

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2016
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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00198937.</p> <p>Complaint IN00198937 - Substantiated. Federal/State deficiencies related to the allegations are cited at F221.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: May 20 & 23, 2016</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Census bed type: NF: 39 Total: 39</p> <p>Census payor type: Medicaid: 39 Total: 39</p> <p>Sample: 04</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on May 27, 2016.</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action(s). These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the</p>	

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

TITLE

(X6) DATE

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.

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F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a restraint was not used without a physician order for 1 of 3 residents reviewed for restraints in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Review on May 20, 2016; of a facility self- reported incident dated 4/25/16 at 3:59 p.m., indicated LPN#1 (off going nurse) reported to LPN #2 (on coming nurse) during the change of shift report, LPN #1 had placed Resident #A in another resident's Broda chair and applied thigh straps to keep Resident #A</p>	F 0221	<p>opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p> <p>F0221 1) What action(s) will be accomplished for those residents found to have been affected? The event in question was self reported by the facility to the ISDH. The nurse in question did not return to the facility after this event. The nurse involved is a state licensed individual. Her excuse for not obtaining a physician's order for a temporary restraint was that "she forgot" although she had spoken to the physician / his designee about this patients difficulties at the time of the event. Facility patients do have the right to be free and are free from any physical restraints imposed for purposes of discipline or convenience and this is facility policy and procedure. According to the nurse involved and facility staff witnesses the</p>	06/22/2016

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	<p>safe.</p> <p>On initial tour, on 5/20/16 at 10:20 a.m., Resident #A was observed in a high back wheelchair, unrestrained.</p> <p>On 5/20/16, at 11:05 a.m., Resident # A was observed propelling self around in a high back wheelchair with no restraints.</p> <p>The clinical record for Resident #A was reviewed on 5/20/16 at 11:45 a.m. The record indicated Resident #A had diagnoses that included, but were not limited to: profound intellectual disabilities, diabetes, dysphagia unspecified.</p> <p>The MDS (Minimum Data Set) assessment, dated 2/18/16, indicated Resident #A had severe cognitive impairment, and required extensive assistance with bed mobility, transfers, ambulation and toilet use.</p> <p>Review of current May 2016, physician orders did not indicate an order for Resident #A to have restraints used .</p> <p>Review of Resident #A's care plan, dated 2/24/16, did not indicate any need for an order for the use of restraints for Resident #A.</p> <p>LPN #1 was interviewed (undated) via</p>				<p>temporary restraint was utilized to prevent the patient from causing injury to herself and to maintain an upright, safe position while up in the chair. This patient was also kept "one on one" with staff (direct supervision) while the thigh strap was in use. As per this complaint survey, this was an isolated event; no other patients were found to have been affected. The event in question was self reported immediately to the state by the facility and the facility followed expected procedure(s). The patient involved received no ill effects. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any patient had the potential to be affected by this event however none were involved in said event except one. (isolated event) The patient involved received no ill effects. The nurse in question did not return to the facility after this event. 3) What measures will be put into place or what systemic changes will be made? The nurse in question did not return to the facility after this event. Licensed staff will be in serviced/re-educated on the proper use of restraints for an emergency event, times three over the next six months. Licensed staff will also be in serviced/re-educated on nursing documentation practices, including the proper procedure for</p>		

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	<p>phone by the ED (Executive Director) and LPN #1 indicated Resident #A was under one to one direct supervision during the short period Resident#A was in the chair with thigh straps in use. When interviewed by ED via phone, related to why an order for the restraint placed on Resident #A was not gotten, LPN#1 indicated to the ED they just forgot. LPN # 1 also indicated to the ED Resident #A was on one to one and was only in the chair for 20 to 30 minutes.</p> <p>On 05/23/16 at 10:05 a.m., interview with LPN #2 indicated LPN #1 reported having placed Resident #A in another resident's geri-chair for a short period of time. LPN #2 indicated having asked if LPN #1 if she had received an order for restraint usage and LPN#1 had indicated "no," but indicated they/LPN #1 had to. LPN #2 indicated Resident #A's inner bilateral thighs were assessed and no skin issues were noted. LPN# 2 did not indicate restraints were on Resident #A at time of shift change.</p> <p>An statement, reviewed on May 20, 2016; written by CNA #1, dated 4/25/16, indicated Resident #A woke up and was disturbing the roommate, so they/CNA #1 got Resident #A up into their high back wheelchair and put her close to CNA #1 while CNA #1 was completing</p>		<p>notification of the physician, taking and writing/documenting physician orders; times three over the next six months. The Director of Nursing and/or her licensed designee will verbally counsel and discuss the facility's restraint policy with each nurse during the month of June 2016. The Director of Nursing will maintain records of the counseling discussions. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance Licensed staff will be in serviced/re-educated on the proper use of restraints for an emergency event, times three over the next six months. Licensed staff will also be in serviced/re-educated on nursing documentation practices, including the proper procedure for notification of the physician, taking and writing/documenting physician orders; times three over the next six months. The Director of Nursing will maintain records of the counseling discussions. The Director of Nursing will ensure that all licensed nursing staff complete the aforementioned in services and re-education. The Director of Nursing will maintain records of the in services and re-education. 5) By what date the systemic changes will be completed. 6-22-16</p>				

