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	05/04/2023

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

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F 0000 Bldg. 00	This visit was the 23 day Revisit to the Complaint survey exited on April 22, 2023 with Immediate Jeopardy not removed at F600. The Immediate Jeopardy has been removed. Survey date: May 4, 2023 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census Bed Type: NF: 29 Total: 29 Census Payor Type: Medicaid: 29 Total: 29 During the visit, Lynhurst Healthcare was found to have removed the Immediate Jeopardy deficient practice previously cited at F600 as of April 24, 2023 with the the facility inserviced the facility staff abuse prevention and the administrative staff was educated on the interventions for and prevention of abuse, including care of resident with history of being violent sexual offenders. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. This visit only reviewed the noncompliance cited at Immediate Jeopardy in the April 22, 2023 visit.	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nelene Reisinger	LHFA	05/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.			
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the resident's right to be free from abuse by another resident for 1 of 3 residents reviewed for abuse. A male resident with a history of sexual battery was obsessing and taking photographs of a female resident. During an unsupervised smoke time the male resident stabbed the female resident in the neck with a sharp silver object. The female resident was sent to the emergency room for evaluation. (Resident B, Resident C) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 4/19/23 at approximately 6:30 p.m., when the facility neglected to protect a female resident from physical abuse. This resulted in the female resident being stabbed in the neck and then being	F 0600	1) What action(s) will be accomplished for those residents found to have been affected? No other patient was identified to have been affected, during the survey. Due to the prompt actions of staff. the offender was removed from the facility quickly. The two patients in question were separated immediately and the offending patient was removed form the facility by the police , the same day, and will not return. The female patient was sent out to the hospital to be assessed. While at the hospital, the female patient reported that she wanted	05/09/2023

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	sent to the emergency room for evaluation. The Administrator, Administrator in Training, Director of Nursing and the Regional Director of Nursing were notified of the Immediate Jeopardy on 4/20/23 at 3:00 p.m. The Immediate Jeopardy was not removed by the exit date of the survey. The Immediate Jeopardy was removed on 4/24/23 at 8:30 p.m., but noncompliance remained at a lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: During an interview on 4/20/23 at 10:34 a.m., the Social Service Director indicated on 4/19/23 at approximately 6:20 p.m., LPN 1 (Licensed Practical Nurse) notified the Social Service Director, via text, that Resident C stabbed Resident B in the neck. After that happened, Resident C ran out the front door and down the street. Resident B was being sent to the emergency department. This happened in the smoking area right outside the main dining room sliding glass doors. Resident C had been taking photographs of Resident B and not following the smoking policy, so Resident C was given a 30 day discharge notice on 4/19/23. During an interview on 4/20/23 at 10:51 a.m., LPN 1 indicated she was the nurse in the facility, on 4/19/23, when Resident C stabbed Resident B. Resident B and Resident C were both outside during an unsupervised smoke time. The smoking area was right outside the main dining room sliding glass doors. CNA 1 (Certified Nursing Aide) was sitting at a table inside the dining room near the sliding glass doors. CNA 1 reported to LPN 1 that Resident C was walking toward the sliding door. Then, when he got close to Resident B, CNA 1 thought Resident C hit Resident B. CNA		to return to this facility and not be relocated. She has returned to the facility. The facility has also adopted a policy of Zero Tolerance and are not accepting "violent offenders" from the DOC. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although all patients in the facility may have been affected, none were identified as having been so. Corrective Action : Offending patient removed from facility. All offenders are placed on a 15 minute check ,each shift, done per staff. Care Plans have been updated for all housed offenders (see attached) (There are 11 offenders in the facility; 3 of these are "bedridden") Staff has been in-serviced by an outside vendor; the Indiana Dept. of Corrections, twice. (a total of three outside vendors) In-servicing and staff training will continue , with outside vendors and in house in-services, with no end date. In-services for staff will continue monthly. (Recent in-services May 1, May 5th and May 9th, May 18th) The facility has also adopted a	

