DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 00 B. WING	02/22/2022

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00369949, IN00370822, IN00372713, IN00372909, and IN00372972. This visit was in conjunction with the Investigation of Complaint IN00373415. Complaint IN00369949 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759. Complaint IN00370822 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00372713 - Substantiated. No deficiencies related to allegations were cited. Complaint IN00372909 - Substantiated. No deficiencies related to allegations were cited. Complaint IN00372972 - Unsubstantiated. Due to lack of evidence. Complaint IN00373415 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: February 15, 16, 17, 18, 21, and 22, 2022. Facility number: 000385 Provider number: 15E667 AIM number: 100291340	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. The facility respectfully request a paper review.	

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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	Census Bed Type: NF: 37 Total: 37 Census Payor Type: Medicaid: 36 Other: 1 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 3, 2022.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on observation, interview, and record review, the facility failed to ensure residents were free from verbal and physical abuse for 2 of 3 residents reviewed for abuse. (Resident B, Resident C)	F 0600	F0600 1) Corrective actions for those patients found to have been affected by the deficient practice: Although any patient could have been affected, 2 of three patients	04/13/2022

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	Findings include: 1. On 2/17/22 at 2:00 p.m., Resident B was observed in his room resting on his bed. On 2/18/22 at 12:00 p.m., the clinical record of Resident B was reviewed. The diagnosis included, but were not limited to, adjustment disorder with mixed disturbance of emotions and conduct. The Quarterly Minimum Data Set (MDS) assessment, dated 1/31/22, indicated Resident B was cognitively intact. A late entry progress note, dated 2/18/22 at 11:46 a.m., indicated "...I pressed for details [alleged verbal abuse incident] but resident continued to state that 'it's nothing'..will speak with other residents as needed..." During an interview on 2/17/22 at 11:20 a.m., the Administrator (ADM) indicated an allegation of verbal abuse occurred on 2/17/22 at 11:00 a.m. between Licensed Practical Nurse (LPN) 1 and Resident B. LPN 1 had "cussed out" Resident B. LPN 1 was terminated for verbal abuse and left the facility. During an interview on 2/17/22 at 2:30 p.m., Resident B indicated earlier in day while standing near the nurse's station, a verbal altercation occurred between LPN 1 and Resident B. "Words were exchanged" between LPN 1 and Resident B. LPN 1 had "cussed out" Resident B and "she should have taken the higher road because she was a nurse." During an interview on 2/18/22 at 11:21 a.m., the Director of Nursing (DON) indicated she had		were noted. The goal of this facility is to maintain zero events between residents ensured by sufficient staffing coverage, available activities and reasonable medical and psycho-social care. The following are some of the measures taken in this facility to ensure the facility meets patient needs: Actions: The facility provides sufficient staff based on the needs of our patients. Patient Care Plans ensure the current patient standards of practice, provides the clinical/technical direction for such provision of care. This includes: Care Plans and Care Plan meetings, doctor visits (in person), Psychiatric visits and medication audits. Along with this facility following state and federal guidelines. Patient B no longer resides with the facility as he was discharged to home (unrelated to events in the facility). The follow up with this patient showed no psycho-social ill effects. Patient C has diagnosis of schizophrenia and anxiety with other medical diagnosis that affect how he relates to others; these include fabricated accusations towards others. 12/19/21 it was reported by one	

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	heard yelling near the nurse's station area, investigated, and found that LPN 1 had "cussed out Resident B." LPN 1 was terminated and left the facility. During an interview on 2/21/22 at 1:55 p.m., the Activity Director indicated, she was near the dining room area, located halfway down the hall from the nurse's station, when she heard LPN 1 "cussing out" Resident B around 11:00 a.m. on 2/17/22. During an interview on 2/21/22 at 2:00 p.m., Certified Nursing Assistant (CNA) 3 indicated on 2/17/22 sometime between 11:00 a.m. and 11:30 a.m., she was working on the adjacent hall to the nurse's station when she heard LPN 1 and Resident B "cussing each other out". CNA 3 indicated no other staff were in the area at that time. On 2/17/22 at 11:50 a.m., the facility provided a copy of a Facility Reportable Incident (FRI) #226. A review of the FRI indicated on 2/17/22 at 11:01 a.m. the ADM submitted the following report: "Brief Description of Incident...[Licensed Practical Nurse (LPN) 1] for unknown reasons, was standing by the medicine cart screaming obscenities at [Resident B]. DON [Director of Nursing] present and attempted to calm nurse; nurse walked off her shift and left the facility. Nurse has been terminated..." On 2/18/22 at 12:02 p.m., LPN 1's personnel file was reviewed. On 2/17/22, LPN 1 was "terminated for Resident verbal abuse and insubordination..." On 2/21/22 at 9:36 a.m., the DON provided an undated copy of the Abuse policy and indicated it		staff member that C struck another patient in the head but other staff that witnessed the exchange related that no physical contact had taken place rather the patient had exchanged words with another. Patient C behaviors are followed closely by medical professional including nurses, doctors and psych. Medications are also reviewed by pharmacy and the doctor. Medications are reviewed in Quality Assurance meetings and PRN for needs and behaviors. Patient C is also followed by 15 minute checks, increased activity functions and rewards for more pleasant behavior. Care team members will be in-serviced on the facility's Abuse Policy/abuse and respect of patient's and dealing with aggressive patients, once weekly (all shifts), for 4 weeks and then twice per month for 4 weeks. 2)How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: The following are some of the measures taken in this facility to ensure the facility meets patient needs:	

