

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
F000000	<p>This visit was for the Investigation of Complaints IN00139959 and IN00140220.</p> <p>Complaint IN00139959 - Substantiated. Federal/state deficiencies related to allegation are cited at F157 and F309.</p> <p>Complaint IN00140220 - Substantiated. No deficiencies related to allegation are cited.</p> <p>Survey dates: December 16 and 17, 2013.</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: NF: 38 Total: 38</p> <p>Census payor type: Medicaid: 38 Total: 38</p> <p>Sample: 03</p>	F000000	<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 opinion that it was in</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 27, 2013; by Kimberly Perigo, RN.</p>		<p>compliance with the requirements of participation or that corrective action was necessary.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(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			
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a physician and an interested family</p>	F000157	F0157 Addendum: The deficient practice for resident A was corrected by the following: The resident was treated with analgesics as ordered for complaints--the resident's pain	01/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(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			
	<p>member had been notified of a fall as indicated by facility policy for 1 of 3 residents reviewed for falls. (Resident #A)</p> <p>Findings include:</p> <p>Interview with CNA #1 on 12/16/13 at 4:15 p.m., indicated [gender] was working 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7 a.m., on November 15, 2013. CNA #1 indicated on 11/15/13 at approximately 5:30 p.m., another CNA came down the hall to get him to come to Resident #A's room as [gender] had fallen and LPN #1 needed some help to get Resident #A back up.</p> <p>Resident #A's clinical record was reviewed on 12/16/13 at 2:15 p.m., and on 12/17/13 at 11:00 a.m. The clinical record lacked documentation regarding Resident #A having fallen in bathroom and injuring her leg.</p> <p>Resident #A's care plans with revised date of 12/17/13, indicated Resident #A was a risk for falls. Resident #A's BIMS (Brief initial Mental Status) dated 9/12/13 was a 15, which represented cognitively intact. Resident #A's diagnoses, include, but are not limited to: dementia, hypertension , stroke, and</p>		<p>level was assessed along with the resident's reaction(s) to the ordered and administered medications--the facility contacted the physician and obtained and order for an x ray. The interested parties were notified-- the resident was sent to the hospital--the nurse involved in the event had her employment terminated and her state nursing licensure was submitted to the Indiana Attorney General as a complaint and for that departments review. The facility provided the state with a report on the event. Licensed nursing staff were re-educated on the facility's fall policy and procedures. () All residents have the ability to be affected by such a deficient practice by a licensed nurse, however after state survey of events (the facility falls and state reportable events), no other resident were found to have been affected. Residents assigned to the terminated nurse, will be reviewed for 4 weeks prior to her termination and assessed for potential injury(ies) and/or pain. Residents with a recent (30 day) history of fall events will be reassessed for injury and/or untreated pain. These assessments will be discussed in the next Quality Assurance meeting and the care plans for such injury or pain will be reviewed during that meeting. The DON and/or her designee will be responsible for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(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			
	<p>non insulin dependent diabetic.</p> <p>Review of Resident #A's nursing notes indicate no incident documentation was done for the fall (as indicated by facility policy). The nursing notes had no documentation the physician, family, nor the DON were notified. Resident #A nursing noted dated 11/15/13 at 10:00 p.m. indicated Resident #A was complaining of pain to right inner thigh, and QMA (Qualified Medication Assistant) gave Resident #A a pain pill and LPN #1 indicated [gender] would follow up. No other documentation noted from LPN #1.</p> <p>On 12/16/13 at 2:00 p.m., the DON provided the facility's fall prevention policy dated 7/30/12, and indicated the policy was the one currently used by the facility. Review of the policy indicated, the first priority was to assess the resident for any injuries and ask what happened. Second the nurse was to fill out an incident report, call the family and physician, and notify the DON or Administrator (none of these things were done according to the DON).