DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 00 B. WING	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00373415. This visit was in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaints IN00372972, IN00372909, IN00372713, IN00370822, and IN00369949. Complaint IN00373415 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00369949 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759. Complaint IN00370822 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00372713 - Substantiated. No deficiencies related to allegations were cited. Complaint IN00372909 - Substantiated. No deficiencies related to allegations were cited. Complaint IN00372972 - Unsubstantiated. Due to lack of evidence. Survey dates: February 15, 16, 17, 18, 21, and 22, 2022. Facility number: 000385 Provider number: 15E667 AIM number: 100291340	F 0000	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 facilities statement of compliance. The facility respectfully request a paper compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Bed Type: NF: 37 Total: 37 Census Payor Type: Medicaid: 36 Other: 1 Total: 37 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 3, 2022.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on interview and record review, the facility failed to implement interventions to prevent falls for 3 of 4 residents reviewed for falls. (Resident L, Resident M, Resident N) Findings include: 1. The clinical record for Resident N was reviewed on 2/21/22 at 10:55 a.m. The diagnoses included, but were not limited to, history of traumatic brain injury, history of falls, dementia with behavioral disturbances, type 2 diabetes mellitus, mild cognitive impairment, and	F 0689	1) Corrective actions for those patients found to have been affected by the deficient practice: Due to the facility's survey list of patients being listed numerically and the tag on the Gateway site being listed alphabetically, the facility is unable to determine what patients belong to "L", "M" and "N"; however the facility is aware of 'who falls' and all patient falls are now discussed in each am	04/13/2022

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	schizoaffective disorder. A progress note dated, 9/26/21 at 4:05 p.m., indicated Resident N had a witnessed fall when his legs became weak and he fell onto his knees. He sustained a scrape on his right knee. A progress note dated, 10/27/21 at 7:05 p.m., indicated Resident N had a witnessed fall as he tripped over his foot, lost balance, and fell. He sustained a cut on his chin. A progress note dated, 11/27/21 at 6:00 p.m., indicated Resident N had a witnessed fall as he tripped over his feet due to " ill-fitting pants". He sustained an abrasion to the cheek bone, bilateral lip lacerations, and a chipped and loose front tooth. The resident was transferred to the Emergency Room for care and a CT of his head to check for bleeding. A progress note dated, 12/20/21 at 1:00 p.m., indicated Resident N had a witnessed fall as he had a "shuffled gait" and lost his balance. Resident N was to be reevaluated by the physician in the morning. A progress note dated, 2/16/22 at 10:00 a.m., indicated Resident N had a witnessed fall due to generalized weakness during ambulation. There were no injuries. He was to be referred to physical therapy for an ambulation evaluation. A care plan, created and initiated on 4/13/21 and current through 3/21/22, indicated Resident N had a fall care plan. The interventions included, but were not limited to, check range of motion every shift (initiated 4/13/21), continue interventions on the at-risk plan (initiated 4/13/21), for no apparent acute		meeting, every month at Quality Assurance meeting (QA). QA (Pharmacy attending) will review the medications of patients who fall. 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: Patient falls are now discussed in each am meeting and every month at Quality Assurance meeting (QA). QA (Pharmacy) will review the medications of patients who fall. 3) Measures put into place and systemic changes: Changes: Patient falls are now discussed in each am meeting and every month at Quality Assurance meeting (QA). QA (Pharmacy) will review the medications of patients who fall. Fall information (Interventions) are to be documented within 24 hours by the DON. Should the DON and MDS nurses be unable to document interventions, the facility will have the reporting nurse document interventions immediately following the fall.	