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	was the current policy in use by the facility. A review of the policy indicated, "...employees of this facility that have been accused of resident abuse will be suspended pending investigation...facility protects individuals from abuse..." 2. On 2/17/22 at 10:00 a.m., the clinical record of Resident C was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, and obsessive compulsive disorder. A Discharge Minimum Data Set (MDS) assessment, dated 7/14/21, indicated Resident C had a moderately impaired cognitive status and had physical and verbal behaviors directed towards others. A Care Plan, dated 8/26/21 and current through 3/28/22, indicated Resident C had a behavior problem including hitting, kicking and agitation. The interventions included, but were not limited to, intervene as necessary. A Behavior note, dated 12/14/21 at 5:16 p.m., indicated Resident C screamed out everyone in here is a bunch of lying whores. A Behavior note, dated 12/19/21 at 8:11 a.m., indicated Resident C was accused of slapping another resident in the head. A Behavior note, dated 12/22/21 at 3:05 p.m., indicated Resident C was slamming other residents doors, stated the other residents were too loud. A Behavior note, dated 12/23/21 at 9:07 a.m., indicated Resident C was having verbally aggressive and intrusive behaviors. Resident C		Actions: The facility provides sufficient staff based on the needs of our patients. Patient Care Plans ensure the current patient standards of practice, provides the clinical/technical direction for such provision of care. This includes: Care Plans and Care Plan meetings, doctor visits (in person), Psychiatric visits and medication audits. Along with this facility following state and federal guidelines. Patient B no longer resides with the facility as he was discharged to home (unrelated to events in the facility). The follow up with this patient showed no psycho-social ill effects. Patient C has diagnosis of schizophrenia and anxiety with other medical diagnosis that affect how he relates to others; these include fabricated accusations towards others. 12/19/21 it was reported but one staff member that C struck another patient in the head but other staff that witnessed the exchange related that no physical contact had taken place rather the patient had exchanged words with another. Patient C behaviors are followed closely by medical professional including nurses, doctors and psych. Medications are also reviewed by pharmacy and the doctor. Patient C is also followed	

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	was stating that he will beat his "a**" and the other resident did not have enough money to have sex with him. A Behavior note, dated 12/29/21 at 2:44 p.m., indicated Resident C was yelling out in hall that he was going to beat everyone's "a**". A Behavior note, dated 1/10/22 at 12:21 a.m., indicated Resident C was continuously screaming "f*** you all". The attempts to redirect the resident only caused more agitation. The resident stated I don't give a "d***". I will "f***" everybody up. A Psychiatry Consult note, dated 6/30/21, indicated Resident C had agitation, delusions, hallucinations, intrusiveness, and low frustration tolerance. Resident C's schizoaffective disorder and anxiety disorder were unstable. On 2/16/22 at 9:30 a.m., the Director of Nursing (DON) provided a copy of a facility reported incident #223, dated 1/10/22. The incident included, but was not limited to: Description: "Resident [Resident C] [was] reportedly threatening to kill other residents and calling them names. Resident C attempts to push the wheelchairs of other residents when 'he deems they are not moving fast enough and his action causes difficulties.' On 1/10/21 Resident C was reported to have 'hit' another resident. No injury to either resident. Due to verbalizations, this patient [Resident C] is to be sent out of the facility for a psych eva. [psychiatric evaluation] and medication review, today. It is reported that during the above event this resident struck out at Resident D. Both residents were separated, no injuries noted at that time. Both residents were placed on 15 minute checks. Staff will be		by 15 minute checks, increased activity functions and rewards for more pleasant behavior. 3) Measures put into place and systemic changes: Measure: Nursing staff will be in-serviced by the Director of Nursing or her designee on the facility's Abuse Policy/abuse and respect of patient's and dealing with aggressive patients, once weekly (all shifts), for 4 weeks and then twice per month for 4 weeks. Included in these in-services will be a refresher on proper immediate reporting of abuse. Incoming employees are also in-serviced on the subjects: as it is included in the employee orientation packet. All behaviors are followed closely by medical professional including nurses, doctors and psych. Medications are also reviewed by pharmacy and the doctor when behaviors occur. Patient C was also followed by 15 minute checks, increased activity functions and rewards for more pleasant behavior; which will be continued as applicable. The facility has placed patient C in a private room.	

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	instructed to keep these residents separated from one another and an inservice will be provided on handling resident aggression will be given. Both Residents were separated and placed on 15 minute checks." The Director of Nursing provided a policy, titled Preventing Resident to Resident Altercations in Nursing homes, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...The goal is to keep residents around the agitated resident safe." The Director of Nursing provided a policy, titled Resident Rights, undated and indicated it was the current policy being used by the facility. A review of the policy indicated "You must not be abused by anyone-physically, verbally..." This Federal tag relates to Complaint IN00370822. 3.1-27(a)(1) 3.1-27(b)		The facility provides sufficient staff based on the needs of our patients. Patient Care Plans ensure the current patient standards of practice, provides the clinical/technical direction for such provision of care. This includes: Care Plans and Care Plan meetings, doctor visits (in person), Psychiatric visits and medication audits. Along with this facility following state and federal guidelines. Systemic Changes: The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure care plans are up dated correctly. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. Nursing staff will be in-serviced as above. (see "actions") Other departments will also in-service their staff. The Director of Social Services will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about facility policy and practices. Specifically, the Director of Social Services will review the policies and practices related to the assessment processes used by the facility beginning at the time of admission and continuing as	