</p> <p>The physician orders for X-ray of right leg were dated 11/16/13, and transfer orders to the hospital were</p>		<p>these assessments. The facility reviews reported events in morning meetings (including the event for resident A) whose attendees normally include the Director of Nursing Services, the Licensed Health Facility Administrator, the Social Services manager and the MDS nurse. The facility also reviews these events in monthly Quality Assurance meetings that include (but are not limited to) the physician, the psychology group and the licensed pharmacist. The facility policy: Events that are 'with injury' are to be called in to the Director of Nursing and/or to the Administrator as those events occur: The interested family, guardian and the physician are to be notified, with or without known or suspected injury to the resident, when the event occurs. The facility immediately in-serviced nursing staff on the policy and procedures for falls and proper nursing follow up for falls. (please see exhibit Z) The facility's Incident Reporting form does ask for notification of the physician and the interested family/guardian/poa (which includes time of notification and date). The facility has also added an additional form to the 'Fall Circumstance Report' to ensure documentation of a proper physical assessment following a fall will be accomplished. (please see exhibit Y--'Physical Assessment Following a Fall</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
	<p>on 11/18/13.</p> <p>Review of DON notes dated 11/18/13 at 10:30 a.m., indicated that Resident #A was being admitted to the hospital for surgery of a fractured right femur.</p> <p>This Federal tag relates to Complaint IN00139959.</p> <p>3.1-5(a)</p>		<p>Checklist'). To abide by state plan of correction guidelines the facility will continue to in-service the nurses on the facility's fall policy/prevention and/or risk management, every other week for four weeks (two month total) and then once per month times four months. The fall policy will also be reviewed by nursing staff (nurses, qualified medication aides and certified nursing aides). () The aforementioned steps to re-educate licensed nursing staff will be accomplished and the facility includes in all employed personnel ; reference checks (at least x3), state and/or national criminal history checks and license/certification checks. (State and /or national criminal history checks are also revisited for approximately 60% of employees who have worked for the facility for a period of one year.) The facility also drug tests employees. The Director of Nursing and/or the Assistant to the Director of nursing will monitor nursing re-education (which will include fall policy and procedures, risk management and the steps the nurse must take to assess a fall and how to follow through with documentation after an event occurs.) and all events that occur in this facility. Licensed staff are trained to give notification of events to the interested family/guardian/poa and this will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>be reinforced through re-education and in service training of our staff (as aforementioned). Events as reported, regarding this particular event were reviewed by the DON the ADON and the Administrator of this facility, as any future reported events will be reviewed (daily and monthly.) These reviews are documented as being accomplished for the residents, the DON will maintain the documentation regarding these events and their reviews. (1) What actions will be accomplished for those residents found to have been affected by this deficiency? The facility maintains that as soon as they were made aware of the situation concerning resident A, the facility provided follow up for pain management, medical care, documentation and notifications to all interested parties. (please see exhibit one, two pages) When pain management was accomplished by physician ordered analgesics and the resident was noted to have continued complaints, the physician was notified as well as the POA. The facility provides all residents with proper pain management and follows fall history and fall risks according to the state and federal guidelines. It is the facility's desire to keep all of our residents safe. (2) How the facility will identify other residents having the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			<p>potential to be affected and what corrective action will be taken? The facility provides all residents with proper pain management and follows fall history and fall risks and follow ups according to the state and federal guidelines. It is the facility's desire to keep all of our residents safe. All of the residents in the facility are cared for under strict facility and state regulations. A resident who has a change of status such as continued pain that is unrelieved by physician prescribed analgesic(s) is cared for according to facility and state policy and regulations. (Both the physician and the POA of resident A were notified once the facility became aware of events and circumstance.) Resident A has the following medical diagnosis: Vascular dementia with Depressive Mood, Constipation, Essential HTN, Diabetes without compliance and uncontrolled, Chronic Pain, Pseudobulbar Affect, Obesity. Resident A is also Care Planned for non-compliant behaviors such as purposefully "falling" onto the floor; attention seeking behaviors including being accusatory of staff , persistent anger with self and with others (including family); socially inappropriate behaviors (such as aggression, the telling of untruths and disruptive behaviors); short term memory loss and the refusal