PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		15E667	B. WI	NG		03/14/2022	
				CED FEET	A PRINCIPLE OF A PRIN		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
1.74.11.115	OT LIE 41 TUO 4 DE				MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN	APOLIS, IN 46241		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWINED'S BLAN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
E 0000							
Bldg							
Ĭ	An Emergency Prep	paredness Survey was	E 00	000	Preparation and execution		
		diana Department of Health in		, , ,	of this plan of correction		
	accordance with 42	-			does not constitute an		
					admission to or an		
	Survey Date: 03/14/	/22			agreement by the provider		
	J				with the truth of the facts		
	Facility Number: 0	00385			alleged or the conclusions		
	Provider Number:				set forth in the Statement of		
	AIM Number: 1002				Deficiencies rendered by		
					the reviewing agency. The		
	At this Emergency I	Preparedness survey,			Plan of Correction is		
		e was found not in compliance			prepared and executed		
	-	eparedness Requirements for			solely because it is required		
		caid Participating Providers			by the provisions of federal		
	and Suppliers, 42 C				and state laws. Lynhurst		
	and Suppliers, 12 C.	110 105.75.			Healthcare maintains that		
	The facility has 40 o	certified beds. At the time of			the alleged deficiencies do		
	the survey, the cens				not individually or		
	the survey, the cons	us (145 52)			collectively jeopardize the		
	Quality Review con	onleted on 03/17/22			health and/or the safety of		
	Quanty Review con	ipicted on 03/17/22			its residents nor are they of		
	The requirement at	42 CFR, Subpart 483.73 is NOT			such character as to limit		
	MET as evidenced b	-			the provider's capacity to		
	as evidenced t	~J.			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

Any defiency statement 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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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		15E667	B. W		_	03/14/	2022
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD  MORRIS ST		
LYNHUR	RST HEALTHCARE				APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	(EACH DEFICIENT REGULATORY OF				(EACH CORRECTIVE ACTION SHOULD BE		
	section. The police be reviewed and u years [annually fo	cies and procedures must updated at least every 2 r LTC facilities]. At a cies and procedures must					
		(7), or (9)] The role of the vaiver declared by the					

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Event ID:

 $SK2K21 \qquad {\it Facility ID:} \quad 000385$ 

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	ENT OF DEFICIENCIES  N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	l í	JILDING	NSTRUCTION	(X3) DATE COMPL 03/14	ETED
	PROVIDER OR SUPPLIER	<b>.</b>		5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of the Act, in the partreatment at an all by emergency material way an all by emergency material way and a procedures. (8) The waiver declared by accordance with seprovision of care as identified by emerofficials. Based on record result and procedures included a waiver declared accordance with seprovision of care are care site identified officials in accordance with seprovision of care are care site identified officials in accordance. Based on record result and an on 03/14/22 by a policy and proceding facility under a wai in accordance with not available for restime of record review advised that the fact working at updating binder and that it we explaining that she entire binder as of the exit conference the facility Administration additional information of the service of the service of the service of the service of the facility Administration additional information of the service of the servi	ordance with section 1135 provision of care and ternate care site identified inagement officials.  3403.748(b):] Policies and the role of the RNHCI under a yethe Secretary, in section 1135 of Act, in the fact an alternative care site regency management which will be secretary and interview, the facility ergency preparedness policies and the role of the LTC facility lared by the Secretary, in action 1135 of the Act, in the fact treatment at an alternate by emergency management ince with 42 CFR 483.73(b) (8). icide could affect all occupants.  Aview with the Maintenance etween 12:12 pm and 12:41 p.m., therefore the role of the LTC in the	E 00	026	1) Corrective actions for those patients found to have been affected by the deficient praction. The facility does have an Emergency Preparedness bin which was given to the inspect This binder has been 'examinable by several management staff are no longer employed by the facility) and who left this binder disarray. (explained to the inspector). The facility will comply with whatever the waiver states LT shall do. (specific to 1135).  2) How other patients having the potential to be affected by the same practice are identified at what corrective actions will be taken:  The facility does have an Emergency Preparedness bin which was given to the inspect This binder has been 'examinable by several management staff	der, tor. ed' (who e er in  CC the der, tor. ed'	04/14/2022

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2022
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225	ADDRESS, CITY, STATE, ZIP COD W MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				are no longer employed by th facility) and who left this bind disarray. (explained to the inspector).	
				Corrective Action: The facility does have an Emergency Preparedness binder, which was given to the inspector.  This binder has been 'examin by several management staff are no longer employed by the facility) and who left this binder disarray. (explained to the inspector).  This author, the ED/Admin. is currently continuing to audit the Emergency Preparedness bire This binder has, as an estimation over two thousand pieces of documentation that must be audited and edited as applications.	ed' (who e er in s ne nder. tte,
				3) Measures put into place ar systemic changes:  This author, the ED/Admin. is currently auditing the Emerge Preparedness binder.  This binder has, as an estima over two thousand pieces of documentation that must be audited and edited as applica	ency te,
				Measure/Change: The nursin binder is downstairs in the DC office however the newly aud binder will not replace said ur the audit is complete.	DN's ited

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIEI		5225	T ADDRESS, CITY, STATE, ZIP COD W MORRIS ST ANAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				The facility will comply with whatever the waiver states LT shall do. (specific to 1135). This statement has been add the facility's Emergency Preparedness Plan.  4) How corrective actions will monitored and what quality assurance will be put into place.  Corrective Action: The nursing binder is downstairs in the DC office however the newly aud binder will not replace said ure the audit is complete and will available to staff and for emergency preparedness trainings.  The facility will comply with whatever the waiver states LT shall do. (specific to 1135). This statement has been add the facility's Emergency Preparedness Plan.  The Administrator and the DC will be responsible to monitor and adjust the binder as applicable.  5) Date the systemic changes be completed: 4-14-22	be ce: g DN's ited itil be  CC ed to DN /audit	
E 0035 SS=C Bldg	483.475(c)(8), 48 LTC and ICF/IID \$ §483.73(c)(8); §4 *[For LTC Facilitie	Sharing Plan with Patients 83.475(c)(8)				

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	AN OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING B. WING	construction 	COMPLETED 03/14/2022
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE			5225	ET ADDRESS, CITY, STATE, ZIP COD W MORRIS ST ANAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	maintain an emery communication plane reviewed and upd communication plane following:]  *[For ICF/IIDs at § [(c) The ICF/IID material mate	ty must develop and gency preparedness an that complies with d local laws and must be ated at least annually. The an must include all of the an an aredness communication with Federal, State and st be reviewed and updated ears. The communication all of the following:]  The facility has representatives, with residents [or amilies or representatives. With an includes a method for sharing the emergency preparedness in includes a method for sharing the emergency plan that the facility emergency plan that the families or representatives in CFR 483.73(c)(8). This build affect all occupants.	E 0035	1) Corrective actions for those patients found to have been affected by the deficient pract.  The facility does have an Emergency Preparedness bir which was given to the inspect This binder has been 'examin by several management staff are no longer employed by th facility) and who left this binded disarray. (explained to the inspector).  The facility is emailing and or mailing by post, invitations for families/guardians etc, to look and discuss our emergency preparedness plans. A copy of finalized facility plan will be emailed out to interested	tice:  nder, ctor. ned' (who ne er in  ck over

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	A. BUILDING COMP.		(X3) DATE SURVEY COMPLETED 03/14/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	working at updating binder and that it we explaining that she entire binder as of the exit conference the facility Administracy.			CROSS-REFERENCED TO THE APPROPRI	the ender, ctor. leed' (who ee er in ee		
				Measures put into place ar systemic changes:     This author, the ED/Admin. is	nd		

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SK2K21 Facility ID: 000385

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPLETED	
		15E667	B. WI	NG		03/14/	2022
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LYNHUR	ST HEALTHCARE				MORRIS ST APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION		TAG	currently auditing the Emerger Preparedness binder. This binder has, as an estimat over two thousand pieces of documentation that must be audited and edited as applicated. The nursing binder is downstated the DON's office however the newly audited binder will not replace said until the audit is complete.  "To ensure the emergency preparedness communication includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance 42 CFR 483.73(c)(8). This deficient practice could affect a occupants.": The facility is emailing and or mailing by post, invitations for families/guardians etc, to look and discuss our emergency preparedness plans. A copy of finalized facility plan will be emailed out to interested guardians and families.  4) How corrective actions will be monitored and what quality assurance will be put into place.  The nursing binder is downstated the DON's office however the	plan cy with all over f the	DATE
1	i		1		newly audited binder will not		Ī

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIER	1		5225 W	ADDRESS, CITY, STATE, ZIP COD  / MORRIS ST IAPOLIS, IN 46241			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)  replace said until the audit is complete.  Once the binder is completed the Admin. a copy will be place in the Director of Nursing's of and will be available to staff a emergency preparedness trainings.  "To ensure the emergency preparedness communication includes a method for sharing information from the emerger plan that the facility has determined is appropriate wit residents and their families or representatives in accordance 42 CFR 483.73(c)(8). This deficient practice could affect occupants.":  The facility is emailing and or mailing by post, invitations for families/guardians etc, to look and discuss our emergency preparedness plans. A copy of	l by ced fice and for plan dicy h e with all	(X5) COMPLETION DATE	
E 0036 SS=F Bldg	484.102(d), 485.6	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d),			finalized facility plan will be emailed out to interested guardians and families.  5) Date the systemic changes be completed: 4-14-22	s will		