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			required but at least quarterly thereafter. SSD will also be available to counsel patients one on one and follow with actions and documentation as applicable Nursing staff will be in-serviced as above. (eight week total) 4) How corrective actions will be monitored and what quality assurance will be put into place: Nursing staff will be in-serviced by the Director of Nursing or her designee on the facility's Abuse Policy/abuse and respect of patient's and dealing with aggressive patients, once weekly (all shifts), for 4 weeks and then twice per month for 4 weeks. The Director of Nursing will be responsible for in-servicing staff. New employees will be in-serviced on the same by use of the employee applications paperwork. Quality Assurance: Patient behaviors will be discussed with appropriate actions taken, during the morning meeting (daily/ongoing) and documented (both the issue and the actions that may be taken as applicable). They will also be discussed and documented as such in the facility's Quality Assurance meeting every month. (ongoing) The facility provides sufficient staff based on the needs of our patients. Patient Care Plans	

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			ensure the current patient standards of practice, provides the clinical/technical direction for such provision of care. This includes: Care Plans and Care Plan meetings, doctor visits (in person), Psychiatric visits and medication audits. Along with this facility following state and federal guidelines. Monitoring: The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure care plans are up dated correctly. (no end date) The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. (also ongoing with no end date) The Director of Social Services will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about facility policy and practices. Patient B no longer resides with the facility as he was discharged to home (unrelated to events in the facility). The follow up with this patient showed no psycho-social ill effects. Patient C has diagnosis of schizophrenia and anxiety with other medical diagnosis that affect	

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			how he relates to others; these include fabricated accusations towards others. 12/19/21 it was reported by one staff member that C struck another patient in the head but other staff that witnessed the exchange related that no physical contact had taken place rather the patient had exchanged words with another. Patient C behaviors are followed closely by medical professional including nurses, doctors and psych. Specifically, the Director of Social Services will review the policies and practices related to the assessment processes used by the facility beginning at the time of admission and continuing as required but at least quarterly thereafter. This measure will be ongoing. SSD will also be available to counsel patients one on one and follow with actions and documentation as applicable and this is ongoing. Nursing staff will be in-serviced as above. Other departments will also in-service their staff. In-services are continued with all departments participating, as	

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			related to their field: this is an ongoing measure) New admits are screened prior to acceptance in the facility, for histories that may include aggressiveness and other 'behaviors' . 5) Date the systemic changes will be completed: 4-13-22	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure residents had a person-centered comprehensive care plan for 1 of 5 residents reviewed for monitoring of medication side effects. Care plans for anticoagulant medications were not developed. (Resident 34)	F 0656	1) Corrective actions for those patients found to have been affected by the deficient practice: Although any patient could have been affected, 1 of 5 patients were noted.	04/13/2022

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	Finding includes: The clinical record for Resident 34 was reviewed on 2/16/22 at 2:46 p.m. The diagnoses included, but were not limited to, end stage renal disease requiring hemodialysis, dementia with behavioral disturbances, and early onset Alzheimer's disease. A review of the most current Quarterly Minimum Data Set (MDS) assessment, dated 12/27/21, indicated that Resident 34 was severely cognitively impaired and was receiving an anticoagulant medication (blood thinner). A review of the Physician orders indicated Resident 34's medications included, but were not limited to, Eliquis (anticoagulant medication) 5 milligrams (mg) twice a day, ordered on 7/27/21. The Physician's orders on 11/10/21 also indicated to monitoring for adverse events related to the use of blood thinners, such as discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, and nose bleeds. During an interview on 2/22/22 at 2:30 p.m., the Administrator indicated she was unable to locate a care plan for the monitoring of an anticoagulant medication. On 2/22/22 at 2:35 p.m., the Administer provided an undated copy of the policy, titled: Care Plan Policy, and indicated it was the policy currently being used in the facility. A review of the policy indicated, " ...Every effort must be made to ensure that all orders are followed, all		The medication orders and follow ups with care plans for these individuals have been verified/corrected. 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: The nurse responsible for MDS/medication errors, no longer is employed by this facility. The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure care plans are up dated correctly. As new orders are received , they are available to the MDS nurse , on PCC. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. The Director of Nursing and/or her designee will in-service nurses and QMA's on the proper way to follow up , using PCC, on medication that calls for nursing to monitor, including anticoagulants.. (IE: using Point Click Care to confirm the right dose, the right patient, the right medication etc.) In-Servicing (as above) will be done once weekly for 4 weeks and then every other week for 4 weeks.	

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	care needs are addressed, and that the care plan has been implemented." 3.1-35(a)		3) Measures put into place and systemic changes: Along with in-servicing the staff, the facility will have a "cart audit" done via pharmacy, this will be accomplished every 90 days. Medications requiring follow up will be discussed with the Director of Nursing and these follow up procedures added to the electronic medication pass with Point Click Care. The Director of Nursing and/or her designee will ensure that any follow up to these audits take place along with proper documentation. (ongoing) 4) How corrective actions will be monitored and what quality assurance will be put into place: Quality Assurance: Along with in-servicing the staff, the facility will have a "cart audit" done via pharmacy, this will be accomplished every 90 days. The nurse responsible for MDS/medication errors, no longer is employed by this facility. The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure care plans are up dated correctly. Medications requiring follow up; such as anticoagulants, will be discussed with the Director of Nursing and these follow up	