of care and medications. (please see Exhibit's</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			'B' and 'C') Resident A was also being seen by the facility's physical therapist to increase strength and promote independence with transfer and or ambulation. Resident A is documented to have complained of 'right leg pain', 'all over pain' and 'back pain' at separate times during the hours investigated. (IE right leg pain was not being reported by this resident on a continuous basis) It is documented that the Registered Nurse completed a physical assessment of the resident due to complaints of pain. The resident's right leg was assessed by the Registered nurse and it is documented that, "No swelling, redness or bruising" of this body part was noted at the time of that assessment. The facility would like to note that directly following this event the POA, for resident A , spoke with the facility and the POA wanted this resident to return to this facility for follow up care. After consideration by the facility's team members it was believed that this resident would require a more structured physical therapy need then what this facility could offer and our recommendation was to find placement for this resident's rehabilitation elsewhere. The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			<p>professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up. Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other week for four weeks (two month total) and then once per month times four months. (3) What measures will be put into place or what systemic changes will be made? The facility maintains that as soon as they were made aware of the situation concerning resident A, the facility provided follow up for pain management, medical care, documentation and notifications of all interested parties. (please see exhibit one, two pages). The nurse that provided the immediate resident assessment and care regarding resident A was instructed to return to the facility (off shift) to document that such had been accomplished for this resident,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>while on her shift. The nurse involved informed the facility's Director of Nursing that "she (the nurse) had the documentation in her purse at home". (Staff members on the shift when the event occurred have confirmed that the nurse did perform a resident fall assessment at the time the event was discovered on her shift.) This nurse did not deliver the required documentation to this facility. Nor did this nurse give follow up written or verbal report to the oncoming change of shift nurse that an event concerning a resident had occurred. (no paperwork) This nurse was terminated and her licensure turned in to the Indiana Attorney General Office. The facility is not recognized by the laws of the state or of the government to physically enforce that an event in such a nature as this will be documented properly by the employee who has been issued a nursing license by the state. However by filing a grievance regarding the nurse's licensure and by the termination of the nurse's employment, the facility has taken what steps are available to it, in an attempt to ensure this nurse does not have the opportunity to repeat her (non) actions. Reported events, when they occur, are documented and passed on in nursing report to the Director of Nursing or to the Assistant Director of Nursing who</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			attempt to ensure that proper documentation and care was accomplished and follow up is completed. (please see Exhibit 'D' which is the facility's Fall and Fall Prevention Policy) The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up (including documentation practices). Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other week for four weeks (two month total) and then once per month times four months. (4) How the corrective action(s) will be monitored and what quality assurance program will be put into place and who will monitor? The Director of Nursing and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>the Assistant Director of Nursing are responsible for resident safety, care and follow ups concerning all resident status changes in this facility. (Including falls with or without injury) Reported events are discussed in morning staff meeting with employees who are appropriate to the event(s). Falls are reviewed in these meetings and also by monthly Quality Assurances meetings, where the facility's physician physically participates. (please see Exhibit E- 8 pages) The facility continues with its "Falling Star Program" (Quality Assurance measure) for any resident who has been *found on the floor (a fall) for 2 times in a 60 day period and takes appropriate action(s) for such resident. (* At any time when a resident has been "found on the floor", for any reason, the facility considers this to have been a 'fall'; including a resident who purposely places themselves (sits) onto the floor; according to state guidelines; even when care planned for such behavior). The physician and the POA or Resident Guardian is also notified and kept informed as per facility policy. The facility abides by state and federal guidelines and must