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EP Training and Testing

§403.748(d), §416.54(d), §418.113(d),

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AND PLANO F CORRECTION  IDENTIFICATION NUMBER  ISEG67  ISTREET ADDRESS, CITY, STATE, ZIP COD S225 W MORRIS ST INDIANAPOLIS, IN 46241  IDENTIFICATION IN	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AMBE OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  (X4) ID  SUMMARY STATIMENT OF DEFICIENCE:  (RACH DEFICIENCY MUST BE PRECEDED BY ULL  TAG  RECULATORY OR LSC IDENTIFYING INFORMATION  \$441.184(0), \$460.84(0), \$482.15(0), \$485.373(0), \$483.475(0), \$484.102(0), \$485.88(0), \$485.82(0), \$485.727(0), \$485.920(0), \$486.360(0), \$491.12(0), \$494.62(0).  "[For RNCHIs at \$400.84, Hospitals at \$482.15, HHAs at \$484.102, CORFs at \$445.88, CAH's at \$486.82, Corganizations" under  485.727, CMHCs at \$485.920, OPOs at \$486.830, and RFLCFHOs at \$498.121(0) Training and testing. The [facility] must develop and maintain an emergency preparedness training and lesting program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) of this section, risk assessment at paragraph (a) (1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (a) of this section. The training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, and the communication plan at paragraph (a) of this section. The training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, and the communication plan at paragraph (b) of this section, and the communication plan testing. The LTC facility must develop and maintain an emergency perparedness training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, now, assessment at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least	AND PLAN	OF CORRECTION				<del></del>		
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  SUMMARY STATIMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INTOKANTON  S441-184(d), \$460.84(d), \$462.15(d),  \$483.73(d), \$483.475(d), \$484.102(d),  \$485.820(d), \$485.625(d), \$485.727(d),  \$4845.820(d), \$486.300(d), \$491.12(d),  \$494.62(d).  "[For RNCHIs at \$403.748, ASCs at \$416.54, Hospice at \$418.13, PRTFs at \$441.184, PACE at \$460.84, Hospitals at \$482.15, HHAs at \$484.6102, CORFs at \$485.80, CAHs at \$486.802, Organizations' under  485.727, CMHCs at \$405.920, OPOs at  \$486.300, and RHC/FHOs at \$491.121(d) Training and testing. The [facility] must develop and maintain an emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (a)(1) of this section, and the communication pand maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, nick assessment at paragraph (a)(1) of this section, nick assessment at paragraph (a)(1) of this section, now, and the communication pand maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, now, assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least			15E667	B. WI	NG		03/14/	2022
LYNHURST HEALTHCARE  (X4) ID  PREFIX  (RACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  S441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$483.475(d), \$484.102(d), \$486.58(d), \$486.562(d), \$486.5727(d), \$486.58(d), \$486.562(d), \$487.27(d), \$486.58(d), \$487.27(d), \$487.27(d), \$486.58(d), \$487.27(d), \$487.27	NAME OF P	ROVIDER OR SUPPLIER	3					
(X4) ID PREFIX TAG SEMENT (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG S441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$483.475(d), \$484.102(d), \$485.68(d), \$485.52(d), \$485.272(d), \$485.68(d), \$485.52(d), \$485.727(d), \$485.92(d), \$								
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  S441.184(d), \$486.084(d), \$482.15(d), \$483.73(d), \$483.475(d), \$484.102(d), \$484.58(d), \$485.625(d), \$484.102(d), \$485.920(d), \$486.625(d), \$484.102(d), \$494.62(d).  "[For RNCHIs at \$403.748, ASCs at \$416.54, Hospice at \$418.113, PRTFs at \$441.184, PACE at \$460.84 (hospitals at \$482.15, HHAs at \$484.102, CORFs at \$485.68, CAHs at \$486.625, "Organizations" under 485.727, CMHCs at \$459.20, OPOs at \$486.380, and RHC/FHQs at \$491.12[d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, and the communication plan at paragraph (a) fraining and testing. The LTC facilities at \$483.73(d); [d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) of this section, policies and procedures at paragraph (a) of this section, policies and procedures training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, ploicies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, and the communication plan at paragraph (b) of this section. The training and testing program	LYNHUR	STHEALTHCARE			INDIAN	APOLIS, IN 46241		
TAG  REGULATORY OR ISC IDENTIFYING INFORMATION  \$441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$483.475(d), \$484.102(d), \$485.920(d), \$485.525(d), \$485.727(d), \$485.920(d), \$486.360(d), \$491.12(d), \$494.62(d).  "[For RNCHIs at \$403.748, ASCs at \$416.54, Hospice at \$418.113, PRTFs at \$441.184, PACE at \$460.84, Hospitals at \$482.15, HHAs at \$484.102, CORFs at \$485.68, CAHs at \$486.625, "Organizations" under 485.727, CMHCs at \$495.920, OPOs at \$486.360, and RHC/FHQs at \$491.12] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (4) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.  "[For LTC facilities at \$483.73(d)] (d) Training and testing, The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (b) of this section, plan at forth in paragraph must be reviewed and updated at least	` ′					PROVIDER'S PLAN OF CORRECTION		(X5)
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*[For ICF/IIDs at §483.475(d):] Training and		*[For ICF/IIDs at §	3483.475(d):] Training and					
testing. The ICF/IID must develop and		testing. The ICF/II	D must develop and					

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

Event ID:

SK2K21

Facility ID: 000385

If continuation sheet

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PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING B. WING		COMPLETED 03/14/2022
	PROVIDER OR SUPPLIER	t.	5225	FADDRESS, CITY, STATE, ZIP COD W MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i).  *[For ESRD Facility Training, testing, adialysis facility must emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at paragraph the communic of this section. The orientation programupdated at every 20 communication programupdated	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and			
	Based on record rev failed to develop an preparedness trainin accordance with 42 practice could affect Findings include:  Based on record rev Man on 03/14/22 be the emergency prep portion of emergency located for review.	view and interview, the facility d maintain an emergency ag and testing program in CFR 483.73(d). This deficient	E 0036	1) Corrective actions for those patients found to have been affected by the deficient pract.  No patients were noted to be negatively affected by the alle practice.  The facility does have an Emergency Preparedness bin which was given to the inspect This binder has been 'examine by several management staff are no longer employed by the facility) and who left this binder.	ice: ged der, stor. ed' (who

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

Event ID:

SK2K21

Facility ID: 000385

If continuation sheet

Page 11 of 76

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2022
		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241		
PREFIX	(EACH DEFICIEN REGULATORY OI	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	updating the emerg that it was still a "w that she had not bee of the time of this s conference with the facility Administral additional informat	ency preparedness binder and york in progress" explaining en through the entire binder as urvey. During the exit e Maintenance man and the tor on 03/14/22 at 1:30 p.m., no ion or evidence could be		disarray. (explained to the inspector). This author, the ED/Admin. is currently auditir the Emergency Preparedness binder.  This binder has, as an estima over two thousand pieces of documentation that must be audited and edited as applicated. All pervious emergency training and testing documentation was removed from this facility by pemployees and the facility has means available to recover the documents.  New employees have emergentraining in services included in their hire on paperwork.  2)How other patients having the potential to be affected by the same practice are identified as what corrective actions will be taken:  All pervious emergency training and testing documentation was removed from this facility by pemployees and the facility has means available to recover the documents.  New employees have emergency training in services included in their hire on paperwork.  The facility is unable to obtain documents for the past training but will start emergency training as an and have proper	te, ble. ng as prior s no ese ency n he as prior s no ese ency n he as prior s no ese

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		IDENTIFICATION NUMBER	A. BUILDING COM		(X3) DATE COMPL 03/14/	ETED	
			D. W1		ADDRESS, CITY, STATE, ZIP COD	03/14/	2022
	PROVIDER OR SUPPLIEF ST HEALTHCARE			5225 W	MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					documentation of such, for the year 2022.  The facility does have an	9	
					Emergency Preparedness bin which was given to the inspec		
					Corrective Action: The facility does have an Emergency Preparedness binder, which we given to the inspector. This binder has been 'examine by several management staff are no longer employed by the facility) and who left this binder disarray. (explained to the inspector). This author, the ED/Admin. is currently auditing the Emergency Preparedness binder.  This binder has, as an estimation over two thousand pieces of documentation that must be	vas ed' (who e er in	
					audited and edited as applical **The facility has developed a written ER Training/testing Po (see attached)		
					Measures put into place an systemic changes:	d	
					The nursing binder is downstated the DON's office however the newly audited binder will not replace said until the audit is complete.  All pervious emergency training and testing documentation was	ng	

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	T OF DEFICIENCIES  DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COME	E SURVEY PLETED 4/2022
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP C V MORRIS ST NAPOLIS, IN 46241	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				removed from this faciliemployees and the faciliemployees and the faciliemployees and the faciliemployees and the facility will start entraining and have propied documentation of such year 2022.  New employees have training in services incitation their hire on paperwork.  4) How corrective action monitored and what quassurance will be put in the nursing binder is of the DON's office howen ewly audited binder we replace said until the acomplete.  Once the binder is conthe Admin. a copy will in the Director of Nursiliand will be available to emergency prepared not trainings.  Quality Assurance: All emergency training and documentation was result this facility by prior emand the facility by prior emand the facility has no available to recover the documents.  The facility will start entraining and have propied documentation of such year 2022. The Adminior her designees will me these training exercises **The facility has deve	cover these cover the cover these cover the cover the cover these cover the cove	

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15E667 B.	A. BUILDING  B. WING	<del></del>	COMPLETED 03/14/2022
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE	5225 W N	DDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
E 0037		written ER Training/testing Pol (see attached)  5) Date the systemic changes be completed: 4-14-22	DATE icy

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			ETED	
		15E667	B. W	ING		03/14/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			MORRIS ST		
LYNHUR	ST HEALTHCARE				APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(i) Initial training ir	n emergency preparedness					
		edures to all new and					
	_	viduals providing services					
	under arrangement, and volunteers,						
	consistent with the						
	, ,	ency preparedness training					
	at least every 2 ye						
	, ,	mentation of all emergency					
	preparedness trail						
	(iv) Demonstrate s						
	emergency proced						
	, ,	cy preparedness policies					
	•	re significantly updated, the duct training on the					
		<u> </u>					
	updated policies a	and procedures.					
	*IFor Hospices at	§418.113(d):] (1) Training.					
	-	do all of the following:					
	•	n emergency preparedness					
	,,	edures to all new and					
		employees, and individuals					
		s under arrangement,					
	consistent with the	_					
	(ii) Demonstrate s						
	emergency proced	_					
		gency preparedness training					
	at least every 2 ye	ears.					
	(iv) Periodically re	view and rehearse its					
	emergency prepar	redness plan with hospice					
	employees (includ	ling nonemployee staff),					
	with special emph	asis placed on carrying out					
	the procedures ne	ecessary to protect patients					
	and others.						
	(v) Maintain docur	mentation of all emergency					
	preparedness trai	ning.					
	, ,	ncy preparedness policies					
	•	re significantly updated, the					
	hospice must con-	duct training on the					
	updated policies a	and					
	procedures.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVE  COMPLETED  03/14/2022			ETED		
		132007	В. W1			03/14/	2022
NAME OF P	ROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP COD  MORRIS ST		
LYNHUR	ST HEALTHCARE		_		APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	program. The PRT following:  (i) Initial training in policies and proce existing staff, individual under arrangemer consistent with the (ii) After initial train preparedness train (iii) Demonstrate semergency proced (iv) Maintain docur preparedness train (v) If the emergent and procedures and procedures and PRTF must condupolicies and procedures of whom to contact in (iv) Maintain docur (v) If the emerger and procedures an	eir expected roles.  Ining, provide emergency Ining every 2 years.  Istaff knowledge of Idures. Imentation of all emergency Ining. It is graph of the provide experimentation of all emergency Ining. It is graph of the policies It is graph of the policies It is emergency preparedness It is graph of the following: In emergency preparedness It is graph of the policies					

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	ENT OF DEFICIENCIES  N OF CORRECTION	IDENTIFICATION NUMBER  15E667	 UILDING	NSTRUCTION	COMPL 03/14/	ETED
	F PROVIDER OR SUPPLIEF JRST HEALTHCARE		5225 W	.DDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	*[For LTC Facilities Training Programs of the following: (i) Initial training in policies and proce existing staff, indiv under arrangement consistent with the (ii) Provide emerg at least annually. (iii) Maintain docu preparedness trai (iv) Demonstrate as emergency proce  *[For CORFs at & CORF must do all (i) Provide initial to preparedness polities under arrangement consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docu (iv) Demonstrate as emergency procee must be oriented as responsibilities re- emergency plan w workday. The train instruction in the le systems and signal equipment. (v) If the emerge and procedures a CORF must condi- policies and procedures and procedures and condi-	res at §483.73(d):] (1) The LTC facility must do all remergency preparedness redures to all new and riduals providing services redures to all new and riduals providing services respected role. rency preparedness training rementation of all emergency ring. retaff knowledge of redures.  485.68(d):](1) Training. The red of the following: reaining in emergency reies and procedures to all restaff, individuals providing reangement, and volunteers, reir expected roles. rency preparedness training rears. rementation of the training. retaff knowledge of redures. All new personnel reand assigned specific regarding the CORF's rithin 2 weeks of their first realing program must include recation and use of alarm reals and firefighting recy preparedness policies re significantly updated, the rect training on the updated				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUI		l í	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 03/14/2022			
	PROVIDER OR SUPPLIE		522	REET ADDRESS, CITY, STATE, ZI 25 W MORRIS ST DIANAPOLIS, IN 46241	PCOD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREF	CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION
TAG	program. The CA following: (i) Initial training in policies and procedures and procedures are generally provided and disaster auth existing staff, indiced arrangeme consistent with the site of provided and disaster auth existing staff, indiced arrangeme consistent with the site of provided arrangeme consistent with the site of provided and provided arrangement, and procedures are consistent with the site of provided and procedures are consistent with the site of provided and procedures are consistent with the site of procedures and procedures and procedures and procedures and procedures and procedures to all individuals provided arrangement, and their expected rold documentation of must demonstrate emergency procedures training are consistent and the site of provided arrangement, and their expected rold documentation of must demonstrate emergency procedures training are consistent and the site of provided arrangement, and their expected rold documentation of must demonstrate emergency procedures training are consistent and the site of provided arrangement, and their expected rold documentation of must demonstrate emergency procedures training are consistent and the site of provided arrangement, and the site of provided arrangement arrangeme	imentation of the training. Instaff knowledge of dures. Incompreparedness policies re significantly updated, the cottraining on the updated redures.  Incompression of the updated redures and redures and redures and redures and redures and redured redured reduced redu	E 0037			04/14/2022
	failed to ensure the training and testing program. The LTC following: (i) Initia	emergency preparedness program includes a training facility must do all of the distraining in emergency less and procedures to all new	E 003/	Corrective actions patients found to have affected by the deficiency.  No patients were no negatively affected by the deficiency.	ve been ient practice: ted to be	04/14/2022

