PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-039

07/28/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		A. BUILDING B. WING	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING B. WING		
	PROVIDER OR SUPPLIE RST HEALTHCARE		522	EET ADDRESS, CITY, STATE, ZIP COD 5 W MORRIS ST IANAPOLIS, IN 46241	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
Bldg	conducted by the Ir accordance with 42 Survey Date: 02/28 Facility Number: 02/28 Facility Number: 100 At this Emergency Lynhurst Healthcar with Emergency Production and Suppliers, 42 of The facility has 40 the survey, the cen Quality Review co	2000385 15E667 2291340 Preparedness survey, re was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.73. certified beds. At the time of sus was 33. mpleted on 03/07/23	E 0000	Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provide with the truth of the facts alleged or the conclusions set forth in the Statement Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is require by the provisions of feder and state laws. Lynhurst Healthcare maintains that the alleged deficiencies of not individually or collectively jeopardize the health and/or the safety of its residents nor are they such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhum Healthcare asserts that it and was in substantial compliance with regulation 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	er s cof e red red ral t lo e of of of e irst is ons of nd its
LABORATOF	KY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

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 discloded 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.

Nelene Reisinger

LHFA

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			· ′	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED B. WING 02/28/2023					
		15E667	B. WI	NG		02/28/	2023	
	ROVIDER OR SUPPLIER			5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE .	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0006 SS=F Bldg	(1)-(2), 441.184(a), 483.475(a)(1)-(2), (1)-(2), 485.625(a), 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2), §418.113(a)(1)-(2), §483.73(a)(1)-(2), §485.625(a)(1)-(2), §485.920(a)(1)-(2), §491.12(a)(1)-(2), [(a) Emergency Pl develop and main preparedness plar and updated at learnust do the follow (1) Be based on a	491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment), §416.54(a)(1)-(2),), §441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),), §486.360(a)(1)-(2), §494.62(a)(1)-(2) an. The [facility] must tain an emergency n that must be reviewed, ast every 2 years. The plan			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 necessa	ry.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

81SR21

Facility ID: 000385

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIEI		5225 \	ADDRESS, CITY, STATE, ZIP COD W MORRIS ST NAPOLIS, IN 46241		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	PRIATE	DATE
	assessment, utiliz approach.*	ing an all-hazards				
	1 ' '	gies for addressing s identified by the risk				
	Plan. The Hospic	t §418.113(a):] Emergency e must develop and				
	that must be revie every 2 years. Th	gency preparedness plan ewed, and updated at least e plan must do the				
	following: (1) Be based on and include a documented, facility-based and community-based risk					
		ing an all-hazards				
	approach.	gies for addressing				
	1 ' '	s identified by the risk				
		iding the management of				
	•	s of power failures, natural				
		er emergencies that would 's ability to provide care.				
	*[For LTC facilities	s at §483.73(a):] The LTC facility must				
	develop and main	tain an emergency				
		n that must be reviewed,				
	and updated at le do the following:	ast annually. The plan must				
	1	and include a documented,				
		community-based risk				
		ring an all-hazards ng missing residents.				
		gies for addressing				
	1 ' '	s identified by the risk				
	assessment.	-				
	-	§483.475(a):] Emergency must develop and maintain				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15E667	B. W	NG		02/28/	/2023
e e e e			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	{		5225 W	MORRIS ST		
LYNHUR	RST HEALTHCARE			INDIAN	APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		eparedness plan that must					
		updated at least every 2					
	years. The plan must do the following:						
	(1) Be based on a	nd include a documented,					
		community-based risk					
	_	ing an all-hazards					
	approach, includir	•					
		gies for addressing					
		s identified by the risk					
	assessment.	•					
	Based on record rev	view and interview, the facility	E 00	006	0006		05/26/2023
	failed to maintain a	n emergency preparedness			1) What action(s) will be		
	plan that was (1) ba	sed on and includes a			accomplished for those reside	nts	
	documented, facilit	y-based, and community-based			found to have been affected?		
	risk assessment, uti	lizing an all-hazards approach,			***The processes that led to th	nis	
	including loss of na	tural gas and (2) included			deficiency being cited:		
	strategies for addres	ssing emergency events			Documents were not marked		
	identified by the ris	k assessment in accordance			appropriately so that finding a		
	with 42 CFR 483.7	3(a) (1) and 42 CFR 483.73(a) (2).			specific document was difficul	t.	
	This deficient pract	ice could affect all occupants.			No resident was identified to h		
	Findings include:				been affected during this survented the facility based training example was given to the	∋у.	
	During record revie	w with the Maintenance			inspector.		
	Director at 9:10 a.n	n. on 02/28/23, documentation			The facility follows state and		
	could not be found	regarding a documented,			federal guidelines.		
	facility-based, and	community-based risk			The survey tag states:		
	assessment, utilizin	g an all-hazards approach,			"utilizing an all-hazards		
	including loss of na	tural gas which was the fuel			approach, including loss of na	tural	
	source for that facil	ity emergency generator.			gas which was the fuel source	for	
	Furthermore, there	was no plan, policy, or			that facility emergency genera	itor.	
	_	at the facility would do if their			Furthermore, there was no pla	ın,	
	_	function or needed serious			policy, or procedure as to wha	t the	
		nt. Based on interview at the			facility would do if their genera	ator	
		ew, the Maintenance Director			ceased to function or needed		
		s no policy, procedure, or plan			serious repair or replacement.		
		forementioned issues. During			The Facility has a "Utility Outa	ige	
		with the facility Executive			and Shut off" section of the		
	Director and the Ma	aintenance Director at 3:50	1		Emergency Preparedness Pla	n.	

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Event ID:

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Facility ID: 000385

If continuation sheet Page 4 of 70

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STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION DESTRICTION NUMBER 15E067 NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE STREET ADDRESS. CITY, STATE, ZIP COD S2525 W MORRIS ST INDIANAPOLIS, IN 46241 NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE STREET ADDRESS. CITY, STATE, ZIP COD S2525 W MORRIS ST INDIANAPOLIS, IN 46241 TAG PREFIX TAG PUTIL, REGULATORY OR ILSE IDENTIFYING INFORMATION TAG PUTIL, no additional information or evidence could be provided contrary to this deficient finding. STREET ADDRESS. CITY, STATE, ZIP COD S2525 W MORRIS ST INDIANAPOLIS, IN 46241 (See attached) PUTIL, REGULATORY OR ILSE IDENTIFYING INFORMATION TAG (see attached) "Gas Quage Information attached. This had been shared with maintenance and will be placed in the maintenance book. 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 or after the survey. The facility shased training example was given to the inspector. The facility shased staff education. (It is did not occur in patient areas and no patients were affected.). "The procedure for implementing an acceptable POC for this specific sare easier to locate. The facility based staff education. (It is did not occur in patient areas and no patients were affected.). "The procedure for implementing an acceptable POC for this specific sare." The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the		TOF HEALTH AND HUI R MEDICARE & MEDIC					ORM APPROVED MB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667 INDIANAPOLIS, IN 46241			ī	(X2) MULTIPLE	CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE (X3) ID PREFIX TAG ID TAG ID				î î		r í	
S225 W MORRIS ST LYNHURST HEALTHCARE (X3) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG P.M., no additional information or evidence could be provided contrary to this deficient finding. P. H. A. (See Contrary to this deficient finding). SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG P. M., no additional information or evidence could be provided contrary to this deficient finding. SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (See SEPTEMENT OF THE APPROPRIATE COMPLETION DATE "GROSS-REFERENCE OF THIS APPROPRIATE COMPLETION TAG "GROSS-REFERENCE OF THIS APPROPRIATE COMPLETION DATE "GROSS-REFERENCE OF THIS APPROPRIATE (See all tached) "GROSS-REFERENCE OF THIS APPROPRIATE (See all tached) "GROSS-REFERENCE OF THIS APPROPRIATE (SEE ALL TACHED "GROSS-REFERENCE OF THIS APPROPRIATE (SEE ALL TACHED "GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION DATE "GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION THE GROSS-REFERENCE OF THIS APPROPRIATE (SEE ALL TACHED "GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION THE PREFIX TAGE (CX5) COMPLETION THE PREFIX TAGE (CX5) COMPLETION THE GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION TAGE "GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION THE PROPRIATE (CX5) COMPLETION THE PROPRIATE (CX5) COMPLETION TAGE "GROSS-REFERENCE OF THIS APPROPRIATE (CX5) COMPLETION THE PROPRIATE (CX5) COMPLETION TAG "GROS -REFERENCE OF THE APPROPRIATE (COMPLETION TO APPROPRIATE (CX5) COMPLETION TAG "CAS CHARCH THE PROPRIATE TAG "CAS CHARCH THE PROPRIATE TAG "CAS CHARCH THE PROPRIATE TAG "CAS CHARC			15E667	B. WING		02/28	3/2023
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PREFIX TAG	LIMITOR	OTTILALITIOANL					
p.m., no additional information or evidence could be provided contrary to this deficient finding. See attached See attach	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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The facility also included it's recent pipe breakage and flooding in the facility based staff education. (this did not occur in patient areas and no patients were affected). ***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					The facility strives to follow	s state	
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in the facility based staff education. (this did not occur in patient areas and no patients were affected). ***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					-		
education. (this did not occur in patient areas and no patients were affected). ***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the						looding	
patient areas and no patients were affected). ***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the							
affected). ***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					·		
***The procedure for implementing an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the						its were	
an acceptable POC for this specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					1		
specific tag: The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the						•	
The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					•	,	
book will be adjusted so that specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					1 '	2000	
specifics are easier to locate. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the							
The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					-		
Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the					I *		
inspectors during survey. Front page has dates of 4/2022 and the						to the	
page has dates of 4/2022 and the					I		
I DOOK IS ONE TO BE DODATED AS					book is due to be updated		
necessary this month.							

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4-13-23.