also abide by the state's determination that "the resident has the right to refuse or to be non-compliant (refuse) with any/all interventions" (and care) that the facility may initiate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			to assure resident safety. (non verbatim quote). This facility's Fall Prevention Program states the following:"...due to the progressive nature of memory loss disorders, behavior disorders and the aging process, the facility understands that there may be no appropriate intervention to prevent a resident from experiencing a fall. Promoting the independence and maintaining mobility is a priority and nurse does not have the opportunity to repeat her (non) actions. Reported events, when they occur, are documented and passed on in nursing report to the Director of Nursing or to the Assistant Director of Nursing who attempt to ensure that proper documentation and care was accomplished and follow up is completed. (please see Exhibit 'D' which is the facility's Fall and Fall Prevention Policy) The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up (including documentation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure an assessment had been implemented followed by prompt medical treatment after a fall with injury as indicated by the facility's policy for 1 of 3 residents reviewed for falls. (Resident #A)</p> <p>Findings include: Interview with Resident #A on 12/17/13 at 9:45 a.m., indicated</p>	F000309	<p>practices). Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other week for four weeks (two month total) and then once per month times four months. (5) Date this will be corrected? 1-16-2014</p> <p>F0309 Addendum: The deficient practice for resident A was corrected by the following: The resident was treated with analgesics as ordered for complaints--the resident's pain level was assessed along with the resident's reaction(s) to the ordered and administered medications--the facility contacted the physician and obtained and order for an x ray. The interested parties were notified-- the resident was sent to the hospital--the nurse involved in the event had her</p>	01/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
	<p>[gender] had fallen in the bathroom, while attempting to get from the wheelchair to the bathroom. Resident #A stated [gender] having yelled for help until LPN #1 arrived. LPN #1 called for assistance and CNA #1 helped her back up. Resident #A indicated no assessment was done by LPN #1 before or after [gender] was placed back in bed. Resident #A indicated LPN#1 told [gender] she thought it was just a sprain. Resident #A indicated the next night [gender] mentioned to RN #1 [gender] had fallen the day before, so RN #1 checked her over and called the doctor for an x-ray.</p> <p>Interview with CNA #1 on 12/16/13 at 4:15 p.m., indicated (gender) was working 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7 a.m., on November 15, 2013. CNA #1 indicated on 11/15/13 at approximately 5:30 p.m., another CNA came down the hall to get him to come to Resident #A's room as [gender] had fallen and [gender] and LPN#1 could not get her up. CNA #1 came into Resident #A's room and noticed Resident #A on the floor. Resident #A was alert and oriented and complaining of right hip pain. CNA#1 indicated Resident #A was helped back into</p>		<p>employment terminated and her state nursing licensure was submitted to the Indiana Attorney General as a complaint and for that departments review. The facility provided the state with a report on the event. Licensed nursing staff were re-educated on the facility's fall policy and procedures. The facility also added a ford to ensure documentation, to it's Fall Circumstance Report. (please see exhibit Y: Physical Assessment Following Fall Checklist.) () All residents have the ability to be affected by such a deficient practice by a licensed nurse, however after state survey of events (the facility falls and state reportable events), no other resident were found to have been affected. The facility reviews reported events in morning meetings (including the event for resident A) whose attendees normally include the Director of Nursing Services, the Licensed Health Facility Administrator, the Social Services manager and the MDS nurse. The facility also reviews these events in monthly Quality Assurance meetings that include (but are not limited to) the physician, the psychology group and the licensed pharmacist. The facility policy: Events that are 'with injury' are to be called in to the Director of Nursing and/or to the Administrator as those events occur: The interested family,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