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		15E667	B. WI	NG		03/14/	2022
	PROVIDER OR SUPPLIER			5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	and existing staff, in	ndividuals providing services			practice.		
	under arrangement,	and volunteers, consistent			The facility does have an		
	with their expected	roles; (ii) at least annually; (iii)			Emergency Preparedness bin	der,	
	Maintain documentation of all emergency				which was given to the inspec	tor.	
	preparedness training; (iv) Demonstrate staff				This binder has been 'examine	ed'	
	knowledge of emergency procedures in				by several management staff	(who	
	accordance with 42 CFR 483.73(d) (1). This				are no longer employed by the	•	
	deficient practice could affect all occupants.				facility) and who left this binde	r in	
					disarray. (explained to the		
	Findings Include:				inspector). This author, the		
					ED/Admin. is currently auditing	g	
		view with the Maintenance			the Emergency Preparedness		
	Man on 03/14/22 between 12:12 pm and 12:41 p.m.,				binder.		
		aredness documentation of			This binder has, as an estimat	e,	
		ergency preparedness training			over two thousand pieces of		
		e located for review. Based on			documentation that must be		
		e of record review, the			audited and edited as applical	ole.	
		dvised that the facility			All previous emergency trainir	-	
		working at updating the			and testing documentation wa		
		dness binder and that it was			removed from this facility by p		
		gress" explaining that she had			employees and the facility has		
	_	e entire binder as of the time			means available to recover the	ese	
	1	ng the exit conference with the			documents.		
		nd the facility Administrator			l.,		
		p.m., no additional information			New employees have emerge	-	
		e provided contrary to this			training in services included in	l	
	deficient finding.				their hire on paperwork.		
					2)How other petients having 4		
					2)How other patients having the potential to be affected by the	IC	
					same practice are identified a	nd	
					what corrective actions will be		
					taken:		
					lanen.		
					All previous emergency trainir	ıa	
					and testing documentation wa	•	
					removed from this facility by p		
					employees and the facility has		
					means available to recover the		
					documents		

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING B. WING		COMPLETED 03/14/2022
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				New employees have emergy training in services included their hire on paperwork. The facility will start emerger training and have proper documentation of such, for the year 2022. The facility will act to life safety guidelines.	in ncy
				Measures put into place a systemic changes:	nd
				The nursing binder is downs the DON's office however the newly audited binder will not replace said until the audit is complete.  All previous emergency train and testing documentation were moved from this facility by employees and the facility has means available to recover the documents.  The facility will start emerger training and have proper documentation of such, for the year 2022.  New employees have emerged training in services included their hire on paperwork.  **The facility has developed written ER Training/testing Proceedings of the power of the	ing ras prior ras no hese ncy ne ency in a olicy

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	ľ í	JILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/14/2022	
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION			5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					monitored and what quality assurance will be put into place. The nursing binder is downstate the DON's office however the newly audited binder will not replace said until the audit is complete.  Once the binder is completed the Admin. a copy will be place in the Director of Nursing's office and will be available to staff are emergency preparedness trainings.  Quality Assurance: All previous emergency training and testing documentation was removed if this facility by prior employees and the facility has no means available to recover these documents.  New employees have emergency training in services included in their hire on paperwork.  The facility will start emergency training and have proper documentation of such, for the year 2022. The Administrator are or her designees will monitor these training exercises.  **The facility has developed a written ER Training/testing Policise attached)  5) Date the systemic changes be completed: 4-14-22	by ed ce nd for us grown row	
E 0039	403.748(d)(2), 410	6.54(d)(2), 418.113(d)(2),					

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441.184(d)(2), 482.15(d)(2), 483.475(d)(2),

483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),

SS=F

Bldg. --

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		15E667	B. W	ING		03/14	/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					MORRIS ST		
LYNHUR	RST HEALTHCARE			INDIAN.	APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1.12(d)(2), 494.62(d)(2)					
	EP Testing Requi						
		18.113(d)(2), §441.184(d)(2),					
	§460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)						
	- , , , , -						
	(2), §491.12(d)(2)	, <del>9494.02(u)(2)</del> .					
	*[For ASCs at §41	16.54, CORFs at §485.68,					
	OPO, "Organization	ons" under §485.727,					
	CMHCs at §485.9	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [f	facility] must conduct					
		he emergency plan					
		ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based						
		nunity-based exercise is					
		enduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the [facility]					
	is exempt from en	gaging in its next required					
	community-based	or individual, facility-based					
	functional exercise	e following the onset of the					
	actual event.						
	` '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
	' '	scale exercise that is					
	· · · · · · · · · · · · · · · · · · ·	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	(C) A tabletop exe	ercise or workshop that is					I

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667		A. BUILDING B. WING		COMPLETED 03/14/2022				
	OF PROVIDER OR SUPPLIEF	<b>R</b>	STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE	
	discussion using a clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and enthe [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annual the following:  (i) Participate in a community based (A) When a community based (A) When a community based functional etc.  (B) If the hospice man-made emerging of the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop (C) A mock disas (C) A tabletop (C	emergency scenario, and a stements, directed pared questions designed mergency plan. acility's] response to and station of all drills, tabletop mergency events, and revise regency plan, as needed.  418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or munity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. dditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 03/14/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241						
(X4) ID PREFIX TAG	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		LATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	set of problem sta	emergency scenario, and a tements, directed pared questions designed							
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engangull-scale community (ii) Conduct an activat may include, following:  (A) A second full-	nunity-based exercise is not ct an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the							
	functional exercise (B) A mock disas (C) A tabletop exercise facilitator that inclusing a narrated, emergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency and emergency plan.	ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared							

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667		A. BUILDING B. WING		COMPLETED 03/14/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	§482.15(d), CAHs (2) Testing. The [F conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community. (A) When a comm accessible, condu facility-based func (B) If the [PRTF, F an actual natural of that requires activ plan, the [facility] i its next required fu or individual, facili following the onse (ii) Conduct a exercise or and th limited to the follor (A) A second full- community-based facility-based func (B) A mo (C) A tabletop is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze th and maintain docu tabletop exercises	PRTF, Hospital, CAH] must to test the emergency in The [PRTF, Hospital, following: In annual full-scale exercise abased; or unity-based exercise is not ct an annual individual, tional exercise; or dospital, CAH] experiences or man-made emergency ation of the emergency is exempt from engaging in ull-scale community based ty-based functional exercise to fithe emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed						

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PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667		A. Bl	A. BUILDING B. WING			COMPLETED 03/14/2022		
	F PROVIDER OR SUPPLIEF JRST HEALTHCARE	e e	STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	conduct exercises plan at least annu organization must (i) Participate in a that is community. (A) When a commaccessible, condufacility-based function of the exempt from enfull-scale community conset of the emericality-based functional exercise of this section is continuity-based functional exercise of this section is continuity-based functional exercise of this section is continuity-based functional exercise of the emerical functional exercise of this section is continuity-based functional exercise functional exercise functional exercise functional exercise functional exercises functional exercises, and emerical functional exercises.	ACE organization must to test the emergency ally. The PACE do the following: an annual full-scale exercise abased; or annual individual, stional exercise; or aperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required aity based or individual, stional exercise following the gency event. In additional exercise every he year the full-scale or a under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. PACE's response to and antation of all drills, tabletop mergency events and revise gency plan, as needed.						

