

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 04/04/2012
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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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F0000	<p>This visit was for the Investigation of Complaint IN00106357, and Complaint IN00105877.</p> <p>Complaint IN00106357-Substantiated with Federal/State deficiencies related to the allegations cited at F309.</p> <p>Complaint IN00105877-Substantiated with Federal/State deficiencies related to the allegations cited at F223.</p> <p>Survey Date: 4/04/2012</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Barb Hughes, RN Karina Gates, Medical Surveyor</p> <p>Census Bed Type: NF: 37 Total: 37</p> <p>Census Payor Type: Medicaid: 37 Total: 37</p>	F0000	<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 law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of it's 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 this Plan of Correction in its entirety, constitutes this provider's allegation of compliance and thereby, we request re-survey to verify such. 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. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is</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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	<p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/10/12 by Suzanne Williams, RN</p>		<p>under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p>		

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F0223 SS=D	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal and physical abuse during care by a staff member, for 1 of 3 residents reviewed for potential abuse in a total sample of 5. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 4/4/12 at 9:30 a.m. The diagnoses for Resident B included, but were not limited to: schizophrenia, hallucinations, and delusions.</p> <p>A 1/29/12 psychological evaluation indicated Resident B was moderately cognitively impaired.</p> <p>A report to the Indiana State Department of Health, dated 3/20/12, by the facility, was reviewed on 4/4/12 at 10:00 a.m. The report indicated on 3/20/12, Resident B reported that a CNA (Certified Nursing Assistant), CNA #1, was very rough with</p>	F0223	<p>F223 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>It is the practice of Lynhurst Healthcare to ensure that all alleged violations regarding mistreatment, neglect or abuse, including injuries of unknown etiology (unknown source) and misappropriation of resident property are reported immediately to the Administrator of the facility and to other outside officials in accordance with state and federal law, including the state survey and certification agency. Officials that are notified immediately include the police, the ombudsman, adult protective services, the family/POA/guardian, the physician and the Indiana State Board of Health. The survey team and all other investigating parties were notified of this alleged event immediately on the day of occurrence. (3-20-2012). The survey team entered the facility in regards to this complaint/self reporting event</p>	05/04/2012	

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	<p>him and pulled him to the floor. CNA #1 was called and suspended pending investigation. The police were called and a report was made. Another resident, Resident C, who resided in the room next door, stated he was in the hallway and witnessed the incident.</p> <p>Information pertaining to the above incident was provided by the Executive Director on 4/4/12 at 10:30 a.m.</p> <p>A written statement from CNA #2 indicated "...the resident infomed (sp) me that he witnessed (name of CNA #1) being very crul (sp) to another resident. I asked him wat (sp) he meant. He stated that the resident mad (sp) a bowl (sp) movement and (name of CNA #1) took his bm (bowel movement) and made him smell it and he also made him sit in it. As the resident was telling me this he began to cry...I informed the DON (Director of Nursing) and had the resident tell her exactly wat (sp) he witnessed."</p> <p>A written statement, dated 3/20/12 with no time indicated, from the DON indicated, "On 3-20-12 at 7:15 A.M. I was approached by (name of Resident C) (resident) and (name and title of CNA #2), (Name of Resident C) stated "(Name of Resident B) had an accident in his bed and when (name of CNA #1) came to</p>		<p>by Lynhurst Healthcare, on 4-4-2012. Resident B and resident "C"; and/or any of the facility's other resident's, did not report a problem or any concern r/t this event, prior to the time and/or the date of this facility's report via the ISDH self reporting services. (3-20-2012). The facility immediately followed protocol on the alleged event, within a two hour window of the residents complaint of possible injury. (Residents "B") The facility notified the police, who entered the building at 9am. The facility also notified the ISDH, the Ombudsman, the guardian , the doctor and Adult Protective Services. On 3-20-2012 the CNA involved in this event, left the facility and has never returned to the facility. This particular CNA was terminated 3-20-2012. A doctor's ordered x ray and a full body assessment of resident "B" was accomplished by licensed personnel and showed no noted injury to the resident after this event. (At the date of this POC, both resident's appear to be medically stable and there are no noted reports of mental changes or distress.) Psych services has interviewed and counseled the two residents involved in this event. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? CNA's and staff were re-educated at the</p>				