The book audit was started

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]	DEPARTMENT OF HEALTH AND HU	FOR		
	CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMB
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE S

	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING		COMPLETED 02/28/2023
	ROVIDER OR SUPPLIER ST HEALTHCARE	· ·	5225	T ADDRESS, CITY, STATE, ZIP COD W MORRIS ST ANAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Section 4 of the Emergency Preparedness Book, includes "gas outage". (see attached) a an addendum has been adder further clarify the actions that must occur should the natural (running the generator) experience difficulties/outage. (attached) **Gas Outage Information attached. This has been shared with maintenance and will be placed in the maintenance book. 3) What measures will be put place or what systemic chang will be made? The facility based training example was given to the inspector. The facility also included it's recent pipe breakage and floor in the facility based staff education. (this did not occur patient areas and no patients affected). The facility's Emergency Preparedness was shown to transpectors during survey. From page has dates of 4/2022 and book is due to be updated as necessary this month. The book audit was started 4-13-23. The survey tag states: "utilizing an all-hazards approach, including loss of nat gas which was the fuel source that facility emergency general Furthermore, there was no place.	and d to gas see into es ding in were he nt the the the the the the the the the th

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD V MORRIS ST		
LYNHUF	RST HEALTHCARE				NAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP TAG DEFICIENCY)			ATE	(X5) COMPLETION DATE
TAG	REGULATORY	K LSC IDENTIFITING INFORMATION		TAU	policy, or procedure as to what facility would do if their generations repair or replacement Systemic Changes: ***The monitoring procedure ensure that this POC is effect and that the specific deficiency was corrected and/or in compliance with the regulator requirements: ***The Emergency Preparedry book will be adjusted so that specifics are easier to locate. ***This book will be audited to every other month basis, by the Maint. Director and/or his designee and the Administrate ensure it has been updated an added to as appropriate. Section 4 of the facility's Emergency Preparedness includes "gas outage". (see attached) and an addendum I been added to further clarify the actions that must occur should the natural gas (running the generator) experience difficulties/outage. (attached) **Gas Outage Information attached. This has been shar with maintenance and will be placed in the maintenance bod 4) How the corrective actions be monitored and what quality assurance program will be put	ator t. " to tive cy ry ness on an he or, to nd has the d ook. s will	DATE

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inspector.

place; who will monitor? The facility based training example was given to the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DAT	(X3) DATE SURVEY COMPLETED 02/28/2023		
	ROVIDER OR SUPPLIE		5225 V	ADDRESS, CITY, STATE, ZIP CO V MORRIS ST NAPOLIS, IN 46241	DD .	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION
TAG	REGULATORY	ALESC IDENTIFYING INFORMATION	TAG	The facility follows state federal guidelines. (plea attached examples). The facility also included recent pipe breakage are in the facility based staff education. (this did not patient areas and no patient areas was shown inspectors during survey page has dates of 4/2/2 the book is due to be up necessary this month. The book audit was start 4-13-23. Section 4 of this book, in "gas outage". (see attack and an addendum has be to further clarify the action further clarify the action (running the generator) experience difficulties/or (attached) **Gas Outage Information attached. This had been with maintenance and we placed in the maintenance and we placed in the maintenance and the Admirensure it has been updated added to as appropriate attached. The Emergency Prephook will be adjusted so specifics are easier to lot the Maint. Director is not the maint.	and ase see dit's and flooding foccur in tients were y wn to the y. Front 022 and odated as a ched) obeen added ons that anatural gas a ched will be accepted on an anatural gas a ched on an a shared will be accepted on an anatural gas a ched on an a shared will be accepted on an anatural gas a ched on anatural gas a ch	DATE

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for the generator and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE		522	EET ADDRESS, CITY, STATE, ZIP 25 W MORRIS ST DIANAPOLIS, IN 46241	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE	SHOULD BE COMPLETION	
E 0013 SS=F Bldg	403.748(b), 416.5 441.184(b), 482.1 484.102(b), 485.5 485.727(b), 494.62 Development of E §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485 §485.920(b), §48 §494.62(b). (b) Policies and p develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The polic be reviewed and years.	54(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 525(b), 485.68(b), 920(b), 486.360(b),		documentation associate the Administrator and designee as applicable responsible for imple acceptable POC. The Director of Nursi working with the Admithe HR Dept, is responsible in-services and other monitoring and documents. 5) By what date the sechanges will be computed by 5/26/23	ciated with; and her ble is menting the ng Services , ninistrator and consible for staff training menting of	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		UILDING	nstruction 	COMPI 02/28	LETED	
	OF PROVIDER OR SUPPLIEF		5225 W	NDDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The policibe reviewed and was additional Requires. The develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The policibe address manager nonmedical emerginited to: Fire; expending the properties of the particular the policies and previewed and upded to the particular the policies and previewed and upded to the particular the policies and preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication plecommunication plecommunicat	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually. The ments for PACE and procedures and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must				

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	î ´	JILDING	ONSTRUCTION	(X3) DATE COMPL 02/28/	LETED
	OF PROVIDER OR SUPPLIED JRST HEALTHCARE			5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
	years. These emenot limited to, fire failures, care-rela supply interruptio likely to occur in tarea. Based on record refailed to develop an preparedness policipolicies and procedupdated at least and CFR 483.73(b). The all residents in the Findings include: During record revious Director at 9:13 a.r. could not be found complete emergency plan available did refor loss of natural gemergency generat getting a replacement was also not address interview at the time Maintenance Director and the fagetting a replacement policies and procedure that supplied the fagetting a replacement the exit conference Director and the Mp.m., no additional	aughated at least every 2 ergencies include, but are a equipment or power atted emergencies, water and natural disasters the facility's geographic and implement emergency ties and procedures. The dures must be reviewed and anually in accordance with 42 this deficient practice could affect facility. The ew with the Maintenance and the or include a policy or procedure gas that supplied the facilities for for review. Furthermore, and generator from a vendor seed either. Based on an and of record review, the atternation and the of record review, the atternation and the of record review. During the with the facility Executive and another or evidence could ary to this deficient finding.	E 0	013	0013 1) What action(s) will be accomplished for those reside found to have been affected? ***The processes that led to the deficiency being cited. Although all resident had the potential to be affected-No resident was identified to be affected by emergency preparedness documentation. The facility follows state and federal guidelines for emerge preparedness and staff re-education. (all staff, all departments) (see attached examples of fabased education and risk assessments). ***Documents were not marked appropriately so that finding a specific document was difficulated process *** This book will be audited of every other month basis, by the Maint. Director and/or his designee and the Administrate ensure it has been updated a added to as appropriate. The facility generator is tested per state and federal guideling and the addendum to the emergency preparedness pole	ncy ed att. on an he or, to nd d as es	05/26/2023

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	CONSTRUCTION (X3) DATE SURVEY COMPLETED 02/28/2023		
	PROVIDER OR SUPPLIER		5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) and procedures, and the "what do if natural gas is unavailable was in our emergency book. (titled, 'Gas Outage', see attach This has been updated. **Gas Outage Information attached. This had been share with maintenance and will be placed in the maintenance book The facility generator is tested per state and federal guideline and the addendum to the emergency preparedness policiand procedures, This has been up dated to income a secondary 'what the facility' do when the natural gas to rungenerator becomes unavailable (see attached) The facility's Emergency Preparedness was shown to the inspectors during survey. From page has dates of 4/2022 and book is due to be updated as necessary this month. The book audit was started 4-13-23. 2) How the facility will identify other residents having the potential to be affected and who corrective action will be taken? Although any patient may have had the potential to be affected.	t to "" hed) ed ok. as sicies slude will n the le'. he the	(X5) COMPLETION DATE
				other patients were identified		

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during or after the survey. The facility follows state and federal guidelines for emergency

preparedness and staff re-education. (all staff, all

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF I	PROVIDER OR SUPPLIEF	· {		ADDRESS, CITY, STATE, ZIP COD	
LYNHUR	ST HEALTHCARE			V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	departments) (see attached examples of fac	DATE
				based education and risk assessments.) **Gas Outage Information	
				attached. This has been share with maintenance and we be placed in the maintenance boo	
				The facility's Emergency Preparedness was shown to the inspectors during survey. Front	t
				page has dates of 4/2022 and book is due to be updated as necessary this month.	the
				The book audit was started 4-13-23. ***Documents were not market	ed
				appropriately so that finding a specific document was difficult	
				What is the procedure for implementing an acceptable Pofor the cited deficiency?	ос
				The facility generator is tested per state and federal guideline	s
				and the Emergency Preparedn Book has been updated to incl 'what to do when the natural ga	ude
				becomes unavailable'. An addendum to the emergency	
				preparedness policies and procedures has been added, (see attached)	
				*** This book will be audited or every other month basis, by the	
				Maint. Director and/or his designee and the Administrato ensure it has been updated an	•