	<p>her wheelchair then assisted into bed.</p> <p>Resident #A's clinical record was reviewed on 12/16/13 at 2:15 p.m., and on 12/17/13 at 11:00 a.m.</p> <p>Resident #A's care plan with a revised date of 12/17/13, indicated Resident #A was a risk for falls. Resident #A's BIMS (Brief initial Mental Status) dated 9/12/13 was a 15, which indicated cognitively intact. Resident #A's diagnoses, include, but are not limited to: dementia, hypertension, stroke, and non insulin dependent diabetic.</p> <p>Resident #A's nursing notes dated for 11/15/13, indicated nothing was charted related to the fall, nor was the physician, family, and DON notified.</p> <p>Resident #A's nursing note dated 11/15/13 at 10:00 p.m., indicated Resident #A was complaining of pain to the right inner thigh, and QMA (Qualified Medication Assistant) gave Resident #A a pain pill and LPN #1 indicated (gender) would follow up. No other documentation noted from LPN #1.</p> <p>Nurses notes dated 11/16/13 at</p>		<p>guardian and the physician are to be notified, with or without known or suspected injury to the resident, when the event occurs. The facility immediately in-serviced nursing staff on the policy and procedures for falls and proper nursing follow up for falls.(please see exhibit Z) The facility's Incident Reporting form does ask for notification of the physician and the interested family/guardian/poa (which includes time of notification and date). The facility has also added an additional form to the 'Fall Circumstance Report' to ensure documentation of a proper physical assessment following a fall will be accomplished. (please see exhibit Y--'Physical Assessment Following a Fall Checklist'). To abide by state plan of correction guidelines the facility will continue to in-service the nurses on the facility's fall policy/prevention and/or risk management, every other week for four weeks (two month total) and then once per month times four months. The fall policy will also be reviewed by nursing staff (nurses, qualified medication aides and certified nursing aides). Residents assigned to the terminated nurse, will be reviewed for 4 weeks prior to her termination and assessed for potential injury(ies) and/or pain. Residents with a recent (30 day) history of fall events will be reassessed for injury and/or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(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			
	<p>12:30 a.m., indicated RN #2 documented Resident #A was complaining of back pain. Resident was re-position and given a PRN (as needed) pain medication. RN #2 on 11/16/13 at 2:00 a.m., reassessed the resident and documented Resident #A continued to yell intermittently, wanting staff to stay with [gender] to talk. Resident #A was repositioned to help with discomfort and documentation indicated continued efforts to make Resident #A comfortable would continue.</p> <p>Nurses notes dated 11/16/13 at 10:00 p.m., indicated Resident complained of leg pain. Assessment was done by RN #2 with no redness or bruising noted and skin was dry and intact. Resident received PRN pain medication. When asked by RN #2 where on leg was pain located, Resident #A indicated it was all over. Documentation at 10:45 p.m. indicated Resident #A advised some staff members that [gender] had fallen in the bathroom last night.</p> <p>Nurses note dated 11/17/13 at 11:00 p.m., indicated Resident #A continued to complain of back and right leg pain. RN #1 informed</p>		<p>untreated pain. The DON and/or her designee will be responsible for these assessments. These assessments will be discussed in the next Quality Assurance meeting and the care plans for such injury or pain will be reviewed during that meeting and updated as necessary. () The aforementioned steps to re-educate licensed nursing staff will be accomplished and the facility includes in all employed personnel ; reference checks (at least x3), state and/or national criminal history checks and license/certification checks. (State and /or national criminal history checks are also revisited for approximately 60% of employees who have worked for the facility for a period of one year.) The facility also drug tests employees. The Director of Nursing and/or the Assistant to the Director of nursing will monitor nursing re-education (which will include fall policy and procedures, risk management and the steps the nurse must take to assess a fall and how to follow through with documentation after an event occurs.) and all events that occur in this facility. Licensed staff are trained to give notification of events to the interested family/guardian/poa and this will be reinforced through re-education and in service training of our staff (as aforementioned). Events as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
	<p>Nurse Practitioner (NP) on call and received order for an XR (x-ray) of Resident #A's right leg. RN #1 did advise NP Resident #A was favoring [gender] right leg and requested change in pain medication as present medication was not helping. RN #1 documented Resident #A informed (gender) on 11/17/13 at 11:00 p.m., she had fell on 11/15/13, but there was no evidence of said statement. Resident #A's POA (family / power of attorney) was called on 11/18/13 at 7 :00 a.m., and notified of Resident #A's condition and that an X-Ray had been ordered.</p> <p>Clinical record notes dated 11/17/13 at 1:30 p.m., indicated Medical Diagnostic Services was there to take Resident #A's x-ray. At 5:00 p.m. results had been received, the Medical Doctor notified, and a new Doctor's order for transfer to the Emergency Room for further evaluation was received. The POA was notified at 6:00 p.m., of the transfer.</p> <p>Review of DON notes dated 11/18/13 at 10:30 a.m., indicated Resident #A was being admitted to the hospital for surgery of a fractured right femur.