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	1 heard Resident B yell out, and CNA 1 ran to Resident B. Resident C ran inside the sliding doors and back to his room. Once LPN 1 called 911, Resident C walked out of his room and CNA 2 followed him out of his room. When CNA 2 opened the front door Resident C ran out. When the police pulled into the parking lot, LPN 1 pointed in the direction Resident C ran. The police met Resident C approximately 600 feet away near a wooded area. LPN 1 believed Resident D witnessed everything that happened outside. During an interview on 4/20/23 at 11:12 a.m., Resident D indicated he was outside yesterday during an unsupervised smoke time at approximately 6:30 p.m. Resident B was sitting to the side of the sliding glass door. He saw Resident C quickly walk toward Resident B. When Resident C got next to Resident B's left side, Resident C punched Resident B with a closed, right, fist 4 times. Then, Resident C appeared to have a silver object, in the left hand, that was 3 to 4 inches in length and looked like it was sharp. Resident C stabbed Resident B in the neck using his left hand. Resident C walked inside the sliding glass doors and staff came outside to help Resident B. This all happened fast, and Resident B didn't have time to protect herself. Resident D was not sure how long it took for staff to come outside to help Resident B. Resident C told Resident D he was upset because Resident B wouldn't have sex with him anymore and was really upset after getting a 30 day discharge notice to move out from the Social Service Director. Resident D didn't see staff in the area and indicated the people outside could smoke without staff because they could smoke unsupervised. During an interview on 4/20/23 at 11:25 a.m., the DON (Director of Nursing) indicated Resident C		policy of Zero Tolerance and are not accepting "violent offenders" from the DOC. (see attached Green Light Admission Protocol example that is being adopted by this facility) Physical attempts to harm another (patient to patient) are met with a 30 Day Notice of Discharge for being a threat to other patients. Offenders are no also placed on "One on One within arms reach" staff care until they are discharged from the facility. 3) What measures will be put into place or what systemic changes will be made? The most profound systemic change is that the facility will no longer admit "violent offenders". (example attached of Admission Wheel Protocol) All referrals must go through the Administrator, who has the final say on admissions. Additionally as above: In-servicing and staff training will continue , with outside vendors and in house in-services, with no end date. The facility has scheduled Ms. R. Normand RN to give an in-service for our staff (mandatory for all departments) for Monday at 330 pm; staff will be educated on interventions for and prevention of abuse, including care of residents with a history of being	

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	had been accusing Resident B of being a prostitute for the past couple months. Resident C had been obsessive over Resident B for the past couple weeks and Resident C had been taking pictures of her on his phone. Resident C was already on 15 minute checks due to being convicted of sexual battery. The DON indicated the facility did not increase supervision for Resident C because he had not been physical with Resident B and Resident B said she was not afraid of Resident C. During an interview on 4/20/23 at 11:30 a.m., CNA 3 indicated Resident C obsessed over Resident B. Resident B told CNA 3 that she had a sexual relationship with Resident C but told Resident C she didn't want that anymore. Resident C had been telling staff and residents that Resident B was a prostitute. During an interview on 4/20/23 at 11:58 a.m., QMA 1 (Qualified Medication Aide) indicated the incident between Resident B and Resident C took place during an unsupervised smoke time. QMA 1 was sitting inside the dining room next to the sliding door that was open. Resident B was sitting to the right of the sliding glass door, but QMA 1 was not able to totally visualize Resident B. Resident C was walking toward the sliding doors then it happened very fast. QMA 1 wasn't able to see if Resident C was holding anything, was not able to see which hand Resident C used, was not sure if Resident C hit Resident B, and if it was more than once. QMA 1 thought Resident C stabbed Resident B in the neck but wasn't sure which side of the neck. When the staff got to Resident B, they got towels to try to stop the bleeding. During an interview on 4/20/23 at 12:14 p.m., CNA		violent sexual offenders.{see attached in-service and sign n sheet} The facility will follow this in-service with more re-education for staff, through the Indiana Department of Corrections (Facility contacts: G. White pastor for the DOC and J. Hill have been contacted and are interested in coming into the facility for staff education, however they have not decided on the dates to visit the facility. It is difficult to give exact dates for continuing in-services, as outside sources are not always available, however the facility will continue these in-services by outside sources when possible, twice per month, for 2 months and then once per month for 3 months. The facility has also adopted a policy of Zero Tolerance(all patients have now discussed and signed the new policy) and the facility is not accepting "violent offenders" from the DOC. Physical attempts to harm another are met with a 30 Day Notice of Discharge for being a threat to other patients. Offenders are now placed on "One on One within arms reach " staff care until they are discharged from the facility. The smoking policy will be adjusted to say that a staff member must be physically outside on the patio for direct	