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added to as appropriate.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		15E667	B. W	ING		02/28	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L	5225 W MORRIS ST				
LYNHUR	ST HEALTHCARE		INDIANAPOLIS, IN 46241				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					3) What measures will be put i		
					place or what systemic change will be made?	es	
					***What is the monitoring		
					procedure to ensure that the F	POC	
					is effective and that the deficie		
					cited remains corrected and/or	-	
					compliance with the regulatory		
					requirements.		
					***Documents were not mark	ed	
					appropriately so that finding a		
					specific document was difficul	t.	
					*** This book will be audited o	n an	
					every other month basis, by th	ie	
					Maint. Director and/or his		
					designee and the Administrate		
					ensure it has been updated ar	nd	
					added to as appropriate.		
					The facility follows state and		
					federal guidelines for emerger	тсу	
					preparedness and staff		
					re-education. (all staff, all		
					departments) (see attached examples of fac	cility	
					based education and risk	onity	
					assessments.)		
					The facility generator is tested	as	
					per state and federal guideline		
					and the addendum to the		
					emergency preparedness poli	cies	
					and procedures, has been up		
					dated to include 'what the facil	lity	
					will do when the natural gas to	run	
					the generator becomes		
					unavailable'. (see attached)		
					The facility's Emergency		
					Preparedness was shown to the		
					inspectors during survey. From		
					page has dates of 4/2022 and	the	
1	I				hook is due to be undated as		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLE	TED
		15E667	B. WI	NG		02/28/2	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			V MORRIS ST		
I YNHUR	RST HEALTHCARE				NAPOLIS, IN 46241		
211111011		· 		11401741			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					necessary this month.		
					The book audit was started		
					4-13-23.		
					4) 11-11-11-11-11-11-11-11-11-11-11-11-11-		
					4) How the corrective actions		
					be monitored and what quality		
					assurance program will be pu	i into	
					place; who will monitor?		
					***The title of the person who		
					responsible for implementing acceptable POC.	aii	
					***The Administrator or her		
					designee is responsible for		
					implementing the POC.		
					*** The emergency Preparedr	2000	
					book will be audited on an eve		
					other month basis, by the Mai	· .	
					Director and/or his designee a		
					the Administrator, to ensure it		
					been updated and added to a		
					appropriate.]	
					The facility follows state and		
					federal guidelines for emerger	ncv	
					preparedness and staff	,	
					re-education. (all staff, all		
					departments)		
					(see attached examples of fa	cility	
					based education and risk	·	
					assessments.		
					The facility generator is tested	l as	
					per state and federal guideline		
					and the addendum to the		
					emergency preparedness poli	cies	
					and procedures, has been up		
					dated to include 'what the faci	lity	
					will do when the natural gas to	run	
					the generator becomes		
					unavailable'. (see attached)		
					quality assurance		
					The Emergency Preparednes	s	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15E667	B. WING		02/28/2023	
	PROVIDER OR SUPPLIE		5225	r address, city, state, zip cod W MORRIS ST NAPOLIS, IN 46241	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) book was updated in late 202 the previous book disappeare (just in time for our previous f inspection). First page showin signatures for reviews, as of	DATE 22, as ed irre	
				signatures for reviews, as of 4-2-22. ***The Maint. Director and the Executive Director will meet of month to discuss and audit the generator inspections. This wan ongoing measure with no date. ***the company that inspects systems, will email the Executive Director (ED) all invoices etc, show what services they have accomplished for the facility. The title of the person respons for implementing an acceptate POC: The Executive Director and the Director of Nursing Services are responsible and will maintain re-education for staff re: emergency preparedness and Emerg. Preparedness Book, with the Maint. Director. 5) By what date the systemic changes will be completed 5-	every ae rill be end sour ative to e asible ale are the ad the along	
K 0000						
Bldg. 02	Licensure Survey	e Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 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		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPL	ETED
		15E667	B. W	ING		02/28/	2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			/ MORRIS ST		
 YNHIIR	ST HEALTHCARE		INDIANAPOLIS, IN 46241				
					CLIO, III 10271	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					alleged or the conclusions		
	Facility Number: 0				set forth in the Statement of		
Provider Number: 15E667				Deficiencies rendered by			
	AIM Number: 100	291340			the reviewing agency. The		
					Plan of Correction is		
	-	Code survey, Lynhurst			prepared and executed		
		nd not in compliance with			solely because it is required		
	*	articipation in Medicaid, 42			by the provisions of federal		
	•	0(a), Life Safety from Fire and			and state laws. Lynhurst		
		the National Fire Protection			Healthcare maintains that		
) 101, Life Safety Code (LSC),			the alleged deficiencies do		
		g Health Care Occupancies and			not individually or		
	410 IAC 16.2.				collectively jeopardize the		
					health and/or the safety of		
		ucted in two sections, is fully			its residents nor are they of		
	-	lest section, a former two-story			such character as to limit		
	-	ith a basement and the newer			the provider's capacity to		
	section, a one-story				render adequate resident		
		Type V (000) construction.			care. Furthermore, Lynhurst		
	-	re alarm system with smoke			Healthcare asserts that it is		
		ridors and all areas open to the			and was in substantial		
		y has battery operated smoke			compliance with regulations		
		n all resident sleeping rooms.			governing the operation of		
		g rooms were surveyed. The			long term care facilities and		
		ty of 40 and had a census of			the Plan of Correction in its		
	33 at the time of thi	s visit.			entirety, constitutes this		
					provider's allegation of		
		idents have customary access			compliance. Completion		
	-	he facility has two detached			dates are provided for		
		facility services which are the			procedural processing		
		d a metal storage shed which			purposes to comply with		
	were each not sprin	klered.			federal and state		
		1 . 1 . 00 (07/07			regulations and to correlate		
	Quality Review con	npleted on 03/07/23			with the most recent		
					contemplated or		
					accomplished corrective		
					action(s). These do not		
					necessarily chronologically		
					correspond to the date that		
					Lynhurst Healthcare is		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		A. BUILDING <u>02</u> COMPLETED		(X3) DATE SURVEY COMPLETED 02/28/2023	
	ROVIDER OR SUPPLIER	2	5225	T ADDRESS, CITY, STATE, ZIP COD W MORRIS ST ANAPOLIS, IN 46241	
			<u>, l</u>	1 000, 114 40241	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOUL)	
PREFIX	*	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE CONTENTION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE
				under the opinion that it was in compliance with the requirements of participation or that corrective action was nece	
K 0161 SS=F Bldg. 02	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5 Construct I (442), I of stories sprinklered II (111) non-sprinklered II (000) non-sprinklered III (211)				
	sprinklered 5 IV (2HH) 6 V (111) 7 III (200)				
	non-sprinklered	NOT AllOWED			
	8 V (000)	Maximum 1 story			
	sprinklered	maximani i otory			
		s must be sprinklered			
		approved, supervised			
		in accordance with section			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED			LETED	
		15E667	B. W	ING		02/28	/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEBIG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
	9.7. (See 19.3.5)						
	Give a brief descri	iption, in REMARKS, of the					
		number of stories, including					
		on which patients are					
		of smoke or fire barriers and					
		Complete sketch or attach					
		the building as appropriate.					
		view, observation and	K 0	161	0161		09/24/2023
		ty failed to ensure the building	150	101	1) What action(s) will be		05,2 2025
		or the two story portion of the			accomplished for those reside	ents	
		itted type as listed in Table			found to have been affected?		
	19.1.6.1. Table 19.1.6.1 prohibits a two story				process that led to this citation		
	sprinklered building to be of Type V(000)				***The process that led to this		
		deficient practice could affect			citation is the age of the facilit		
	all occupants.	1			itself, which has passed all pri	-	
	1				Life Safety Code Survey's up		
	Findings include:				the present, or has been		
					grandfathered in.		
	During record revie	w with the Maintenance			Although any patient may have	/e	
	_	3 between 9:10 a.m. and 12:10			had the potential to be affecte		
		eys indicated the facility was			No other patient was found to		
		11) rating as required for a			affected/identified during or af		
	two-story sprinklere				the survey process.		
					The attic and the basement a	re	
	During a subsequen	it tour of the basement on the			sprinkled. (every floor is sprinkled)		
		wing were observed:			*** The attic area in question I		
		basement ceiling had exposed			been decommissioned for the		
		. These were made from lumber			FSES survey, per FSES. Plea		
	-	ole protection or flame spread			see attached email. The facilit		
	rated covering.	•			will in the future be surveyed a	•	
	[two story structure and not a t		
	During a tour of the	attic, the following was noted:			story structure by FSES.		
	_	e attic walls and ceiling were			Extra fire extinguishers have t	oeen	
		ard material that facility did not			placed in the basement and th		
		rating documentation for.			attic spaces. Two more smoke		
	_	ew at the time of both			alarms have also been placed		
	aforementioned obs	servations, the Maintenance			***The facility is filing an FSE		
		t the building did not meet the			this tag to obtain approved		
		n rating as it could not be			equivalency.		
	1 1	ement ceiling / floor had			2) How the facility will identify		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
PREFIX TAG	REGULATORY OR 1-hour fire resistant had a 1-hour fire rat During the exit cont Executive Director at 3:50 p.m., no add	LSC IDENTIFYING INFORMATION rating or that the attic walls	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	hat ? enting re al that ead time e ng not c ng an nd ES I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	*** The attic area in question been decommissioned by FS per FSES surveyor. Please s attached email. (the attic sparare now empty) 3) What measures will be put place or what systemic change will be made? The monitoring procedure to ensure that the POC is effection and the specific citation rematorrected and/or in compliant with regulatory requirements. ***The facility is filling an FSE this tag to obtain approved equivalency. ***The attic area in question been decommissioned by FS per FSES surveyor. Please so attached email. The Administrator and the Madoirector are working with the FSES company and the FSES survey is in progress. ***The attic has been cleared will no longer be utilized for storage. The attic door is lock. The facility will in the future be surveyed as a two story struct and not a three story structure the FSES survey. Monitoring process: ***The Maint. Supervisor will perform a safety check on both the basement and attic, daily will report any issues immediated to the Administrator; to be corrected as applicable.	has ES, eee ces into es Ve ins ee ins ee int. S and ed. ee ture ee for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15E667		(X2) MULTIPLE C A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 02/28/2023			
	ROVIDER OR SUPPLIER ST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE		
				Systemic Changes ***The attic area in questic been decommissioned by per FSES Consultant. Plea attached email. The attic s has been cleaned out and longer be used for storage purposes. The attic door is ***The facility is filing an F3 this tag to obtain approved equivalency. Extra fire extinguishers have ordered for the attic and the basement. Two more smol alarms have also been plae ***Patients in the two story section of the facility have moved into the one story stemporarily, to accommodate repairs. 4) How the corrective actic be monitored and what quassurance program will be place; who will monitor? ***The title of the person responsible for implementing the acceptable POC is the Administrator. and the Mai Director. The facility will be requesting was the place of the pass future inspection of t	FSES, ase see pace will no slocked. SES for less been exelfire ced. been ections ate less will ality put into less will ality put into less ee and be tions SES		

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 02/28/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA' DEFICIENCY) has not been obtained at this t as the FSES survey remains of	ime DATE		
				going. The FSES survey is now in progress. ***Patients in the two story section of the facility have bee moved into the one story sectitemporarily so that any repairs can be made. ***The attic space has been cleaned out and will no longer used for storage purposes. Th door is locked. Extra fire extinguishers have bordered. Two more smoke/fire alarms have also been placed the basement area and two malarms have been placed in thattic. The facility will in the future be surveyed as a two story structure facility and not a three story structure facility and have been placed the attic and basement daily a will report any issues immediated to the Administrator; to be corrected as applicable. Monitoring and documented by Maint. Director FSES has given us two option	be e e e e e e e e e e e e e e e e e e		
				Decommission the attic spa in the old structure, resulting ir complete closure of the attic			

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space. (No storage) Proceed with

2) Move all patients (6) into the one story newer building, only

the FSES survey.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	r í	JILDING	onstruction 02	(X3) DATE : COMPL 02/28/	ETED
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LYNHUR	ST HEALTHCARE				MORRIS ST APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	RESOLUTION I UN				using the older section for administration purposes. (no patients, no PT/OT etc) ***The facility is going through option #1. ***It is the facility's wish to go through with the FSES survey pass it. The FSES survey is in progress at this time. ***The Administrator and the Maint. Director are working with the FSES company to file an FSES for this issue to obtain approved equivalency. ***The attic area in question heen decommissioned by FSE per our FSES consultants. Please see attached email. Thattic space has been cleaned and will no longer be used for storage purposes. ***Patients in the two story section of the facility are being moved into the one story section of the facility is sec	and th an as ES, ne out dons n be y can h and attely	

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STATEMENT OF DEFIC	IENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORREC	TION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	
		15E667	B. W	ING		02/28/	/2023
NAME OF PROVIDER O		·		5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
	H DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE).TE	COMPLETION
TAG REGUI	LATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	DATE
Bldg. 02 Means of Aisles, prodischarger in according of egressiall obstruction of the second of the	of Egress of Egress assagewa es, exit lo dance with s is continuctions to ncy, unles 18/19.2.1 9.2.1, 7.1 observation ensure the was continues as 8 reside		K 0	211	regulations. At present, the at area has been decommission by FSES and there are no patients in the two story struct at this time. This structure will remain off limits to patients an non office staff (excluding vendors) until construction is complete and the facility pass the FSES survey. A 2 hour fir door separates the two story section of the building, from thone story and this will be kept closed. It is our hope to fix any issues noted by the FSES, so that the facility can pass the FSES. 5) By what date the systemic changes will be completed: 9-24-23	ed ture II nd es re he he he What	05/26/2023

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"...the ramp between resident

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023
	PROVIDER OR SUPPLIER		5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	ramp between residence out into the corridor ramp extension created anyone coming from facility. Based on an observation, the Matacknowledged the related the options with the Exchad time to do so. If the facility Executive Maintenance Direct	or 02/28/23 at 2:34 p.m., the ent rooms #1 and #3 extended approximately 12 inches. This sted a trip / fall hazard to in the dining room area of the interview at the time of the intenance Director amp extension as being a trip at he would discuss repair ecutive Director as soon as he during the exit conference with the Director and the or at 3:50 p.m., no additional ence could be provided		rooms #1 and #3 extended o into the corridor approximate inches. This ramp extension created a trip / fall hazard to anyone coming from the dinir room area of the facility." Although any patient may have had the potential to be affected other patients were identified during the survey. ***The processes that led to cited deficiency; ***The loss of a maintenance d/t Covid and the age of the facility. A railing has been placed to accommodate all patients. ar negate any tripping issue. Please see below for facility's plan. 2) How the facility will identify other residents having the potential to be affected and we corrective action will be taker. The procedure for implement acceptable POC for the citatical Although any patient may have had the potential to be affected other patients were identified during the survey. The ramp in question, by the office, has been fixed. A chain the patient's has been placed and secured to the floor) and remaining inches of the ramp extension will be beveled. The prevent any hazard that has a possibility to negatively affecting patient.	ly 12 ng ve ed, no the ecrew nd to s y what n? ing an on? ve ed, no DON r for I (the 's is will the