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	<p>clean him up he made (name of Resident B) smell the soiled brief and made him 'rub his booty in it.'" I asked (name of Resident C) to come into my office and called the night charge nurse, (name and title of LPN #3), into my office."</p> <p>A written statement, dated 3/20/12 with no time indicated, from LPN #3 indicated, "Evening shift nurse gave (Name of Resident B) Milk of Mag (a laxative). Night shift was waiting for results. (Name of Resident B) had lg (large) results. (Name and title of CNA #1) informed me that he had BM all over bed & (name of Resident B) did not want to get up to get cleaned up. (Name of Resident B) was directed to the shower room by (name of CNA #1) & I witnessed (name of CNA #1) taking clean linens & mop to room..."</p> <p>The written statement, dated 3/20/12 with no time indicated, from the DON indicated, "(Name of Resident B) told (name of Social Services Director) and I that "(Name of CNA #1) was mad at him for having a BM all over his bed and himself and that he had pulled him out of the bed, hurting his neck and head." He also stated that "(name of CNA #1) beat the f--- out of me, and I was shaking," then he started to cry.</p>		<p>time following the event regarding the facility Abuse Policy and reporting abuse allegations immediately to the administrator or to her designee. The facility also conducted random resident and staff interviews following this event to ensure that no other residents were affected. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. As indicated in the survey report, the facility does have and follows the Abuse Policy and a Zero Tolerance policy. Following this event staff were re-educated on these policies. This education is also provided quarterly and is provided to all new employees during orientation to the building and to their chosen area of employment. Residents during Resident Council were re-educated about their right to be free from abuse. Residents during Resident Council, will also be re-educated regarding the matter of freedom from abuse, on a quarterly basis for 6 months and prn. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The Director of Social Services or her designee will be conducting quality improvement audits to ensure residents are aware of their right to be free from abuse. Random samples of</p>				

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	<p>A written statement, dated 3/20/12 with no time indicated, from the Social Services Director indicated "I was informed by resident (name of Resident C) that CNA that was taking care of (name of Resident B) was very mean to (name of Resident B). (Name of Resident C) stated "(Name of Resident B) had a accident and (name of CNA #1) made (name of Resident B) sniff the dirty brief and also rubbed his butt in the s---". Resident stated that he was really afraid and that (name of Resident B) was so afraid he was shaking. Writer spoke (symbol for with) (name of Resident B) briefly. (Name of Resident B) was crying and shaking and stated, 'He was violent towards me.'"</p> <p>A written statement, dated 3/20/12 with no time indicated, from CNA #4 indicated "I was here, and I remember (name of CNA #1) saying (name of Resident B) made a big mess and he was upset."</p> <p>During a telephone interview with CNA #4 on 4/4/12 at 2:20 p.m., she indicated CNA #1 was the person who was upset. She stated, "He was mad." "He told me there was a d--n mess on the floor."</p> <p>During an interview with the Executive Director on 4/4/12 at 12:20 p.m., the Executive Director indicated she spoke</p>		<p>4 residents will be interviewed weekly for 30 days, then monthly for 6 months. Results of these audits will be discussed during the facility's monthly Quality Assurance meetings. (the QA meetings may include but are not limited to, the presence of the doctor, the Administrator, the DON, Social Services, pharmacy services and psych. services.) Included with our ongoing facility QA process, will be the random interviews from 4 staff members for 30 days and then monthly for 6 months, to ensure understanding and compliance with the facility's abuse prevention program. These interviews will also be the responsibility of Social Services to perform and to monitor and to document Residents during Resident Council, will also be re-educated regarding the matter of freedom from abuse, on a quarterly basis for 6 months. and prn. Resident Council and re-education of the resident's on this matter, will be monitored by the facility's Activity Director 5) By what date the systemic changes will be completed. May 4, 2012.</p>				