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	1 indicated she worked evening shift on 4/19/23. The residents were outside during an unsupervised smoke time. CNA 1 indicated she had asthma, so she didn't go outside when the residents went out to smoke. She sat inside the sliding glass doors. Resident C was standing approximately 10 feet away from Resident B. All the sudden, Resident C walked toward the sliding doors. Resident B was sitting close to the sliding door and to the right side. Resident C walked up, and CNA 1 thought Resident C hit Resident B on the left side. CNA 1 was not sure which hand he used to hit Resident B and didn't know how many times Resident C hit Resident B. When CNA 1 thought Resident C hit Resident B, she yelled stop. Then, Resident C looked at CNA 1 and walked passed her in the dining room. CNA 1 ran to Resident B and held her neck. That's when CNA 1 noticed blood on her hand and Resident B's neck. The nurse came to help, the other QMA came to help, and the CNA came to help. There were 4 of us outside helping Resident B. CNA 1 was not sure where Resident C went when he came back in the building, but another resident told CNA 1 that Resident C went back to his room. CNA 1 was told Resident C was obsessed with Resident B for the past few weeks. CNA 1 witnessed Resident D tell police that Resident C told him he was going to "get [Resident B]." Resident C cut up Resident B's shoes. CNA 1 worked a couple months ago when Resident C was walking around the facility around 2:00 a.m., CNA 1 watched him walk to a trash can, out in the hallway, that he usually doesn't use. CNA 1 asked Resident C what was wrong and Resident C told her he was having trouble sleeping and wanted to walk. Later that shift, in the morning, Resident B was crying and told CNA 1 someone had cut up her shoes that she normally kept next to the door to her room and her slippers were missing. CNA 1		supervision of patients who are smoking and are deemed to require supervision. In-services for all staff, on the smoking policy will take place once a week x2, every other week x2 and once a month x2. The smoking policy will also be added to new hire packets. Offenders will be assessed once per month by the facility's Psych. doctor and facility consultants will audit the offenders care plans to ensure these are updated and they will also audit Psych. notes for changes, monthly. Monitored by the SSD and the DON. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The Charge Nurse will be held accountable for his or her staff being physically present in the patient smoking area. The Charge Nurse will sign off on a shift basis that staff is following the changes to this policy. Staff will be re-educated on changes to the smoking policy and the expectations of this facility. In-services for all staff, on the smoking policy will take place once a week x2, every other week x2 and once a month x2. The facility has also adopted a policy of Zero Tolerance and the facility will not be accepting	