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BU B. WI	ILDING NG	02	COMPL 02/28/	
		13E001	D. WI			02/28/	2020
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MORRIS ST		
LYNHUR	ST HEALTHCARE				APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	3) What measures will be put place or what systemic change will be made? ***The monitoring procedure to ensure the POC is effective are that the specific deficiency cite remains corrected and/or in compliance with the regulatory requirements? "the ramp between resident rooms #1 and #3 extended ou into the corridor approximately inches. This ramp extension created a trip / fall hazard to anyone coming from the dining room area of the facility." The ramp in question, by the E office, has been fixed. A chair the patient's has been placed and secured to the floor) This prevent any hazard that has the possibility to negatively affect patient. The Maint. Director is response for this project and to monitor other part of the facility for trip hazards. Monitoring of the facility for trip hazards will take place were by the Maint. Director and/or has designee, and they will meet with the Administrator. 4) How the corrective actions be monitored and what quality assurance program will be put place; who will monitor? The tiof the person responsible for implementing the acceptable POC?	es o o o o d d d f t t t t t t t t t t t t t t t t	DATE

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0271 SS=E Bldg. 02	7.7, provides a lev the provisions of 7 changes in elevati free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure 2 of constructed of a har surface in accordance Certification Letter.		K 0271	quality assurance The ramp in question, by the I office, has been fixed. A hand has been placed in order to avany possible trip hazard. The Maint. Director is responsions for this project and to monitor other part of the facility for trip hazards. Monitoring of the factor for hazards will take place we by the Maint. Director and/or hazards will take place we by the Maint. Director and/or hazards will take place we by the Administrator. The Administrator is responsite for implementing the acceptate POC. 5) By what date the systemic changes will be completed 5-20 was the process that led to the citation for this deficiency? ***The processes that led to the cited deficiency; ***The loss of a maintenance d/t Covid and the age of the face.	d rail void sible any or cility ekly his with ble ble ble 26-23 09/24/2023 ents What e he crew

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTII A. BUILDI B. WING		nstruction 02	(X3) DATE COMPL 02/28 /	ETED
PROVIDER OR SUPPLIE		52	225 W	DDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
ST HEALTHCARE SUMMARY (EACH DEFICIENT REGULATORY OF PARTICULATORY OF PART	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ons made with the tor on a tour of the facility on 2:15 p.m. and 3:42 p.m., the toed: ged identified as the west exit tutside the facility did not have reather travel surface to the mp leading to the public way rface where there were two tunges from 1 and ½ inches to tt. ge nearest to the Director of the following issues: ay concrete had been worn so to longer smooth and had and holes in it. tutside this entrance had not in a very long time and inches over the walkway the of only 18 inches on the	52	225 W DIANA	MORRIS ST	oint. ed the I not er y. t to nad orn aters oeen me over idth vay."	(X5) COMPLETION DATE
Director at 3:50 p.n	n., no additional information or provided contrary to this			The areas in question are not utilized by patient's or their farmembers. ***The facility is to file an FSE equivalency for this issue (the concrete areas of the ramp an the area to the west), to obtain approved equivalency. This will require a waiver for allotted time to repair this tag. (attached) ***Patients are being moved to one story section of the facility	S d n an	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	02	COMPL	
		15E667	B. WI	NG		02/28	72023
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
LVNIJID	CT LICAL THOADE				MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN	APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					temporarily for work to take pla		
					in the wood framed section of	ıne	
					facility. The FSES survey is in progre		
					Attaching documents.		
					The facility is filing for a waive	r to	
					ensure adequate time is given		
					fix the two areas of concrete.		
					2) How the facility will identify		
					other residents having the		
					potential to be affected and wh		
					corrective action will be taken	?	
					***The procedure(s) for	100	
					implementing an acceptable P for the deficiency cited?	OC	
					Although any patient may have	۵	
					had the potential to be affected		
					other patients were identified	u, 110	
					during or after the survey.		
					The areas in question are not		
					utilized by patient's or their far	nily	
					members.		
					The area was utilized by staff	for	
					smoking, until the rules of		
					smoking changed the distance		
					the smoker and the building to distance of 8 feet. Patients do		
					utilize the area. The area is als		
					not an entrance for vendors et		
					The procedure(s) for implement		
					an acceptable POC for the	3	
					deficiency cited?		
					The bush in front of the DON's	3	
					office has been trimmed back.		
					***The facility is to file an FSE		
					for this issue (the concrete are		
					of the ramp and the area to the	e	I

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west), to obtain an approved equivalency. This will require a waiver for allotted time to repair

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 02/28/2023
	ROVIDER OR SUPPLIE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The ramp itself (west exit): We were informed that the enthe ramp is required to be extended with concrete to eradicate the height changes were sited with this survey. ***The facility is to file an FSE with CMS for this issue to obtain approved equivalency. 3) What measures will be put place or what systemic chang will be made? ***The monitoring procedure the ensure the POC is effective and that the specific deficiency cite remains corrected and/or in compliance with the regulatory requirements? The area in question is not utilized by patient's or their farmembers, at all. These are also not near the main entrance to facility. The bush in front of the DON's office has been trimmed back ***The facility is to file an FSE equivalency for this issue to obtain an approved equivalen. The ramp itself (west exit): We were informed that the enthe ramp is required to be extended with concrete to eradicate the height changes were sited with this survey. Monitoring: The area in question is not utility patient's or their family	that Sain into es o nd ed y mily so the s . S cy. d of

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		15E667	B. W	ING		02/28	/2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	07.115.41.711.04.05				MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN	APOLIS, IN 46241		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
					members, at all. These are als	SO	
					not near the main entrance to		
					facility. The areas in question		
					also not used by vendors.		
					***The facility is to file an FSE	S	
					for this issue to obtain an	_	
					approved equivalency. This w	ill	
					require a waiver for allotted tin		
					repair this tag.		
					***Patients are being moved to	o the	
					one story section of the facility		
					temporarily so that repairs to		
					these concrete areas can be		
					made.		
					***The Maint. Director is		
					responsible for this project and	d to	
					monitor any other part of the		
					facility for hazards. Monitoring	of of	
					the facility for hazards will take		
					place weekly by the Maint.		
					Director and/or his designee.\	and	
					discussed with the LHFA.		
					4) How the corrective actions	will	
					be monitored and what quality		
					assurance program will be put		
					place; who will monitor? The t		
					of the person responsible for		
					implementing the acceptable		
					POC?		
					The bush in front of the DON's	5	
					office has been trimmed back.		
					***Patients are being moved to		
					one story section of the facility		
					temporarily so that repairs ma		
					done.	,	
					***The facility is to file an FSE	S	
					for this issue to obtain an	~	
					approved equivalency. This w	ill	
			1		i approvou ogurvulorioj. Tilio W		1

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require a waiver for allotted time to

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COMF	E SURVEY PLETED 3/2023
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP C V MORRIS ST NAPOLIS, IN 46241	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				repair this tag. (attached We were informed that the ramp is required to extended with concrete eradicate the height change were sited with this sumplements. The Maint. Director responsible for this promonitor any other part facility for hazards. Moreover, the facility for hazards place weekly by the M. Director and/or his designated with the LHI. The FSES survey is in Attaching documents. The title of the person for implementing an act POC is the Administrational and/or her designees.	t the end of be e to hanges that rvey. is bject and to of the conitoring of will take aint. signee.\ and FA. n progress. responsible cceptable tor/LHFA	
K 0321 SS=E Bldg. 02	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatoption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				

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EPARTMENT OF HEALTH AND HU	MAN SERVICES			FORM APPROVED
ENTERS FOR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>02</u>	COMPLETED
	15E667	B. Wl	NG	02/28/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF TROVIDER OR SUFFLIER			5225 W MORRIS ST	
LANGUEDOT LIEALTHOADE			INIDIANIA DOLLO INI 40044	

LYNHURST HEALTHCARE			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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
IAG	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 attic, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 5 staff and while working on the second-floor office area. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 at 12:17 p.m., the door in the business office area leading up to the attic did not have a self-closing device installed on it. The attic was being used for storage of cardboard boxes, plastic totes, and numerous combustible items and all four rooms were approximately 450 square feet in size and a hazardous area. Based on an interview	K 0321	0321 1) What action(s) will be accomplished for those residents found to have been affected? The processes that led to this deficiency being cited? No resident was identified to have been affected during this survey and the attic is not a patient common area, it is located near the upstairs offices. The areas in question are not utilized by patient's or their family members. The processes that led to this deficiency being cited: The age of the facility which has passed all prior Life Safety Code Survey's up until the present, or had been grandfathered in and using this attic for storage.	05/26/2023		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		A. BUILDING B. WING	02	COMPLETED 02/28/2023			
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 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	FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CO			
	at the time of the ob Director stated that cleaned up and a se the attic door as soo During the exit con Executive Director at 3:50 p.m., no add	oservations, the Maintenance he would have the area lf-closing device installed on on as he was able to do so. ference with the facility and the Maintenance Director litional information or evidence contrary to this deficient		***The attic has been decommissioned by FSES. T attic has been emptied and w longer be used for storage. The attic door has been locked and has a self closing appara The attic is also sprinkled. The attic door is locked. ***Patients are being moved if the one story building temporal until work is done. 2) How the facility will identify other residents having the potential to be affected and w corrective action will be taken ***The procedure for implement an acceptable POC for the citation? Although any patient may have had the potential to be affected during or after the survey. The procedure for implementiacceptable POC for this deficited: ***The attic door now has a selosing apparatus placed. The attic has been emptied a will no longer be used for storage. The attic has been decommissioned by FSES consultants. The attic has been decommissioned by FSES consultants. The attic has been decommissioned and will no longer be for storage. The attic door has been locked the areas in question are not utilized by patient's or their famembers.	ill no id tus. e nto arily / that ? enting / ed, no ing an iency elf nd rage. en used		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023		
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	***Patients are being moved in the one story building tempora to accommodate repairs to thi section of the facility. ***Monitoring procedure to enable facility remains in compliant Monitoring of the facility for hazards will take place weekly the Maint. Director and/or his designee and will be discusse with the Administrator., issues be corrected as applicable. Maintenance is responsible for monitoring and ensuring that in one stores anything in the attic space. 3) What measures will be put place or what systemic change will be made? ***The monitoring procedure the ensure the POC is effective and that the specific deficiency cite remains corrected and/or in compliance with the regulatory requirements? The attic door now has a self closing apparatus placed. The attic has been emptied and will longer be used for storage. Systemic Changes: ***The attic has been decommissioned by FSES. The attic has been emptied and will longer be used for storage. The attic door has been locked. ***Patients are being moved in the one story building temporato accommodate repairs to thi	arily, is sure noce: y by ed s will or no c into es		

