STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING -- B. WING	02/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/28/23 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this Emergency Preparedness survey, Lynhurst Healthcare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 40 certified beds. At the time of the survey, the census was 33. Quality Review completed 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 provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nelene Reisinger	LHFA	07/28/2023

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

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			federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action(s). These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk			

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	assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain			

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	an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach, including loss of natural gas and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: During record review with the Maintenance Director at 9:10 a.m. on 02/28/23, documentation could not be found regarding a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach, including loss of natural gas which was the fuel source for that facility emergency generator. Furthermore, there was no plan, policy, or procedure as to what the facility would do if their generator ceased to function or needed serious repair or replacement. Based on interview at the time of record review, the Maintenance Director confirmed there was no policy, procedure, or plan that addressed the aforementioned issues. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50	E 0006	0006 1) What action(s) will be accomplished for those residents found to have been affected? ***The processes that led to this deficiency being cited: Documents were not marked appropriately so that finding a specific document was difficult. No resident was identified to have been affected during this survey. The facility based training example was given to the inspector. The facility follows state and federal guidelines. The survey tag states: "...utilizing an all-hazards approach, including loss of natural gas which was the fuel source for that facility emergency generator. Furthermore, there was no plan, policy, or procedure as to what the facility would do if their generator ceased to function or needed serious repair or replacement. " The Facility has a "Utility Outage and Shut off" section of the Emergency Preparedness Plan.	05/26/2023

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	p.m., no additional information or evidence could be provided contrary to this deficient finding.		(see attached) **Gas Outage 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 based training example was given to the inspector. The facility strives to follows state and federal guidelines. 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 book is due to be updated as necessary this month. The book audit was started 4-13-23.	

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			Section 4 of the Emergency Preparedness Book , includes "gas outage". (see attached) and an addendum has 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 shared with maintenance and will be placed in the maintenance book. 3) What measures will be put into place or what systemic changes will be made? The facility based training example was given to the inspector. 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 facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the 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 natural gas which was the fuel source for that facility emergency generator. Furthermore, there was no plan,	

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			policy, or procedure as to what the facility would do if their generator ceased to function or needed serious repair or replacement. " Systemic Changes: ***The monitoring procedure to ensure that this POC is effective and that the specific deficiency was corrected and/or in compliance with the regulatory requirements: ***The Emergency Preparedness book will be adjusted so that specifics are easier to locate. *** This book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate. Section 4 of the facility's Emergency Preparedness includes "gas outage". (see attached) and an addendum has 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 shared with maintenance and will be placed in the maintenance book. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The facility based training example was given to the inspector.	

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			The facility follows state and federal guidelines. (please see attached examples). 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 facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2/2022 and the book is due to be updated as necessary this month. The book audit was started 4-13-23. Section 4 of this book, includes "gas outage". (see attached) and an addendum has 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 had been shared with maintenance and will be placed in the maintenance book. *** This book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate. ***The Emergency Preparedness book will be adjusted so that specifics are easier to locate. The Maint. Director is responsible for the generator and	

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			documentation associated with; ***the Administrator and her designee as applicable is responsible for implementing the acceptable POC. The Director of Nursing Services , working with the Administrator and the HR Dept, is responsible for in-services and other staff training monitoring and documenting of such. 5) By what date the systemic changes will be completed 5/26/23	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies			

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	and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: During record review with the Maintenance Director at 9:13 a.m. on 02/28/23, documentation could not be found regarding documentation for a complete emergency program. The emergency plan available did not have a policy or procedure for loss of natural gas that supplied the facilities emergency generator for review. Furthermore, getting a replacement generator from a vendor was also not addressed either. Based on an interview at the time of record review, the Maintenance Director indicated the facilities emergency preparedness program did not address policies and procedures for loss of natural gas that supplied the facilities emergency generator or getting a replacement generator for review. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0013	0013 1) What action(s) will be accomplished for those residents 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 emergency preparedness and staff re-education. (all staff, all departments) (see attached examples of facility based education and risk assessments). ***Documents were not marked appropriately so that finding a specific document was difficult. Process *** This book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate. The facility generator is tested as per state and federal guidelines and the addendum to the emergency preparedness policies	05/26/2023

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			and procedures, and the "what to do if natural gas is unavailable" was in our emergency book. (titled, 'Gas Outage', see attached) This has been updated. **Gas Outage Information attached. This had been shared with maintenance and will be placed in the maintenance book. The facility generator is tested as per state and federal guidelines and the addendum to the emergency preparedness policies and procedures, This has been up dated to include a secondary 'what the facility 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. Front page has dates of 4/2022 and the 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 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 follows state and federal guidelines for emergency preparedness and staff re-education. (all staff, all	

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			departments) (see attached examples of facility based education and risk assessments.) **Gas Outage Information attached. This has been shared with maintenance and we be placed in the maintenance book. The facility's Emergency Preparedness was shown to the inspectors during survey. Front page has dates of 4/2022 and the book is due to be updated as necessary this month. The book audit was started 4-13-23. ***Documents were not marked appropriately so that finding a specific document was difficult. What is the procedure for implementing an acceptable POC for the cited deficiency? The facility generator is tested as per state and federal guidelines and the Emergency Preparedness Book has been updated to include 'what to do when the natural gas becomes unavailable'. An addendum to the emergency preparedness policies and procedures has been added, (see attached) *** This book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate.	

