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	12/21/2021

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 IN00369439. Complaint IN00369439 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: December 20 and 21, 2021 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census Bed Type: NF: 35 Total: 35 Census Payor Type: Medicaid: 34 Other: 1 Total: 35 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on December 29, 2021.	F 0000	Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this facilities statement of compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident did not elope for 1 of 3 residents reviewed for elopement risk. (Resident B) Findings include: On 12/20/21 at 6:05 p.m., Resident B's clinical record was reviewed Diagnoses included, but not limited to dementia with behavioral issues, delusional disorder, and hallucinations. Resident B had been admitted to the facility in June 2020 as a justice involved, "compassionate probation." A wandering Risk Scale for Resident B, dated 12/15/2021, indicated "Resident is at risk for wandering and elopement, resident is cognitive impaired, with dx [diagnosis], able to communicate, but not always able to verbalize/express thoughts." Resident B's quarterly Minimum Data Set Assessment, dated 9/23/2021, indicated Resident B was cognitively impaired and he had not exhibited any current wandering behaviors during the look back period. A progress noted, dated 12/19/2021 at 3:15 p.m., indicated after shift change and bed check, it was noted that Resident B was not found to be in the facility. "Elopement protocol was put in place." Interview with RN 1, on 12/21/2021 at 1:19	F 0689	1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Only one resident was found to be affected. This resident was located and found to be without harm, by a hospital emergency department. This resident was taken to another facility after release from the hospital. 2) How other residents having the potential to be affected by the same practice will be identified and what corrective action will be taken? Several residents may talk occasionally about leaving the facility however, most are not physically able to do so and no others have attempted to do so as yet. All residents are given an Elopement Risk assessment upon admission and according to Federal and State regulations they are reassessed as required. The facility is installing a Wander Guard System to help prevent any future elopements. The facility will also utilize Apple Air tags (GPS) for some residents who are assessed to be a direct elopement risk.	01/31/2022

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	p.m., indicated on 12/19/21 at approximately 2:30 p.m., she observed Resident B standing near the nurse's station. She had said hi to Resident B, he then turned around, and went back to his room located at the end of the hall. RN 1 then bent over the nurse's station, to where the front exit door code pad box was, pressed the code to unlock the door, and went out the door alone. As she went to her car, which was on the west part of the parking lot and backed in, she did not see Resident B inside or outside of the facility. RN 1 then went to a nearby gas station, approximately one block away, and while she was in line at the gas station she turned around and saw Resident B was behind her standing in line to purchase items. She had not taken her phone with her. She asked Resident B to come back with her and he refused. She asked the gas station attendant to please use the phone, to which she was refused. Resident B walked out and again she asked him to come with her and again he refused. She indicated she got back into her car, returned to the facility, and got a male aide to come with her to try and get Resident B to come back. When they got back to the gas station Resident B was gone. She returned to the facility and called 911, the DON (Director of Nursing), and the ED (Executive Director). Interview with the DON, on 12/20/21 at 6:20 p.m., indicated a detective from Marion County reported to her that Resident B was now a "parole violator." Review of written statements by RN and CNA 1, on 12/19/2021 at 2:10 p.m., indicated agreement with RN 1's interview, dated 12/21/2021 at 1:19 p.m., that Resident B would not return to the facility.		3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? As per State and Federal guidelines for long term care, the residents have the right to exit the facility. The facility must follow policies when an actual elopement occurs and this facility did follow policies. The facility reviewed it's policy for Elopement 12/21. and found it to be precise and in conformity with State and Federal regulations. All residents are given an Elopement Risk assessment upon admission and according to Federal and State regulations they are reassessed as required. The facility is installing a Wander Guard System to help prevent any future elopements. The facility will also utilize Apple Air tags (GPS) for some residents who are assessed to be a direct elopement risk. SSD audits the Elopement Risk documentation on a quarterly basis along with the Wandering Risk Scale assessment from Point Click Care. 4) How the corrective action (s) will be monitored to ensure the practice does no recur/ what quality assurance program will be put into place?	

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	On 12/21/2021 at 11:00 a.m., the Executive Director indicated Resident B had been located, was transferred to a local hospital for evaluation, had no injuries, and was transported to the local jail due to Resident B's parole violation. On 12/22/2021 the Executive Director provided the current elopement/missing resident policy, dated 03/09, and indicated it was the current policy used by the facility. A review of the policy indicated if the resident is outside of the building but staff is pursuing through the building to head the resident off, is not an elopement, and when the search time between the resident being noticed missing and the authorities being called would be expected to be less than 20 minutes and it exceeded that time, the authorities were called due to elopement. This Federal tag relates to Complaint IN00369439. 3.1-45(a)(2)		The facility reviewed it's policy for Elopement 12/21. and found it to be precise and in conformity with State and Federal regulations. All residents are given an Elopement Risk assessment upon admission and according to Federal and State regulations they are reassessed as required. Systemic Changes: The facility is installing a Wander Guard System to help prevent any future elopements. The facility will also utilize Apple Air tags (GPS) for some residents who are assessed to be a direct elopement risk. SSD audits the Elopement Risk documentation on a quarterly basis along with the Wandering Risk Scale assessment from Point Click Care. (All residents were recently audited the end of December 2020.) Quality Assurance: All staff are to be In Serviced on facility Elopement Policy and action that they may take to help prevent reoccurrence. In Services will be once a week times 4 weeks, all shifts, for nursing staff. Then, In Serviced on the same subjects, once every month for 4 months. The DON will monitor these In Services or may assign that task to another employee. Resident elopement risks will de discussed in the upcoming Quality Assurance meeting that is	

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			scheduled for 1-19-21. The ARNP. the Pharmacy Rep., the DON , SSD and the psych. doctor are expected to be in attendance. 5) Date the changes will be complete? 1-31-21	