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			procedures added to the electronic medication pass with Point Click Care. Nurses are able to care plan on the PCC system and will be instructed to do so. This will be an ongoing expectation. Monitoring: The Director of Nursing and/or her designee will ensure that any follow up to these audits take place along with proper documentation and proper care planning; also an ongoing measure. 5) Date the systemic changes will be completed: 4-13-22	
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 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 implement interventions to prevent falls for 3 of 4 residents reviewed for falls. (Resident L, Resident M, Resident N) Findings include:	F 0689	1) Corrective actions for those patients found to have been affected by the deficient practice: The Director of Nursing and the Executive Director have discussed the M-N-L patients fall history and interventions will be updated.	04/13/2022

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	1. The clinical record for Resident N was reviewed on 2/21/22 at 10:55 a.m. The diagnoses included, but were not limited to, history of traumatic brain injury, history of falls, dementia with behavioral disturbances, type 2 diabetes mellitus, mild cognitive impairment, and schizoaffective disorder. A progress note dated, 9/26/21 at 4:05 p.m., indicated Resident N had a witnessed fall when his legs became weak and he fell onto his knees. He sustained a scrape on his right knee. A progress note dated, 10/27/21 at 7:05 p.m., indicated Resident N had a witnessed fall as he tripped over his foot, lost balance, and fell. He sustained a cut on his chin. A progress note dated, 11/27/21 at 6:00 p.m., indicated Resident N had a witnessed fall as he tripped over his feet due to " ill-fitting pants". He sustained an abrasion to the cheek bone, bilateral lip lacerations, and a chipped and loose front tooth. The resident was transferred to the Emergency Room for care and a CT of his head to check for bleeding. A progress note dated, 12/20/21 at 1:00 p.m., indicated Resident N had a witnessed fall as he had a "shuffled gait" and lost his balance. Resident N was to be reevaluated by the physician in the morning. A progress note dated, 2/16/22 at 10:00 a.m., indicated Resident N had a witnessed fall due to generalized weakness during ambulation. There were no injuries. He was to be referred to physical therapy for an ambulation evaluation. A care plan, created and initiated on 4/13/21 and		(The facility list of patients , given to us by surveyors, actually lists patients as alphabetical tags however this survey lists them numerically. The facility will attempt to decipher who the patients 'M-N-L ' are so as to provide appropriate patient centered corrective actions) Falls are followed closely by medical professional including nurses, doctors and psych. Medications are also reviewed by pharmacy and the doctor. The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure care plans are up dated correctly. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: Currently the facility utilizes PCC electronic records. Falls are recorded along with pertinent information and monitored by the Director of Nursing. In the PCC program under 'risk management'. The Director of Nursing follows each fall by entering the	

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	current through 3/21/22, indicated Resident N had a fall care plan. The interventions included, but were not limited to, check range of motion every shift (initiated 4/13/21), continue interventions on the at-risk plan (initiated 4/13/21), for no apparent acute injury, determine and address causative factors of the fall (initiated 4/13/21), provide activities that promote exercise and strength building where possible (initiated 4/13/21), provide 1:1 activities if bed bound (initiated 4/13/21), referral has been made to psychiatrist for a medication review with potential need to decrease or eliminate some of the resident's medications (initiated 4/13/21). The fall care plan had not been updated with goals and interventions since being initiated on 4/13/21. During an interview on 2/22/22 at 2:30 p.m., the Administrator indicated she was unable to locate any additional care plan goals or interventions. 2. On 2/16/22 at 9:29 A.M., Resident L's clinical record was reviewed. The Quarterly MDS (Minimal Data Set) assessment, dated 1/15/22, indicated severe cognitive impairment. The diagnoses included, but were not limited to, cerebral infarction (a stroke) and heart failure. A facility incident report, dated 12/16/21 at 7:33 A.M., indicated Resident L had an unwitnessed fall on 12/16/21 in the room and was sent out to the ER (emergency room) for evaluation as the fall was unwitnessed and the resident exhibited pain. Resident L returned with no injury noted. A facility incident report, dated 1/28/22 at 2:23 P.M., indicated Resident L had an unwitnessed		interventions into the electronic program. She also prints the information out and keeps these documents in a Fall Book. Falls are followed closely by medical professional including nurses, doctors and psych. Medications are also reviewed by pharmacy and the doctor. Action: A list of new falls will be shared with the MDS nurse so that the fall care plan may be updated in a timely manner. The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure that fall care plans are up dated correctly. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. 3) Measures put into place and systemic changes: New falls documented in the fall book and their interventions will be discussed in the facility's QA meeting once per month. A sign off sheet to these discussion will be signed by participants of the QA. Falls will be discussed daily in the morning meeting.(ongoing) The facility has employed an MDS nurse, experienced in MDS and	