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			3) What measures will be put into place or what systemic changes will be made? ***What is the monitoring procedure to ensure that the POC is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. ***Documents were not marked appropriately so that finding a specific document was difficult. *** This book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate. The facility follows state and federal guidelines for emergency preparedness and staff re-education. (all staff, all departments) (see attached examples of facility based education and risk assessments.) The facility generator is tested as per state and federal guidelines and the addendum to the emergency preparedness policies and procedures, has been up dated to include 'what the facility 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. Front page has dates of 4/2022 and the book is due to be updated as	

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			necessary this month. The book audit was started 4-13-23. 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 who is responsible for implementing an acceptable POC. ***The Administrator or her designee is responsible for implementing the POC. *** The emergency Preparedness book will be audited on an every other month basis, by the Maint. Director and/or his designee and the Administrator, to ensure it has been updated and added to as appropriate. The facility follows state and federal guidelines for emergency preparedness and staff re-education. (all staff, all departments) (see attached examples of facility based education and risk assessments. The facility generator is tested as per state and federal guidelines and the addendum to the emergency preparedness policies and procedures, has been up dated to include 'what the facility will do when the natural gas to run the generator becomes unavailable'. (see attached) quality assurance The Emergency Preparedness	

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	15E667	A. BUILDING -- B. WING	02/28/2023

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			book was updated in late 2022, as the previous book disappeared (just in time for our previous fire inspection). First page showing signatures for reviews, as of 4-2-22. ***The Maint. Director and the Executive Director will meet every month to discuss and audit the generator inspections. This will be an ongoing measure with no end date. ***the company that inspects our systems, will email the Executive Director (ED) all invoices etc, to show what services they have accomplished for the facility. The title of the person responsible for implementing an acceptable POC: The Executive Director and the Director of Nursing Services are responsible and will maintain the re-education for staff re: emergency preparedness and the Emerg. Preparedness Book, along with the Maint. Director. 5) By what date the systemic changes will be completed 5-26-23	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/28/23	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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	Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this Life Safety Code survey, Lynhurst Healthcare was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, constructed in two sections, is fully sprinklered. The oldest section, a former two-story private residence with a basement and the newer section, a one-story addition were both determined to be of Type V (000) construction. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 40 and had a census of 33 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services which are the laundry building and a metal storage shed which were each not sprinklered. Quality Review completed on 03/07/23		alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with 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	

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			under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
K 0161 SS=F Bldg. 02	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section			

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	9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation and interview; the facility failed to ensure the building construction type for the two story portion of the facility was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 prohibits a two story sprinklered building to be of Type V(000) construction. This deficient practice could affect all occupants. Findings include: During record review with the Maintenance Director on 02/28/23 between 9:10 a.m. and 12:10 p.m., previous surveys indicated the facility was constructed to V (111) rating as required for a two-story sprinklered structure. During a subsequent tour of the basement on the same date, the following were observed: a) At 2:18 p.m. the basement ceiling had exposed wooden floor joists. These were made from lumber and had no noticeable protection or flame spread rated covering. During a tour of the attic, the following was noted: b) At 12:17 p.m. the attic walls and ceiling were covered in fiber board material that facility did not have flame spread rating documentation for. Based on an interview at the time of both aforementioned observations, the Maintenance Director agreed that the building did not meet the V (111) construction rating as it could not be proven that the basement ceiling / floor had	K 0161	0161 1) What action(s) will be accomplished for those residents found to have been affected? The process that led to this citation? ***The process that led to this citation is the age of the facility itself, which has passed all prior Life Safety Code Survey's up until the present, or has been grandfathered in. Although any patient may have had the potential to be affected, No other patient was found to be affected/identified during or after the survey process. The attic and the basement are sprinkled. (every floor is sprinkled) *** The attic area in question has been decommissioned for the FSES survey, per FSES. Please see attached email. The facility will in the future be surveyed as a two story structure and not a three story structure by FSES. Extra fire extinguishers have been placed in the basement and the attic spaces. Two more smoke/fire alarms have also been placed. ***The facility is filing an FSES for this tag to obtain approved equivalency. 2) How the facility will identify	09/24/2023

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	1-hour fire resistant rating or that the attic walls had a 1-hour fire rating. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		other residents having the potential to be affected and what corrective action will be taken? ***The procedure for implementing an acceptable POC for the citation? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. During a tour of the attic, the following was noted from the surveyors: The attic walls and ceiling were covered in fiber board material that facility did not have flame spread rating documentation. Based on an interview at the time of both aforementioned observations, the Maintenance Director agreed that the building did not meet the V (111) construction rating as it could not be proven that the basement ceiling / floor had 1-hour fire resistant rating or that the attic walls had a 1-hour fire rating. The procedure for implementing an acceptable POC for this tag and the corrective actions: ***The facility is filing an FSES for this tag to obtain approved equivalency. ***The Maint. Supervisor will perform a safety check on both the basement and attic, daily and will report any issues immediately to the Administrator; to be corrected as applicable.	

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			*** The attic area in question has been decommissioned by FSES, per FSES surveyor. Please see attached email. (the attic spaces are now empty) 3) What measures will be put into place or what systemic changes will be made? The monitoring procedure to ensure that the POC is effective and the specific citation remains corrected and/or in compliance with regulatory requirements. ***The facility is filing an FSES for this tag to obtain approved equivalency. *** The attic area in question has been decommissioned by FSES, per FSES surveyor. Please see attached email. The Administrator and the Maint. Director are working with the FSES company and the FSES survey is in progress. ***The attic has been cleared and will no longer be utilized for storage. The attic door is locked. The facility will in the future be surveyed as a two story structure and not a three story structure for the FSES survey. Monitoring process: ***The Maint. Supervisor will perform a safety check on both the basement and attic, daily and will report any issues immediately to the Administrator; to be corrected as applicable.	