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	injury, determine and address causative factors of the fall (initiated 4/13/21), provide activities that promote exercise and strength building where possible (initiated 4/13/21), provide 1:1 activities if bed bound (initiated 4/13/21), referral has been made to psychiatrist for a medication review with potential need to decrease or eliminate some of the resident's medications (initiated 4/13/21). The fall care plan had not been updated with goals and interventions since being initiated on 4/13/21. During an interview on 2/22/22 at 2:30 p.m., the Administrator indicated she was unable to locate any additional care plan goals or interventions. 2. On 2/16/22 at 9:29 A.M., Resident L's clinical record was reviewed. The Quarterly MDS (Minimal Data Set) assessment, dated 1/15/22, indicated severe cognitive impairment. The diagnoses included, but were not limited to, cerebral infarction (a stroke) and heart failure. A facility incident report, dated 12/16/21 at 7:33 A.M., indicated Resident L had an unwitnessed fall on 12/16/21 in the room and was sent out to the ER (emergency room) for evaluation as the fall was unwitnessed and the resident exhibited pain. Resident L returned with no injury noted. A facility incident report, dated 1/28/22 at 2:23 P.M., indicated Resident L had an unwitnessed fall without injury on 1/28/22 when the resident slid out of the wheelchair in the room. A facility incident report, dated 2/4/22 at 8:34 A.M., indicated Resident L had a witnessed fall without injury on 2/4/22 ambulating from the		The MDS nurse has also been instructed on fall program follow up within 24 hours. Unwitnessed falls are followed by Neuro Checks X 72 hours. Witnessed falls are followed by a fall report documented either on PCC electronically or written on a paper incident report. Measures: The nursing staff is to be in-serviced on fall documentation (all three shifts); with the DON or her designee responsible for follow up's to this in-service. Nurses found to be remiss on this documentation will receive employee counseling and re-education documented by the DON. Should the DON and MDS nurses be unable to document interventions, the facility will have the reporting nurse document interventions immediately following the fall. Unwitnessed falls are followed by Neuro Checks X 72 hours. Witnessed falls are followed by a fall report documented either on PCC electronically or written on a paper incident report. 4) How corrective actions will be monitored and what quality assurance will be put into place: Corrective Actions:	

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	resident's wheelchair in the dining room without assistance. A current care plan for falls, revised 2/21/22, included, but were not limited to interventions of: anticipate and meet the resident's needs (initiated 7/16/21), be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance (initiated 7/16/21), follow facility fall protocol (initiated 7/16/21), lay resident down in bed after lunch and dinner (initiated 11/17/21), PT (physical therapy) evaluate and treats as ordered or as needed (initiated 7/16/21), and resident will not be dressed and out of bed before breakfast (initiated 12/19/21). 3. On 2/16/22 at 9:38 A.M., Resident M's clinical record was reviewed. The Quarterly MDS assessment, dated 12/13/21, indicated a moderate cognitive impairment. The diagnoses included, but were not limited to, Alzheimer's disease and schizoaffective bipolar type disorder. A nurse's note, dated 12/26/21 at 1:30 P.M., indicated Resident M had a witnessed fall without injury on 12/26/21 trying to get out of a chair in the dining area. A nurse's note, dated 1/7/22 at 2:05 A.M., indicated Resident M had a witnessed fall without injury on 1/7/22 walking without using walker. A current care plan for falls, revised 6/11/21, included, but were not limited to interventions of: anticipate and meet the resident's needs (initiated 1/8/20), call light in reach and cue to use (initiated 1/8/20), encourage non skid foot		Patient falls are now discussed in each am meeting and every month at Quality Assurance meeting (QA). Quality assurance: In the monthly QA meetings (Pharmacy attending) will review the medications of patients who fall. Fall information (Interventions) are to be documented within 24 hours by the DON on PCC. Should the DON and MDS nurses be unable to document interventions, the facility will have the reporting nurse document interventions immediately following the fall. The MDS nurse has also been instructed on fall program follow up within 24 hours. The nursing staff is to be in-serviced on fall documentation (all three shifts); with the DON or her designee responsible for follow up's to this in-service. Nurses found to be remiss on this documentation will receive employee counseling and re-education documented by the DON. Unwitnessed falls are followed by Neuro Checks X 72 hours. Witnessed falls are followed by a fall report documented either on PCC electronically or written on a paper incident report. The Fall binder will be kept in the	

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	wear (initiated 1/8/20), encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (initiated 1/8/20), fall assessment quarterly and as needed (initiated 1/8/20), follow facility fall protocol (initiated 1/8/20), keep living area free of clutter with good lighting (initiated 1/8/20), keep personal items in reach (initiated 1/8/20), and PT to evaluate and treat as ordered or as needed (initiated 3/14/14). On 2/21/22 at 1:30 P.M., the DON (Director of Nursing) provided an undated policy, titled Care Plan Policy, and indicated it was the current policy being used by the facility. The policy included falls as requiring interventions in response to resident incidents. A review of the policy indicated "When an incident does occur, the facility/team/workgroup must: ...2. Develop and implement revised interventions to prevent additional avoidable accidents." During an interview on 2/22/22 at 10:55 A.M., the DON indicated that care plans for falls were to be updated after the IDT (Interdisciplinary) meetings to discuss the root cause analysis for the fall and appropriate interventions; usually the next day after a fall occurred. The DON further indicated if interventions were not on the care plan for the dates of specific falls that those interventions had been missed. This Federal tag relates to Complaint IN00373415. 3.1-45(a)(2)		DON's office. 5) Date the systemic changes will be completed: 4-13-22	