</p>		<p>reported, regarding this particular event were reviewed by the DON the ADON and the Administrator of this facility, as any future reported events will be reviewed (daily and monthly.) These reviews are documented as being accomplished for the residents, the DON will maintain the documentation regarding these events and their reviews. (1) What actions will be accomplished for those residents found to have been affected by this deficiency? The facility maintains that as soon as they were made aware of the situation concerning resident A, the facility provided follow up for pain management, documentation, medical care and notifications of all interested parties. When pain management was accomplished by physician ordered analgesics and the resident was noted to have continued complaints, the physician was notified as well as the POA being notified. (documented) The facility provides all residents with proper pain management and follows fall history and fall risks according to the state and federal guidelines. The facility follows all guidelines for documentation concerning a resident's medical record. It is the facility's desire to keep all of our residents safe. The nurse that provided the immediate resident assessment and care regarding resident A was instructed to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
	<p>On 12/16/13 at 2:00 p.m., the DON provided the facility's fall prevention policy dated 7/30/12, and indicated the policy was the one currently used by the facility. Review of the policy indicated, the first priority was to assess the resident for any injuries and ask what happened. Second the nurse was to fill out an incident report, call the family and physician, and notify the DON or Administrator (none of these things were done according to the DON).</p> <p>Interview with the DON on 12/16/13 at 12:00 p.m., indicated after the fall care to the Resident not been done according to the facility fall policy.</p> <p>This Federal tag relates to Complaint IN00139959.</p> <p>3.1-37(a)</p>		<p>return to the facility (off shift) to document that such had been accomplished for this resident, while on her shift. The nurse involved informed the facility's Director of Nursing that "she (the nurse) had the documentation in her purse at home". (Staff members on the shift when the event occurred have confirmed that the nurse did perform a resident fall assessment at the time the event was discovered on her shift.) This nurse did not deliver the required paperwork. Nor did this nurse give follow up written or verbal report to the oncoming change of shift nurse that an event concerning a resident had occurred. (no paperwork) This nurse was terminated and her licensure turned in to the Indiana Attorney General Office. The facility is not recognized by the laws of the state or of the government to physically or to otherwise enforce that an event in such a nature as this will be documented properly by the employee who has been issued a nursing license by the state. However by filing a grievance regarding the nurse's licensure and by the termination of the nurse's employment, the facility has taken what steps are available to it, in an attempt to ensure this nurse does not have the opportunity to repeat her (non) actions. (2) How the facility will identify other residents having the potential to be affected and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>what corrective action will be taken? Although all residents have the potential to be negatively affected by a nurse's lack of documentation and lack of professional ethics: the facility strives to provide all residents with proper pain management and nurse are licensed and educated in the need for proper documentation according to the state and federal guidelines. It is the facility's desire to employ licensed personnel that follow the rules and regulations of their chosen professions. This nurse was terminated and her licensure turned in to the Indiana Attorney General. The facility followed all managerial and nursing procedures as soon as the event was noted. The facility provides many staff/nursing in-services throughout the year and documentation/risk management in-services will be held additionally four times per annum. All of the residents in the facility are cared for under strict facility and state regulations. A resident who has a change of status such as continued pain that is unrelieved by physician prescribed analgesics is cared for according to facility and state policy and regulations. (Both the physician and the POA of resident A were notified once the facility became aware of events and circumstance.) Resident A has the following medical diagnosis: Vascular dementia</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			with Depressive Mood, Constipation, Essential HTN, Diabetes without compliance and uncontrolled, Chronic Pain, Pseudobulbar Affect, Obesity. Resident A is also Care Planned for non-compliant behaviors such as purposefully "falling" onto the floor; attention seeking behaviors including being accusatory of staff , persistent anger with self and with others (including family); socially inappropriate