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	02/07/2023

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00395795. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. This visit was in conjunction with the Investigation of Complaint IN00400690. Complaint IN00395795 - Unsubstantiated due to lack of evidence. Complaint IN00400690 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F609, and F656. Survey dates: January 31, February 1, 2, 3, 6, and 7, 2023 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census Bed Type: NF: 35 Total: 35 Census Payor Type: Medicaid: 33 Other: 2 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2023.	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 provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nelene Reisinger	LHFA	03/08/2023

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	02/07/2023

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

(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
			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 compliance with the requirements of participation or that corrective action was necessary.	
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 observation, interview, and record view, the facility failed to protect the resident's right to be free from sexual abuse for 1 of 2 residents reviewed for sexual abuse. (Resident D, Resident F, Resident G, Resident E) This deficient practice resulted in an Immediate	F 0600	1) What action(s) will be accomplished for those residents found to have been affected? Patient E was removed asap from patient D's room. Patient E was kept separated from patient D.	02/27/2023

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	02/07/2023

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

(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
	Jeopardy. The Immediate Jeopardy began on, 1/31/23 at approximately 6:11 p.m., when the facility failed to protect the residents right to be free from sexual abuse. The resident was tearful and fearful following the incident. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 2/1/23 at 4:30 p.m. The Immediate Jeopardy was removed on 2/3/23 at 2:30 p.m., but 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. Findings include: On 2/1/23 at 9:00 a.m., a progress note, dated 1/31/23 at 6:11 p.m., was reviewed. The progress note indicated, Resident E (male) was found in a Resident D's (female) room. Resident D was alert and oriented. Resident E was witnessed with his hand on Resident D's right breast squeezing it tightly. Staff removed Resident E from the Resident D's room. Resident E became combative and the police were called. Resident E was taken into police custody. During an interview on 2/1/23 at 9:45 a.m., Resident G indicated she had witnessed what had happened "yesterday evening." Resident G indicated on the afternoon of 1/31/23 she was entering her room and noticed the door was shut. "It is usually kept open." After entering the room, Resident G heard a commotion on her roommate's (Resident D) side of the room and noticed the curtain was drawn. Resident G observed Resident E next to Resident D's bed. Resident E had his right hand on Resident D's breast and was squeezing it really hard. Resident G yelled at Resident E "what the he** are you doing." Resident E then removed his hand. Resident G		Patient E was placed on one on one care with a staff member. Patient E was escorted out of the facility by the police and is not returning to this facility. Patient D was assessed by a licensed nurse and the following day, assessed by the Psych Nurse Practioner. No remaining trauma from Patient D was noted or reported. Patient was not tearful and did not appear in distress r/t this event. Staff were all informed to monitor Patient D. Patient F was in a bathroom with the door ajar (it does have a lock) Staff stated they were immediately present went Patient D attempted to go into the same bathroom as Patient F and stated that patient D never entered the bathroom, further that Patient D did not physically touch/accost or otherwise physically threaten Patient F. Patient F care plans will be updated to show accusatory behavior. (Please note that Patient D was in a bariatric wheelchair and has hemiplegia. Patient D could not have placed his w/c into the bathroom while it was occupied - would not fit- and staff was questioned anew and denied that Patient D ever entered the bathroom) .	

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	02/07/2023

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

(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
	went to look for a staff member. Resident G informed the Activity Director (AD) of the incident. Resident G indicated the AD removed Resident E from the room. During an interview on 2/1/23 at 10:00 a.m., Resident D indicated Resident E had entered her room last evening he (Resident E), molested and raped her. He exposed my breast and he (Resident E) was twisting it really hard. This went on for awhile. I started to fight him off and then he (Resident E) put his hand on my "p****". He kept feeling me. I bit his hand that he [Resident E] was using on me." Resident D also indicated she was afraid someone else was going to come into her room and do the same thing. Resident D was observed to be teary eyed. Resident D held out her arm and pointed to a long (approximately 3 inch) light red area on her arm. Resident D moved her gown over and a small red (dime size) area was observed on Resident D's right breast. During an interview on 2/1/23 at 10:22 a.m., the Activity Director (AD) indicated after a game of yatzee with the residents she heard Resident G yelling. The AD then entered Resident D and Resident G's room. The AD observed Resident E in his wheel chair next to Resident D's bed. The AD observed the top of Resident D's gown was pulled down. The AD removed the Resident E from the room and notified the Social Service Director and the Director of Nursing. The AD indicated she was not aware of Resident G doing this before. During an interview on 2/1/23 at 10:55 a.m., the Social Services Director (SSD) indicated on 1/31/23 around 3:30 p.m., the AD informed him (SSD) of what had occurred between Resident D and Resident E. The SSD indicated he went to		Please see attached examples A-D of diagnosis that affect patients mental capacities. This author spoke with Guidestar Psych Services (the entity that the facility utilizes for Psych Services) and it is reported that Patient F stated to them that "he never touched me"; when Psych interviewed with Patient F after the said event. (please see example E attached) 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any patient may have had the potential to be affected, no other patients were identified during the survey. Patient D is no longer in the building. Corrective Action: All other patients with the history of sexual offender were placed on 15 minute checks by staff, ongoing and not to be discontinued. (14 patients) Documentation and maintenance of this documentation is kept and monitored daily by the Director of Nursing.: no end date. 3) What measures will be put into place or what systemic changes will be made? All patients (14) with the history of sexual offender were placed on 15 minute checks by staff,	