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PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		15E667	B. W	ING		03/14/	/2022
NAME OF I	DDOMDED OD GIDDI IEI	)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF			5225 W	MORRIS ST		
LYNHUR	RST HEALTHCARE			INDIAN.	APOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	•	ency plan at least twice per					
	, ,	announced staff drills using ocedures. The [LTC facility,					
	ICF/IID] must do t	=					
	-	an annual full-scale exercise					
	that is community						
	•	nunity-based exercise is not					
	, ,	ict an annual individual,					
	facility-based fund						
	(B) If the [LTC fac	ility] facility experiences an					
	actual natural or n	nan-made emergency that					
		n of the emergency plan, the					
		mpt from engaging its next					
		lle community-based or					
	1	based functional exercise					
	_	et of the emergency event.					
	1 ' '	dditional annual exercise					
	-	but is not limited to the					
	following:	and average that is					
		scale exercise that is					
	based functional	or an individual, facility					
	(B) A mock disas						
	` '	ercise or workshop that is					
	led by a facilitator						
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	·					
	_	LTC facility] facility's					
	. ,	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del>-</del>	COMPL	
		15E667	B. WI	NG		03/14/	/2022
NAME OF I	DROVIDED OD CHDDI IEE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	C		5225 W	MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN	APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	following:	n annual full acala avaraica					
		n annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ct an annual individual,					
	•	ctional exercise; or. experiences an actual					
	` '	experiences an actual addeding and actual addedings are actual and actual addedings are actual and actual addedings are actual addedings and actual addedings are actual a					
		mergency plan, the ICF/IID					
		gaging in its next required					
	•	nity-based or individual,					
		ctional exercise following the					
	onset of the emer	<del>-</del>					
		ditional annual exercise					
	, ,	but is not limited to the					
	following:						
	_	scale exercise that is					
	community-based						
	_	ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using						
	_	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er						
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	24 1021					
		e HHA must conduct					
		he emergency plan at					
	least annually. The HHA must do the						
	following: (i) Participate in a full-scale exercise that is						
	community-based						
		ommunity-based exercise					
	l (A) when a c	ommunity-based exercise					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667		A. B	A. BUILDING B. WING			COMPLETED 03/14/2022	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD MORRIS ST		
LYNHUR	ST HEALTHCARE				APOLIS, IN 46241		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		conduct an annual					
		based functional exercise					
	every 2 years; or.	A experiences an actual					
	1 ' '	ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer	_					
	(ii) Conduct an ad	ditional exercise every 2					
	years, opposite th	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
		full-scale exercise that is					
	community-based						
	facility-based fund						
	, ,	isaster drill; or					
		exercise or workshop that					
	· ·	or and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
	· ·	pared questions designed					
	to challenge an er	·					
	_	HA's response to and					
	, ,	ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §48	86.360]					
	(d)(2) Testing. The	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	S					
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a					
		using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667		A. BUILDING  B. WING		COMPLETED 03/14/2022			
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PROPERTY OF LSC IDENTIFY CONTROL OF LSC I	RECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE			
problem statements, directed in prepared questions designed to emergency plan. If the OPO exactual natural or man-made en requires activation of the emer OPO is exempt from engaging required testing exercise follow of the emergency event.  (ii) Analyze the OPO's responsions maintain documentation of all exercises, and emergency eventhe [RNHCl's and OPO's] emericeded.  *[RNCHIs at §403.748]:  (d)(2) Testing. The RNHCl must exercises to test the emergency RNHCl must do the following:  (i) Conduct a paper-based, tab at least annually. A tabletop exproup discussion led by a facili narrated, clinically-relevant emscenario, and a set of problem directed messages, or prepared designed to challenge an eme  (ii) Analyze the RNHCl's responsionation of all exercises, and emergency eventhe RNHCl's emergency plan, Based on record review and interfailed to conduct exercises to test plan at least twice per year, including an emergency eventhe RNHCl's emergency plan, Based on record review and interfailed to conduct exercises to test plan at least twice per year, including an emergency eventhe RNHCl's emergency plan, Based on record review and interfailed to conduct exercises to test plan at least twice per year, including an emergency eventher. The LTC facility must following:  (i) Participate in an annual full-so is community-based; or a. When a community-based exercises to exercise to exe	messages, or to challenge an experiences an ergency that regency plan, the prin its next wing the onset ergency plan, as est conduct experience is a sitator, using a ergency plan. The experience is a sitator, using a ergency plan. Every plan ergency entatements, end questions ergency plan. Every plan ergency ergency plan ergency ergenc	E 0039	1) Corrective actions for those patients found to have been affected by the deficient practic.  No patients were noted to be negatively affected by the alleg practice.  The facility does have an Emergency Preparedness bind which was given to the inspect This binder has been 'examine	04/14/2022 ce: ged der, for.			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15E667		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/14/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY)			(X5) COMPLETION DATE
TAG	b. If the LTC facility or man-made emerge of the emergency perform engaging its not community-based of full-scale functional the onset of the acturation (ii) Conduct an addinclude, but is not learn as A second full-scale community-based of functional exercises. b. A mock disaster c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or prepare challenge an emergen (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice confidence in the control of the	y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based lexercise for 1 year following nal event. itional exercise that may imited to the following: alle exercise that is or an individual, facility-based drill; or see or workshop that is led by a des a group discussion, using y relevant emergency scenario, an statements, directed red questions designed to ency plan. The facility's response to and action of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.		TAG	by several management staff are no longer employed by the facility) and who left this binded disarray. (explained to the inspector).  This author, the ED/Admin. is currently auditing the Emerger Preparedness binder. This binder has, as an estimate over two thousand pieces of documentation that must be audited and edited as applical All pervious emergency training and testing documentation was removed from this facility by pemployees and the facility has means available to recover the documents.  New employees have emerge training in services included in their hire on paperwork.  **The facility has developed a written ER Training/testing Por (see attached).	(who	DATE
	Man on 03/14/22 be the emergency prep annual full-scale ex				The facility will participate in a least an annual full-scale exer that is community or facility based; participate in an additional control of the facility based.	cise	
	facility-based funct or man-made emerg of the emergency p that is community-l	an annual individual, ional exercise, an actual natural gency that requires activation lan, a second full-scale exercise based or an individual,			annual exercise; analyze the facility's response; on an annubasis, as required by LSC/Staguidelines.		
	facility-based funct drill, or a tabletop e	ional exercise, a mock disaster xercise or workshop that is led includes a group discussion,			2)How other patients having the potential to be affected by the same practice are identified at		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		A. BU	(X2) MULTIPLE CONSTRUCTION (X:  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIE RST HEALTHCARE			5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPL	
TAU	using a narrated, cl scenario, and a set directed messages, designed to challer on interview at the Maintenance man a Administrator was emergency prepare still a "work in pro not been through th of this survey. Dur Maintenance man a on 03/14/22 at 1:30	inically relevant emergency of problem statements, or prepared questions age an emergency plan. Based time of record review, the advised that the facility working at updating the dness binder and that it was agress" explaining that she had be entire binder as of the time and the facility Administrator by p.m., no additional information be provided contrary to this		IAC	what corrective actions will be taken:  All pervious emergency training and testing documentation was removed from this facility by pemployees and the facility has means available to recover the documents.  Wayne Township Fire Departed does provide mock disaster drafor fire drill and evacuations procedures twice per year.  New employees have emerged training in services included in their hire on paperwork.  The facility will start emergency training and have proper documentation of such, for the year 2022. The facility will adhe to life safety guidelines.	g s rior no ese nent tills	.D.
					3) Measures put into place and systemic changes:  The nursing binder is downstate the DON's office however the newly audited binder will not replace said until the audit is complete.  All pervious emergency training and testing documentation was removed from this facility by pemployees and the facility has means available to recover the	g s ior no	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETED						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. Bl B. W		<del></del>	03/14/2		
		10007	ъ. w	_		00/14/2	-022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST					
LYNHUR	ST HEALTHCARE		INDIANAPOLIS, IN 46241					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	`				CROSS-REFERENCED TO THE APPROPRIA	TE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  The facility will start emergency training and have proper documentation of such, for the year 2022. New employees have emerge training in services included in their hire on paperwork.  **The facility has developed a written ER Training/testing Po (see attached).  The facility will participate in a least an annual full-scale exer that is community or facility based; participate in an addition annual exercise; analyze the facility's response; on an annubasis, as required by LSC/Sta guidelines.  4) How corrective actions will monitored and what quality assurance will be put into place The nursing binder is downsta the DON's office however the newly audited binder will not replace said until the audit is complete.  Once the binder is completed the Admin. a copy will be place in the Director of Nursing's offi and will be available to staff an	cy e ncy licy t cise onal ual te be ee: eirs in	COMPLETION DATE	
					emergency preparedness trainings. Quality Assurance: All perviou emergency training and testing	g		
					documentation was removed this facility by prior employees			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	<del></del>	(X3) DATE SURVEY COMPLETED 03/14/2022			
	ROVIDER OR SUPPLIER ST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.1 (e) Emergency an The [LTC facility and implement emergency systems based on forth in paragraph §482.15(e)(1), §48 Emergency generates	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. and the CAH] must ency and standby power in the emergency plan set (a) of this section.		and the facility has no means available to recover these documents.  New employees have emerge training in services included in their hire on paperwork.  The facility, unable to provide previous documentation, will semergency training and have proper documentation of such the year 2022. The Administration and or her designees will monthese training exercises.  5) Date the systemic changes be completed: 4-14-22	start , for ator itor			

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Care Facilities Code (NFPA 99 and Tentative

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  15E667	UILDING		COMPLETED 03/14/2022		
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' TAG DEFICIENCY)		ιΤΕ	(X5) COMPLETION DATE	
	12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §483. Emergency generating The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, Nocode.  482.15(e)(3), §483. Emergency generating and LTC facilities source to power endure and LTC facilities source to power endure appears of the standards incomposed to the	and is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. If and LTC facility] must ergency power system and [maintenance] and in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs athat maintain an onsite fuel amergency generators must aw it will keep emergency berational during the as it evacuates.  §482.15(h), LTC at acade (AHs) corporated by reference in co					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED		
		15E667	B. WING		03/14/2022
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	http://www.archive	es.gov/federal_register/code			
		ations/ibr_locations.html.			
		this edition of the Code are			
		eference, CMS will publish a			
		ederal Register to			
	announce the cha	_			
	, ,	Protection Association, 1			
	Batterymarch Par				
	Quincy, MA 02169	9, www.nfpa.org,			
	1.617.770.3000.	11 O F 1111 O I			
	. ,	th Care Facilities Code,			
		ed August 11, 2011.			
		im amendment (TIA) 12-2 to			
	NFPA 99, issued	_			
	2012.	FPA 99, issued August 9,			
		FPA 99, issued March 7,			
	2013.	FFA 99, ISSUEU MAICH 7,			
		PA 99, issued August 1,			
	2013.	1 7 7 30, 133ded 7 dgd3t 1,			
		FPA 99, issued March 3,			
	2014.				
		fe Safety Code, 2012			
	edition, issued Au	•			
		IFPA 101, issued August			
	11, 2011.	<u> </u>			
	(ix) TIA 12-2 to NF	FPA 101, issued October			
	30, 2012.				
	(x) TIA 12-3 to NF	PA 101, issued October			
	22, 2013.				
	(xi) TIA 12-4 to NF	FPA 101, issued October			
	22, 2013.				
	. ,	tandard for Emergency and			
		ystems, 2010 edition,			
	including TIAs to a 2009	chapter 7, issued August 6,			
		view and interview, the facility	E 0041	1) Corrective actions for those	04/14/2022
	_	the emergency power system		patients found to have been	
	_	and maintenance requirements		affected by the deficient pract	ice:
	found in the Health	Care Facilities Code, NFPA			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	A. BUILDING <u></u>		(X3) DATE COMPL <b>03/14</b> /	ETED	
	PROVIDER OR SUPPLIER			5225 W	ADDRESS, CITY, STATE, ZIP COD ' MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	l '	y Code in accordance with 42 This deficient practice could .			No patients were noted to be negatively affected by the allequence.	ged	
	Man on 03/14/22 be the emergency prep 52 or 52 weekly an inspections and test record review. Base record review, the Mand could not locate documentation as the person had taken all she was fired. During Maintenance man a on 03/14/22 at 1:30	view with the Maintenance etween 12:12 pm and 12:41 p.m., paredness documentation for d 10 of 12 monthly generator ing were not available for ed on interview at the time of Maintenance man advised that the facility for seven weeks e any prior testing he previous maintenance I documentation with her when high the exit conference with the not the facility Administrator p.m., no additional information he provided contrary to this			2)How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken:  The facility does have an Emergency Preparedness bind which was given to the inspect This binder has been 'examine by several management staff are no longer employed by the facility) and who left this binded disarray. (explained to the inspector).  This author, the ED/Admin. is currently auditing the Emerger Preparedness binder. This binder has, as an estimat over two thousand pieces of documentation that must be audited and edited as applicated. All pervious emergency training and testing documentation was removed from this facility by premployees and the facility has means available to recover the documents. The facility has established a Fire Log book and has perform 2 unannounced fire drills. Future fire drills will meet the required standards. The facility will continue to	der, tor. ed' (who e r in ncy e, g s rior e no esee new	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPLETED	
		15E667	B. W	ING		03/14/2022	
				_	_		-
NAME OF I	PROVIDER OR SUPPLIEF	<b>?</b>			ADDRESS, CITY, STATE, ZIP COD		
				V MORRIS ST			
LYNHUF	RST HEALTHCARE			INDIAN	NAPOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	REGUENTORT OF	CESC IDENTIFICATION ORGANITOR		1710	document actions including		DATE
						4:	
					generator inspections and tes	-	
					The generator at the facility do	oes	
					"self test" once per week for		
					approximately ten minutes.		
					3) Measures put into place an	d	
					systemic changes:		
					The feeilibe has established a		
					The facility has established a new		
			Fire Log book and has performed				
					2 unannounced fire drills. Fire		
					drills will meet the required		
					standards.		
					The facility will continue to		
					document actions including		
					generator inspections and tes	ting.	
					The generator at the facility do	oes	
					"self test" once per week for		
					approximately ten minutes.		
					, ,		
					4) How corrective actions will	be	
					monitored and what quality		
					assurance will be put into place	e:	
					The Maintenance person and	the	
					LHFA will be responsible to		
					monitor and meet required		
					standards.		
					The facility has established a	new	
					Fire Log book and has perforr		
					2 unannounced fire drills. Fire		
					drills will meet the required		
					standards.		
					Superior systems is currently		
					emailing this author all relevan	nt	
					tests that they perform on	14	
	I		- 1		l resis mar mey benonin on		I

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schedule and this record will be keep in a binder for maintenance