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			Systemic Changes ***The attic area in question has been decommissioned by FSES, per FSES Consultant. Please see attached email. The attic space has been cleaned out and will no longer be used for storage purposes. The attic door is locked. ***The facility is filing an FSES for this tag to obtain approved equivalency. Extra fire extinguishers have been ordered for the attic and the basement. Two more smoke/fire alarms have also been placed. ***Patients in the two story section of the facility have been moved into the one story sections temporarily, to accommodate repairs. 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 the acceptable POC is the Administrator. and the Maint. Director. The facility will be requesting a Waiver., to allow time for repairs and the FSES Survey to be completed. (IE: attic walls and basement ceiling; all must be fixed to pass future inspections and obtain compliance). FSES survey documentation for specifics	

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			has not been obtained at this time as the FSES survey remains on going. The FSES survey is now in progress. ***Patients in the two story section of the facility have been moved into the one story sections temporarily so that any repairs can be made. ***The attic space has been cleaned out and will no longer be used for storage purposes. The door is locked. Extra fire extinguishers have been ordered. Two more smoke/fire alarms have also been placed in the basement area and two more alarms have been placed in the attic. The facility will in the future be surveyed as a two story structure and not a three story structure by FSES. The Maint. Director will check both the attic and basement daily and will report any issues immediately to the Administrator; to be corrected as applicable. Monitoring and documented by Maint. Director FSES has given us two options. 1) Decommission the attic space in the old structure, resulting in complete closure of the attic space. (No storage) Proceed with the FSES survey. 2) Move all patients (6) into the one story newer building, only	

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			using the older section for administration purposes. (no patients, no PT/OT etc) ***The facility is going through with option #1. ***It is the facility's wish to go through with the FSES survey and 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 an approved equivalency. ***The attic area in question has been decommissioned by FSES, per our FSES consultants. Please see attached email. The attic space has been cleaned out 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 sections temporarily so that repairs can be made or an FSES equivalency can be reached. ***The FSES survey is in progress. ***The Maint. Supervisor will perform a safety check on both the basement and attic, daily and will report any issues immediately to the Administrator; to be corrected as applicable. The facility was being surveyed as a three story building however and had passed all prior survey	

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			regulations. At present, the attic area has been decommissioned by FSES and there are no patients in the two story structure at this time. This structure will remain off limits to patients and non office staff (excluding vendors) until construction is complete and the facility passes the FSES survey. A 2 hour fire door separates the two story section of the building, from the one 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	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure the means of egress in 1 of 6 corridors was continuously maintained free of obstructions. This deficient practice would affect as many as 8 residents and 2 staff. Findings include:	K 0211	0211 1) What action(s) will be accomplished for those residents found to have been affected? What was the process that led to the citation for this deficiency? "...the ramp between resident	05/26/2023

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	Based on observations made with the Maintenance Director 02/28/23 at 2:34 p.m., the ramp between resident rooms #1 and #3 extended out into the corridor approximately 12 inches. This ramp extension created a trip / fall hazard to anyone coming from the dining room area of the facility. Based on an interview at the time of the observation, the Maintenance Director acknowledged the ramp extension as being a trip hazard and stated that he would discuss repair options with the Executive Director as soon as he had time to do so. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		rooms #1 and #3 extended out into the corridor approximately 12 inches. This ramp extension created a trip / fall hazard to anyone coming from the dining room area of the facility." Although any patient may have had the potential to be affected, no other patients were identified during the survey. ***The processes that led to the cited deficiency ; ***The loss of a maintenance crew d/t Covid and the age of the facility. A railing has been placed to accommodate all patients. and to 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 what corrective action will be taken? The procedure for implementing an acceptable POC for the citation? Although any patient may have had the potential to be affected, no other patients were identified during the survey. The ramp in question, by the DON office, has been fixed. A chair for the patient's has been placed (and secured to the floor) and the remaining inches of the ramp's extension will be beveled. This will prevent any hazard that has the possibility to negatively affect an patient.	

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			3) What measures will be put into place or what systemic changes will be made? ***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 ramp between resident rooms #1 and #3 extended out into the corridor approximately 12 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 DON office, has been fixed. A chair for the patient's has been placed (and secured to the floor) This will prevent any hazard that has the possibility to negatively affect a patient. The Maint. Director is responsible for this project and to monitor any other part of the facility for trip hazards. Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee. and they will meet with 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?	

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			quality assurance The ramp in question, by the DON office, has been fixed. A hand rail has been placed in order to avoid any possible trip hazard. The Maint. Director is responsible for this project and to monitor any other part of the facility for trip hazards. Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee. and they will meet with the Administrator. The Administrator is responsible for implementing the acceptable POC. 5) By what date the systemic changes will be completed 5-26-23	
K 0271 SS=E Bldg. 02	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 2 of 5 exit discharges was constructed of a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect as many as 20 residents, 5 staff, and 2 visitors. Findings include:	K 0271	0271 1) What action(s) will be accomplished for those residents found to have been affected? What was the process that led to the citation for this deficiency? ***The processes that led to the cited deficiency ; ***The loss of a maintenance crew d/t Covid and the age of the facility	09/24/2023