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	<p>their paperwork. CNA #1 indicated later Resident #A started kicking, standing, sitting, and about to fall. LPN #1 called the doctor, and when no response was received LPN #1 told CNA #1 to put Resident #A into another chair (another resident's Broda chair) where Resident #A could calm down, and prevent Resident #A from falling and injuring themselves. So both LPN #1 and CNA #1 put Resident #A into the Broda chair and CNA#1 indicated they did not want to do it, but they felt they had to obey their charge nurse (LPN#1).</p> <p>On 5/20/16 at 12:00 p.m. the ED provided the facility's current policy, ("Physical and chemical restraints"), 9/28/06 review 12/2009. and indicated the policy was the one currently being used by the facility. The policy indicated, The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. It is also indicated the physician is to be made aware within the hour if emergency restraints are used.</p> <p>This Federal tag relates to Complaint IN00198937.</p> <p>3.1-3(w)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed ensure staff followed physician orders in the dispensing of a one time medication order for 1 of 4 residents reviewed. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record for Resident #A was reviewed on 5/20/16 at 11:45 a.m. The record indicated Resident #A had diagnoses that included, but were not limited to: profound intellectual disabilities, diabetes, dysphagia unspecified. The MDS (Minimum Data Set) assessment, dated 2/18/16, indicated Resident #A had severe cognitive impairment, and required extensive</p>	F 0282	<p>F0282 1) What action(s) will be accomplished for those residents found to have been affected? The event in question was self reported by the facility to the ISDH. The nurse in question did not return to the facility after this event. As per this complaint survey, this was an isolated event; no other patients were found to have been affected. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any resident had the potential to be affected, as per this complaint survey, this was an isolated event; no other patients were found to have been affected. The Nurses Notes, dated 4/24/16 at 2:45 a.m. indicated Resident #A was resisting care, screaming, and LPN#1 called the physician.</p>	06/22/2016

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	<p>assistance with bed mobility, transfers, ambulation and toilet use.</p> <p>The Nurses Notes, dated 4/24/16 at 2:45 a.m. indicated Resident #A was resisting care, screaming, and LPN#1 called the physician. On 4/24/16 at 2:50 a.m., the physician returned her call and ordered for Resident #A to be given trazadone 25 mg via g-tube one time only. This order was written on 4/24/16 at 2:45 a.m., and was signed by physician on 4/29/16. There was no record of the trazadone being administered.</p> <p>Review on 5/23/16 at 10:30 a.m., of the MAR (medication administration record) indicated the one time order was received by pharmacy, but it was not noted if it was given by LPN#1 as was ordered.</p> <p>Reviewed list of residents in facility who are given trazadone on a regular basis, and only one Resident (#B) was on 50 mg trazadone and all areas in the MAR (Medication Administration Record) related to Resident #B's trazadone were filled in. Observation on 5/23/16 at 11:00 a.m., the EDK (emergency drug kit) does contain 50 mg trazadone, however no trazadone 25 mg. EDK was checked by LPN #3 on 5/20/16, and no trazadone was removed, nor any slips relating to trazadone were found.</p>		<p>On 4/24/16 at 2:50 a.m., the physician returned her call and ordered for Resident #A to be given trazadone 25 mg via g-tube one time only. There was no record of the trazadone being administered. The event in question was self reported by the facility to the ISDH. The nurse in question did not return to the facility after this event. The nurse in question made an error and the facility will re-educate it's current licensed staff as follows: Licensed staff will be in serviced/re-educated on nursing medication administration documentation practices, times three over the next six months. The Director of Nursing and/or her licensed designee and/or the facility's licensed pharmacy representative will verbally counsel and discuss the facility's electronic Medication Administration Record and proper documentation there of and within for PRN and /or STAT medication administration, with each nurse during the month of June 2016. The Director of Nursing will maintain records of the counseling discussions and pharmacy re-training. 3) What measures will be put into place or what systemic changes will be made? The facility has a pharmacy representative that comes in monthly and reviews medication administration monthly. This information goes to the Director of Nursing who will</p>				

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	<p>On 5/20/2016 at 1:00 p.m. ED indicated they called the pharmacy who indicated no slips were noted inside any EDK box received from this facility in April 2016, as well as the medication inside the EDK is always counted. No EDK slip completed to indicate trazadone had been signed out for Resident #A on 4/24/2016.</p> <p>3.1-35(g)(2)</p>		<p>sign off that this information is reviewed by her with appropriate nursing action plans put into place for nursing medication errors; next 6 months. (systemic change) 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Licensed staff will be in serviced/re-educated on nursing medication administration documentation practices, times three over the next six months. The Director of Nursing and/or her licensed designee and/or the facility's licensed pharmacy representative will verbally counsel and discuss the facility's electronic Medication Administration Record and proper documentation there of and within for PRN and /or STAT medication administration, with each nurse during the month of June 2016. The Director of Nursing will maintain records of the counseling discussions and pharmacy re-training. The facility has a licensed pharmacy representative that comes in monthly and reviews medication administration monthly*. This information goes to the Director of Nursing who will sign off that this information is reviewed by her with appropriate nursing action plans put into place for nursing medication errors; next 6 months. (systemic change/quality assurance). The facility also has a registered pharmacist that</p>	

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			audits medications and medication errors on a monthly basis and attends Quality Assurance meetings monthly. * Pharmacy has begun staff education on 6-7-2016. "Proper procedure for EDK medications/orders". 5) By what date the systemic changes will be completed. 6-22-16		