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	fall without injury on 1/28/22 when the resident slid out of the wheelchair in the room. A facility incident report, dated 2/4/22 at 8:34 A.M., indicated Resident L had a witnessed fall without injury on 2/4/22 ambulating from the resident's wheelchair in the dining room without assistance. A current care plan for falls, revised 2/21/22, included, but were not limited to interventions of: anticipate and meet the resident's needs (initiated 7/16/21), be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance (initiated 7/16/21), follow facility fall protocol (initiated 7/16/21), lay resident down in bed after lunch and dinner (initiated 11/17/21), PT (physical therapy) evaluate and treats as ordered or as needed (initiated 7/16/21), and resident will not be dressed and out of bed before breakfast (initiated 12/19/21). 3. On 2/16/22 at 9:38 A.M., Resident M's clinical record was reviewed. The Quarterly MDS assessment, dated 12/13/21, indicated a moderate cognitive impairment. The diagnoses included, but were not limited to, Alzheimer's disease and schizoaffective bipolar type disorder. A nurse's note, dated 12/26/21 at 1:30 P.M., indicated Resident M had a witnessed fall without injury on 12/26/21 trying to get out of a chair in the dining area. A nurse's note, dated 1/7/22 at 2:05 A.M., indicated Resident M had a witnessed fall without injury on 1/7/22 walking without using walker.		care plans, to ensure fall care plans are up dated correctly. A list of new falls will be shared with the MDS nurse so that the fall care plan may be updated in a timely manner. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. 4) How corrective actions will be monitored and what quality assurance will be put into place: The Director of Nursing and the MDS nurse will work conjointly to ensure falls and fall care plans are updated /monitored appropriately. --Monitoring randomly, including all shifts: Falls are now discussed every morning in the am meeting. The DON is responsible to monitor her nursing reports on a daily basis and in service her staff once per week times 6 weeks, (all shifts) re; fall follow up and fall prevention. A list of new falls will be shared with the MDS nurse so that the fall care plan may be updated in a timely manner. Quality Assurance: New falls documented in the fall book and their interventions will be discussed in the facility's QA meeting once per month. (Also,	

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	A current care plan for falls, revised 6/11/21, included, but were not limited to interventions of: anticipate and meet the resident's needs (initiated 1/8/20), call light in reach and cue to use (initiated 1/8/20), encourage non skid foot wear (initiated 1/8/20), encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (initiated 1/8/20), fall assessment quarterly and as needed (initiated 1/8/20), follow facility fall protocol (initiated 1/8/20), keep living area free of clutter with good lighting (initiated 1/8/20), keep personal items in reach (initiated 1/8/20), and PT to evaluate and treat as ordered or as needed (initiated 3/14/14). On 2/21/22 at 1:30 P.M., the DON (Director of Nursing) provided an undated policy, titled Care Plan Policy, and indicated it was the current policy being used by the facility. The policy included falls as requiring interventions in response to resident incidents. A review of the policy indicated "When an incident does occur, the facility/team/workgroup must: ...2. Develop and implement revised interventions to prevent additional avoidable accidents." During an interview on 2/22/22 at 10:55 A.M., the DON indicated that care plans for falls were to be updated after the IDT (Interdisciplinary) meetings to discuss the root cause analysis for the fall and appropriate interventions; usually the next day after a fall occurred. The DON further indicated if interventions were not on the care plan for the dates of specific falls that those interventions had been missed. This Federal tag relates to Complaint IN00373415.		falls will be discussed every morning in the am meeting.) A sign off sheet to these discussion will be signed by participants of the QA. The Director of Nursing will monitor. The facility has employed an MDS nurse, experienced in MDS and care plans, to ensure fall care plans are up dated correctly. Comprehensive, resident centered fall prevention plans for patients as applicable are the responsibility of the nursing and MDS team and is ongoing . A list of new falls will be shared with the MDS nurse so that the fall care plan may be updated in a timely manner. The facility hired a consultant firm that will assist the facility as necessary with MDS rules and regulations. Fall Prevention will be reviewed to ensure that the measure are appropriate and are in place. 5) Date the systemic changes will be completed: 4-13-22	

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	3.1-45(a)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			
	Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate greater than 5% for 2 of 3 residents observed for medication administration, for 2 of 34 opportunities. This resulted in an error rate of 6%. (Resident 5, Resident 6) Findings include: 1. On 2/18/22 at 8:33 a.m., Licensed Practical Nurse (LPN) 1 was observed to prepare to administer Resident 5's medication. The prepared medication cup included, but was not limited, to clonazepam 0.5 mg. Clonazepam is a controlled medication used to treat anxiety. The physicians order in the Medication Administration Record indicated, Clonazepam 0.25 mg (milligram) one tablet twice a day, initiated on 12/15/2021. During an interview on 2/18/22 at 8:34 a.m., LPN 1 indicated "everyone gives that (0.5 mg) dose" and "that dose is what is in the narcotic box." LPN 1 was observed to turn toward Resident 5 to administer the medication that included the clonazepam 0.5 mg tablet. At that time, LPN 1 was questioned about the dose. LPN 1 indicated she would pull out the clonazepam 0.5 mg tablet and clarify the order	F 0759	1) Corrective actions for those patients found to have been affected by the deficient practice: The medication orders for these individuals were immediately verified/corrected. The error was reported to the physician. The nurse responsible for noted errors is no longer employed by the facility. Licensed staff were able to verbalize how to transcribe orders and ask questions of Pharmacy re: Electronic Medical Records (EMR) on the facility's current system. 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: Medication orders were corrected for both medications listed. Any patient has the potential for medications errors.	04/13/2022