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	Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 between 12:15 p.m. and 3:42 p.m., the following was noticed: a) The exit discharged identified as the west exit near the stairwell outside the facility did not have a hard packed all-weather travel surface to the public way. The ramp leading to the public way ended in a grass surface where there were two different height changes from 1 and ½ inches to two inches in height. b) The exit discharge nearest to the Director of Nursing office had the following issues: 1) The walkway concrete had been worn so badly that it was no longer smooth and had numerous craters and holes in it. 2) The bush outside this entrance had not been trimmed back in a very long time and extended over 30 inches over the walkway leaving a clear width of only 18 inches on the walkway. Based on interview at the time of each observation, the Maintenance Director provided the measurements and confirmed the lack of a hard packed all-weather surface that led to a public way. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		that has passed all prior Life Safety Surveys up until this point. Per survey, "The exit discharged identified as the west exit near the stairwell outside the facility did not have a hard packed all-weather travel surface to the public way. The ramp leading to the public way ended in a grass surface where there were two different height changes from 1 and ½ inches to two inches in height. b) The exit discharge nearest to the Director of Nursing office had the following issues: 1) The walkway concrete had been worn so badly that it was no longer smooth and had numerous craters and holes in it. 2) The bush outside this entrance had not been trimmed back in a very long time and extended over 30 inches over the walkway leaving a clear width of only 18 inches on the walkway." No resident was identified to have been affected during or after this survey. The areas in question are not utilized by patient's or their family members. ***The facility is to file an FSES equivalency for this issue (the concrete areas of the ramp and the area to the west), to obtain an approved equivalency. This will require a waiver for allotted time to repair this tag. (attached) ***Patients are being moved to the one story section of the facility	

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	15E667	A. BUILDING 02 B. WING	02/28/2023

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			temporarily for work to take place in the wood framed section of the facility. The FSES survey is in progress. Attaching documents. The facility is filing for a waiver to ensure adequate time is given to fix the two areas of concrete. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. The areas in question are not utilized by patient's or their family members. The area was utilized by staff for smoking, until the rules of smoking changed the distance of the smoker and the building to a distance of 8 feet. Patients do not utilize the area. The area is also not an entrance for vendors etc. The procedure(s) for implementing an acceptable POC for the deficiency cited? The bush in front of the DON's office has been trimmed back. ***The facility is to file an FSES for this issue (the concrete areas of the ramp and the area to the west), to obtain an approved equivalency. This will require a waiver for allotted time to repair	

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			this tag. The ramp itself (west exit): We were informed that the end of the ramp is required to be extended with concrete to eradicate the height changes that were sited with this survey. ***The facility is to file an FSES with CMS for this issue to obtain an approved equivalency. 3) What measures will be put into place or what systemic changes will be made? ***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 area in question is not utilized by patient's or their family members, at all. These are also not near the main entrance to the facility. The bush in front of the DON's office has been trimmed back. ***The facility is to file an FSES equivalency for this issue to obtain an approved equivalency. The ramp itself (west exit): We were informed that the end of the ramp is required to be extended with concrete to eradicate the height changes that were sited with this survey. Monitoring: The area in question is not utilized by patient's or their family	

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			members, at all. These are also not near the main entrance to the facility. The areas in question are also not used by vendors. ***The facility is to file an FSES for this issue to obtain an approved equivalency. This will require a waiver for allotted time to repair this tag. ***Patients are being moved to 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 to monitor any other part of the facility for hazards. Monitoring 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 into place; who will monitor? The title of the person responsible for implementing the acceptable POC? The bush in front of the DON's office has been trimmed back. ***Patients are being moved to the one story section of the facility temporarily so that repairs may be done. ***The facility is to file an FSES for this issue to obtain an approved equivalency. This will require a waiver for allotted time to	

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			repair this tag. (attached) We were informed that the end of the ramp is required to be extended with concrete to eradicate the height changes that were sited with this survey. ***The Maint. Director is responsible for this project and to monitor any other part of the facility for hazards. Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee.\ and discussed with the LHFA. The FSES survey is in progress. Attaching documents. The title of the person responsible for implementing an acceptable POC is the Administrator/LHFA and/ or her designees. 5) By what date the systemic changes will be completed 9-24-23	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	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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	at the time of the observations, the Maintenance Director stated that he would have the area cleaned up and a self-closing device installed on the attic door as soon as he was able to do so. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		***The attic has been decommissioned by FSES. The attic has been emptied and will no longer be used for storage. The attic door has been locked and has a self closing apparatus. The attic is also sprinkled. The attic door is locked. ***Patients are being moved into the one story building temporarily until work is done. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? ***The procedure for implementing an acceptable POC for the citation? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. The procedure for implementing an acceptable POC for this deficiency cited: ***The attic door now has a self closing apparatus placed. The attic has been emptied and will no longer be used for storage. ***The attic has been decommissioned by FSES consultants. The attic has been emptied and will no longer be used for storage. The attic door has been locked. The areas in question are not utilized by patient's or their family members.	

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			***Patients are being moved into the one story building temporarily, to accommodate repairs to this section of the facility. ***Monitoring procedure to ensure the facility remains in compliance: Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee and will be discussed with the Administrator., issues will be corrected as applicable. Maintenance is responsible for monitoring and ensuring that no one stores anything in the attic space. 3) What measures will be put into place or what systemic changes will be made? ***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 attic door now has a self closing apparatus placed. The attic has been emptied and will no longer be used for storage. Systemic Changes: ***The attic has been decommissioned by FSES . The attic has been emptied and will no longer be used for storage. The attic door has been locked. ***Patients are being moved into the one story building temporarily, to accommodate repairs to this section of the facility.	

