at 10:55 a.m. It indicated, .On admission resident(s) will be offered the COVID-19 vaccinations based on their COVID-19 vaccination history.