behaviors (such as aggression, the telling of untruths and disruptive behaviors); short term memory loss and the refusal of care and medications. (please see Exhibit's 'B' and 'C') Resident A is also documented to have complained of 'right leg pain', 'all over pain' and 'back pain' at separate times during the hours investigated. It is documented that the Registered Nurse completed an assessment of the resident due to complaints of pain. The resident's right leg was assessed by the Registered nurse and it is documented that, "No swelling, redness or bruising" of this body part was noted at the time of that assessment. The facility would like to note that directly following this event the POA for resident A , spoke with the facility and wanted this resident to return to this facility for follow up care. After consideration by the facility's team members it was believed that this resident would require a more structured physical therapy need then what		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>this facility could offer and our recommendation was to find placement for this resident elsewhere. The facility maintains that as soon as they were made aware of the situation concerning resident A, the facility provided follow up for pain management, medical care and notifications of all interested parties. (please see exhibit one, two pages). The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up. Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other week for four weeks (two month total) and then once per month times four months. (3) What measures will be put into place or what systemic changes will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			made? Measure 1-This nurse was terminated and her licensure turned in to the Indiana Attorney General Office. The facility is not recognized by the laws of the state or of the government to physically enforce that an event in such a nature as this will be documented properly by the employee who has been issued a nursing license by the state. However by filing a grievance regarding the nurse's licensure and by the termination of the nurse's employment, the facility has taken what steps are available to it, in an attempt to ensure this nurse does not have the opportunity to repeat her (non) actions. our residents safe. It is the facility's desire to employ licensed personnel that follow the rules and regulations of their chosen professions. Measure 2-The facility provides many staff/nursing in-services throughout the year as per given regulations and documentation and/or risk management in-services will be held additionally four times per annum/quarterly. (IE: Systemic change). The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up. Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other week for four weeks (two month total) and then once per month times four months. (4) How the corrective action(s) will be monitored and what quality assurance program will be put into place and who will monitor? The facility maintains that as soon as they were made aware of the situation concerning resident A, the facility provided follow up (medically and written documentation) however to abide by state plan of correction guidelines: the Director of Nursing and/or the Assistant Director of Nursing are responsible for nursing in-services in this facility. The quality assurance follow up on these specific in-services regarding nursing documentation and/or risk management will be discussed quarterly in morning meetings. (Morning meeting attendees may include the DON,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(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	
			<p>the ADON, the LHFA, the SSD and medical records personnel.) The Medical Records Department will maintain those documents for review and inspections. (The nurse involved in the event was terminated and her licensure turned in to the Indiana Attorney General Office. The facility is not recognized by the laws of the state or of the government to physically enforce that an event in such a nature as this will be documented properly by the employee who has been issued a nursing license by the state.) The facility will continue to educate staff regarding policy and procedures and also to re-educate our licensed professional nurses of the Nursing Scope of Practice Act. This education and re-education takes place in the form of conferences and in-servicing staff. The facility's Fall Policy is in-serviced at least once per annum. However all nursing staff have been in-serviced within the past few weeks on Fall Policy, Fall Prevention and Follow Up. Information on in-services and other facility policies are also available in a Communication Book kept at the nursing station. In-service information is also made freely available to nursing staff on request. To abide by state plan of correction guidelines the facility will in-service the nurses on the facility's fall policy/prevention, every other</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
---	---

(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
			week for four weeks (two month total) and then once per month times four months. (5) Date this will be corrected? 1-16-2014	