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section of the facility.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COMP	E SURVEY PLETED 3/2023
	ROVIDER OR SUPPLIE		5225 W	ADDRESS, CITY, STATE, ZIP CO V MORRIS ST NAPOLIS, IN 46241	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				Monitoring of the facility hazards will take place of the Maint. Director and/ordesignee and will be diswith the Administrator., be corrected as applical ***Maintenance is responsion to the attic sparage of the person responsible implementing the acceptor of the acceptor of the person responsible implementing the acceptor of the acceptor of the person responsible implementing the acceptor of the acceptor of the sparage of the acceptor of the sparage of the acceptor of the sparage of the facility hazards will take place of the Maint. Director and/ordesignee and will be disposed in the acceptor of the sparage of the facility hazards will take place of the Maint. Director and/ordesignee and will be disposed in the designee and will be disposed in the acceptor of the sparage of the facility hazards will take place of the Maint. Director and/ordesignee and will be disposed in the designee and will be disposed in the designee and will be disposed in the acceptor and the designee and will be disposed in the acceptor and the designee and will be disposed in the acceptor and the designee and will be disposed in the acceptor and the accepto	weekly by or his scussed issues will ble. onsible for ores ce. ctions will quality be put into or the title le for stable a self d. (IS, per RM as been ger be used for has oved into ons will be Director sign for Storage. sible for ores ce and ce is kept or his or hi	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING <u>02</u>		COMPLETED 02/28/2023	
		15E667	B. WIN	1Ú		02/28/	2023
	PROVIDER OR SUPPLIER			5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					with the Administrator., issues be corrected. ***The title of the person responsible for implementing a acceptable POC is the Administrator/LHFA and/ or he designees if applicable.	an	
					5) By what date the systemic changes will be completed 5-26-23		
K 0331 SS=E Bldg. 02	exposed interior s as fixed or movab columns, and have Class A or Class E	ceiling Finish eiling finishes, including urfaces of buildings such le walls, partitions, e a flame spread rating of 3. The reduction in class of sprinkler system as 8.1 is permitted. 3.3.2					
	failed to ensure 1 of complete interior fir of Class A or Class LSC 101 10.2.3.4 st tested in accordance Method of Test of S Characteristics of B grouped in the follo with their flame spr (a) Class A Interior	on and interview, the facility I attic was provided with a nish with a flame spread rating B for a sprinklered facility. Lates products required to be with NFPA 255, Standard Surface Burning uilding Materials, shall be wing classes in accordance lead and smoke development. Wall and Ceiling Finish. Flame development 0-450. Includes	K 03	31	0331 1) What action(s) will be accomplished for those reside found to have been affected? processes that led to this deficiency being cited? The process that led to this citation? The age of the facility which has passed all prior Life Safety Code Survey's up until present, or had been grandfathered in.	The /	09/24/2023

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OMP NO. 0038, 039

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/28/2023 15E667 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5225 W MORRIS ST LYNHURST HEALTHCARE INDIANAPOLIS, IN 46241 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE any material classified at 25 or less on the flame The facility was being surveyed as spread test scale and 450 or less on the smoke test a three story building however, scale. Any element thereof, when so tested, shall the attic area has been not continue to propagate fire. decommissioned by the FSES (b) Class B Interior Wall and Ceiling Finish. Flame consultant and there are no spread 26-75; smoke development 0-450. Includes patients in the two story structure any material classified at more than 25 but not at this time. The facility will in the more than 75 on the flame spread test scale and future be surveyed by FSES as a 450 or less on the smoke test scale. two story structure and not a three (c) Class C Interior Wall and Ceiling Finish. Flame story structure. This two story spread 76-200; smoke development 0-450. structure will remain off limits to Includes any material classified at more than 75 patients and non office staff (but not more than 200 on the flame spread test excluding vendors) until scale and 450 or less on the smoke test scale. construction is complete and the This deficient practice could affect as many as 2 facility passes the FSES. staff. No resident was identified to have been affected during this survey. Findings include: The attic and the basement are sprinkled. (every floor is sprinkled) Based on observations made with the These areas of concern are not Maintenance Director on a tour of the facility on patient common areas nor are 02/28/23 at 1:42 p.m., all three rooms and the they used by patients and visitors common area in the attic was covered in a painted fiber board that was part of the original house. The Maint. Supervisor will perform The facility could not provide a flame spread a safety check on both the rating document showing that it met the basement and attic, daily and will requirements for class A or B flame spread rating. report any issues immediately to Based on interview at the time of the the Administrator; to be corrected observations, the Maintenance Director stated as applicable. that he would see what he could do about finding The attic door has been locked a flame spread rating for the fiber board located and the attic has been emptied. therein. During the exit conference with the facility ***The attic has been Executive Director and the Maintenance Director decommissioned by FSES at 3:50 p.m., no additional information or evidence consultants. The attic has been could be provided contrary to this deficient emptied and will no longer be used finding. for storage. The attic door has been locked. 3.1-19(b) ***Patients have been moved into

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the one story building temporarily ,to allow construction to be

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023
	ROVIDER OR SUPPLIER		5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				complete. ***No patients will occupy the 2 story structure a fire door that meets regulation separates the two buildings.	
				***These corrective actions we and will be monitored by the Maint. Director and the Administrator to remain in compliance with regulatory requirements. *** The attic door will have a se for No Admittance and No Storage. ***the fire door that separates one story building from the twe story building, that meets code will have a no admittance sign be kept closed. Extra fire extinguishers have be ordered. Two more smoke/fire alarms have also been placed the basement and the attic are the story will be corrected as applicable. The FSES survey is in progre	the o e, n and peen e l in eas. vill be tt. c, to
				2) How the facility will identify other residents having the potential to be affected and w corrective action will be taken ***The procedure(s) for implementing an acceptable F for the deficiency cited? Although any patient may hav had the potential to be affected other patients were identified during or after the survey.	POC e

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 02/28/2023
	ROVIDER OR SUPPLIE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE
				The attic and the baseme sprinkled. (every floor is some section of the facility have moved into the one story stemporarily, to accommod repairs. ***These corrective action and will be monitored by the Maint. Director and the Administrator. ***The attic has been decommissioned by FSES consultants. The attic has emptied and will no longer for storage. ***The attic door will have for No Admittance. The attic locked. ***The FSES survey is in progress. 3) What measures will be place or what systemic chewill be made? ***The monitoring procedures are the POC is effective that the specific deficiency remains corrected and/or compliance with the regular requirements? ***Patients in the two story section of the facility have moved into the one story stemporarily, to accommod repairs. ***These corrective action monitored by the Maint. Duand the Administrator, to be a story stemporarily, to accommod repairs.	prinkled) y been sections late ss were he S been r be used e a sign tic door put into langes ure to live and ly cited in latory y been sections late las will be lirector

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PARTMENT OF HEALTH AND HUN	FORM APP		
NTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 09
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND DLAN OF CODDECTION	IDENTIFICATION NUMBER	A DIJII DING 02	COMPLETED

	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	r í	JILDING	ONSTRUCTION 02	(X3) DATE COMPI 02/28	
	ROVIDER OR SUPPLIEI ST HEALTHCARE			5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON O BE OPRIATE	(X5) COMPLETION DATE
AND REGULATORI OR LSC.				corrected as applicable. *** The attic door will have for No Admittance and it is locked. ***The attic has been decommissioned by FSES consultants. (see attached The attic has been emptied will no longer be used for see the seed for seed fo	letter),		
					4) How the corrective action be monitored and what quassurance program will be place; who will monitor? The of the person responsible from the process of the person responsible from the process of the process of the person responsible from the process of the person responsible from the process of t	ality put into ne title for ble at are brinkled) and brinkled sible port any	
					***Patients in the two story section of the facility have moved into the one story s temporarily, to accommodarepairs. ***These corrective actions and will be monitored by the Maint. Director and the Administrator. *** The attic door will have for No Admittance and No and be locked.	been ections ate s were ne a sign	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE COMPI 02/28	LETED
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP CO V MORRIS ST NAPOLIS, IN 46241	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				The process that led to citation? The age of the facility (passed all Life Safety sthe present time) and The facility was being stather attic area has been decommissioned by FS attic has been emptied longer be used for storattic will not be used. There are no patients in story structure at this times to patients and non offit excluding vendors) untias applicable are compute facility passes the F survey, and a fire door regulations, separates sections of the building kept closed. 5) By what date the systhanges will be completed.	that has surveys until surveyed as owever, SES. The and will no age. The in the two me. ain off limits ce staff (il all repairs olete and FSES that meets the two s, that is	
K 0353 SS=F Bldg. 02	Sprinkler System - Automatic sprinkler are inspected, test accordance with North Inspection, Testing Water-based Fire Records of system inspection and test secure location and secure secure sprinkler inspection and test secure secure sprinkler inspection and test secure secure sprinkler inspection and test secure sprinkler inspection and test secure secure sprinkler inspection and test secure secure sprinkler inspection and test secure sec	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a readily available. system last checked				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/28/2023 15E667 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5225 W MORRIS ST LYNHURST HEALTHCARE INDIANAPOLIS, IN 46241 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility K 0353 0353 05/26/2023 failed to ensure 1 of 1 automatic sprinkler piping 1) What action(s) will be systems was examined for internal obstructions accomplished for those residents where conditions exist that could cause found to have been affected? obstructed piping as required by NFPA 25, 2011 ***The processes that led to this Edition, the Standards for the Inspection, Testing deficiency being cited? and Maintenance of Water-Based Fire Protection No resident was identified to have Systems, Section 14.2.1. Section 14.2.1 states, been affected during this survey. "except as discussed in 14.2.1.1 and 14.2.1.4 an Please see facility plan below. inspection of piping and branch line conditions The processes that led to this shall be conducted every 5 years by opening a deficiency being cited? flushing connection at the end of one main and by documentation was misplaced by removing a sprinkler toward the end of one branch the Maint. Director. line for the purpose of inspecting for the presence The vendor that inspects for this of foreign organic and inorganic material. This facility) has sent document noting deficient practice affects all residents, staff, and that interior pipe inspection was visitors in the facility. completed as of June 30th, 2019. (see attached) and the next Findings include: inspection is not due at this time. 2) How the facility will identify Based on record review with the Maintenance other residents having the Director on 02/28/23 at 12:00 p.m., the sprinkler potential to be affected and what systems inspection document titled "Sprinkler corrective action will be taken? System Inspection Form" dated 09/14/2022 and ***The procedure(s) for 12/14/2022 indicated the internal pipe implementing an acceptable POC investigation was past due. Based on an interview for the deficiency cited? with the Maintenance Director at the time of Although any patient may have record review, he stated that an internal pipe had the potential to be affected, no investigation has not yet been scheduled as he other patients were identified was unaware it was past due. During the exit during or after the survey. conference with the facility Executive Director and Per survey: "...resident in room #6