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	with the physician for the correct dosage. On 2/18/22 at 1:00 p.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder and generalized anxiety disorder. A Physicians order, with a start date of 12/15/21, indicated "clonazepam 0.25 mg [milligrams] one tab PO [by mouth] BID [twice a day]." A Controlled Drug Record, dated 1/7/22, indicated Resident 5 had received 30 doses of clonazepam 0.5 milligrams from the pharmacy. The record also indicated the staff administered clonazepam 0.5 mg twice a day from 1/7/2022 until 1/25/22. On 2/18/22 at 1:30 p.m., the Director of Nursing indicated the clonazepam order should have been clarified by a physician prior to LPN 1 dispensing the medication. 2. On 2/18/22 at 9:10 a.m., LPN 1 was observed to prepare Resident 6's medication. The prepared medication cup included, but was not limited to, Cozaar 100 mg. Cozaar is a medication used to treat hypertension. The Medication Administration Record indicated the Cozaar 100 mg was to be given at 7:00 a.m. During an interview at that time LPN 1 indicated "since the medication is showing up highlighted in red [late] on the computer, it means the previous shift did not give it, so I will go ahead and administer it." LPN 1 then turned toward Resident 6 to administer the medication. At that time, the LPN was questioned about the time the dose should have been given. LPN 1 indicated she would clarify to ensure the previous shift had not given the 7:00 a.m. dose, and also indicated		The nurse responsible for noted errors , is no longer employed by the facility. Medications are signed off monthly by the facility physician. The Director of Nursing will in-service nursing staff on the Five R's of medication pass and these in-services will take place twice per week for four weeks and then once a week for 4 weeks. New hired nurses and QMA,s will be in-serviced as they are hired. 3) Measures put into place and systemic changes: 4-13-22 The nurse responsible for medication errors, no longer is employed by this facility. The Director of Nursing and/or her designee will in-service nurses and QMA's on the proper way to pass medication (IE: using Point Click Care to confirm the right dose, the right patient, the right medication etc.) In-Servicing (as above) will be done once weekly for 4 weeks and then every other week for 4 weeks. New hired nurses and QMA's will be in-serviced as they are hired. Measure: The DON will monitor physician orders on a weekly basis (ongoing). 4) How corrective actions will be	

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	she would let the physician know the medication was held. On 2/18/22 at 1:00 p.m., Resident 6's clinical record was reviewed. The diagnosis included, but were not limited to, hypertension. A Medication Administration Record, dated February, 2022, indicated Resident 6 was to receive "Cozaar Tablet 100 mg" at 7:00 a.m., for hypertension. On 2/18/22 at 1:40 p.m., the Director of Nursing indicated, the Cozaar should have been given on the previous shift. On 2/18/22, at 2:00 p.m., the Director of Nursing provided a policy, titled Lynhurst Medication Administration and Storage Policy, dated 5/17/21, and indicated it was the current policy being used by the facility. A review of the policy indicated "...Licensed staff shall confirm the following information prior to administering medication to a resident: ...Right dose and Right time..." This Federal tag relates to complaint IN00369949. 3.1-48(c)(1)		monitored and what quality assurance will be put into place: Monitoring: Pharmacy will audit medication carts (medication administration records) every 90 days with reports given to the DON and the Administrator for their review. Quality Assurance: The DON and/or her designee will issue and monitor nursing in-services. The DON is responsible to monitor the monthly medication reports and she will monitor physician orders on a weekly basis to correct possible errors prior to those orders reaching the nursing staff. (ongoing) Medication administration will be observed by the DON and/or her designee, and /or the pharmacy to ensure medications are being administered as ordered: Quality Assurance--this monitoring will be done every 90 days by pharmacy and once per week by the DON and/or her designee, once per week times 4 weeks and the ongoing, PRN. 5) Date the systemic changes will be completed: 4-13-22	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to serve food in a sanitary manner during 3 of 3 observations where staff's facial hair was uncovered and refrigerator/freezer temperatures were not recorded. (Cook 2) Findings include: 1. On 2/15/22 from 10:50 a.m. to 11:10 a.m., Cook 2 was observed at the kitchen's stove preparing hamburger for the evening meal. Cook 2 was observed to have facial hair (beard and mustache) that was ½ inch in length. The facial hair was observed to not be covered. On 2/15/22 from 12:05 p.m. to 12:15 p.m., Cook 2 was observed at the kitchen's steamtable taking the initial food temperatures and plating	F 0812	1) Corrective actions for those patients found to have been affected by the deficient practice: Any patient could have been affected however, none were found to be so. Upon being informed that refrigerator temperatures were not being performed correctly, this author provided three temperature gauges for the kitchen. (This was accomplished prior to state exit). 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken:	04/13/2022

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	food for the noon meal. Cook 2 was observed to have facial hair (beard and mustache) that was ½ inch in length. The facial hair was observed to not be covered. During an interview at that time, Cook 2 indicated all facial hair was to be covered and all 37 residents residing in the facility received food from the kitchen. On 2/15/22 from 1:00 p.m. to 1:05 p.m., Cook 2 was observed at the dish machine washing the serving pans from the noon meal. During an interview at that time, Cook 2 indicated he had just completed plating the resident's noon meal. Cook 2 was observed to have facial hair (beard and mustache) that was ½ inch in length. The facial hair was observed to not be covered. During an interview on 2/15/22 at 1:30 p.m., the Dietary Manager (DM) indicated all facial hair was to be covered while in the kitchen and all 37 residents residing in the facility received food from the kitchen. On 2/16/22 at 10:42 a.m., the Human Resources Director provided a copy of the Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy, dated October 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils..." On 2/16/22 at 10:30 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as ...hair coverings or nets, beard restraints ...that are designed and worn to wear effectively keep their hair from		Any patient could have been affected however, none were found to be so. Upon being informed that refrigerator temperatures were not being performed correctly, this author provided three temperature gauges for the kitchen. (This was accomplished prior to state exit). The dietary manager will check daily that temps are being recorded as per rules and regulations and will document that this has been accomplished by signing off on the temperature logs daily. Should the dietary manager be out of the facility, she will check the logs as applicable upon her return. The facility policy clearly states that facial hair is required to be covered and a copy of this policy was given to surveyors and the dietary manager. At the same time the dietary manager had the staff member cover his facial hair. 3) Measures put into place and systemic changes: The dietary manager will check daily that temps are being recorded as per rules and regulations and will document that this has been accomplished by signing off on the temperature logs daily. Should the dietary manager be out of the facility, she	