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	02/07/2023

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

(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
	talk with Resident E. Resident E denied the allegation and indicated "I was only talking to her." SSD explained to Resident E he had to switch to a different room so that the residents were further apart. Resident E indicated to the SSD he was not moving. Resident E refused to switch to a different room. The SSD notified the police department. The police arrived and investigated for approximately 4 hours and apprehended Resident E for sexual assault. The SSD indicated Resident E was admitted to the facility from the Department of Corrections and had a history of violent sexual behavior. During an interview on 2/1/23 at 2:03 p.m., the AD indicated she had recalled an incident when Resident F reported to her on 1/31/23. Resident F reported a few weeks ago when she was in the shower room, Resident E entered the shower room and attempted to pull her (Resident F) pants down. The AD then stated she did not report the sexual allegation to the administration of the facility. During an interview on 2/1/23 at 2:30 p.m., the police department detective on the case from the incident on 1/31/23, indicated Resident E was going to be charged with sexual battery and would not be returning to the facility. The detective indicated Resident E had a "no contact order." During an interview on 2/1/23 at 3:00 p.m., Registered Nurse 2 indicated a head to toe skin assessment was completed after the sexual assault on Resident D. Redness was noted on the right breast and the right arm, the skin was intact at that time. Resident D refused to let RN 2 examine her genitals.		ongoing and not to be discontinued. Monitor: Documentation and maintenance of this documentation is kept by the Director of Nursing. Care Plans of sexual offenders are also being updated and will show 15 minute checks by the staff. Care plans will also show "Psych to assess at least once monthly". This corrective action is monitored by the MDS nurse and the SSD and has no end date. Staff will be in-serviced on proper reporting both to the Administrator and the State Department of Health. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. The Director of Nursing to monitor and maintain for the time frame set above. Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and signed off to denote the new hire's understanding. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: Patients with the history of sexual	

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	02/07/2023

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

(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
	On 2/1/23 at 1:45 p.m., the Director of Nursing (DON) provided a facility reported incident, incident number: 242, dated 1/31/23, indicated Brief description of incident: Staff heard Resident D yelling out from her room "help me, he's molesting me." Staff went into residents room and found Resident E sitting beside her (Resident D's) bed in his wheel chair and her (Resident D) blanket was pulled down to her knees. On 2/1/23 at 11:30 a.m., the SSD provided a hand written list of residents that were directly admitted from the Department of Corrections and currently reside at the facility. The list identified 8 residents that were directly admitted from the Department of Corrections, that included Resident E. The list also indicated 14 residents that currently reside in the facility are registered sex offenders that included Resident E. On 2/1/23 at 2:00 p.m., the clinical record of Resident D was reviewed. The diagnoses included, but were not limited to, schizophrenia and hallucinations. A Quarterly Minimum Data Set (MDS) assessment, dated 12/1/22, indicated Resident D was moderately cognitively impaired and required extensive assistance with bed mobility. A progress note, dated 1/31/23 at 4:10 p.m., indicated "skin check completed skin irritation noted on right breast." A progress note, dated 2/1/23 at 8:41 a.m., indicated "[writer] spoke with resident [resident D] about incident. [writer] noticed distress in her voice." On 2/1/23 at 2:33 p.m., the clinical record of		offender were placed on 15 minute checks by staff; ongoing and not to be discontinued. (14 patients) No end date. Monitor Documentation/monitoring and maintenance of such is by the Director of Nursing. Monitoring is done daily by the DON. If DON is unavailable, the HR Department will monitor. Care Plans of sexual offenders are also being updated and will show 15 minute checks by the staff. {monitored daily by the DON} Care plans will also show "Psych to assess at least once monthly". Courtney Consulting monitors the facility's Social Service person, every month; no end date. This corrective action is monitored by the MDS nurse and the SSD , monitored daily and reviewed quarterly. This will be an ongoing process with no end date. *Staff re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Monitor: To be monitored by the Director of Nursing. (*time frame as above) Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and	