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/28/2023 15E667 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5225 W MORRIS ST INDIANAPOLIS, IN 46241 LYNHURST HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the Maintenance Director at 3:50 p.m., no had a television antenna hanging additional information or evidence could be from the sprinkler piping above his provided contrary to this deficient finding. bed." The patient antenna was removed 3.1-19(b) from the pipes and reasonings were explained to the patient. 2) Based on record review and interview, the Each room was checked, to facility failed to maintain 1 of 1 sprinkler system in ensure this had not occurred in accordance with LSC 9.7.5. LSC 9.7.5 requires all any other room. (3-13-23) automatic sprinkler systems shall be inspected The standards for inspection, and maintained in accordance with NFPA 25, testing and maintaining the fire Standard for the Inspection, Testing, and systems, will be maintained in Maintenance of Water-Based Fire Protection the maintenance Fire Book and Systems. NFPA 25, 2011 edition, 5.2.2.2 requires updated as necessary, to be sprinkler piping shall not be subjected to external readily available for Life Safety loads by materials either resting on the pipe or inspectors. hung from the pipe. This deficient practice could The vendor that inspects for this affect up to 12 residents, 4 staff, and 1 visitors. facility has sent document noting that interior pipe inspection was Findings include: completed as of June 30th, 2019. (see attached) and the next Based on observations made with the inspection is not due at this time. Maintenance Director on a tour of the facility on This information was placed in the 02/28/23 at 1:42 p.m., a resident in room #6 had a Maint, book. television antenna hanging from the sprinkler The procedure piping above his bed. Based in an interview at the A weekly Maint. round procedure time of the observation, the Maintenance Director has also been added for the Maint. acknowledged that sprinkler pipe was indeed Director and/or his designee to supporting the resident's television antenna and assess the building for hazards stated that he would have it taken care of as soon and these rounds will be as he could. During the exit conference with the discussed with the Administrator. facility Executive Director and the Maintenance Any noted hazards will be fixed. Director at 3:50 p.m., no additional information or 3) What measures will be put into evidence could be provided contrary to this place or what systemic changes deficient finding. will be made? ***The monitoring procedure to 3.1-19(b) ensure the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory

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	T OF HEALTH AND HU				FORM APPROVED	
	R MEDICARE & MEDIC	•			OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED	
		15E667	B. WING		02/28/2023	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
			5225 V	V MORRIS ST		
LYNHUR	ST HEALTHCARE		INDIA	NAPOLIS, IN 46241		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				requirements?		
				The vendor that inspects for the		
				facility has sent document noti	ing	
				that interior pipe inspection wa		
				completed as of June 30th, 20	119.	
				(see attached) and the next		
				inspection is not due at this tim	ı	
				The above named company w	'ill	
				share all information with the		
				Administrator via email, in hop		
				to avoid any lack of documents	ation	
				for our survey members.		
				The patient antenna was remo		
				from the pipes and reasonings	;	
				were explained to the patient.		
				Each room was checked, to		
				ensure this had not occurred in	n	
				any other room. (3-13-23)		
				Systemic Change/Monitoring		
				The rooms will be checked		
				monthly by Maint. Director, for		
				compliance, to be readily avail		
				for Life Safety inspectors. Wee		
				"hazard" rounds have also bee	en	
				added to the Maint. Director		
				schedule.		
				The standards for inspection,		
				testing and maintaining the fire	ı	
				systems , will be maintained in	ı	
				the maintenance Fire Book by		
			1	Maint. Director and updated as	S	

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POC?

necessary.

4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? ***The title of the person responsible for implementing the acceptable

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE COMP 02/28	
	ROVIDER OR SUPPLIE ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP C V MORRIS ST NAPOLIS, IN 46241	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				The patient antenna we from the pipes and real were explained to the peach room was checked ensure this had not occur any other room. (3-13-Quality Assurance The rooms will be checked monthly for compliance Director. Weekly "haza have also been added Maint. Director schedu Nursing and housekee will be re-educated to are aware that nothing hanging on the pipes at the rooms orderly and The Maint. Director and Admin (and or her desidiscuss findings re to sin the am meeting or in office. The standards for inspecting and maintaining systems, will be mainted the maintenance Fire Eupdated as necessary. The vendor that inspecting and the inspection is not due at (this is also denoted by date on the pipes in quention of the above named completed and plack of dofor our survey member	sonings patient. ed, to curred in -23) cked e by Maint. ard" rounds to the alle. eping staff ensure they is to be and keeping neat. and the signee) will such, either a the Admin. ection, g the fire tained in Book and cts for this nent noting ction was 30th, 2019. a next t this time. y the tag uestion.) npany will rith the l, in hopes cumentation	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF I	PROVIDER OR SUPPLIER	- }		ADDRESS, CITY, STATE, ZIP COD	
LYNHUR	RST HEALTHCARE			V MORRIS ST NAPOLIS, IN 46241	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				The title of the person respons for implementing the acceptate POC is the Administrator. and her designee. 5) By what date the systemic changes will be completed 5-2	ole or
K 0363	NFPA 101				
SS=E	Corridor - Doors				
Bldg. 02	Corridor - Doors				
J	_	corridor openings in other			
		losures of vertical openings,			
	exits, or hazardou	s areas resist the passage			
	of smoke and are	made of 1 3/4 inch			
		wood or other material			
	1 -	ng fire for at least 20			
		fully sprinklered smoke			
		e only required to resist the			
		e. Corridor doors and doors			
	to rooms containir	_			
		rials have positive latching atches are prohibited by			
		hese requirements do not			
	_	spaces that do not contain			
	flammable or com	- T			
		en bottom of door and floor			
	covering is not ex	ceeding 1 inch. Powered			
	_	vith 7.2.1.9 are permissible			
		device capable of keeping			
	the door closed w	hen a force of 5 lbf is			
	applied. There is	no impediment to the			
	_	rs. Hold open devices that			
		door is pushed or pulled are			
	1 -	ed protective plates of			
	1	re permitted. Dutch doors			
	_	6 are permitted. Door			
		beled and made of steel or			
		compliance with 8.3,			
	unless the smoke				
	sprinklered. Fixed	fire window assemblies are			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02		COMPLETED	
		15E667	B. W	ING		02/28	2023	
	OF PROVIDER OR SUPPLIER JRST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rational devices, etc. Based on observational failed to ensure 1 on completely resist the deficient practice control or residents, 4 staff, and Findings include: Based on observational Maintenance Directional failed to ensure 1 on completely resist the deficient practice of residents, 4 staff, and Findings include: Based on observational Maintenance Direction for the door; therefore, Based on an intervitobservation, the Macknowledged the land have it fixed as soon conference with the Maintenance Direction for material fixed as soon conference with the difference of glassical fixed as soon conference with the Maintenance Direction for material fixed as soon conference with the difference of glassical fixed as soon conference of glassical fixed as soon confere		K 0	363	0363 1) What action(s) will be accomplished for those reside found to have been affected? ***The processes that led to the deficiency being cited? No resident was identified to he been affected during the surve but all could possibly be affect. Per survey: "the corridor do the furnace and hot water hear room near the kitchen had the door handle replaced. There way through the door; therefore, this door was not so tight." The processes that led to this deficiency being cited was a replacement door handles that 3/8th inch holes. This was repaired immediately 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? ***The procedure(s) for implementing an acceptable Pror the deficiency cited?	nis nave ey eed. or to ter was a II noke t left /.	05/26/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	02	COMPLETED	
		15E667	B. W	'ING		02/28/	2023
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					/ MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN	IAPOLIS, IN 46241		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Although any patient may hav		
					had the potential to be affecte	d, no	
					other patients were identified		
					during or after the survey.		
					Maint. fixed the doorknob on 3/10/23.		
					The door handle, when placed	4	
					originally, did not completely o		
					the area that the handle enter		
					The approx. 1/8th inch holes		
					(times 4), have been sealed.		
					The procedure(s) for impleme	nting	
					an acceptable POC for the	-	
					deficiency cited?		
					A weekly Maint. round proced	dure	
					has also been added for the N		
					Director and/or his designee to		
					assess the building for hazard	ls	
					and these rounds will be		
					discussed with the Administra	tor.	
					3) What measures will be put	into	
					place or what systemic chang		
					will be made?***The monitorir		
					procedure to ensure the POC	-	
					effective and that the specific		
					deficiency cited remains corre	cted	
					and/or in compliance with the		
					regulatory requirements?		
					The door knob has been fixed	d.	
					The facility follows state and		
					federal guidelines for emerger	псу	
					preparedness and staff		
					re-education. (all staff, all		
					departments)		
					Systemic Changes/Procedure	and	
					Monitoring		
					On Maint. rounds, Maint. will		
					check all door handles in the		
					facility, to ensure proper fit; or	ıa	

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023
	ROVIDER OR SUPPLIER ST HEALTHCARE	R	5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
				monthly basis. A weekly Maint. round has als been added for the Maint. Dire and/or his designee to assess building for hazards. Issues will be brought to the Administrators attention immediately. 4) How the corrective actions be monitored and what quality assurance program will be put place; who will monitor? ***Thittle of the person responsible implementing the acceptable POC? The facility follows state and federal guidelines for emerger preparedness and staff re-education. (all staff, all departments) Quality Assurance and Monito On the Maint. monthly rounds, Maint. will check all door hand in the facility, to ensure proper A weekly Maint. round has als been added for the Maint. Dire and/or his designee to assess building for hazards and these rounds will be discussed with a Administrator. Issues will be brought to the Administrators attention immediately. ***The title of the person responsible for implementing to acceptable POC is the Administrator and or her designs of the systemic changes will be completed 5-20.	will into e for ring les fit. o ector the ethe the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIEF			5225 W	DDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
K 0522 SS=F Bldg. 02	NFPA 101 HVAC - Any Heat HVAC - Any Heat Any heating device heating plant, is d combustible mate device, and has a and shut down eq excessive temper fuel fired, the devi * is chimney or ve * takes air for com * provides for a co from occupied are 19.5.2.2 Based on observation failed to ensure 2 or equipment was in u combustion air from containing fuel fire practice could creat carbon monoxide w problems for as man the area of these roo Findings include: Based on observation Maintenance Direct 02/28/23 between 1 following was notice a) The basement ha located in it. This w outside air source to within the area. b) The first-floor fuel dining room had a r furnace located insi room, no air intake	ing Device e, other than a central esigned and installed so rials cannot be ignited by safety feature to stop fuel uipment if there is ature or ignition failure. If ce also: nt connected. abustion from outside. abustion from outside. and interview, the facility f 2 rooms where fuel fired se were provided with intake the outside for rooms d equipment. This deficient e an atmosphere rich with which could cause physical my as 16 residents and 4 staff in the outside with the cor on a tour of the facility on 2:15 p.m. and 3:42 p.m., the	K 052		0522 1) What action(s) will be accomplished for those reside found to have been affected? ***The processes that led to the deficiency being cited? No resident was identified to he been affected during this surviculational three possibility is that resident's could be affected. Based on observations made the Maintenance Director on a of the facility on 02/28/23 betw 12:15 p.m. and 3:42 p.m., the following was noticed: a) The basement had a natural gas water heater located in it. water heater did not have an outside air source to reduce the carbon monoxide within the arb) The first-floor furnace room the main dining room had a natural gas water heater and furnace located inside. Upon inspection this room, no air intake from the	his nave ey all with a tour veen This ne rea. n near atural	05/26/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	O2	(X3) DATE COMPL 02/28/	ETED
	PROVIDER OR SUPPLIEF	8	5225 V	ADDRESS, CITY, STATE, ZIP CO W MORRIS ST NAPOLIS, IN 46241	D .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	Maintenance Direct locate or identify ar either of the aforem exit conference with and the Maintenance additional informat	at the time of observation, the for agreed that he could not by source of outside air in mentioned rooms. During the in the facility Executive Director to Director at 3:50 p.m., no ion or evidence could be to this deficient finding.		outside could be located. The processes that led to citation are: ***the air intake pipe was marked as such. It has to marked (see attached possessed the air intake in the base not there. This has been and a pipe in furnace room has been the air intake pipe. A weekly Maint. round I been added for the Main and/or his designee to a building for hazards and rounds will be discussed Administrator, with corresponding potential to be affected a corrective action will be ***The procedure(s) for implementing an accept for the deficiency cited? Although any patient may had the potential to be a other patients were idented during or after the survey. Per survey: "The base natural gas water heater did an outside air source to the carbon monoxide with area. b) The first-floor furnace the main dining room had gas water heater and furnace was marked to the carbon monoxide with a swater heater and furnace was marked as water heater and furnace was water heater and fu	as not peen hotos) and pement was a fixed. It in the tagged as tagged	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		15E667	B. WING 02/28/2023			
NAME OF F	PROVIDER OR SUPPLIEI	· }		ADDRESS, CITY, STATE, ZIP COD		
				W MORRIS ST		
LYNHUR	RST HEALTHCARE		INDIAN	IAPOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	located inside. Upon inspection this room, no air intake " In the basement, a vent has be placed for air intake. The first floor furnace room has air intake pipe already in placed. However, the air intake pipe who not marked as such. It has be marked (see attached photos) ***The procedure(s) for implementing an acceptable of the deficiency cited were the unidentified intake pie in the furnace room, that is now marked. Secondly, the air intain the basement was not there has been installed. 3) What measures will be put place or what systemic change will be made? ***The monitori procedure to ensure the POC effective and that the specific deficiency cited remains correand/or in compliance with the regulatory requirements? In the basement a vent has be placed for air intake. The first floor furnace room has air intake pipe already in placed. However, the air intake pipe who marked as such. systemic change The pipe has been marked(so attached photos) The monitoring procedure to ensure the POC is effective as	DATE On of een as an e. vas een O OC ne ke e and into es ng is octed een as an e. vas ee	
				that the specific deficiency cite remains corrected and/or in		