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			Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee and will be discussed with the Administrator., issues will be corrected as applicable. ***Maintenance is responsible for ensuring that no one stores anything in the attic space. 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 attic door now has a self closing apparatus placed. (3-13-23) ***The attic has been decommissioned by CMS, per RM Consultants. The attic has been emptied and will no longer be used for storage. The attic door has been locked. ***Patients are being moved into the one story building . ***These corrective actions will be monitored by the Maint. Director *** The attic door has a sign for No Admittance and No Storage. Maintenance is responsible for ensuring that no one stores anything in the attic space and that the door to the space is kept locked. Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee and will be discussed	

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			with the Administrator., issues will be corrected. ***The title of the person responsible for implementing an acceptable POC is the Administrator/LHFA and/ or her designees if applicable. 5) By what date the systemic changes will be completed 5-26-23	
K 0331 SS=E Bldg. 02	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 1 attic was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes	K 0331	0331 1) What action(s) will be accomplished for those residents found to have been affected? The 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 the present, or had been grandfathered in.	09/24/2023

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	any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect as many as 2 staff. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 at 1:42 p.m., all three rooms and the common area in the attic was covered in a painted fiber board that was part of the original house. The facility could not provide a flame spread rating document showing that it met the requirements for class A or B flame spread rating. Based on interview at the time of the observations, the Maintenance Director stated that he would see what he could do about finding a flame spread rating for the fiber board located therein. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		The facility was being surveyed as a three story building however, the attic area has been decommissioned by the FSES consultant and there are no patients in the two story structure at this time. The facility will in the future be surveyed by FSES as a two story structure and not a three story structure. This two story structure will remain off limits to patients and non office staff (excluding vendors) until construction is complete and the facility passes the FSES. No resident was identified to have been affected during this survey. The attic and the basement are sprinkled. (every floor is sprinkled) These areas of concern are not patient common areas nor are they used by patients and visitors . The Maint. Supervisor will perform a safety check on both the basement and attic, daily and will report any issues immediately to the Administrator; to be corrected as applicable. The attic door has been locked and the attic has been emptied. ***The attic has been decommissioned by FSES consultants. The attic has been emptied and will no longer be used for storage. The attic door has been locked. ***Patients have been moved into the one story building temporarily ,to allow construction to be	

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			complete. ***No patients will occupy the 2 story structure and a fire door that meets regulations, separates the two buildings. ***These corrective actions were and will be monitored by the Maint. Director and the Administrator to remain in compliance with regulatory requirements. *** The attic door will have a sign for No Admittance and No Storage. ***the fire door that separates the one story building from the two story building, that meets code, will have a no admittance sign and be kept closed. Extra fire extinguishers have been ordered. Two more smoke/fire alarms have also been placed in the basement and the attic areas. ***These corrective actions will be monitored weekly by the Maint. Director and the Administrator, to be corrected as applicable. The FSES survey is in progress. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey.	

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			The attic and the basement are sprinkled. (every floor is sprinkled) The procedure(s) ***Patients in the two story section of the facility have been moved into the one story sections temporarily, to accommodate repairs. ***These corrective actions were and will be monitored by the Maint. Director and the Administrator. ***The attic has been decommissioned by FSES consultants. The attic has been emptied and will no longer be used for storage. *** The attic door will have a sign for No Admittance .The attic door is locked. ***The FSES survey is in progress. 3) What measures will be put into place or what systemic changes will be made? ***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? ***Patients in the two story section of the facility have been moved into the one story sections temporarily, to accommodate repairs. ***These corrective actions will be monitored by the Maint. Director and the Administrator, to be	

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			corrected as applicable. *** The attic door will have a sign for No Admittance and it is locked. ***The attic has been decommissioned by FSES consultants. (see attached letter), The attic has been emptied and will no longer be used for storage. 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 attic and the basement are sprinkled. (every floor is sprinkled) Monitoring: Maint. Director and documented by same; also checking for any other possible hazards weekly and will report any issues immediately to the Administrator; to be corrected as applicable. ***Patients in the two story section of the facility have been moved into the one story sections temporarily, to accommodate repairs. ***These corrective actions were and will be monitored by the Maint. Director and the Administrator. *** The attic door will have a sign for No Admittance and No Storage and be locked.	

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			The process that led to this citation? The age of the facility (that has passed all Life Safety surveys until the present time) and The facility was being surveyed as a three story building however, the attic area has been decommissioned by FSES. The attic has been emptied and will no longer be used for storage . The attic will not be used. There are no patients in the two story structure at this time. This structure will remain off limits to patients and non office staff (excluding vendors) until all repairs as applicable are complete and the facility passes the FSES survey. and a fire door that meets regulations, separates the two sections of the buildings , that is kept closed. 5) By what date the systemic changes will be completed 9-24-23	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			

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	15E667	A. BUILDING 02 B. WING	02/28/2023

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

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	_____ 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 failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff, and visitors in the facility. Findings include: Based on record review with the Maintenance Director on 02/28/23 at 12:00 p.m., the sprinkler systems inspection document titled "Sprinkler System Inspection Form" dated 09/14/2022 and 12/14/2022 indicated the internal pipe investigation was past due. Based on an interview with the Maintenance Director at the time of record review, he stated that an internal pipe investigation has not yet been scheduled as he was unaware it was past due. During the exit conference with the facility Executive Director and	K 0353	0353 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. Please see facility plan below. The processes that led to this deficiency being cited? documentation was misplaced by the Maint. Director. The vendor that inspects for this facility) has sent document noting that interior pipe inspection was completed as of June 30th, 2019. (see attached) and the next inspection is not due at this time. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. Per survey: "...resident in room #6	05/26/2023