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	02/07/2023

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

(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
	Resident E was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and dementia. An Annual MDS assessment, dated 12/30/22, indicated Resident E was cognitively intact. Resident E required extensive assist with bed mobility and all transfers. A Care plan, initiated on 8/26/22 and current through 4/19/23, indicated resident is considered a violent sexual predator and is on a lifetime registry for convictions. Goal: Resident E will not show any signs of sexual aggressiveness through review date. Interventions included, allow deputies to interview Resident E at their discretion and ensure (county) sheriff is kept up to date with Resident E's location." No other interventions were indicated. A progress note, dated 1/31/23 at 6:11 p.m., indicated Resident E was "found in a female resident's [Resident D] room. He [Resident E] was witness [witnessed] with hand on female resident [Resident D] right breast squeezing it tightly." During an interview on 2/1/23 at 2:00 p.m., the DON indicated Resident E's care plan should have been initiated upon admission (date of admission 12/16/21). The DON was not sure why the violent sexual behavior care plan was initiated on 8/26/22. During an interview on 2/2/23 at 9:46 a.m., Resident F indicated a few weeks ago she was in the shower room. "I was sitting on the commode with my pants down. [Resident E] started knocking on the door and opened it. I told him I was busy and to go away. I told him to please go away and he [Resident E] then yelled at me shut the f*** up, I tried to pull my pants up and he		signed off to denote the new hire's understanding. This has no end date. New hires will be in serviced on same upon hire and PRN thereafter. (no end date) Monitored by Human Resources. 5) By what date the systemic changes will be completed. February 27, 2023	

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	02/07/2023

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

(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
	pulled them back down. The CNA heard me screaming and entered the room and moved Resident E to another location. I have been afraid to use that bathroom since the incident." During an interview on 2/2/23 at 10:37 a.m., the (DON) indicated the AD should have reported the abuse allegation to administration. The reportable should have been submitted to the State agency. On 2/2/23 at 4:30 p.m., the Administrator provided a policy, titled Sexual Predators, dated January 2022, and indicated it was the current policy being used by the facility. A review of the policy indicated, "it is the job of the facility and our staff, to maintain a safe environment for all patients, at all times as applicable by law and regulations. The Immediate Jeopardy, that began on 1/31/23, was removed on 2/3/23 when the facility inserviced the facility staff on abuse and resident triggers, initiated monitoring for residents with a history of sexual behaviors, and implemented policies and procedures for sexual predators and how they will be monitored, 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 Complaint IN00400690. 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,			

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	02/07/2023

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

(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
	the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation sexual abuse was reported to facility management for 1 of 2 residents reviewed for reporting resident abuse. (Resident F, Resident E, Activity Director) Findings include: During an interview on 2/1/23 at 2:03 p.m., the Activity Director (AD) indicated on 1/31/23,	F 0609	1) What action(s) will be accomplished for those residents found to have been affected? Although any patient may have had the potential to be affected, no other patients were identified during the survey. Patient D is no longer in the building. Patient F was in a bathroom with the door ajar (it does have a lock)	02/27/2023