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 02/28/2023
	ROVIDER OR SUPPLIEI ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) To ensure compliancy, a wee	ekly
				Maint. round has also been ad for the Maint. Director and/or designee to assess the buildir for hazards and these rounds be discussed with the Administrator.	nis ng
				4) How the corrective actions be monitored and what quality assurance program will be purplace; who will monitor? ***The title of the person responsible implementing the acceptable POC?	t into e
				In the basement a vent has be placed for air intake. The first floor furnace room had air intake pipe already in placed However, the air intake pipe who the marked as such. Systemic change	as an e.
				The first floor furnace room had air intake pipe already in place has been marked(see attached photos) The facility follows state and federal guidelines: as noted in maint, book.	e. It d
				Maint. Director is in charge of monitoring and record keeping A weekly Maint. round has a been added for the Maint. Director and/or his designee to assess building for hazards and these	g. Iso ector the
				rounds will be discussed with Administrator. The title of the person responsor implementing the acceptate POC is the Administrator, and	sible ole

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
					her designee.		
					5) By what date the systemic changes will be completed 5-	26-23	
K 0712 SS=F Bldg. 02	alarm signal and conditions. Fire d and unexpected t conditions, at least The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record refailed to conduct of 4 quarters. LSC conducted quarters conditions. This defand residents. Findings include: During record review Director on 02/28/2 p.m. the following a) The fire drills for drills documented a sheet, just different b) Four of the 12 find no time docume c) All of the fire drills drive the fire drive the conditions of the fire drive days and the fire drive documented a sheet, just different b) Four of the 12 find no time docume c) All of the fire drive the conditions of the fire drive dr	ay be used instead of 19.7.1.7 view and interview, the facility omplete quarterly fire drills for 4 19.7.1.6 requires drills to be y on each shift under varied ficient practice affects all staff ew with the Maintenance 23 between 9:10 a.m. and 12:10 was noted: r all four quarters had multiple as being complete on the same times. re drills submitted for review ented for the drill. ills submitted for review on the neld at 3:30 p.m. and therefore	K 071	12	0712 1) What action(s) will be accomplished for those reside found to have been affected? ***The processes that led to the deficiency being cited? Per survey: "During record rewith the Maintenance Directorous, 2/28/23 between 9:10 a.m. at 12:10 p.m. the following was noted: a) The fire drills for all four quith ad multiple drills documented being complete on the same sheet, just different times. b) Four of the 12 fire drills submitted for review had no tidocumented for the drill. c) All of the fire drills submitter review on the second shift we	his view r on and arters d as	05/26/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 02/28/2023
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	d) All of the fire dri third shift were held times were not varie e) There was no do fourth quarter (Octo December) of 2022 Based on interview Maintenance Direct was no additional a documentation avai and date of this sur- conference with the the Maintenance Di additional informati	Ils submitted for review on the d at 11:30 p.m. and therefore the ed. cumentation available for a ober, November, and on the first shift. during record review, the for acknowledged that there wailable fire drill lable for review as of the time		held at 3:30 p.m. and therefore times were not varied. d) All of the fire drills submitted review on the third shift were at 11:30 p.m. and therefore the times were not varied." No resident was identified to been affected during or after survey although all residents have been affected. The processes that led to this deficiency being cited; Maintenance possibly unfamily with the regulations. 2) How the facility will identify other residents having the potential to be affected and we corrective action will be taken ***The procedure(s) for implementing an acceptable for the deficiency cited? Although any patient may have had the potential to be affected during the survey. The procedure(s) for implementant to be affected during the survey. The procedure(s) for implementant acceptable POC for the deficiency cited? The facility had the correct amount of fire drills. The shift overlap (1st, 2nd and 3rd). The Maint. Director used one she both shifts during the overlap This practice has been stopp Maint. Director is now using one sheet for each shift. 3) What measures will be purplace or what systemic change will be made?	re the ed for held he have this could siliar y what he? POC ve hed, no henting the held he he held he have this could siliar he held held held held held held held h

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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE LYNHURST HEALTHCARE STREET ADDRESS, CITY, STATE, ZIP COD \$225 W MORRIS ST INDIANAPOLIS, IN 46241 D PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION **The monitoring procedure to ensure the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements? The facility had the correct amount of fire drills. The shifts overlap (1st, 2nd and 370). The Maint, Director used one sheet for both shifts during the overlap. This practice has been stopped, He is now using one sheet for each shift. Each fire drill will be placed on a separate dire drills will be monitored monthly by the Maintenance Director and /or the Administrator. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? **The title of the person responsible for implementing the acceptable POC? The facility had the correct amount of fire drills. The shifts overlap, This practice has been stopped. He is now using one sheet for each shift. Each fire drill will be placed on a separate dire drills will be monitored monthly by the Maintenance Director and /or the Administrator. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? **The title of the person responsible for implementing the acceptable POC? The facility had the correct amount of fire drills. The shifts overlap (1st, 2nd and 370), The Maint, Director used one sheet for both shifts during the overlap. This practice has been stopped.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
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both shifts during the overlap. This practice has been stopped.					overlap (1st, 2nd and 3rd). Th	e	
practice has been stopped.							
					-	This	
					1		
Each fire drill will be placed on a					•	n a	
separate document.					1	,	
The Maint. Director is in charge of					1	·	
monitoring fire drills and getting them done correctly. He is now					_	_	

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Event ID:

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using one sheet for each shift.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MUI A. BUII B. WIN	LDING	nstruction 02	(X3) DATE COMPL 02/28 /	ETED
	PROVIDER OR SUPPLIER			5225 W	DDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					The documentation for separa fire drills will be monitored moby the Maintenance Director a for the Administrator. The title of the person respons for implementing the acceptal POC is the Administrator and Maint. Director.	onthly and sible ole	
					5) By what date the systemic changes will be completed 5-2	26-23	
K 0741 SS=E Bldg. 02	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care a smoking is prohibit prominently place secondary signs was moking shall not (3) Smoking by paresponsible shall level (4) The requirement apply where the parent supervision. (5) Ashtrays of not safe design shall level where smoking is	ns shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is do in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are do at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Into f 18.7.4(3) shall not attent is under direct incombustible material and be provided in all areas					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	02	COMPLETED		
		15E667	B. W	ING		02/28/	02/28/2023	
NAME OF B	AD CLUBED OD CLUBELIED			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>		5225 W	/ MORRIS ST			
LYNHUR	ST HEALTHCARE			INDIAN	IAPOLIS, IN 46241			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ashtrays can be emptied						
		ailable to all areas where						
	smoking is permitt	ied.						
	18.7.4, 19.7.4	an and interview the facility	17.0	7.41	0744		05/06/0000	
		on and interview, the facility	K 0	/41	0741		05/26/2023	
	-	htrays and metal containers ver devices into which			What action(s) will be accomplished for those reside	nte		
	_				accomplished for those reside found to have been affected?	iilS		
		ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor area where smoking is permitted. This deficient practice could affect as many as 12 residents, 4			***The processes that led to the	nie		
					deficiency being cited?	li o		
					No resident was identified to h	nave		
	staff and 1 visitor using the designated smoking area.				been affected during survey.	lavc		
					Cigarette butts are to be clear	ned		
	arca.				up.	.04		
	Findings include:				The processes that led to this			
	Ü				deficiency being cited are pos			
	Based on observation	ons made with the			patients with cognitive decline	-		
	Maintenance Direct	or on a tour of the facility on			diagnosis, not utilizing the			
	02/28/23 between 1	2:15 p.m. and 3:42 p.m., the			provided ashtrays and fire			
	following was notic	eed:			resistant ashtrays that have co	ome		
	a) The facilities des	ignated smoking area had five			up missing.			
	-	scattered around it. Each of			The large plastic barrel has be	een		
		d a small amount of water and			moved out of the smoking are	a.		
	~	butts contained in it.			Fire resistant ashtrays have b			
	1	oking area had a 55-gallon			provided in the spaces in ques	stion.		
	-	ner located in it. This container						
		ed with miscellaneous trash			2) How the facility will identify	1		
	O 1 1	combustible materials.			other residents having the			
	_	this trash were around 200 to			potential to be affected and w			
	300 cigarette butts.	ti at			corrective action will be taken	?		
		side the emergency exit nearest			***The procedure(s) for	200		
		ursing's office was a small			implementing an acceptable F	JOC		
		oximately 50 cigarette butts			for the deficiency cited?			
		e was also well over 50 vn into the rock garden			Although any patient may hav			
	immediately outside	_			had the potential to be affecte	u, no		
	•	lesignated smoking area)			other patients were identified			
	Based on interview				during or after the survey.	conc		
		intenance Director stated that			Unfortunately the proper ash or had been removed from the	Jaiis		
		outts picked up and the						
	ne would have the t	outes picked up and the	ı		smoking areas.		I	

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	soon as he was able conference with the the Maintenance Di additional informati	s removed from the area as to do so. During the exit facility Executive Director and rector at 3:50 p.m., no on or evidence could be this deficient finding.		These have been ordered and be replaced. (see example pherice resistant ashtrays have be provided in the spaces in questive provided in the spaces in questive procedure (s) for implement an acceptable POC for the deficiency cited, was to remove the cigarette debris off the grown the area and provide fire resistant ashtrays; this has be accomplished. The Maint. Director has been informed that this area is to be checked frequently to ensure cigarette debris is kept off the ground. 3) What measures will be put place or what systemic change will be made? ***The monitoring procedure to ensure the POC effective and that the specific deficiency cited remains correand/or in compliance with the regulatory requirements? Per survey: "a) The facilities designated smoking area had one-gallon tin cans scattered around it. Each of these cans contained a small amount of wand around 50 cigarette butts contained in it. b) The facilities smoking area a 55-gallon plastic trash contained in it. This container was one-quarter filled with miscellaneous trash including paper and combustible material intermingled within this trash with the second combustible material intermingled within this trash with the second combustible material intermingled within this trash with the second combustible material intermingled within this trash with the second combustible material intermingled within this trash with the second combustible material intermingled within this trash within this trash.	oto) peen stion. nting /e pund, el pen into es ng is poted five vater had ainer as als.