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	contacting...exposed food..." 2. On 2/15/22 at 10:55 a.m., during the initial kitchen tour with Cook 2, the kitchen area was observed to have 1 large reach-in refrigerator unit, 2 smaller refrigerator/freezer units, and 1 large reach-in freezer unit. The following refrigerator and freezer temperature records were reviewed: a. The large reach-in refrigerator unit was located next to the stove area and inside the unit were dairy products. Hanging on the outside of the reach-in refrigerator unit door was a clear plastic sheet holder. Inside the plastic sheet holder was the January 2022 Refrigerator Temperature Log document. A review of the January 2022 log document, indicated 21 of 31 days lacked recorded morning refrigerator temperatures and 24 of 31 days lacked recorded afternoon refrigerator temperatures. Located behind the January 2022 log document was the February 2022 Refrigerator Temperature Log document. The February 2022 reach-in refrigerator temperature log lacked any recorded temperatures for the month of February. b. Along the opposite wall from the reach-in refrigerator unit was a smaller white refrigerator/freezer unit. Prepared desserts were observed inside the refrigerator/freezer unit. The refrigerator/freezer unit lacked a January 2022 and February 2022 Refrigerator/Freezer Temperature Log. c. Next to the smaller white refrigerator/freezer unit was a small silver refrigerator/freezer unit. Prepared salads and juices were observed inside the refrigerator/freezer unit. The refrigerator/freezer unit lacked a January 2022		will check the logs as applicable upon her return. The dietary manager will also in-service her staff on temperature log upkeep and proper hair covering(s), once a week times 4 weeks and then, once every two weeks times four weeks. 4) How corrective actions will be monitored and what quality assurance will be put into place: The dietary manager will check daily that temps are being recorded as per rules and regulations and will document that this has been accomplished by signing off on the temperature logs daily. Should the dietary manager be out of the facility, she will check the logs as applicable upon her return. Quality Assurance: The dietary manager will also in-service her staff on temperature log upkeep and proper hair covering(s), once a week times 4 weeks and then, once every two weeks times four weeks. The dietary manager will be responsible to monitor her staff's temp logs and she has been asked to let the LHFA know immediately re: equipment needs (i.e.: thermometers etc.)	

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	and February 2022 Refrigerator/Freezer Temperature Log. d. Next to the silver refrigerator/freezer unit was a large reach-in freezer unit. Frozen meats and vegetables were observed inside the freezer. Hanging on the outside of the reach-in freezer unit door was a clear plastic sheet holder. Inside the plastic sheet holder were the January 2022 and February 2022 Refrigerator Temperature Log documents. The January 2022 and February 2022 reach-in freezer temperature logs lacked any recorded temperatures for the months of January and February. 3. On 2/21/22 at 10:30 a.m., during a follow up kitchen visit, the kitchen's small refrigerator/freezer units were observed: a. The white refrigerator/freezer unit was observed. Inside the unit, desserts for the noon meal were observed. The refrigerator/freezer unit lacked a January 2022 and February 2022 Refrigerator/Freezer Temperature Log. b. The silver refrigerator/freezer unit was observed. Inside the unit, salad foods and juices for the noon meal were observed. The refrigerator/freezer unit lacked a January 2022 and February 2022 Refrigerator/Freezer Temperature Log. During an interview on 2/15/22 at 1:15 p.m., the Dietary Manager (DM) indicated the refrigerator and freezer temperatures were to be recorded 2 times daily on the monthly Refrigerator/Freezer Temperature Logs. All 37 residents residing in the facility received food form the kitchen. On 2/15/22 at 2:19 p.m., the DM provided a copy		The Dietary Manager will be responsible that her staff adheres to the policy re: facial hair being covered. 5) Date the systemic changes will be completed: 4-13-22	

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	of the Refrigerator and Freezer policy, dated December 2014, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures...food services supervisors or designated employees will check and record refrigerators and freezer temperatures daily with first opening and at closing in the evening..." On 2/16/22 at 10:30 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...temperature measuring devices...shall have a numerical scale, printed record...frozen foods shall be maintained frozen and should be stored at zero (0) degrees Fahrenheit...maintains the food temperature at forty-one (41) degrees Fahrenheit or less..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0814 SS=E Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the ground surrounding the facility's dumpster area was free from rubbish and failed to ensure the dumpster's sliding side panel door and top lid were kept closed when not in use for 5 of 5 observations. Findings include: 1. On 2/15/22 from 9:30 a.m. to 9:35 a.m., the dumpster container area, located adjacent to the front parking lot and near the facility's front	F 0814	1) Corrective actions for those patients found to have been affected by the deficient practice: The facility dumpster is located 85 feet from the front entrance and off to the side of the building. Due to logistics, the facility finds that there is no other area to place the dumpster in. Dietary staff has been notified to check this dumpster are three times per day and maintenance	04/13/2022