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	02/07/2023

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

(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
	Resident F reported "a few weeks ago [mid January of 2023]" when she was in the shower room, Resident E entered the shower room and attempted to pull her (Resident F's) pants down. The AD indicated the alleged sexual abuse was not reported to the facility management team (Administrator or Director of Nursing Services). During an interview on 2/2/23 at 9:46 a.m., Resident F indicated a few weeks ago (mid January of 2023) she was in the shower room. "I was sitting on the commode with my pants down. [Resident E] started knocking on the door and opened it. I told him I was busy and to go away. I told him to please go away and he [Resident E] then yelled at me shut the f*** up, I tried to pull my pants up and he pulled them back down. The CNA heard me screaming and entered the room and moved Resident E to another location. I have been afraid to use that bathroom since the incident." During an interview on 2/6/23 at 9:11 a.m., the Director of Nursing Services indicated the AD should have reported the abuse allegation to the facility administration and a reportable should have been submitted to the State Agency. On 2/3/23 at 2:00 p.m., Resident F's clinical record was reviewed. The Quarterly Minimum Data Set (MDS) assessment, dated 11/7/22, indicated Resident F was cognitively intact. On 2/3/23 at 1:15 p.m., the Director of Nursing Services provided a copy of the Division of Long-Term Care Reportable Incident Policy, dated 7/15/15, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...The facility must ensure that all alleged violations involving...abuse...are reported		Staff stated they were immediately present went Patient D attempted to go into the same bathroom as Patient F and stated that patient D never entered the bathroom, further that Patient D did not physically touch/accost or otherwise physically threaten Patient F. Patient F care plans will be updated to show accusatory behavior. This author spoke with Guidestar Psych Services (the entity that the facility utilizes for Psych Services) and it is reported that Patient F stated to them that "he never touched me"; when Psych interviewed with Patient F after the said event. (please see example E attached) This was not reported to State because staff was present and stated nothing occurred to report. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any patient may have had the potential to be affected, no other patients were identified during the survey. Corrective Action: Staff stated they were immediately present went Patient D attempted to go into the same bathroom as Patient F and stated that patient D never entered the bathroom, further that Patient D did not	

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	02/07/2023

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

(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
	immediately to the administrator of the facility and to other officials in accordance with State law through the established procedures...Abuse-willful infliction of injury...intimidation...sexual abuse...sexual assault...nonconsensual sexual contact with a resident by another resident..." On 2/6/23 at 9:45 a.m., the Director of Nursing Services provided an undated copy of the Policy & Procedure for Reporting Suspected Crimes Under the Federal Elder Justice act and indicated it was the current policy in use by the facility. A review of the policy indicated, "...it is Lynhurst Healthcare policy to comply with the Elder Justice Act...when staff...suspect a crime has occurred against a resident at Lynhurst Healthcare they must report the incident to the Administrator...Staff MUST report immediately to the Director of Nursing and to the Executive Director (administrator) any reasonable accusations of abuse..." On 2/6/23 at 10:21 a.m., the Director of Nursing Services provided a copy of the Lynhurst Healthcare: Investigation Policy and Procedures, dated 5/18/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...It is the policy of Lynhurst Healthcare to promptly and thoroughly investigate all reported incidents of abuse...the facility or system develops and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse...what incidents are to be reported and when: (any reasonable allegations...) to the Administrator IMMEDIATELY..." This Federal tag relates to Complaint IN00400690.		physically touch/accost or otherwise physically threaten Patient F. Staff will be in-serviced on proper reporting both to the Administrator and the State Department of Health. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and signed off to denote the new hire's understanding. New hires will be in-serviced at the time of hire and periodically thereafter. (This was not reported because staff was present and stated nothing occurred to report.) 3) What measures will be put into place or what systemic changes will be made? The facility Policy and Procedures re reportable events is to be posted in the nursing station. All other patients with the history of sexual offender were placed on 15 minute checks by staff, ongoing and not to be discontinued. Staff will be in-serviced on proper reporting both to the Administrator and the State Department of	

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	02/07/2023

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

(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
	3.1-28(c)		Health. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and signed off to denote the new hire's understanding. New hires will be in-serviced at the time of hire and periodically thereafter. Signage regarding proper reporting will be placed at the nursing station. Phone numbers for the Administrator and the DON will be posted. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Corrective Actions: Staff will be in-serviced on proper reporting both to the Administrator and the State Department of Health. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Staff in-services are monitored and maintained	

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	02/07/2023

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

(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
			by the Director of Nursing and the Human Resource Dept. Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and signed off to denote the new hire's understanding. This has no end date. New hires will be in-serviced at the time of hire and periodically thereafter. Monitored by Human Resources. and no end date. Signage regarding proper reporting will be placed at the nursing station. Phone numbers for the Administrator and the DON will be posted. Staff will be in-serviced on proper reporting both to the Administrator and the State Department of Health. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Staff in-services are monitored and maintained by the Director of Nursing and the Human Resource Dept. Staff in-services after the "allotted time " will still continue periodically. Signage regarding proper reporting	

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	02/07/2023

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

(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
			will be placed at the nursing station. 5) By what date the systemic changes will be completed. February 27,2023	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	02/07/2023