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AND PLAN OF CORREC	· ´	A. BUILDING B. WING		COMPLETED 03/14/2022
NAME OF PROVIDER O		5225 W	ADDRESS, CITY, STATE, ZIP COD  / MORRIS ST  IAPOLIS, IN 46241	ļ
PREFIX (EAC	SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000			to share with surveyors.  5) Date the systemic changes be completed: 4-14-22	s will
Licensure Department 483.90(a) Survey E Facility N Provider AIM Nun At this L Healthca Requiren CFR Sub the 2012 Associati Chapter 410 IAC This facil sprinkler private re section, a determin The facil detection corridor. detectors	Jumber: 000385 Number: 15E667 Inber: 100291340  If e Safety Code survey, Lynhurst If was found not in compliance with It nents for Participation in Medicaid, 42 Inpart 483.90(a), Life Safety from Fire and Indedicated the Mational Fire Protection In the National Fire Protection In the N	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 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	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15E667		A. BUILDING B. WING	01	COMPLETED 03/14/2022	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD  / MORRIS ST	
LYNHUR	ST HEALTHCARE		INDIAN	IAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility has a capaci 32 at the time of this All areas where resi were sprinklered. The buildings providing	ty of 40 and had a census of s visit.  dents have customary access he facility has two detached facility services which are the d a metal storage shed which klered.		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 under the opinion that it was in compliance with the requirements of participation or that corrective action was necessarial	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 7.1 Based on observation failed to ensure the corridors was continuous through 18/19.2.1, 7.1 based on obstructions. This districtions.	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211	1) Corrective actions for those patients found to have been affected by the deficient praction. Although any patient could habeen negatively affected, no patients were noted to be	ice:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  03/14/2022	
	ROVIDER OR SUPPLIER		5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Based on observation of the facility, then 11:58 a.m. with the the following was not an act and a cart made of PV South Hall corridor contained five patien four bedsheets, and bothere were two be room chair being striumediately outside items were not in us wall or the floor. c) a two-drawer cab and a cart made of I the West Hall corridorart contained five pair six bedsheets, three blankets.  Based on an intervict at the time of each of items stored in the corresponding to the cart contained five pair items stored in the corresponding to the cart contained five pair items stored in the corresponding to the cart contained five paramently because room to store these the exit conference and the maintenance no additional inform	ons made on a pre-survey tour again between 10:51 a.m. and maintenance man on 03/14/22, oted:  // C pipe was being stored in the and was not in use. This cart nt gowns, seven pillowcases,		negatively affected by the alle practice.  2)How other patients having the potential to be affected by the same practice are identified at what corrective actions will be taken:  Linen carts ( carts made of PV pipe) were stored in each hall staff use.  These carts have been remove and linen is stored in cabinets two closets near or in the Activ room. There will also be on line cart in Act. Rm, strategically placed so as not to impede egress.  The two drawer cabinet found the west hall has been removed. It had bee placed in the hall do a room cleaning).  The chair near the main dining room hall, has been removed.  3) Measures put into place an systemic changes:  Linen carts ( carts made of PV pipe) were stored in each hall staff use.  These carts have been removed.	ped  me  md  /C  for  ed  and  /ity  en  in  ed. (  uring  d  //C  for
				and linen is stored in cabinets two lockable closets near or in Activity room. There will also to on linen cart in Act. Rm, strategically placed so as not	and the pe

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/14/2022
	PROVIDER OR SUPPLIE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				4) How corrective actions will be monitored and what quality assurance will be put into place.  Linen carts ( carts made of PV pipe) were stored in each hall staff use.  These carts have been remove and linen is stored in cabinets two lockable closets near or in Activity room. There will also be on linen cart in Act. Rm, strategically placed so as not to impede egress. Maintenance who had in the responsible to monitor the redaily and keep	ect for ed and the e
K 0225 SS=E Bldg. 01	Stairways and Sn Stairways and Sn as exits are in acc 18.2.2.3, 18.2.2.4 Based on observatifailed to ensure iter fire escape stairway egress. LSC 7.2.2.5 the exit enclosure spurpose that has the egress. This deficies	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2. 1, 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility ms stored under 1 of 1 interior ys would not interfere with 5.3.1 states open space within shall not be used for any the potential to interfere with ent practice could affect as working in the basement.	K 0225	1) Corrective actions for those patients found to have been affected by the deficient practice.  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the alleg practice.	04/14/2022 ce:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIE	5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
	SUMMARY (EACH DEFICIENT REGULATORY OF Findings include:  Based on observating facility on 03/14/22 maintenance man, least 40 cardboard stored underneath to time of observation acknowledged the stored under the base he would find another the stored under the base he would find another stored under the base he would find another the stored under the base he would find another stored under the stored under the base he would find another stored under the stored unde	5225 V	V MORRIS ST	the e and e
			Working with this Administrate the expectations of Life Safe Codes and other regulations.	ty

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X	3) date survey completed 03/14/2022
	PROVIDER OR SUPPLIER	5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, 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
			be followed.  5) Date the systemic changes v be completed: 4-14-22	vill
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1			
	Based on observation, record review, and interview, the facility failed to ensure all battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.  Findings include:  Based on observations made on a pre-survey tour of the facility, then again during a tour of the facility between 10:51 a.m. and 11:58 a.m. with the maintenance man on 03/14/22, several battery-operated emergency lights were noted	K 0291	1) Corrective actions for those patients found to have been affected by the deficient practice.  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the allege practice.  2) How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken:  The new records for tests on emergency lighting (documentation and actions) have been started.  Facility documentation will meet Life Safety Codes.  This facility was left without proper documentation due to previous employees destroying/absconding previous	ed ve

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/14/2022	
	ROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
	ST HEALTHCARE  SUMMARY:  (EACH DEFICIEN  REGULATORY OR  throughout the facil between 9:40 a.m. a records available fo monthly testing or t for the battery-opers on an interview at tl and record review, t acknowledged that t for the 30-second m testing of the battery stating that he had of seven weeks and co documentation prior as the previous main documentation with During the exit cont man and the facility 1:30 p.m., no additi	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ity. During record review and 10:50 a.m., there were no r review on the 30-second the 90-minute annual testing ted emergency lights. Based the time of both observation the maintenance man there was no documentation then there was no documentation tonthly or the 90-minute annual ty-operated emergency lights only been at the facility for	5225 V	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  years records.  3) Measures put into place ar systemic changes:  This facility is working with LS inspectors to replenish require correct documentation forms will adhere to LSC standards. The facility does have a hard emergency generator (Generand testing for this equipment be updated.  4) How corrective actions will monitored and what quality assurance will be put into place.  The facility has new records for tests on emergency lighting and (documentation and actions) been started. Documentation battery operated emergency I has begun and will be documented and meet LSC standards. The Maintenance person is responsible to update all documentation and maintain	DATE  and  Compared accompany to will  be  ce:  for  and  have  for  ights
				binders. Working with this Administrate the expectations of Life Safet Codes and other regulations, be followed.  5) Date the systemic changes be completed: 4-14-22	y will

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667			JILDING	01	COMPL 03/14/	ETED	
	PROVIDER OR SUPPLIER			5225 W	ADDRESS, CITY, STATE, ZIP COD MORRIS ST APOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NF should be included Based on record revolution, the facility between 9:40 a.m. a records available for testing of the battery of the facility between 9:40 a.m. a records available for testing of the battery of the strength of the public, if not maintained. NFPA Tests. Fire-warning and tested in accord published instruction of Chapter 14. NFPA testing, and mainten the requirements of equipment manufactory the facility deficient practices that the public include:  Based on observation of the facility between 10: maintenance man or smoke detectors we throughout the facility between 9:40 a.m. a records available for testing of the battery	are not addressed by the ut are deficient. This with the applicable Life PA standard citation, don Form CMS-2567. iew, interview and city failed to ensure the preventative maintenance operated smoke alarms in complete. NFPA 101 in fing life safety features obvious required by the Code, shall be 72, 29.10 Maintenance and equipment shall be maintained ance with the manufacturer's and per the requirements A 72, 14.2.1.1.1 Inspection, ance programs shall satisfy this Code and conform to the turer's published instructions. ce could affect all residents,	K 0	300	1) Corrective actions for those patients found to have been affected by the deficient practice.  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the allegoractice.  2) How other patients having the potential to be affected by the same practice are identified any what corrective actions will be taken:  The new records for tests on battery operated smoke alarms (documentation and actions) here been started.  Facility documentation will meet Life Safety Codes.  This facility was left without proper documentation due to previous employees destroying/absconding previous years records.	ce: ye ged ne nd s ave	04/14/2022

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	OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING B. WING	01	COMPLETED 03/14/2022
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	man acknowledged documentation avail	lable for review on the		Measures put into place an systemic changes:  The new records for tests on.	d
	monthly testing of the detectors stating that facility for seven we documentation prior as the previous main documentation with During the exit confirman and the facility 1:30 p.m., no additional detectors are seven to the detector of the	the battery-operated smoke the had only been at the eeks and could not locate any to January 1st, 2020 and after intenance person had taken all her when she was fired. Ference with the Maintenance Administrator on 03/14/22 at conal information or evidence contrary to this deficient		The new records for tests on battery operated smoke alarm (documentation and actions) heen started. Facility documentation will me Life Safety Codes.  This facility was left without proper documentation due to previous employees destroying/absconding previous years records.  4) How corrective actions will monitored and what quality assurance will be put into place.  The facility has new records for tests on battery operated smod alarms and (documentation and actions) have been started.  Documentation for battery operated smoke alarms has be and will be documented and in LSC standards.	nave eet  us be ce: cr cke nd
				responsible to update all documentation and maintain binders. Working with this Administrate the expectations of Life Safety Codes and other regulations, be followed.	/ will
				5) Date the systemic changes	WIII

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  be completed: 4-14-22	(X5) COMPLETION DATE
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer p conditions under 1 Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on record rev interview; the facili kitchen fire suppres semiannually. NFPA Ventilation Control Commercial Cooking states Maintenance systems and listed e constant or fire-acti listed to extinguish devices. Hood exha ducts shall be made	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small is microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not ridor.	K 0324	1) Corrective actions for those patients found to have been affected by the deficient pract.  Although any patient could habeen negatively affected, no patients were noted to be negatively affected by the alle practice.  2)How other patients having the potential to be affected by the same practice are identified a	ice: ve ged he

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022		
	ROVIDER OR SUPPLIEF	<b>t</b>	STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		at lease every six months. This		IAG	what corrective actions will be		DATE
	•	ould affect four staff in the			taken:		
	Based on observation facility between 10 maintenance man of the facility kitchen protecting the grill between 9:40 a.m. a records available for testing of the kitchen Based on an intervit observation and recomman acknowledged documentation for suppression system at the facility for see locate any testing delate, 2020 and after person had taken all she was fired. It was had been testing the but all documentation maintenance person conference with the facility Administrate additional informat	ons made during a tour of the 1:51 a.m. and 11:58 a.m. with the 10 03/14/22, it was noted that had a fire suppression system area. During record review and 10:50 a.m., there were no or review in reference to the en fire protection system. ew at the time of both ord review, the maintenance			taken:  This facility was left without proper documentation due to previous employees destroying/absconding previous years records.  The new records for these tes (documentation and actions) had been started. Facility documentation will me Life Safety Codes.  3) Measures put into place and systemic changes:  The facility's kitchen fire suppression system is inspect semiannually (every 6 months). The new records for these tes (documentation and actions) had been started. Facility documentation will me Life Safety Codes.  The company that provides inspections on the hood exhaut was contacted and will forward inspection documentation to the author. This documentation will accompany that provides inspection documentation to the author. This documentation will accompany that provides inspection documentation to the author. This documentation will accompany that provides inspection documentation to the author. This documentation will accompany that provides inspection documentation to the author. This documentation will accompany that provides inspection documentation to the author. This documentation will accompany the provides inspection documentation will accompany the provides in t	et ed s).  ts nave et et d'all nis	
					shared with the maintenance person and kept for future inspections. (available for this POC on requestrian This facility was left without		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. W	JILDING	01	COMPL	
		15E667	B. W.	_		03/14/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LYNHUR	ST HEALTHCARE				MORRIS ST APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	proper documentation due to previous employees destroying/absconding previous years records.  4) How corrective actions will monitored and what quality assurance will be put into place. The facility has new records for these tests and (documentation and actions) have been starte. Documentation has begun an will be documented and meet standards.  The Maintenance person is responsible to update all documentation and maintain binders.  Working with this Administrate the expectations of Life Safety Codes and other regulations, who be followed.  5) Date the systemic changes be completed: 4-14-22	be ce: or on d. ad LSC	DATE
K 0345 SS=F	NFPA 101 Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the	-					
		n and Signaling Code.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  03/14/2022	
	PROVIDER OR SUPPLIER		5225 \	ADDRESS, CITY, STATE, ZIP COD W MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR Records of system and testing are ready solution. Special system and testing are ready solution. Special system and testing are ready solution. Special system and maintained in a correquires a fire alarm and maintained in a National Electrical. Fire Alarm Code. Notherwise permitted Code, testing shall lowith the schedules is required by the authorized by the authorized system alternate year theready are permitted by complide ficient practice con 18.23/18 at 9:47 smoke detector sensitive. Based on in review, the maintent aforementioned con only been at the faction of the could not locate any January 1st, 2020 at maintenance person with her when she with the vendor had regular basis, but all the previous maintenance the facility Administration.	LSC IDENTIFYING INFORMATION  n acceptance, maintenance adily available.		1) Corrective actions for those patients found to have been affected by the deficient pract.  Although any patient could habeen negatively affected, no patients were noted to be negatively affected by the alle practice.  2)How other patients having the potential to be affected by the same practice are identified a what corrective actions will be taken:  This facility was left without proper documentation due to previous employees destroying/absconding previous years records.  The new records for these test (documentation and actions) he been started. Facility documentation will metalife Safety Codes.  3) Measures put into place an systemic changes: The facility's kitchen fire suppression system is inspectively semiannually (every 6 month.)  The new records for these test semiannually (every 6 month.)	de O4/14/2022 dice:  ve ged  he nd  sts have bet  d ded s).