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	<p>with CNA #1 over the telephone and he denied everything...the sitting on the soiled brief and the smelling of the soiled brief. She indicated CNA #1 was fired because she had a zero tolerance for abuse. She indicated since there were two residents who corroborated the same story, the story sounded reasonable to her.</p> <p>During interview with Resident C on 4/4/12 at 12:00 p.m., he indicated CNA #1 put a soiled brief in Resident B's nose. He indicated the brief had "dooty" in it. CNA #1 made Resident B sit on the soiled brief in his bare bottom and spun him around on the floor. He indicated this happened in Resident B's room. He indicated he was sitting in the green chair outside of Resident B's room when he heard Resident B yell "help". Resident B indicated that's when he got up and walked to Resident B's door and saw the whole thing. He indicated Resident B looked scared. He indicated he told CNA #1 to get his hands off Resident B. Resident C indicated he cannot really write or spell and that was why there was no written statement from him directly, but he told everyone, including the police.</p> <p>The most recent BIMS (Brief Interview for Mental Status) score reviewed on 4/4/12 at 11:50 a.m. for Resident C was a 15 (highest possible score indicating</p>			

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	<p>resident is cognitively intact).</p> <p>During interview about the incident with Resident B on 4/4/12 at 10:15 a.m., he stated, "I can't describe it. It was horrible."</p> <p>This federal tag relates to Complaint IN00105877.</p> <p>3.1-27(b)</p>				

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F0309 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 record review and interview, the facility failed to initiate cardiopulmonary resuscitation (CPR) for a resident with a full code status, for 1 of 3 residents reviewed for death in the facility in a total sample of 5. Resident #A.</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 4/4/2012 at 9:45 a.m. Diagnoses included but were not limited to; diabetes mellitus type 2, depressive disorder, psychosis, and cerebrovascular accident with right hemiparesis (stroke with right side of body weakness).</p> <p>A 'Cardiopulmonary Resuscitation Status Form,' with Resident #A's name, and dated 4/21/2011, was check marked next to the statement, 'CPR will be initiated.' The form also indicated, "We need to know what measures you and the attending Physician would want us to take in the event of a Cardiac Arrest. Cardiopulmonary Resuscitation (CPR) is</p>	F0309	<p>F309 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Social Services and Medical records have audited the resident's medical records to ensure that CPR and DNR instructions are correct. The nurse's and Qualified Medication Aides have been re-educated times two, regarding the facility's policies on providing CPR in an emergency event. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected. The Medical Records Department and Social Services have performed a chart audit to ensure that all residents have the proper paperwork in their medical records to denote their code status. Nurses and Qma's have been re-educated times two regarding the proper response to a "Full Code" status. The materials used to re-educate these staff members on this</p>	05/04/2012

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	<p>a basic emergency procedure for life support, consisting of artificial respiration and manual external cardiac massage, to establish effective circulation and ventilation in order to prevent irreversible brain damage, resulting from the lack of oxygen to the brain. This procedure will continue until the resident is transported to a hospital site where further life support measures will be taken. It should be understood that without C.P.R. being initiated, death will probably occur. We will do C.P.R. unless you, the resident, or Guardian have stated otherwise." The line next to 'Resident/Responsible Party' was signed and dated 4/21/2011, by the resident and witnessed by the Social Services Director.</p> <p>A nurse's note dated 3/24/2012 at 5:00 a.m. indicated, "Went to resident room to give morning 6 a.m. meds and do accucheck (blood sugar). Found resident RHC (respirations have ceased). Resident with dark colored emesis to left shoulder of gown area. Leaning to left side of bed. This writer had previously been in room at 3:45 a.m. speaking with roommate. Resident asleep at that time with eyes closed. Respirations non labored. Head of bed elevated."</p> <p>A nurse's note dated 3/24/2012 at 5:15 a.m. indicated, "Call placed to MD thru</p>		<p>facility's policies on providing CPR in an emergency event,have also been placed into LPN/RN and QMA new hire orientation paperwork. The nurse involved in this event was given written counseling and was re-educated on this facility's policies on providing CPR in an emergency event. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nurses and Qma's have been re-educated times two regarding the proper response to a "Full Code" status. The Director of Nursing will conduct random nursing staff interviews 4 times per month, times one month then monthly for 6 months, to ensure all staff are aware of this facility's policies on providing CPR in an emergency event. Results of these interviews will be discussed and monitored during the facility's monthly QA meeting. The materials used to re-educate these staff members on this facility's policies on providing CPR in an emergency event,have also been placed into LPN/RN and QMA new hire orientation paperwork. These materials will also be added to the annual in-service packet for LPN's, RN's and QMA's. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The Director of</p>				