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

(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) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to develop a comprehensive person centered care plan for 7 of 16 residents reviewed. Fall care plans were not updated and interventions were not implemented for sexual behaviors. (Resident D, Resident H, Resident M, Resident J, Resident K, Resident L, Resident S) Findings include. 1. On 2/1/23 at 9:00 a.m., a progress note, dated 1/31/23 at 6:11 p.m., was reviewed. The progress note indicated, "Resident E (male) was found in a female (Resident D) room. Resident D was alert and oriented. Resident E was witnessed with his hand on Resident D's right breast squeezing it tightly. Staff removed Resident E from the Resident D's room. Resident E became combative and the police were called. Resident E was taken into police custody. A Care Plan, initiated on 8/26/22 and current through 4/19/23, indicated Resident E is	F 0656	1) What action(s) will be accomplished for those residents found to have been affected? The facility is updating care plans on all patients, care plans are to be updated by the MDS nurse and the SSD. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any patient may have had the potential to be affected, no other patients were identified during the survey. The facility is updating care plans on all patients. Care Plans of sexual offenders will show 15 minute checks by the staff. Care plans of sexual offenders will also show "Psych to assess at	02/27/2023

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	02/07/2023

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

(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
	considered a violent sexual predator and is on a lifetime registry for convictions. Goal: Resident E will not show any signs of sexual aggressiveness through review date. Interventions included, allow deputies to interview Resident E at their discretion and Ensure (county) sheriff is kept up to date with Resident E's location. No other interventions were indicated on the current care plan to protect the residents right to be free of abuse.. 2. On 2/6/23 at 10:33 a.m., the clinical record of Resident H was reviewed. The diagnosis included, but was not limited to, pedophilia. A care plan, dated 2/2/13, indicated Focus: Resident H is a registered sex offender with 2 convictions of child molesting. 3. On 2/6/23 at 11:00 a.m., the clinical record of Resident M was reviewed. The diagnosis included, but was not limited to, family history of alcohol abuse and dependence. A Care Plan, dated 12/21/22, and current through 2/23/23, indicated Focus: Resident M is a registered sex offender with a conviction of attempted illegal transaction and sexual activity with a minor. Interventions included, Keep resident information updated with registry, resident will discuss any issues of barriers that may cause him to be noncompliant, and routine check ins with county Sheriff Department. No other interventions were indicated on the current care plan to protect the residents right to be free of abuse. 4. On 2/6/23 at 1:00 p.m., the clinical record of Resident J was reviewed. The diagnosis included, but was not limited to, major depressive disorder.		least once monthly". This corrective action is monitored by the MDS nurse and the SSD. 3) What measures will be put into place or what systemic changes will be made? The facility is updating care plans on all patients. Care Plans of sexual offenders will show 15 minute checks by the staff. These measures are to protect the other patient's rights to be free of abuse. Care plans of sexual offenders will also show "Psych to assess at least once monthly" . Monitor: This corrective action is monitored by the MDS nurse and the SSD. *As the patients are assigned letters on the tags, and therefore are "unknown", this author is unable to select the care plan issue for each patient and note/or give examples of how each care plan is updated. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Monitoring of care plan updates will be through the MDS nurse and the SSD. Done daily and quarterly. The care plans on all patients will be scrutinized and amended as necessary. and as above. The care plans on sexual	