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	the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect up to 12 residents, 4 staff, and 1 visitors. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 at 1:42 p.m., a resident in room #6 had a television antenna hanging from the sprinkler piping above his bed. Based in an interview at the time of the observation, the Maintenance Director acknowledged that sprinkler pipe was indeed supporting the resident's television antenna and stated that he would have it taken care of as soon as he could. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		had a television antenna hanging from the sprinkler piping above his bed." The patient antenna was removed from the pipes and reasonings were explained to the patient. Each room was checked, to ensure this had not occurred in any other room. (3-13-23) The standards for inspection, testing and maintaining the fire systems , will be maintained in the maintenance Fire Book and updated as necessary, to be readily available for Life Safety inspectors. The vendor that inspects for this facility has sent document noting that interior pipe inspection was completed as of June 30th, 2019. (see attached) and the next inspection is not due at this time. This information was placed in the Maint. book. The procedure A weekly Maint. round procedure has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator. Any noted hazards will be fixed. 3) What measures will be put into place or what systemic changes will be made? ***The monitoring procedure to ensure the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory	

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			requirements? The vendor that inspects for this facility has sent document noting that interior pipe inspection was completed as of June 30th, 2019. (see attached) and the next inspection is not due at this time. The above named company will share all information with the Administrator via email, in hopes to avoid any lack of documentation for our survey members. The patient antenna was removed from the pipes and reasonings were explained to the patient. Each room was checked, to ensure this had not occurred in any other room. (3-13-23) Systemic Change/Monitoring The rooms will be checked monthly by Maint. Director, for compliance, to be readily available for Life Safety inspectors. Weekly "hazard" rounds have also been added to the Maint. Director schedule. The standards for inspection, testing and maintaining the fire systems , will be maintained in the maintenance Fire Book by the Maint. Director and updated as 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 POC?	

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			The patient antenna was removed from the pipes and reasonings were explained to the patient. Each room was checked, to ensure this had not occurred in any other room. (3-13-23) Quality Assurance The rooms will be checked monthly for compliance by Maint. Director. Weekly "hazard" rounds have also been added to the Maint. Director schedule. Nursing and housekeeping staff will be re-educated to ensure they are aware that nothing is to be hanging on the pipes and keeping the rooms orderly and neat. The Maint. Director and the Admin (and or her designee) will discuss findings re to such, either in the am meeting or in the Admin. office. The standards for inspection, testing and maintaining the fire systems , will be maintained in the maintenance Fire Book and updated as necessary. The vendor that inspects for this facility has sent document noting that interior pipe inspection was completed as of June 30th, 2019. (see attached) and the next inspection is not due at this time. (this is also denoted by the tag date on the pipes in question.) The above named company will share all information with the Administrator via email, in hopes to avoid any lack of documentation for our survey members.	

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			The title of the person responsible for implementing the acceptable POC is the Administrator. and or her designee. 5) By what date the systemic changes will be completed 5-26-23	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

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	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 door to the corridor would completely resist the passage of smoke. This deficient practice could affect approximately 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 at 2:18 p.m., the corridor door to the furnace and hot water heater room near the kitchen had the door handle replaced. There was a 3/8ths inch hole that passed all the way through the door; therefore, this door was not smoke tight. Based on an interview at the time of the observation, the Maintenance Director acknowledged the home and stated that he would have it fixed as soon as he could. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0363	0363 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 the survey but all could possibly be affected. Per survey: "...the corridor door to the furnace and hot water heater room near the kitchen had the door handle replaced. There was a 3/8ths inch hole that passed all the way through the door; therefore, this door was not smoke tight." The processes that led to this deficiency being cited was a replacement door handles that left 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 POC for the deficiency cited?	05/26/2023

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			Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. Maint. fixed the doorknob on 3/10/23. The door handle, when placed originally, did not completely cover the area that the handle entered. The approx. 1/8th inch holes (times 4), have been sealed. The procedure(s) for implementing an acceptable POC for the deficiency cited? A weekly Maint. round procedure has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator. 3) What measures will be put into place or what systemic changes will be made?***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 door knob has been fixed. The facility follows state and federal guidelines for emergency 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; on a	

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			monthly basis. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards. Issues will be brought to the Administrators attention immediately. 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 follows state and federal guidelines for emergency preparedness and staff re-education. (all staff, all departments) Quality Assurance and Monitoring On the Maint. monthly rounds, Maint. will check all door handles in the facility, to ensure proper fit. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator. Issues will be brought to the Administrators attention immediately. ***The title of the person responsible for implementing the acceptable POC is the Administrator and or her designee. 5) By what date the systemic changes will be completed 5-26-23	

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K 0522 SS=F Bldg. 02	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 rooms where fuel fired equipment was in use were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for as many as 16 residents and 4 staff in the area of these rooms. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 between 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. This water heater did not have an outside air source to reduce the carbon monoxide within the area. b) The first-floor furnace room near the main dining room had a natural gas water heater and furnace located inside. Upon inspection of this room, no air intake from the outside could be located therein to reduce the carbon monoxide	K 0522	0522 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 although the possibility is that all resident's could be affected. Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 between 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. This water heater did not have an outside air source to reduce the carbon monoxide within the area. b) The first-floor furnace room near the main dining room had a natural gas water heater and furnace located inside. Upon inspection of this room, no air intake from the	05/26/2023