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	<p>med exchange. Nurse Practitioner on call awaiting return call."</p> <p>A nurse's note dated 3/24/2012 at 5:30 a.m. indicated, "Call placed to Director of Nursing to inform of resident's RHC and awaiting return call from Nurse Practitioner."</p> <p>A nurse's note dated 3/24/2012 at 6:45 a.m. indicated, "late entry for 5:30 a.m. Staff cleaning resident up when resident turned to give care moderate amount of blood draining from mouth and nose noted. Staff continued to clean resident. Clothing changed and resident dressed and clean linens placed on bed."</p> <p>A nurse's note dated 3/24/2012 at 8:50 a.m. indicated, "Nurse Practitioner returned call. Apologized for delay. Informed of resident being found RHC and CPR noted not to be done as resident found with dark colored emesis to left shoulder of gown and body being cool to touch. Nurse Practitioner gave order to release body."</p> <p>A phone interview with LPN #6 on 4/4/2012 at 11:05 a.m. indicated the last time she checked on the resident was at approximately 3:45 a.m. and she was fine, breathing normally and asleep. The next time she went in the room at 5 a.m., she</p>		<p>Nursing will conduct random nursing staff interviews 4 times per month, times one month then monthly for 6 months, to ensure all staff are aware of this facility's policies on providing CPR in an emergency event. Results of these interviews will be discussed and monitored during the facility's monthly QA meeting. The materials used to re-educate these staff members on this facility's policies on providing CPR in an emergency event, have also been placed into LPN/RN and QMA new hire orientation paperwork. These materials will also be added to the annual in-service packet for LPN's, RN's and QMA's. 5) By what date the systemic changes will be completed. May 4, 2012.</p> <p>-</p>				

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	<p>found Resident #A cool to touch, and not breathing. LPN #6 indicated she was shocked to find her gone. The resident had a moderate amount of brownish/red in color emesis (vomit) which covered her left shoulder. At 5:30 a.m. when the CNAs were cleaning her up, they came and told LPN #6 that there was more red, dark red blood coming out of the resident's mouth and nose.</p> <p>A phone interview with LPN #6 on 4/4/2012 at 11:50 a.m. indicated, "The resident was on 15 minute checks because of her behaviors, but the CNAs were the ones responsible for doing the checks."</p> <p>A '15 minute check sheet' with Resident #A's name and dated 3/24/2012 indicated a continuous handwritten line started at 23:45 (11:45 p.m.) through 6:30 a.m. with, "RHC found," written in at the 5:00 a.m. space.</p> <p>Interview with the Director of Nursing on 4/4/2012 at 11:20 a.m. indicated the CNAs would initiate the 15 minute checks frequently on Resident #A because of her aggressive behavior. The CNAs would then report the reason why they had initiated the 15 minute checks to the Social Services Director.</p> <p>Interview with CNA #5 on 4/4/2012 at</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 04/04/2012
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	<p>1:00 p.m. indicated he did not remember the resident being on 15 minute checks. He checked on Resident #A when he did rounds that night at 1 a.m. and 3 a.m. and she was alive then. At 3 a.m. he repositioned her because she was leaning up against the wall and she woke briefly, it was harder to wake her but he thought that was just her normal sleepy behavior, didn't think anything was unusual in her behavior at the time. CNA #5 also indicated, "I would've and I wanted to (do C.P.R.) but at the time, LPN #6 said not to, she just said to clean her (the resident) up so I followed her lead and her orders."</p> <p>An 'Advanced Directives' policy provided by the Administrator on 4/4/2012 at 12 p.m. indicated, "Emergency Response- All trained staff have a responsibility to locate the code status in the medical record and commence basic life support whilst awaiting the emergency services as applicable."</p> <p>Interview with the Administrator and the Director of Nursing on 4/4/2012 at 12:20 p.m. indicated, "Our policy is that you initiate CPR for anyone who is a full code, no matter what they look like when you find them. Our expectation is that CPR is begun when someone is found not breathing." When asked specifically about Resident #A and whether C.P.R. should</p>			

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	<p>have been performed, both indicated, "[LPN #6] should have still started C.P.R. even though the resident was found cool to the touch."</p> <p>This deficiency relates to Complaint IN00106357.</p> <p>3.1-37(a)</p>				