STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 00 B. WING	11/10/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00365916. Complaint IN00365916 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey date: November 10, 2021 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census Bed Type: NF: 37 Total: 37 Census Payor Type: Medicaid: 37 Total:37 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on November 15, 2021.	F 0000		
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a homelike	F 0921	Zip ties and locks on patio door have been removed. Patio safety	11/26/2021

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

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	environment in that a pad lock and zip ties were placed on sliding glass patio doors located in the residents' dining room, potentially affecting 37 of 37 residents residing in the facility. Finding include: During the initial tour of the facility, on 11/10/21 from 8:45 A.M. to 9:15 A.M., observed a sliding glass patio door located at the back of the residents' dining room with an unlocked large meta combination pad lock hanging on a single hinge latch bolted to one side of the patio door. The lock was approximately five feet from the floor and visible at the back of the residents' dining room. Also observed were two more sliding glass patio doors to the side of the residents' dining room, across from the kitchen, that had black zip ties secured around the handles of the sliding doors which prevented the doors from opening. All 3 doors lead to a secured, enclosed, outdoor area used by residents who reside in the nursing facility. During an interview, on 11/10/21 at 9:30 A.M., Qualified Medication Aide (QMA) 1 indicated her current job title was Administrator in Training. The metal combination pad lock that was hanging on the metal hinge on the patio door was locked on night shift and the black zip ties on the other sliding doors are always in place. The pad lock and zip ties were placed to keep the sliding doors secured. The metal combination pad lock was installed, on 11/1/21, and QMA 1 was unsure when the zip ties were placed. During an interview, on 11/10/21 at 9:42 A.M., Resident A indicated, the pad lock should not have been installed on the sliding patio door, because no one has a pad lock on their doors at		lock has been installed; creating a home like environment. Residents will continue to be supervised when door is unlocked. Patio door that leads to fenced in yard will be unlocked from 7a to 7p in order to allow residents to go outside as they please (weather pending) during 7am-7pm. System by which the compliance of the corrective action will be monitored: A binder will be created in order for the designated responsible party to monitor and sign off that the patio door is unlocked for residents to enter and exit from 7am-7pm and there are no zip ties or other apparatuses attached to patio doors. This will be monitored and signed off daily for 3 weeks. Three times a week for 3 weeks. One time a week for 2 weeks. Monthly thereafter. Who is responsible for monitoring the corrective actions: DON Who is responsible for documenting compliance of the corrective actions: DON will document Monday-Friday, Activities staff will document Saturday-Sunday for 3 week. DON will document a weekday and Activities staff will document on day during the weekend for 3 weeks. DON will document once a week during the weekday for 2	

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	home. The clinical record of Resident A was reviewed on 11/10/21 at 9:50 A.M. Diagnoses included, but were not limited to, diabetes mellitus type 2 and sarcomas of the liver. An admission Minimum Data Set (MDS), dated 11/4/21, indicated Resident A was cognitively intact. Review of facility census documentation, dated November 10, 2021, indicated 37 residents resided in the nursing facility. On 11/10/21 at 10:40 A.M., the Director of Nursing provided a copy of a facility policy, titled "Resident Rights," dated March 2017, and indicated this was the current policy used by the facility. A review of the policy indicated, "You have the right to a ...homelike environment ..." This Federal tag relates to Complaint IN00365916. 3.1-19(e)		weeks. DON will document monthly thereafter.	