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	02/07/2023

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

(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 Care Plan, dated 8/4/22 and current through 2/9/23, indicated Resident J is on the sex offender registry for conviction on 9/14/1992. Interventions included "get case manager information and keep up to date. No other interventions were indicated on the current care plan to protect the residents right to be free of abuse. 5. On 2/6/23 at 1:10 p.m., the clinical record of Resident K was reviewed. The diagnosis included, but was not limited to, alcohol dependence. A Care Plan, dated 2/2/23, indicated Resident K was a registered sex offender with a conviction of "sexual batter" (battery) in 2001. No other care plan was available prior to 2/2/23. During an interview on 2/7/23 at 10:00 a.m., the Director of Nursing indicated a previous care plan prior to 2/2/23 was unavailable. 6. On 2/6/23 at 2:00 p.m., the clinical record of Resident L was reviewed. The diagnosis included but was not limited to, vascular dementia. A Care Plan, dated 12/24/22 and current through 3/24/23, indicated Resident L is a registered sex offender with a conviction on 6/25/10. Interventions included keep sex registry up to date. Resident L will discuss any issues or barriers that may cause him to be noncompliant, and routine check ins with County Sheriff Department when they make their visits to the facility. No other interventions were indicated on the current care plan. 7. On 2/6/23 at 10:36 a.m. Resident S's clinical record was reviewed. The Quarterly Minimum		offenders will be updated to show 15 minute staff checks in order to protect other patients rights to be free of abuse. Documentation for 15 minute checks on current 14 patients, is done daily by the DON. If DON unavailable, the HR person will monitor. This has no end date. The DON has been counseled on her task of keeping care plans updated for falls. Director of Nursing to monitor. Falls are discussed monthly in the Quality Assurance meeting (The monthly QA includes, Psych services, Physician services, nursing services and social services) and changes or new falls are to be updated in the care plan at that time. The fail safe for internet outages, is to write out the new care plan or the changes (includes dates and signatures), that may be transcribed at a later date and to keep the written records of the care plans. Director of Nursing to monitor. This has no end date. 5) By what date the systemic changes will be completed. February 27,2023	

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	02/07/2023

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

(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
	Data Set (MDS) assessment, dated 10/5/22, indicated Resident S was cognitively intact and walked (with assisted device) and was not steady, but was able to stabilize without staff assistance. Progress notes, dated 8/8/22 at 10:30 a.m., indicated Resident S had an unwitnessed fall. Resident S's fall report, dated 8/8/22, indicated the resident had an unwitnessed fall on 8/8/22. The report indicated Resident S "was found lying on [the] floor in [the] hallway by nurses station. [Resident S] did not have his walker with him." The Post Fall IDT (interdisciplinary team) note, dated 8/9/22 at 10:14 a.m., indicated the fall was unwitnessed and the causative factor included, "Resident was not using his walker." The identified interventions to be implemented included "Remind resident to use his walker. Monitor throughout the day that the walker is placed at bedside." The quarterly fall assessment, dated 9/15/22 at 3:55 p.m., indicated Resident S was at high risk for falls and used crutches, cane or walker. The quarterly fall assessment, dated 12/14/22 at 10:20 a.m., indicated Resident S was at high risk for falls and used crutches, cane or walker. Resident S's fall care plan was not updated to reflect the 8/9/22 IDT's identified intervention to prevent potential falls. During an interview on 2/6/23 at 11:15 a.m., the Director of Nursing Services indicated Resident S's care plan was not updated to include the new 8/9/22 IDT fall intervention to prevent potential falls.			

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	02/07/2023

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

(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
	On 2/7/23 at 10:45 a.m., the Director of Nursing Services provided an undated copy of the Care Plan Policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "Purpose: As part of the ongoing quality assessment and assurance program the resident care planning team will help create the safest possible environment for residents...Focus: the team will conduct necessary reviews and develop/implement/monitor/modify the necessary interventions in response to incidents such as: falls, behaviors..." This Federal tag relates to Complaint IN00400690. 3.1-35(a)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum,			

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	02/07/2023

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

(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
	the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to follow vaccine administration guidelines for the pneumococcal vaccine. The pneumococcal	F 0883	1) What action(s) will be accomplished for those residents found to have been affected? As the vaccines are available /	02/27/2023

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	02/07/2023

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

(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
	vaccine was not given to residents who had consented to receive the vaccinations for 3 of 7 residents reviewed for vaccines. (Resident 4, Resident 18, Resident 28) Findings include: 1. On 2/1/23 at 9:40 a.m., Resident 4's clinical record was reviewed and indicated the following: Resident 4's immunization record indicated that Resident 4 had received a pneumococcal vaccination on 11/18/14 historically (meaning the resident received the vaccine outside of the facility prior to their admission); the immunization tab designated this vaccination as a pneumococcal polysaccharide 23 (PPSV23) vaccine while the scanned documents under immunizations designated this vaccination as a pneumococcal conjugate 13 (PCV13 or Prevnar 13) vaccination. Resident 4's diagnoses included, but were not limited to, chronic obstructive pulmonary disorder (COPD, a group of diseases that cause airflow blockage and breathing-related issues), asthma, and human immunodeficiency virus (HIV, a disease which damages the immune system and interferes with the body's ability to fight infection and disease). Resident 4 had an admission date of 5/7/2015 and was under the age of 65. 2. On 2/1/23 at 10:00 a.m., Resident 18's clinical record was reviewed and indicated the following: Resident 18's immunization record lacked documentation of any pneumococcal vaccinations.		received, will be given in accordance with CDC guidelines. The three cited patients will have vaccines administered as quickly as the vaccines are available and those patients/guardians agree. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any patient may have had the potential to be affected, no other patients were identified during the survey. All patients who have not been assessed for the pneumococcal vaccine for the season had the potential to be affected by the alleged deficient practice. (survey process denoted 4 patients). There were no adverse events and no cases of pneumonia diagnosed for any patient who has not received the vaccine. Corrective Action: The three cited patients will have vaccines administered as quickly as the vaccines are available and those patients/guardians agree. (Vaccines have been ordered as of 2/2023.) The DON will document. The Director of Nursing Services is revamping how she tracks vaccines. She will check the CDC site for any changes, every month. 3) What measures will be put into	