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EPARTMENT OF HEALTH AND HUN	MAN SERVICES				FOF	FORM APPROVED		
ENTERS FOR MEDICARE & MEDIC.	AID SERVICES				OM	B NO. 093	38-039	
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED			
	15E667	B. WING			02/28/2023			
			1					
NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD				
THE STATE OF THE VIBER STATES	•		5225 W MORRIS ST					
LYNHURST HEALTHCARE			INDIANAPOLIS. IN 46241					
				·				

LYNHUR	ST HEALTHCARE	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	
IAU	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	around 200 to 300 cigarette butts. c) Immediately outside the emergency exit nearest to the Director of Nursing's office was a small plastic jar with approximately 50 cigarette butts stuffed into it. There was also well over 50 cigarette butts thrown into the rock garden immediately outside the door." Unfortunately the proper ash cans had been removed from the smoking areas. These ash cans were marked: "For Butts Only" ***Maint. is to check the area frequently to remove any cigarette debris off the ground, remove the plastic waste barrel from the area and provide fire resistant ashtrays, to ensure the facility remains in compliance with the regulatory requirements. Issues are to be discussed with the Administrator. Fire resistant ashtrays have been provided in the spaces in question.	DATE	
			4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? ***The title of the person responsible for implementing the acceptable POC? Unfortunately the proper ash cans had been removed from the smoking areas. These ash cans		
			were marked : "For Butts Only" Fire resistant ashtrays have been provided in the spaces in question.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		A. BUILDING <u>02</u>		(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP COD 225 W MORRIS ST	
LYNHUR	RST HEALTHCARE		IN	NDIANAPOLIS, IN 46241	
(X4) ID		STATEMENT OF DEFICIENCIE	П	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	, and the second	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRE TA	CFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION DATE
				Maint. Director has been requested to check the outsismoking area at least bi-weet including picking up cigarette waste and trash receptacles. The title of the person responsor implementing the accepta POC would be the Administrand/or her designee. 5) By what date the systemic changes will be completed 5	ekly, e . nsible able eator
K 0781 SS=E Bldg. 02	prohibited in all he except, unless use employee areas w do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation failed to ensure 1 or not used in the facility		K 0781	 What action(s) will be accomplished for those residence found to have been affected. ***The processes that led to 	?
	02/28/23 between 1 following was notic a) While the facility portable space heater following: 1) Space heaters	or on a tour of the facility on 2:15 p.m. and 3:42 p.m., the		deficiency being cited? Although any patient may hat had the potential to be affect other patients were identified during the survey. All areas in the facility were checked and any space heat removed. The processes that led to this deficiency being cited possible was the Director of Nursing Services being unaware of the	ted, no d ter s oly

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>		COMPLETED	
	15E667		B. WING 02/28/20		/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			MORRIS ST		
LYNHUR	ST HEALTHCARE				APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ement can not be above 212			regulation that included her o	ffice.	
	degrees Fahrenheit.						
		pace heater must have an			How the facility will identif	У	
	anti-tip device.				other residents having the		
	Based on interview				potential to be affected and w		
		cility Administrator stated			corrective action will be taker	1?	
	1	ow portable space heaters in			***The procedure(s) for		
	U	ere was one in the Activities			implementing an acceptable	POC	
		review was taking place.			for the deficiency cited?		
	_	ference with the facility			Although any patient may ha		
		and the Maintenance Director			had the potential to be affecte		
	_	litional information or evidence			other patients were identified		
	_	contrary to this deficient			during the survey.		
	finding.				A "fireplace" electric heater r		
					was in the activity room. This	i	
	3.1-19(b)				model has no cord (it is not		
					useable). Activities Director s		
					that she uses the "fireplace",		
					replica when she decorates f	or a	
					holiday.		
					All areas in the facility were		
					checked and any space heat	er	
					removed.		
					The procedure(s) for implement	enting	
					an acceptable POC for the		
					deficiency cited:		
					Monitoring of the facility for		
					hazards will take place week		
					the Maint. Director and/or his		
				designee and these rounds will b			
					discussed with the Administra	ator.	
					2) \//bat massaures	t into	
					3) What measures will be put		
					place or what systemic chang	-	
					will be made? ***The monitor	-	
					procedure to ensure the POC		
					effective and that the specific		
					deficiency cited remains corre		
					and/or in compliance with the	,	
			1		regulatory requirements?		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
15E667		B. WING			02/28/2023		
			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER				/ MORRIS ST		
	ST HEALTHCARE				APOLIS, IN 46241		
LIMITOR	IILALIIIOAKE			וואטואוו			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	 	TAG	DEFICIENCY)		DATE
					No electric space heaters are		
					be used in patient common ar	eas.	
					Staff has been informed.		
					A "fireplace" electric heater		
					model was in the activity room		
					This model has no cord (it is i		
					useable). Activities Director st	ated	
					that she uses the "fireplace",		
					replica when she decorates fo	ra	
					holiday.		
					All areas in the facility were		
					checked and any space heate	r	
					removed.		
					***The monitoring procedure t		
					ensure the POC is effective ar		
					that the specific deficiency cite	ed	
					remains corrected and/or in		
					compliance with the regulatory		
					requirements? Monitoring of the		
					facility for hazards will take pla	ace	
					weekly by the Maint. Director		
					and/or his designee. and		
					discussed with the Administra	tor	
					with corrections done as		
					applicable.		
					4) How the corrective actions		
					be monitored and what quality		
					assurance program will be put		
					place; who will monitor? ***Th		
					title of the person responsible	for	
					implementing the acceptable		
					POC?		
					No electric space heaters are	to	
					be used in patient common ar	eas.	
					A "fireplace" electric heater m	odel	
					was in the activity room. This		
					model has no cord (it is not		
					useable). Activities Director st	ated	
			1		that she uses the "firenlace"		

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when she decorates for a holiday.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>02</u>			COMPLETED	
		15E667	B. W	B. WING 02/28/2023			/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				/ MORRIS ST			
LYNHUR	RST HEALTHCARE				IAPOLIS, IN 46241			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA		E COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Because this particular firepla			
					replica has no electric cord, (
					not useable),the administrator			
					allowed the replica to remain			
					the Act. Dir. is to store it out o			
					sight. She has been counsele	d		
					regarding the use of electric			
					heaters in patient common are	eas.		
					All areas in the facility were	_		
					checked and any space heate	:r		
					removed. Staff has been informed.			
					Monitoring of the facility for			
					hazards will take place weekly	, by		
					the Maint. Director and/or his	, Dy		
					designee and discussed with	the		
					Administrator with corrections			
					done as applicable.			
					The title of the person respons	sible		
					for implementing the acceptate			
					POC is the Administrator. and			
					Maintenance Director.			
					5) By what date the systemic			
					changes will be completed 5-2	26-23		
K 0920	NFPA 101							
SS=E	Electrical Equipm	ent - Power Cords and						
Bldg. 02	Extens							
	Electrical Equipm	ent - Power Cords and						
	Extension Cords							
	· ·	patient care vicinity are only						
	used for compone							
	1 3	ed electrical equipment						
		oles that have been						
		alified personnel and meet						
		10.2.3.6. Power strips in						
	1	icinity may not be used for						
	, -	, personal electronics),						
		m care resident rooms that						
	do not use PCRE	E. Power strips for PCREE						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE (A. BUILDING B. WING	02	DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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	
	for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not used wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on observation failed to ensure 1 ordid not use flexible wiring. LSC 9.1.2 requipment shall be National Electrical Article 400.8 requipment shal	the patient care rooms the process of the patient care rooms the process of the patient care rooms, power strips meet the process of the process	K 0920	0920 1) What action(s) will be accomplished for those residents found to have been affected? ***The processes that led to this deficiency being cited? Although any patient may have had the potential to be affected, rother patients were identified during the survey. Per Survey: " a power strip was in use and had a small mini refrigerator plugged into it in the Director of Nursing's office." The processes that led to this deficiency being cited possibly was the Director of Nursing Services being unaware of the regulation that included her office. The mini fridge has been moved a wall outlet and the DON made aware of the issue. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? ***The procedure(s) for		

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	OF CORRECTION	IDENTIFICATION NUMBER 15E667	A. BUILDING B. WING	02	COMPLETED 02/28/2023		
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	3.1-19(b)			implementing an acceptable of for the deficiency cited? Although any patient may have had the potential to be affected other patients were identified during the survey. The refrigerator (a mini fridge) the DON's office was plugged a hospital grade power strip. The was removed from the power and plugged into a wall socke prior to the Life Safety Survey completion. Procedure: The Maint. Director will check appliances monthly to ensure does not happen again. A week maint. round has been added the Maint. Director and/or his designee to assess the building for hazards, to be discussed with the Administrator with correction made as applicable. 3) What measures will be put place or what systemic chang will be made? ***The monitoric procedure to ensure the POC effective and that the specific deficiency cited remains correand/or in compliance with the regulatory requirements? The refrigerator (a mini fridge the DON's office was plugged a hospital grade power strip. The refrigerator (a mini fridge the DON's office was plugged a hospital grade power strip. The refrigerator to the Life Safety Survey completion.	e d, no in in to This strip t this ekly for ng with ons into es ng is cted) in in to This strip t		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST JAPOLIS, IN 46241		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	that the specific deficiency cit remains corrected and/or in compliance with the regulator requirements: The Maint. Director will check appliances monthly to ensure does not happen again. A we Maint. round has also been at for the Maint. Director and/or designee to assess the building for hazards and these rounds be discussed with the Administrator with corrections made as applicable. 4) How the corrective actions be monitored and what quality assurance program will be puplace; who will monitor? ***The title of the person responsible implementing the acceptable POC? The refrigerator (a mini fridge the DON's office was plugged a hospital grade power strip. Was removed from the power and plugged into a wall socke prior to the Life Safety Survey completion. The Maint. Director will check appliances monthly to ensure does not happen again. A we Maint. round has also been at for the Maint. Director and/or designee to assess the building of hazards and these rounds be discussed with the Administrator.	this eekly dded his ng will will y t into ne for this strip et y this eekly dded his ng y this eekly dded his ng	

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Monitoring

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The Maint. Dir. and the Admin.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 15E667 B. WING 02/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5225 W MORRIS ST LYNHURST HEALTHCARE INDIANAPOLIS, IN 46241 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE meet at least monthly to discuss issues and this will be added to our discussions. The title of the person responsible for implementing the acceptable POC is the Maintenance Director and the Administrator. 5) By what date the systemic

changes will be completed 5-26-23

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 81SR21 Facility ID: 000385 If continuation sheet Page 70 of 70