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 03/14/2022				
		15E667	B. WI	NG		03/14	/2022
	PROVIDER OR SUPPLIE		-	5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED OF AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\L	DATE
	provided contrary t	to this deficient finding.			(documentation and actions) I	have	
					been started.		
	3.1-19(b)				Facility documentation will me	eet	
					Life Safety Codes.		
					The company that provides inspections on the fire suppression system was contacted and will forward all inspection documentation to tauthor. This documentation with shared with the maintenance person and kept for future inspections.  (available for this POC on requestions are the companies of the previous employees destroying/absconding previous years records.	uest)	
					monitored and what quality	50	
					assurance will be put into place	ce:	
					The facility has new records for these tests and (documentation and actions) have been started Documentation has begun are will be documented and meet standards.	on ed. nd	
					The company that provides inspections on the kitchen fire suppression system and smol detector sensitivity was contained will forward all inspection documentation to this author.	ke acted	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/14/2022
	ROVIDER OR SUPPLIER		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				This documentation will be sh with the maintenance person kept for future inspections. (available for this POC on req The bulk of the inspections performed and results of said also available in the business office: IE invoices from the company. The Maintenance person is responsible to update all documentation and maintain binders.  Working with this Administrate the expectations of Life Safety Codes and other regulations, be followed.	and uest) are or,
K 0346 SS=F Bldg. 01	services for more period, the authori be notified, and the evacuated or an aprovided for all pashutdown until the been returned to see 9.6.1.6	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has service.	W 0246	5) Date the systemic changes be completed: 4-14-22	
	failed to provide a confor the protection of	riew and interview, the facility omplete 1 of 1 written policy residents indicating lowed in the event the fire	K 0346	Corrective actions for those patients found to have been affected by the deficient pract	

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  01	(X3) DATE S COMPL 03/14/	ETED
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 V	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST NAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
TAG	alarm system has to four hours or more accordance with LS deficient practice afformation of the system of the syst	be placed out of service for in a twenty-four-hour period in C, Section 9.6.1.6. This feets all occupants.  Tiew on 03/14/22 at 12:12 p.m., the man, the facility provided amentation but it was in did not state that the person it will be a trained individual, at the time of record review, an acknowledged the fire watched named "Fire Alarm is - Fire Watch Policy" did not it the individual doing the fire ained individual or have ring the exit conference with	TAG	Although any patient could been negatively affected, no patients were noted to be negatively affected by the apractice.  2)How other patients having potential to be affected by the same practice are identified what corrective actions will be taken:  Facility documentation will reliable Life Safety Codes. The policy has been update include the phrase" a trained individual" regarding fire wan ursing staff are trained on facility fire watch and fire positive systemic changes:  Facility documentation and policies will meet Life Safety Codes. The policy has been update include the phrase" a trained individual" regarding fire wan ursing staff are trained on facility fire watch and fire positive watc	nave  the second of the second	DATE
				The Maintenance person is		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		15E667	B. WI	NG		03/14/	2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					MORRIS ST		
LYNHUR	ST HEALTHCARE			INDIAN.	APOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	COMPLETION
TAG	REGULATORY OK	R LSC IDENTIFYING INFORMATION	├──	TAG	responsible to update all		DATE
					documentation and maintain		
					binders.		
					Working with this Administrato		
					the expectations of Life Safety		
					Codes and other regulations, v	vill	
					be followed.		
					5) Date the systemic changes	will	
					be completed: 4-14-22		
K 0351	NEDA 404						
SS=F	NFPA 101 Sprinkler System -	- Inetallation					
Bldg. 01	Spinkler System -						
	2012 EXISTING	motalia.c.					
		nd hospitals where required					
	by construction type	· · · · · · · · · · · · · · · · · · ·					
		approved automatic					
		n accordance with NFPA					
	13, Standard for tr Systems.	he Installation of Sprinkler					
	•	onstruction, alternative					
		res are permitted to be					
		inkler protection in specific					
	·	or local regulations prohibit					
	sprinklers.						
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed sprinkler coverage covers					
		t as required by NFPA 13,					
	Standard for Instal						
	Systems.						
	-	, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 03	351	1) Corrective actions for those		04/14/2022
		spray pattern for sprinkler			patients found to have been		
	heads were not obst	tructed in 1 of 1 dining area in			affected by the deficient praction	ce:	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		15E667	B. W	ING	<u></u>	03/14/	2022
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ MORRIS ST		
IVNHIID	RST HEALTHCARE				IAPOLIS, IN 46241		
LIMITON				INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with 19	.3.5.1. NFPA 13, 2010 edition,					
		es sprinklers shall be located so			Although any patient could ha	ive	
	as to minimize obstructions to discharge as				been negatively affected, no		
		nd 8.5.5.3 or additional			patients were noted to be		
		provided to ensure adequate			negatively affected by the alle	ged	
	_	ard. Sections 8.5.5.2 and 8.5.5.3			practice.		
	*	nuous or noncontinuous					
		an or equal to 18 inches below			2)How other patients having t		
	the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector				potential to be affected by the		
					same practice are identified a	nd	
	that prevent the spray pattern from fully				what corrective actions will be	)	
	developing. This deficient practice could affect as				taken:		
	many as 25 residents, 6 staff, and 1 visitor eating						
	in the dining room.				Although any patient could ha	ive	
					been negatively affected, no		
	Findings include:				patients were noted to be		
					negatively affected by the alle	ged	
	Based on observation				practice.		
		n 03/14/22 at 11:16 a.m., the			The Maintenance person is		
	_	ceiling fan located in it. This			responsible to follow LSC.		
		roximately four inches from the			The fan blades have been rer	noved	
	_	est to it and would affect the			and the sprinkler head is not		
		t head in the event of a fire.			obstructed.		
		ew at the time of the					
	· · · · · · · · · · · · · · · · · · ·	intenance man stated that he			Working with this Administrate		
		re the fan blades from the			the expectations of Life Safety		
		the entire ceiling fan down if			Codes and other regulations,	will	
		he exit conference with the			be followed.		
		and the facility Administrator					
		p.m., no additional information					
		e provided contrary to this			3) Measures put into place an	ıd	
	deficient finding.				systemic changes:		
	2.1.10(1)						
	3.1-19(b)				The Maintenance person is		
					responsible to follow LSC.		
					The fan blades have been		
					removed.		
					N/a white a suith their A desire!		
					Working with this Administrate		
	1				the expectations of Life Safety	y	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15E667		A. BUILDING  B. WING	01	COMPLETED 03/14/2022	
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD / MORRIS ST IAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Codes and other regulations, be followed.	will
				How corrective actions will monitored and what quality assurance will be put into place.	
				The Maintenance person is responsible to follow LSC. The fan blades have been removed.	
				Working with this Administrate the expectations of Life Safety Codes and other regulations, be followed.	,
				5) Date the systemic changes be completed: 4-14-22	will
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022		
	ROVIDER OR SUPPLIER ST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	system gauge and c documentation for t	an acknowledged sprinkler ontrol valve inspection the aforementioned weekly and us not available for review			valves for 8 months of the most recent 12-month period was no available for review."		
	seven weeks and co documentation prio as the previous mai documentation with was also stated that	only been at the facility for ould not locate any r to January 1st, 2020 and after intenance person had taken all ther when she was fired. It the previous manitenance ting the system on a regular			All previous emergency trainin and testing documentation was removed from this facility by premployees and the facility has means available to recover the documents.	s rior no	
	basis, but all that do previous maintenan exit conference with facility Administrate additional informat	ocumentation was taken by the ce person as well. During the h the Maintenance man and the or on 03/14/22 at 1:30 p.m., no ion or evidence could be			**Corrective Action added: Maintenance will check international pipes for obstructions, every month. (see attached)		
	3.1-19(b)	o this deficient finding.			Measures put into place and systemic changes:		
	facility failed to ensipping systems was obstructions where cause obstructed piges.	review and interview, the sure 1 of 1 automatic sprinkler examined for internal conditions exist that could ping as required by NFPA 25, tandards for the Inspection,			The company that provides the facility sprinkler upkeep and testing/repairs, was contacted immediately and it has been sup that this Admin. receives al test results via email.	een	
	Testing and Mainte Protection Systems states, "except as di 14.2.1.4 an inspecti conditions shall be opening a flushing	nance of Water-Based Fire , Section 14.2.1. Section 14.2.1 scussed in 14.2.1.1 and on of piping and branch line conducted every 5 years by connection at the end of one			Test results were available in the business office but prior year testing was unavailable due to thievery.  (see attached)		
	of one branch line f for the presence of	ing a sprinkler toward the end for the purpose of inspecting foreign organic and inorganic ient practice affects all visitors.			**Corrective Action added: Maintenance will check international pipes for obstructions, every month. (see attached)		
	Findings include:				How corrective actions will be monitored and what quality assurance will be put into place.		

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15E667  A. BUILDING  01  B. WING			COMPL: 03/14/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	Р	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K 0354 SS=F Bldg. 01	with the maintenance inspection documen Inspection documen Inspection of Dry Spinspection dated 12/sprinkler system was investigation on or by years and 9 months interview with the more record review, he stainvestigation has no was unaware that it exit conference with facility Administrate additional information provided contrary to the sprinkler System Sprinkler System Sprinkler System Where the sprinkler extent and duration been determined, are inspected and recommendations management or deand the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an approvided until the serious and the fire depart than 10 hours in a building or portion evacuated or an approvided until the serious desired to provide a we failed to provide a we failed to provide a weight of the spinkler systems.	er system is impaired, the en of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where em is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 03	354	The Admin. will ensure that this information is maintained and readily available for inspections. This information will also be shared with the maintenance person.  5) Date the systemic changes be completed: 4-14-22	s.	04/14/2022

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Event ID:

SK2K21 Facility ID: 000385

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>01</u>		COMPLETED	
		15E667	B. WI	NG		03/14/	2022
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			MORRIS ST		
IVNHIIE	RST HEALTHCARE				APOLIS, IN 46241		
LIMITOR	NOT TIEALTHCANE			INDIAN	AFOLIS, IN 4024 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of 32 residents in the	ne event the automatic sprinkler					
	system has to be pl	aced out-of-service for 10			Although any patient could ha	ve	
	hours or more in a	24-hour period in accordance			been negatively affected, no		
	with LSC, Section 9.7.5. LSC 9.7.5 requires				patients were noted to be		
	sprinkler impairme	nt procedures comply with			negatively affected by the alle	ged	
	NFPA 25, 2011 Ed	ition, the Standard for the			practice.		
		and Maintenance of					
	Water-Based Fire F	Protection Systems. NFPA 25,			2)How other patients having the	ne	
	15.5.2 requires nine	e procedures that the			potential to be affected by the		
	impairment coordir	nator shall follow. This deficient			same practice are identified a	nd	
	practice could affect	et all occupants in the facility.			what corrective actions will be	:	
					taken:		
	Findings include:						
					"The plan did not state that the	Э	
	Based on record rev	view on 03/14/22 at 12:12 p.m.,			person doing the fire watch wi	ll be	
	with the maintenan	ce man, the facility provided		a trained individual."			
	fire watch plan doc	umentation but it was	This plan's verbiage has been				
	incomplete. The pla	an did not state that the person			changed to read appropriately	′ <b>.</b>	
	doing the fire watch	h will be a trained individual.					
	Based on interview	at the time of record review,			3) Measures put into place an	d	
	the maintenance ma	an acknowledged the fire watch		systemic changes:			
	_	vided named "Fire Alarm					
		ts - Fire Watch Policy" did not			LTC health care personnel are	e	
		t the individual doing the fire			frequently trained in all aspect	s of	
		rained individual or have			'fire/fire watch procedures and	ı	
		ring the exit conference with			policies". This facility is confid	ent	
	the Maintenance m	<u>-</u>			that though the verbiage was		
		3/14/22 at 1:30 p.m., no			incorrect, the employees in thi	s	
		ion or evidence could be			facility indeed know how to		
	provided contrary t	o this deficient finding.			proceed with the fire watch po	licy.	
	3.1-19(b)						
					4) How corrective actions will	be	
					monitored and what quality		
					assurance will be put into plac	:e:	
					The Admin. has changed the		
					verbiage of this policy to meet		
					LSC regulations.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	x3) date survey COMPLETED 03/14/2022			
	PROVIDER OR SUPPLIER RST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers		5) Date the systemic changes v be completed: 4-14-22	vill			
	Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.  18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 4 of 15 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 12 residents, 6 staff and 2 visitors within the facility.	K 0355	1) Corrective actions for those patients found to have been affected by the deficient practic Although any patient could have been negatively affected, no patients were noted to be negatively affected by the alleg practice.	е			
	Based on observations made during a tour of the facility between 10:51 a.m. and 11:58 a.m. with the maintenance man on 03/14/22, the following was noted:  a) the portable fire extinguisher located in the lobby immediately inside the main entrance area was mounted on the wall with the top of the extinguisher 62 inches (5 feet 2 inches) above the floor.  b) the portable fire extinguisher located in the smoking area was not mounted on the wall but sitting on the ground. c) the portable fire extinguisher located across		2)How other patients having the potential to be affected by the same practice are identified and what corrective actions will be taken:  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the alleg practice.  3) Measures put into place and systemic changes:	d e			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		15E667	B. W	ING		03/14/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	with the top of the effect 3 1/2 inches) at d) the portable fire of basement on the state basement area was at top of the extinguish above the floor.  Based on interview observation, the Matex inguishers were the first started and It to be mounted more During the exit continuant and the facility	extinguisher located in the irs leading down into the mounted on the wall with the her 68 inches (5 feet 8 inches)			a) the portable fire extinguished located in the lobby immediated inside the main entrance areal mounted on the wall with the troof the extinguisher 62 inches (feet 2 inches) above the floor. (b) the portable fire extinguished located in the smoking area wound mounted on the wall but sit on the ground. (c) the portable fire extinguished located across from resident rewith the top of the extinguisher 63 inches (5 feet 3 1/2 inches)	ely was op 5 er as etting er oom	
	_	ontrary to this deficient			above the floor. d) the portable fire extinguisher located in the basement on the stairs leading down into the basement area was mounted the wall with the top of the extinguisher 68 inches (5 feet inches) above the floor.  A new maintenance person was hired by this facility. Working with the Admin., regulations for LSC will be followed.  The aforementioned have all relocated per LSC regulations extinguisher is kept on the floot this time and all extinguishers have been lowered.  4) How corrective actions will monitored and what quality assurance will be put into place.	e on 8 as with C been . No or at	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/14/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
					The aforementioned have all relocated per LSC regulations extinguisher is kept on the floot this time and all extinguishers have been lowered.	. No or at	
					5) Date the systemic changes be completed: 4-14-22	will	
K 0511 SS=F Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided 18.5.1.1, 19.5.1.1 Based on observati failed to ensure that a reliable source of requirements of NI 19.5.1.1, 9.1, 9.1.3 5.1. LSC section 9 generators shall be maintained in acco Standard for Emerg Systems, 2010 Edi following energy s used for the emerg	B Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview the facility t the emergency generator had Fuel in accordance with the EPA 101 - 2012 edition, Section .1 and NFPA 110, 2010 Edition, .1.3.1 states emergency installed, tested, and rdance with NFPA 110, gency and Standby Power tion. Section 5.1.1 states the ources shall be permitted to be ency power supply (EPS):	K 05	11	1) Corrective actions for those patients found to have been affected by the deficient practice.  Although any patient could habeen negatively affected, no patients were noted to be negatively affected by the alle practice.  2) How other patients having the potential to be affected by the second control of the potential to be affected by the second control of the patients having the potential to be affected by the second control of the patients having the potential to be affected by the second control of the patients having the potential to be affected by the second control of the patients having the potential to be affected by the second control of the patients having the patients having the patients having the patients having the patients have a second control of the patients have been affected by the second control of the patients have been affected by the affected by the second control of the patients have been affected by the affected by the affected by the affected by the second control of the patients have been affected by the affe	ice: ve ged	04/14/2022
	_	m products at atmospheric			same practice are identified at what corrective actions will be	nd	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	l í	JILDING	onstruction 01	COMPL	ATE SURVEY OMPLETED 3/14/2022	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
LYNHUR	RST HEALTHCARE				/ MORRIS ST IAPOLIS, IN 46241			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	withdrawal)	leum gas (liquid or vapor			taken:			
	(3) Natural or synth	netic gas			Although any patient could ha	ave		
		rel 1 installations in locations			been negatively affected, no			
	-	ty of interruption of off-site			patients were noted to be			
		n, on-site storage of an			negatively affected by the alle	eged		
		urce sufficient to allow full			practice.			
	_	to be delivered for the class						
		equired, with the provision for			Citizens Energy Group is the			
		from the primary energy source			provider for this facility's natu			
	to the alternate energy				gas. The letter "for the natura provider indicating the natura			
	A.5.1.1 states examples of probability of interruption could include the following:				was from a reliable source of	i yas		
	earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could				fuel"			
	affect all residents.	•			Legal departments of the nat	ural		
					gas vendors may be reluctan			
	Findings include:				sign a reliability letter that			
					guaranteed that there will nev	er be		
		on made during a tour of the			an interruption of service;			
		intenance man at 11:15 a.m. on			however, this author is presen	ntly		
	generator was foun	ource for the emergency			working with Citizens Energy			
	~	I on interview, the facility did		Group to obtain the required documentation.				
		om their natural gas provider			documentation.			
		ral gas was from a reliable			3) Measures put into place ar	nd		
		was confirmed by the			systemic changes: 4-14-22			
	maintenance man v	who stated that he would ask						
	the facility Admini	strator to contact the gas			When received this letter will	be		
	-	a letter sent to them as soon as			kept in a log book and shared	l with		
		g the exit conference with the			the maintenance person.			
		nd the facility Administrator on			A) 11	L -		
		m., no additional information or provided contrary to this			4) How corrective actions will	pe		
	deficient finding.	brovided contrary to this			monitored and what quality assurance will be put into pla	ra.		
	deficient initing.				assurance will be put into pla	∪ <del>C</del> .		
	3.1-19(b)				This author is presently worki	ng		
					with Citizens Energy Group to	-		
					obtain the required document	ation.		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´	X2) MULTIPLE CONSTRUCTION (X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUIL B. WING		01	COMPLETED 03/14/2022	
		132007				03/14/	72022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD  / MORRIS ST		
LYNHUR	ST HEALTHCARE		INDIANAPOLIS, IN 46241				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	When received this letter will be		DATE
					kept in a log book and shared		
					the maintenance person.		
					5) Data the content of the content		
					5) Date the systemic changes be completed:	WIII	
					be completed.		
K 0712	NFPA 101		İ				
SS=F	Fire Drills						
Bldg. 01	Fire Drills	Allo a Americania di con a fina					
		the transmission of a fire simulation of emergency fire					
	-	rills are held at expected					
		imes under varying					
	conditions, at leas	st quarterly on each shift.					
		ar with procedures and is					
		re part of established					
	9:00 PM and 6:00	rills are conducted between					
		ay be used instead of					
	audible alarms.	ay bo acca metoda or					
	19.7.1.4 through	19.7.1.7					
		view and interview, the facility	K 071	12	1) Corrective actions for those	:	04/14/2022
		uarterly fire drills for 4 of 4			patients found to have been		
	*	.1.6 requires drills to be			affected by the deficient practi	ce:	
		y on each shift under varied ficient practice affects all staff			Although any patient could ha	VO	
	and residents.	ficient practice affects all staff			been negatively affected, no	VC	
					patients were noted to be		
	Findings include:				negatively affected by the alle	ged	
					practice.		
		view of the "Inservice Record			All amondance of the		
		form with the maintenance man 4 a.m., there was no			All previous emergency training and testing documentation wa		
		the following fire drills or			removed from this facility by p		
		ining for the following quarters			employees and the facility has		
	and shifts:	5 51			means available to recover these		
		(January, February, or March)			documents.		
	on the second or th	ird shifts of 2021 or 2022.					

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/14/2022		
	OF PROVIDER OR SUPPLIED JRST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	first, second, or thin c) the third quarter on the first, second d) the fourth quarter December) on the first 2021.  Based on interview the Maintenance St Director acknowled condition. Based or review, the maintenaforementioned conbeen at the facility locate any prior test previous maintenar documentation with During the exit comman and the facility 1:30 p.m., no addition the first previous maintenary documentation with During the exit comman and the facility 1:30 p.m., no addition the first previous maintenary documentation with During the exit comman and the facility 1:30 p.m., no addition the first previous maintenary documentation with During the exit comman and the facility 1:30 p.m., no addition the first previous maintenary documentation with During the exit comman and the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the facility 1:30 p.m., no addition the first previous maintenary documentation with the first previous maintena	er (April, May, or June) on the rd shifts of 2021.  (July, August, or September) , or third shifts of 2021.  Ir (October, November, or first, second, or third shifts of at the time of record review, apervisor and the Executive alged the aforementioned in interview at the time of record mance man acknowledged the addition stating that he had only for seven weeks and could not ting documentation as the ace person had taken all in her when she was fired. If the maintenance of Administrator on 03/14/22 at it ional information or evidence contrary to this deficient			2)How other patients having the potential to be affected by the same practice are identified any what corrective actions will be taken:  All previous emergency training and testing documentation was removed from this facility by premployees and the facility has means available to recover the documents.  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the allegoractice.  "Based on record review of the "In-service Record Sheet - Fire Drill" form with the maintenance man on 03/14/22 at 9:44 a.m., there was no documentation for the following fire drills or acceptable staff training for the following quarters and shifts:  a) the first quarter (January, February, or March) on the second third shifts of 2021 or 2022.  b) the second quarter (April, Mor June) on the first, second, or third shifts of 2021.  c) the third quarter (July, Auguor September) on the first, second, or third shifts of 2021.  d) the fourth quarter (October, November, or December) on the first, second, or third shifts of 2021.  "Based on record review of the maintenance of the following fire drills or acceptable staff training for the following quarters and shifts:  a) the first quarter (January, February, or March) on the second quarter (April, Mor June) on the first, second, or third shifts of 2021.  c) the third quarter (July, Auguor September) on the first, second, or third shifts of 2021.  d) the fourth quarter (October, November, or December) on the first, second, or third shifts of 2021.  "Based on record review of the facility by premplement of the facil	g s rior no ese /e ged e cond day, or st,		