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	02/07/2023

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

(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
	Resident 18 had an admission date of 10/7/21 and was under the age of 65. 3. On 1/31/23 at 1:45 p.m., Resident 28's clinical record was reviewed and indicated the following: Resident 28's immunization record lacked documentation of any pneumococcal vaccinations. Resident 28's diagnoses included, but were not limited to, COPD. Resident 28 had an admission date of 11/5/22 and was under the age of 65. On 1/31/23 at 12:00 p.m., the DON (Director of Nursing) provided a list of residents dated for 12/31/22 which designated the cigarette smoking status of all residents in the facility. Resident 4, Resident 18, and Resident 28 were all designated as cigarette smokers who were safe to smoke without direct supervision. On 2/6/23 at 11:30 a.m., the DON provided pneumococcal vaccine consent forms for Resident 4, Resident 18, and Resident 28. Resident 4's pneumococcal vaccine consent form was signed by Resident 4's guardian on 10/18/16. Resident 18's pneumococcal vaccine consent form was signed by Resident 18 on 10/7/21. Resident 28's pneumococcal vaccine consent form was signed by Resident 28 on 11/7/22. During an interview on 2/6/23 at 9:25 a.m., the DON indicated she was unaware that smoking and		place or what systemic changes will be made? The three cited patients will have vaccines administered as quickly as the vaccines are available and those patients/guardians agree. The DON will document. The Director of Nursing Services is revamping how she tracks vaccines. The DON has begun an audit of all vaccines to ensure vaccines have been administered in a timely manner. Any patient who is found to be unvaccinated will be assessed and offered the missing vaccination. (survey process denoted 4 patients). The DON's binder will have copies of refusal/acceptance sheets included. Refusals are followed up by further explanation to the patient and going over the VIS sheet, if the patient then decides that they have changed their minds and accept the vaccine, the vaccine is given. This will be monitored monthly in the Quality Assurance meeting. She will check the CDC site for any changes, every month. A Vaccine Folder will be available in the DON's office for VIS Sheets (vaccine information) and CDC guidelines. 4) How the corrective actions will be monitored and what quality assurance program will be put into	

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	02/07/2023

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

(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
	other risk factors and/or medical conditions were a part of the CDC (Centers for Disease Control and Prevention) guidelines recommending pneumococcal vaccinations for individuals under the age of 65. After reviewing the CDC guidelines and residents' smoking status and other potential risk factors, the DON indicated that the residents who had not received a pneumococcal vaccination (Resident 18 and Resident 28) or who had only received one pneumococcal vaccination (Resident 4) should have received the appropriate pneumococcal vaccinations according to CDC recommendations. On 1/31/23 at 12:05 p.m., the DON provided an undated copy of the facility policy titled, "Infection Control - Influenza and Pneumococcal Immunizations for Residents", and indicated it was the policy currently in use. Under part five of the pneumococcal immunization, the policy stated that, "Pneumococcal immunization will be offered in accordance with CDC immunization algorithm for PCV13 and PPS[V]23." On 2/6/23 at 9:00 a.m., a review of the CDC guidelines at the following website regarding pneumococcal vaccine timing for adults (https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf, dated as last updated on 4/1/22, indicated that cigarette smoking, chronic lung diseases, and HIV infection are all underlying medical conditions or other risk factors where pneumococcal vaccinations are recommended for adults 19 through 64 years old in addition to being recommended for adults 65 years old and older. 3.1-13(a)		place; who will monitor? The Director of Nursing will monitor the immunization process by observing 5 patients utilizing her audit tool and compliance will be monitored and the ongoing auditing program reviewed at the monthly *Quality Assurance meeting. This monitoring shall continue monthly throughout 2023. (*This meeting includes pharmacy, Psych. NP or MD, SSD, the LHFA as available and the DON.) This will be monitored monthly in the Quality Assurance meeting with no end date. 5) By what date the systemic changes will be completed. February 27,2023	