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	therein. Based on interview at the time of observation, the Maintenance Director agreed that he could not locate or identify any source of outside air in either of the aforementioned rooms. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		outside could be located. The processes that led to this citation are: ***the air intake pipe was not marked as such. It has been marked (see attached photos) and the air intake in the basement was not there. This has been fixed. An air intake was placed in the basement and a pipe in the furnace room has been tagged as the air intake pipe. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator, with corrections as applicable if required. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. Per survey: "..The basement had a natural gas water heater located in it. This water heater did not have an outside air source to reduce the carbon monoxide within the area. b) The first-floor furnace room near the main dining room had a natural gas water heater and furnace	

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			located inside. Upon inspection of this room, no air intake " In the basement, a vent has been placed for air intake. The first floor furnace room has an air intake pipe already in place. However, the air intake pipe was not marked as such. It has been marked (see attached photos) ***The procedure(s) for implementing an acceptable POC for the deficiency cited were the unidentified intake pie in the furnace room , that is now marked. Secondly, the air intake in the basement was not there and has been installed. 3) What measures will be put into place or what systemic changes will be made? ***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? In the basement a vent has been placed for air intake. The first floor furnace room has an air intake pipe already in place. However, the air intake pipe was not marked as such. systemic change The pipe has been marked(see attached photos) 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?	

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			To ensure compliancy, a weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with 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? In the basement a vent has been placed for air intake. The first floor furnace room has an air intake pipe already in place. However, the air intake pipe was not marked as such. systemic change The first floor furnace room has an air intake pipe already in place. It has been marked(see attached photos) The facility follows state and federal guidelines: as noted in the maint. book. Maint. Director is in charge of monitoring and record keeping. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator. The title of the person responsible for implementing the acceptable POC is the Administrator. and or	

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			her designee. 5) By what date the systemic changes will be completed 5-26-23	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct complete quarterly fire drills for 4 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: During record review with the Maintenance Director on 02/28/23 between 9:10 a.m. and 12:10 p.m. the following was noted: a) The fire drills for all four quarters had multiple drills documented as being complete on the same sheet, just different times. b) Four of the 12 fire drills submitted for review had no time documented for the drill. c) All of the fire drills submitted for review on the second shift were held at 3:30 p.m. and therefore the times were not varied.	K 0712	0712 1) What action(s) will be accomplished for those residents found to have been affected? ***The processes that led to this deficiency being cited? Per survey: "During record review with the Maintenance Director on 02/28/23 between 9:10 a.m. and 12:10 p.m. the following was noted: a) The fire drills for all four quarters had multiple drills documented as being complete on the same sheet, just different times. b) Four of the 12 fire drills submitted for review had no time documented for the drill. c) All of the fire drills submitted for review on the second shift were	05/26/2023

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LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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	d) All of the fire drills submitted for review on the third shift were held at 11:30 p.m. and therefore the times were not varied. e) There was no documentation available for a fourth quarter (October, November, and December) of 2022 on the first shift. Based on interview during record review, the Maintenance Director acknowledged that there was no additional available fire drill documentation available for review as of the time and date of this survey. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		held at 3:30 p.m. and therefore the times were not varied. d) All of the fire drills submitted for review on the third shift were held at 11:30 p.m. and therefore the times were not varied." No resident was identified to have been affected during or after this survey although all residents could have been affected. The processes that led to this deficiency being cited; Maintenance possibly unfamiliar with the regulations. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during the survey. The procedure(s) for implementing an acceptable POC for the deficiency cited? The facility had the correct amount of fire drills . The shifts overlap (1st, 2nd and 3rd). The Maint. Director used one sheet for both shifts during the overlap. This practice has been stopped. Maint. Director is now using one sheet for each shift. 3) What measures will be put into place or what systemic changes will be made?	

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			***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 3rd). 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 document. The documentation for separate fire 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 3rd). The Maint. Director used one sheet for both shifts during the overlap. This practice has been stopped. Each fire drill will be placed on a separate document. The Maint. Director is in charge of monitoring fire drills and getting them done correctly. He is now using one sheet for each shift.	

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			The documentation for separate fire drills will be monitored monthly by the Maintenance Director and /or the Administrator. The title of the person responsible for implementing the acceptable POC is the Administrator and the Maint. Director. 5) By what date the systemic changes will be completed 5-26-23	
K 0741 SS=E Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover			

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	devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which 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 staff and 1 visitor using the designated smoking area. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 between 12:15 p.m. and 3:42 p.m., the following was noticed: a) The facilities designated smoking area had five one-gallon tin cans scattered around it. Each of these cans contained a small amount of water and around 50 cigarette butts contained in it. b) The facilities smoking area had a 55-gallon plastic trash container located in it. This container was one-quarter filled with miscellaneous trash including paper and combustible materials. Intermingled within this trash were 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. (Note, this is not a designated smoking area) Based on interview at the time of each observation, the maintenance Director stated that he would have the butts picked up and the	K 0741	0741 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 survey. Cigarette butts are to be cleaned up . The processes that led to this deficiency being cited are possibly patients with cognitive decline diagnosis, not utilizing the provided ashtrays and fire resistant ashtrays that have come up missing. The large plastic barrel has been moved out of the smoking area. Fire resistant ashtrays have been provided in the spaces in question. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during or after the survey. Unfortunately the proper ash cans had been removed from the smoking areas.	05/26/2023