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	went to the trash can that Resident C used, and Resident B's slippers were in the trash can. CNA 1 reported the slippers and shoes to the night shift nurse, but Resident C denied cutting up the shoes and taking the slippers. CNA 1 also indicated all of this information had been passed off in report and all the staff were made aware to supervise the two of them. During an interview on 4/21/23 at 8:15 a.m., Resident B indicated she was sitting out on the patio, to the right side of the sliding doors, during an unsupervised smoke time. She believed staff were inside the facility. Resident C was standing on the opposite side of the patio. Resident C walked up to her and said, "I told you I was going to get you b****," and started punching me. Resident C punched Resident B 4 times with both hands. Then Resident C stabbed her in the left side of her neck with his left hand. After Resident C stabbed Resident B, Resident C stepped back and walked inside. Her pain level after she was stabbed was 10 out of 10, and her pain level last night was 9 out of 10. She needed to take pain medicine to reduce the pain. She was scared when she saw the blood. The clinical record for Resident B was reviewed on 4/20/23 at 12:22 p.m. The diagnoses included, but were not limited to, bipolar disorder and anxiety disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 1/21/23, indicated Resident B was cognitively intact. A progress note, dated 4/19/23 at 7:00 p.m., indicated Resident B was sitting at the right side of the smoking area near the open patio door during a smoke break with other resident that are		"violent offenders" from the DOC. All patients in house have been advised on these changes. The Director of Nursing will maintain a record of all in-services and retraining of staff, in all departments (for this tag). The facility has scheduled Ms. R. Normand RN to give an in-service for our staff (mandatory for all departments) for Monday at 330 pm; staff will be educated on interventions for and prevention of abuse, including care of residents with a history of being violent sexual offenders.{see attached in-service and sign n sheet} The facility will follow this in-service with more re-education for staff, through the Indiana Department of Corrections (Facility contacts: G. White pastor for the DOC and J. Hill have been contacted and are interested in coming into the facility for staff education, however they have not decided on the dates to visit the facility. It is difficult to give exact dates for continuing in-services, as outside sources are not always available, however the facility will continue these in-services by outside sources when possible, twice per month, for 2 months and then once per month for 3 months. The facility is not accepting "violent offenders" from the DOC. Offenders will be assessed once	

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	allowed unsupervised smoking. Staff members within 2 feet, 5 feet and 10 feet of resident. Resident C was smoking in the farthest part of the smoking area and walked through patio doors and instantly struck Resident B with a sharp object to left side of neck. Wound measured 3 centimeters by 1 centimeter with a depth of 3 centimeters. Male resident ran to room as staff ran to Resident B to aide and protect, area cleansed, Resident B was sent to the emergency department for additional evaluation. A progress note, dated 4/20/23 at 8:13 p.m., indicated Resident B returned from the hospital with an admitting diagnosis of penetrating trauma. Resident B was transferred from a wheelchair to her rollator with stand by assistance. Resident B was alert and oriented times three. The measurements from the emergency department were 5.1 centimeters by 1.9 centimeters. Was unable to measure due to current scab. A hospital discharge summary, dated 4/20/23 at 3:54 p.m., indicated Resident B presented as a trauma consult following a stabbing to the left neck. Resident B lived at a nursing home. Fellow resident (Resident C) had been stalking her and today (Resident C) stabbed her in the left side of her neck with a pair of scissors from a shaving kit. He (Resident C) also hit her multiple times. Resident B has been awake and oriented and stable throughout EMS (emergency medical services) encounter. Hematoma on the left side of the neck. Endorses pain with movement of head. 1.5 centimeter laceration to left neck. The clinical record for Resident C was reviewed on 4/20/23 at 1:00 p.m. The diagnoses included, but were not limited to, mild cognitive impairment, major depression, and alcohol use.		per month by the facility's Psych. doctor and facility consultants will audit the offenders care plans to ensure these are updated and they will also audit Psych. notes for changes, monthly. Monitored by the SSD and the DON. 5) By what date the systemic changes will be completed. 5-9-23	

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A Quarterly MDS assessment, dated 1/18/23, indicated Resident C was cognitively intact.

A care plan, dated 2/2/23 and current through 4/27/23, indicated Resident is a registered sex offender with a conviction of sexual battery in 2001. Interventions included, but were not limited to, resident will be on continuous 15 minute checks during the duration of stay at the facility to ensure safety of others and self. Document on Hallway Check List and routine check ins with county sheriff department when they make their visits to the facility.