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	OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING B. WING	01	COMPLETED 03/14/2022
	ROVIDER OR SUPPLIER ST HEALTHCARE		5225 W	ADDRESS, CITY, STATE, ZIP COD V MORRIS ST JAPOLIS, IN 46241	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The new records for these tes (documentation and actions) I been started. Facility documentation will me Life Safety Codes.	nave
				Measures put into place an systemic changes:	d
				The new records for these tes (documentation and actions) I been started. Facility documentation will me Life Safety Codes.	nave
				How corrective actions will monitored and what quality assurance will be put into place	
				Working in unison with the facility's newly hired maintena person, the regulation of LSC followed and documented as required.	
				5) Date the systemic changes be completed: 4-14-22	will
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustible				

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		F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667		ILDING	instruction 01	(X3) DATE SURVEY COMPLETED 03/14/2022		
		ROVIDER OR SUPPLIER ST HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241					
(X4) PREI TA	FIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		location, and such signs that read NC posted with the insembling.  (2) In health care smoking is prohibiperominently place secondary signs was making shall not (3) Smoking by paresponsible shall I (4) The requirement apply where the parent supervision.  (5) Ashtrays of notes as the same shall I where smoking is (6) Metal contained devices into which shall be readily awas moking is permitt 18.7.4, 19.7.4  Based on observation failed to provide as with self-closing consistency can be empaterial and safe downers smoking is practice could affect staff and 1 visitor unarea.  Findings include:  Based on observation facility between 10 maintenance man on noted:  a) at the main entrainent and signs and the main entrainent signs and the main entrainent signs and the main entrainent signs are signs and the main entrainent signs and the main entrainent signs are signs as the signs as the signs are signs as the signs are signs as the signs are signs as the signs as the signs are signs as the signs are signs as the signs as the signs as the signs are signs as the signs as the	area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where sted and signs are d at all major entrances, with language that prohibits be required. Stients classified as not be prohibited. Int of 18.7.4(3) shall not attent is under direct oncombustible material and be provided in all areas permitted.  It with self-closing cover a ashtrays can be emptied attailed to all areas where	K 07	741	1) Corrective actions for those patients found to have been affected by the deficient practice.  Although any patient could have been negatively affected, no patients were noted to be negatively affected by the allepractice.  2) How other patients having the potential to be affected by the same practice are identified at what corrective actions will be taken:  Although any patient could have	ce: ve ged ne	04/14/2022	

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STRIFFT ADDRIES, CITY, STATE, ZIP COD		OF CORRECTION	IDENTIFICATION NUMBER  15E667	A. BUILDING 01  B. WING			COMPLETED 03/14/2022	
NA   ID   RREFX   RAN OF COMPACTION   TAG   RECEIPT   RECEIPT				5225 W MORRIS ST				
buts strewn throughout the area. b) the designated smoking area had well over 100 cigarette butts strewn all over the ground. c) there were two unapproved butt containers, one plastic 5-gallon bucket in use as ashtrays. d) there was also a blue plastic 55-gallon container full of mixed trash and cigarette butts located in the smoking area. Based on interview at the time of each observation, the maintenance man stated that he would have the butts picked up and the unapproved contrains removed from the area as soon as he was able to do so. During the exit conference with the Maintenance man and the facility Administrator on 0314/22 at 1:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.  3.1-19(b)  batteris were noted to be negatively affected by the alleged practice.  "Based on observations made during a tour of the facility between 10.51 a.m. and 11:58 a.m., with the maintenance man on 03/14/22, the following was noted: a) at the main entrance to the facility, there are two areas of mulch near the main entrance.  Both these, and the surrounding areas had over 100 cigarette butts strewn throughout the area. b) the designated smoking area had well over 100 cigarette butts strewn all over the ground. c) there were two unapproved butt containers, one plastic "Tidy Cat" litter container and one plastic 5-gallon bucket in use as ashtrays. d) there was also a blue plastic 55-gallon container full of mixed trash and cigarette butts located in the smoking area. Based on interview at the time of each observation, the maintenance man on 03/14/22, the following was noted: a) at the main entrance to the facility, there are two areas of mulch near the main entrance.  Both these, and the surrounding area had well over 100 cigarette butts strewn all over the ground. c) there were too the facility.	(X4) ID PREFIX	SUMMARY : (EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I PR	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
I been removed and the plastic	TAG	and the surrounding butts strewn through b) the designated so cigarette butts strew c) there were two us one plastic "Tidy Caplastic 5-gallon buc d) there was also a lefull of mixed trash at the smoking area. Based on interview observation, the may would have the buttunapproved contain soon as he was able conference with the facility Administrat additional information provided contrary to	gareas had over 100 cigarette hout the area. Inoking area had well over 100 on all over the ground. Inapproved butt containers, at" litter container and one ket in use as ashtrays. Inolue plastic 55-gallon container and cigarette butts located in at the time of each intenance man stated that he is picked up and the seremoved from the area as to do so. During the exit  Maintenance man and the or on 03/14/22 at 1:30 p.m., no do or evidence could be	Т	bor par not provide a control of the	een negatively affected, no atients were noted to be egatively affected by the allegractice.  Based on observations made uring a tour of the facility etween 10:51 a.m. and 11:58 .m. with the maintenance mar 3/14/22, the following was not) at the main entrance to the acility, there are two areas of nulch near the main entrance. So the designated smoking area and well over 100 cigarette but trewn throughout the area.  I the designated smoking area and well over 100 cigarette but trewn all over the ground.  I there were two unapproved to ontainers, one plastic "Tidy Catter container and one plastic gallon bucket in use as shtrays.  I there was also a blue plastic shand cigarette butts located the smoking area. I have a shand cigarette butts located the smoking area. I have a shand cigarette butts located the smoking area. I have don't he unapproved contains a second the unapproved contains are was able to do so"	ged n on ted: gutts a tts butt at" c d d d of	DATE

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	OF HEALTH AND HUR MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039		
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/14/2022		
LYNHUR	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	TAG REGULATORY OR LSC IDENTIFYING INFORMATION		bucket also removed. These h been replaced with approved r containers.  D) The 55 gallon container was be used for yard waste and it h been emptied.  The facility is instructing it's state to utilize a single are for smoking this area is 8 feet plus form the building and will have proper approved containers for use. The Maintenance person will be responsible to patrol the ground on a daily basis to ensure these issues do not reoccur.	metal s to nas  aff ing. e			
				3) Measures put into place and systemic changes:  The facility is instructing it's state to utilize a single are for smoking This area is 8 feet plus form the building and will have proper approved containers for use.  The Maintenance person will be responsible to patrol the ground on a daily basis to ensure these issues do not reoccur.	aff ng. e e ne nds		

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be followed.

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4) How corrective actions will be monitored and what quality assurance will be put into place:

Working in unison with the facility's newly hired maintenance person, the regulation of LSC will

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPL A. BUILDING B. WING	e construction g <u>01</u>	COM	(X3) DATE SURVEY  COMPLETED  03/14/2022	
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP 5 W MORRIS ST	COD	
LYNHUR	ST HEALTHCARE			IANAPOLIS, IN 46241		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	SHOULD BE E APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	The Maintenance per responsible to patrol on a daily basis to en issues do not reoccur 5) Date the systemic be completed: 4-14-2	the grounds sure these changes will	DATE
K 0918	NEDA 101					
SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer limed in accordance with le inspected weekly, lead 30 minutes 12 times a				
	once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requof maintenance ar and readily availal	intervals, and exercised on the for 4 continuous hours. In the for 4 continuous hours. In the for 4 conditions include the fold start and the fold				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		15E667	B. WING		03/14/2022		
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					/ MORRIS ST		
LYNHURST HEALTHCARE				INDIANAPOLIS, IN 46241			
LINDUKSI DEALIDUAKE				INDIAN	.AI OLIO, IN 4024 I		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
	-	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
		source is a design					
	consideration for i	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	0 (NFPA 70)					
		review and interview, the	K 0	918			04/14/2022
	facility failed to ens	sure a written record of weekly					
		generator was maintained for			1) Corrective actions for those		
	52 of 52 weeks. NF	TPA 99, 6.4.4.1.3 requires onsite			patients found to have been		
	generators shall be	maintained in accordance with			affected by the deficient practi	ce:	
	NFPA 110, Standar	d for Emergency and Standby					
	Power Systems. NF	FPA 110, 8.4.1 requires an			All previous emergency training	ıg	
	Emergency Power	Supply System (EPSS)			and testing documentation wa	s	
	including all appurt	enant components, shall be			removed from this facility by p	rior	
	inspected weekly as	nd exercised monthly. NFPA			employees and the facility has	no	
	99, 6.4.4.2 requires	a written record of inspection,			means available to recover the	ese	
	performance, exerc	ising period, and repairs for the			documents.		
	generator to be regu	ılarly maintained and available					
	for inspection by th	e authority having			Although any patient could ha	ve	
	jurisdiction. This do	eficient practice could affect all			been negatively affected, no		
	residents, staff, and	visitors.			patients were noted to be		
					negatively affected by the alleg	ged	
	Findings include:				practice.		
	Based on record rev	view with the maintenance man					
	on 03/14/22 betwee	en 12:12 pm to 12:41 p.m.,			2)How other patients having the	ne	
	documentation of 5	2 or 52 weekly natural			potential to be affected by the		
		ator inspection and testing			same practice are identified ar	nd	
	documents were no	t available for record review.			what corrective actions will be		
	Based on interview	at the time of record review,			taken:		
	the maintenance ma	an acknowledged the					
		ndition stating that he had only			Although any patient could ha	ve	
		for seven weeks and could not			been negatively affected, no		
	,	ocumentation prior to January			patients were noted to be		
		as the previous maintenance			negatively affected by the alle	ged	
		l documentation with her when			practice.	-	
	_	ng the exit conference with the			[ ·		
		nd the facility Administrator on			"Monthly generator load testir	ng	
		m., no additional information or			l	5	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E667		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/14/2022		
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION evidence could be provided contrary to this deficient finding.		ID PREFIX	(X5) COMPLETION		
TAG			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADETICIENCY)  Weekly natural gas-powered	DATE	
				generator inspection and testi documents were not available	-	
	3.1-19(b)			record review."		
	2) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 10 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA			All previous emergency training and testing documentation was removed from this facility by pure employees and the facility has means available to recover the documents.  The new records for these test (documentation and actions) been started.  Facility documentation will means available to recover the documents.	as prior s no ese sts have	
	99 requires a writter performance, exerci generator to be regu for inspection by th	n record of inspection, sing period, and repairs for the darly maintained and available		Life Safety Codes.  Working in unison with the facility's newly hired maintena person, the regulation of LSC followed and documented as required.	ance	
	Based on record revon 03/14/22 betwee documentation of 10 gas-powered general documents were not based on interview the maintenance material aforementioned combeen at the facility blocate any prior test previous maintenance	riew with the maintenance man n 12:12 pm to 12:41 p.m., 0 or 12 monthly natural stor inspections and testing t available for record review, at the time of record review, an acknowledged the dition stating that he had only for seven weeks and could not ing documentation as the ce person had taken all ther when she was fired.		3) Measures put into place an systemic changes:  The new records for these test (documentation and actions) been started. Facility documentation will measure a safety Codes.  Working in unison with the facility's newly hired maintenate person, the regulation of LSC followed and documented as	sts have eet	
	man and the facility	ference with the maintenance Administrator on 03/14/22 at onal information or evidence		required.		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E667	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/14/2022		
NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 5225 W MORRIS ST INDIANAPOLIS, IN 46241				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	E	(X5) COMPLETION DATE	
	could be provided contrary to this deficient finding.  3.1-19(b)			4) How corrective actions wi monitored and what quality assurance will be put into plate Working in unison with the facility's newly hired mainter person, the regulation of LSG be followed.  The Administrator will audit to document binders that are keep the Maintenance person. two month.  A part time maintenance held has also been hired.  5) Date the systemic change be completed: 4-14-22	ace: nance C will the ept by ce per		

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