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	unapproved contains removed from the area as soon as he was able to do so. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		These have been ordered and will be replaced. (see example photo) Fire resistant ashtrays have been provided in the spaces in question. The procedure(s) for implementing an acceptable POC for the deficiency cited, was to remove the cigarette debris off the ground, remove the plastic waste barrel from the area and provide fire resistant ashtrays; this has been 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 into place or what systemic changes will be made? ***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? Per survey: "...a) The facilities designated smoking area had five one-gallon tin cans scattered around it. Each of these cans contained a small amount of water and around 50 cigarette butts contained in it. b) The facilities smoking area had a 55-gallon plastic trash container located in it. This container was one-quarter filled with miscellaneous trash including paper and combustible materials. Intermingled within this trash were	

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			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. 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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			Maint. Director has been requested to check the outside smoking area at least bi-weekly, including picking up cigarette waste and trash receptacles. The title of the person responsible for implementing the acceptable POC would be the Administrator and/or her designee. 5) By what date the systemic changes will be completed 5-26-23	
K 0781 SS=E Bldg. 02	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 portable space heater was not used in the facility. This deficient practice could affect 12 residents, 4 staff and 1 visitor in the facility. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 between 12:15 p.m. and 3:42 p.m., the following was noticed: a) While the facility had a policy for the use of portable space heaters, it did not address the following: 1) Space heaters are not allowed to be in use within the patient care areas of the facility.	K 0781	0781 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, no other patients were identified during the survey. All areas in the facility were checked and any space heater removed. The processes that led to this deficiency being cited possibly was the Director of Nursing Services being unaware of the	05/26/2023

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	2) The heating element can not be above 212 degrees Fahrenheit. 3) The portable space heater must have an anti-tip device. Based on interview at the time of the observations, the facility Administrator stated that they did not allow portable space heaters in the building, yet there was one in the Activities office where record review was taking place. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		regulation that included her office. 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 POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during the survey. A "fireplace" electric heater model was in the activity room. This model has no cord (it is not useable). Activities Director stated that she uses the "fireplace", replica when she decorates for a holiday. All areas in the facility were checked and any space heater removed. The procedure(s) for implementing an acceptable POC for the deficiency cited: Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee and these rounds will be discussed with the Administrator. 3) What measures will be put into place or what systemic changes will be made? ***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?	

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			No electric space heaters are to be used in patient common areas. Staff has been informed. A "fireplace" electric heater model was in the activity room. This model has no cord (it is not useable). Activities Director stated that she uses the "fireplace", replica when she decorates for a holiday. All areas in the facility were checked and any space heater removed. ***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? Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee. and discussed with the Administrator with corrections done as applicable. 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? No electric space heaters are to be used in patient common areas. A "fireplace" electric heater model was in the activity room. This model has no cord (it is not useable). Activities Director stated that she uses the "fireplace", when she decorates for a holiday.	

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			Because this particular fireplace replica has no electric cord, (is not useable),the administrator has allowed the replica to remain but the Act. Dir. is to store it out of sight. She has been counseled regarding the use of electric heaters in patient common areas. All areas in the facility were checked and any space heater removed. Staff has been informed. Monitoring of the facility for hazards will take place weekly by the Maint. Director and/or his designee and discussed with the Administrator with corrections done as applicable. The title of the person responsible for implementing the acceptable POC is the Administrator. and the Maintenance Director. 5) By what date the systemic changes will be completed 5-26-23	
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE			

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	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 Director of Nursing's office did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects up to 4 residents and 1 staff. Findings include: Based on observations made with the Maintenance Director on a tour of the facility on 02/28/23 at 2:45 p.m., a power strip was in use and had a small mini refrigerator plugged into it in the Director of Nursing's office. Based on an interview at the time of the observation, the Maintenance Director acknowledged that a power strip was in use and stated that he would have it removed immediately. During the exit conference with the facility Executive Director and the Maintenance Director at 3:50 p.m., no additional information or evidence could be provided contrary to this deficient finding.	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, no other 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 to 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	05/26/2023

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	3.1-19(b)		implementing an acceptable POC for the deficiency cited? Although any patient may have had the potential to be affected, no other patients were identified during the survey. The refrigerator (a mini fridge) in the DON's office was plugged in to a hospital grade power strip. This was removed from the power strip and plugged into a wall socket prior to the Life Safety Survey completion. Procedure: The Maint. Director will check appliances monthly to ensure this does not happen again. A weekly Maint. round has been added for the Maint. Director and/or his designee to assess the building for hazards. to be discussed with the Administrator with corrections made as applicable. 3) What measures will be put into place or what systemic changes will be made? ***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 refrigerator (a mini fridge) in the DON's office was plugged in to a hospital grade power strip. This was removed from the power strip and plugged into a wall socket prior to the Life Safety Survey completion. To ensure the POC is effective and	

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			that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Maint. Director will check appliances monthly to ensure this does not happen again. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator with corrections made as applicable. 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 refrigerator (a mini fridge) in the DON's office was plugged in to a hospital grade power strip. This was removed from the power strip and plugged into a wall socket prior to the Life Safety Survey completion. The Maint. Director will check appliances monthly to ensure this does not happen again. A weekly Maint. round has also been added for the Maint. Director and/or his designee to assess the building for hazards and these rounds will be discussed with the Administrator. Monitoring The Maint. Dir. and the Admin.	

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LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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			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	