A care plan, dated 3/13/23 and current through 4/27/23, indicated Resident has potential to be physically aggressive related to anger, poor impulse control, accusation of harm. Interventions included, but were not limited to, when the resident becomes agitated, intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. All interventions on this care plan were initiated on 4/20/23 (one day after Resident C stabbed Resident B)

A progress note, dated 4/11/23 at 1:26 p.m., indicated Resident C remains on 15 minute checks due to pedophilia (Resident C was not diagnosed with pedophilia). It was reported that Resident C called the police and made a report against Resident B, who Resident C believed was a prostitute. Asked Resident C to refrain from taking pictures of other residents due to privacy issues.

A progress note, dated 4/18/23 at 7:37 a.m., indicated Resident C approached a CNA and stated that he saw her (the CNA) at his window

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	last night with a gun. Resident C stated that he did not sell his gun at the crack house, and he still had it. A progress note, dated 4/19/23 at 11:19 a.m., indicated Resident C's room was searched and no weapons were found. A progress note, dated 4/19/23 at 3:34 p.m., indicated Resident C came into the DON's office and stated Resident B was in another resident's room performing a sexual act on another resident and he stated, "I have proof because I took a picture". He then proceeded to show the DON a picture (on his cell phone) of Resident B. In the picture, she was completely dressed, standing up, and holding onto her walker. She was at least 3 feet from any resident. The DON explained to Resident C the residents are both consenting adults and be with each other if they choose and Resident C did not have any proof that Resident B was prostituting herself. When the DON said this to him, he became upset and said Resident B was prostituting herself and we were promoting this. Resident C stated she was having sex with several other residents for money. Resident C said he took pictures of her all the time and went into Resident B's room sometimes in the middle of the night. The DON explained to Resident C that he could not take pictures of other residents without their consent, and he could not go into Resident B's room without her consent. Resident C mumbled something and walked out of the office. The DON went and spoke with Resident B and ask if she has ever saw Resident C taking her picture or harassing her. Resident B said yes, Resident C did this all the time. Resident B has asked him to stop, but Resident C won't. Resident B said she was not scared of him.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A discharge summary note, dated 4/19/23 at 3:53 p.m., indicated Resident C was given a 30 discharge notice. His end date was 5-18-23 by 3:00 p.m. Transfer was needed for safety of others and improvements in health needs. Resident C was given temporary stay by Ascend/Maximus Medicaid. SSD gave Resident C the notice and explained reasoning, process, appeals, rights, and bed hold policy. After every statement resident stated, " I don't give a s***." After informing, Resident C, he took his copy of NOTD (Notice of Transfer/Discharge) and ripped it up and slammed it on the table. Safe discharge to (homeless shelter) is expected but will continue to try to set up other options for resident. A progress note, dated 4/19/23 at 7:23 p.m., indicated Resident C was smoking at the farthest part of smoking area with other resident that are allowed unsupervised smoking. Resident C walked through patio doors of smoking area and instantly struck Resident B with a sharp object to left side of her neck. Staff members within 2 feet, 5 feet, and 10 feet of residents. Staff ran to intervene and provide safety. Resident C ran to his room. Resident C ran outside (front door) and walked through parking lot and along west side of street where police stopped him and arrested him. Resident C was sent to jail. The clinical record for Resident D was reviewed, on 4/21/23 at 9:21 a.m. The diagnoses included, but were not limited to, schizophrenia and diabetes. A Quarterly MDS assessment, dated 3/3/23, indicated Resident D was cognitively intact. On 4/20/23 at 10:40 a.m., the DON provided a copy of a facility policy, titled Abuse Prevention, dated			

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	05/04/2023

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	10/2/06, and indicated this was the current policy used by the facility. A review of the policy indicated, every resident has the right to be free from abuse. Residents must not be subject to abuse by anyone. The Immediate Jeopardy, that began on 4/19/23 was removed on 4/24/23 when the facility inserviced the facility staff abuse prevention and the administrative staff was educated on the interventions for and prevention of abuse, including care of resident with history of being violent sexual offenders, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00406803 and IN00406906. 3.1-27(a)(1)			