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	02/07/2023

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

(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
F 9999 Bldg. 00	ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (C) fires; or This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a fire that occurred in a community resident shower room was reported to the State Agency as indicated by facility policy. Finding includes: During an interview on 2/1/23 at 11:00 a.m., LPN 2 indicated "about six weeks ago" a small fire was started in the community resident shower room located between resident rooms 9 and 10. The cause of the fire was due to "an unknown person had placed a lit cigarette in the trash can." During an interview on 2/3/23 at 10:30 a.m., the Director of Nursing Services indicated on 12/18/22	F 9999	1) What action(s) will be accomplished for those residents found to have been affected? Although any patient may have had the potential to be affected, no patients were identified during the survey. All events potentially fitting reportable guidelines will be reviewed by the Administrator and the DON. There will be a written account of all events on the morning meeting sheets, which will be given to the DON, SSD, Administrator. This documentation will also be reviewed in the monthly Quality Assurance. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although any patient may have had the potential to be affected, no patients were identified during the survey. There were no adverse events for any patient who resides in the hallway where this event took place or any other patient. residing in the facility. Corrective Actions All events potentially fitting reportable guidelines will be reviewed by the Administrator and the DON. There will be a written	02/27/2023

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	02/07/2023

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

(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
	between 1:00 p.m. and 2:00 p.m., staff observed smoke coming from the community resident shower room that was located between resident rooms 9 and 10. Staff used a fire extinguisher to douse the smoke. Staff reported no flames were visible. The local fire department responded to the fire alarm and arrived on the scene. The Director of Nursing Services indicated a facility reportable (unusual occurrence report) "was not submitted to the State Agency because no residents were affected." During an interview on 2/7/23 at 8:23 a.m., CNA 3 indicated on 12/18/22 there was a small fire in the shower room trash can. The fire started from a lit cigarette that was thrown into the trash can. The charge nurse used the fire extinguisher to put out the fire. The fire was already out when the fire department arrived at the facility. During an interview on 2/7/23 at 8:45 a.m., the Director of Nursing Services indicated the facility had no documentation regarding the fire on 12/18/22. On 2/3/23 at 2:00 p.m., observed the community resident shower room located between resident rooms 9 and 10. To the left of the entry door and under the sink area, scorched marks were visible on the floor. On 2/3/23 at 1:15 p.m., the Director of Nursing Services provided a copy of the Division of Long-Term Care Reportable Incident Policy, dated 7/15/15, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...immediately informing the division ...within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents,		account of all events on the morning meeting sheets, which will be given to the DON, SSD, Administrator. The This documentation will also be reviewed in the monthly Quality Assurance. Staff will be re-educated on guidelines to report events. 3) What measures will be put into place or what systemic changes will be made? Systemic Changes: All events potentially fitting reportable guidelines will be reviewed by the Administrator and the DON. There will be a written account of all events on the morning meeting sheets, (daily) which will be given to the DON, SSD, Administrator. This documentation will also be reviewed in the monthly Quality Assurance. Staff will be re-educated on guidelines to report events. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. Guidelines for sentinel events will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines for sentinel events will be placed in new hire packet and signed off to denote the new hire's understanding.	

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	02/07/2023

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

(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
	including, but not limited to, any ...fires ...fires-within facility due to any cause ..."		Guidelines will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines will be placed in new hire packet and signed off to denote the new hire's understanding. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Staff will be re-educated on guidelines to report events. Re-education will take place once a week x4 weeks, then once every other week times 3, then once a month for 4 months (6 month total) and PRN thereafter. The DON will monitor for the times allotted as above. Guidelines will be put into a binder and be kept at the nursing station and in the DON's office. Guidelines will be placed in new hire packet and signed off to denote the new hire's understanding. Monitored by HR with no end date. All potential reportables will be reviewed in the morning meeting. Should the Administrator be unavailable for this meeting, the DON will assume responsibility to notify and discuss with the Administrator, for the appropriate decision to report. The DON will monitor all events and these actions have no end date.	

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	02/07/2023

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

(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
			5) By what date the systemic changes will be completed. February 27, 2023	