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	entrance door was observed. The following was observed at the dumpster area: -Partially filled trash bags were visible on the ground near and around the dumpster container (to the right of the dumpster and behind the dumpster). -A door was leaning against the wooden enclosure surrounding the dumpster container. -A large wooden wardrobe, two small bed-side tables, and a chair were located next to the dumpster container. -Multiple used plastic gloves were visible on the ground near the dumpster container. -A sign, posted near the dumpster container, indicated "close dumpster lid." -No staff members were observed in the area at that time. 2. On 2/15/22 from 10:45 a.m. to 10:50 a.m., the dumpster container area, located adjacent to the front parking lot and near the facility's front entrance door was observed. The following was observed at the dumpster area: -Partially filled trash bags were visible on the ground near and around the dumpster container (to the right of the dumpster and behind the dumpster). -A door was leaning against the wooden enclosure surrounding the dumpster container. -A large wooden wardrobe, two small bed-side tables, and a chair were located next to the dumpster container. -Multiple used plastic gloves were visible on the ground near the dumpster container. -The side sliding side door panel, on the right side of the dumpster container, was observed to not be closed. -A sign, posted near the dumpster container, indicated "close dumpster lid." -No staff members were observed in the area at		will also check this area twice per day. 2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken: No patient was noted to have any negative effects at this time as 'patient areas' do not include the front entrance. The dumpster area has been cleaned and is to remain cleaned up of debris. 3) Measures put into place and systemic changes: The dumpster area has been cleaned and is to remain cleaned up of debris. Dietary staff will be in serviced on checking the dumpster and their responsibilities to help maintain a cleaner are around the dumpster. Systemic Changes: Dietary staff has been notified to check this dumpster are three times per day and maintenance will also check this area twice per day. The dietary manager is responsible to monitor her staff's compliance. (ongoing) The LHFA will monitor the maintenance staff for compliance.	

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	that time. 3. On 2/15/22 from 1:25 p.m. to 1:30 p.m., during a facility tour with the Dietary Manager (DM), the dumpster area, located adjacent to the front parking lot and near the facility's front entrance door was observed. The following was observed at the dumpster area: -Partially filled trash bags were visible on the ground near and around the dumpster container (to the right of the dumpster and behind the dumpster). -A door was leaning against the wooden enclosure surrounding the dumpster container. -A large wooden wardrobe, two small bed-side tables, and a chair were located next to the dumpster container. -Multiple used plastic gloves were visible on the ground near the dumpster container. -The sliding side door panel, on the right side of the dumpster, was observed to not be closed. -A sign, posted near the dumpster container, indicated "close dumpster lid." -No staff members were observed in the area at that time. 4. On 2/16/22 from 8:28 a.m. to 8:33 a.m., the dumpster area, located adjacent to the front parking lot and near the facility's front entrance door was observed. The following was observed at the dumpster area: -Partially filled trash bags were on the ground near and around the dumpster container (to the right of the dumpster and behind the dumpster). -A door was leaning against the wooden enclosure surrounding the dumpster container. -A large wooden wardrobe, two small bed-side tables, and a chair were located next to the dumpster container. -Multiple used plastic gloves were visible on the		4) How corrective actions will be monitored and what quality assurance will be put into place: Dietary staff will be in serviced on checking the dumpster and their responsibilities to help maintain a cleaner are around the dumpster. (by the Dietary Manager) Dietary staff has been notified to check this dumpster area three times per day and maintenance will also check this area twice per day. (these monitoring measures include closing the fence gate around the dumpster) Quality Assurance: The dietary manager is responsible to monitor her staff's compliance. (ongoing measure) The LHFA will monitor the maintenance staff for compliance. 5) Date the systemic changes will be completed: 4-13-22	

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	ground near the dumpster container. -The sliding side door panel, on the right side of the dumpster, was observed to not be closed and a partially filled trash bag was visibly hanging from outside of the opened sliding side door panel. -A sign, posted near the dumpster container, indicated "close dumpster lid." -No staff members were observed in the area at that time. 5. On 2/17/22 from 12:25 p.m. to 12:30 p.m., the dumpster area, located adjacent to the front parking lot and near the facility's front entrance door was observed. The following was observed at the dumpster area: -Partially filled trash bags were observed on the ground near and around the dumpster container (to the right of the dumpster and behind the dumpster). -A door was leaning against the wooden enclosure surrounding the dumpster container. -A large wooden wardrobe, two small bed-side tables, and a chair were located next to the dumpster container. -Multiple used plastic gloves were visible on the ground near the dumpster container. -The sliding side door panel, on the right side of the dumpster container, was observed to not be closed and a partially filled trash bag was hanging from outside of the opened sliding side door. -The dumpster container had 2 separate top lids visible; the top lid, on the right side of the dumpster container, was observed to not be closed. -A sign, posted near the dumpster container, indicated "close dumpster lid." -No staff members were observed in the area at that time.			

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	During an interview on 2/15/22 at 1:40 p.m., the DM indicated the dumpster sliding side panel doors and the top lids were to be kept closed; all trash was to be placed into the dumpster; and all 37 residents residing in the facility received food items from the kitchen. On 2/15/22 at 2:19 p.m., the DM provided an undated copy of the Lynhurst HealthCare Dumpster Care policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Doors: the side and top doors should be closed when the dumpster is not in use...the area surrounding the dumpster will be maintained by the customer, and will be kept free and clean of any accumulation of garbage..." On 2/16/22 at 10:40 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(5)			