STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 00 B. WING	05/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00351815. Complaint IN00351815 - Substantiated. Federal/State deficiencies related to the allegations are cited at F624. Survey dates: May 2, 3, 4, 5, and 6, 2021 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census Bed Type: NF: 38 Total: 38 Census Payor Type: Medicaid: 38 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on May 17, 2021.	F 0000	Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this facilities statement of compliance.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance			

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

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	directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure a resident's preferred	F 0578	Resident 26 has had his profile updated in PPC	05/28/2021

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	code status was documented in the clinical record for 1 of 17 residents reviewed for advanced directives. (Resident 26) Findings include: On 5/5/2021 at 10:44 a.m., the clinical record of Resident 26 was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease and obstructive sleep apnea. An Admission Minimum Data Set (MDS) assessment, dated 1/18/21, indicated Resident 26 was cognitively intact. The Indiana Physicians Orders For Scope Of Treatment (Post), dated 1/29/21, indicated Resident 26's wished to have Cardiopulmonary Resuscitation (CPR), attempt Resuscitation/CPR. The current profile screen for Resident 26, indicated the resident's preferred current code status preference, was blank. The Medication Administration record, dated May 2021, indicated the resident's current code status preference, was blank. During an interview, on 5/5/21 at 11:00 a.m., Licensed Practical Nurse 1 indicated the Residents preferred code status was usually located on the resident's profile sheet, so that it can be found quickly and easily accessed. During an interview, on 5/5/21 at 11:10 a.m., the Director of Nursing (DON) indicated the current wishes of the resident's code status should be on the resident's profile in the clinical record.		All residents have the potential to be affected. All resident profiles will be audited against the code status and changed accordingly. Code status will be audited monthly for 3 months, at admission and upon resident request for change. Monitoring will be documented on the following audit sheet. Social Services Designee Responsible Administrator to monitor and report to QA committee. May 28th, 2021	

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	During an interview, on 5/5/21 at 12:00 p.m.,, the DON indicated she was unable to find Resident 26's code status on the resident's profile in the clinical record. On 5/5/21 at 1:28 p.m., the Director of Nursing provided a policy titled Full Code Status, dated October 2013, and indicated it was the current policy being used by the facility. A review of the policy indicated "...CPR shall be attempted as quickly as possible when a patient suffers a cardiac arrest." 3.1-4(f)(4)(A)(ii)			
F 0583 SS=B Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.			

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	§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review the facility failed to ensure clinical information was kept confidential for 30 of 38 residents that reside in the facility, reviewed for confidentiality of records. (Residents 127, 5, 3, 21, 128, 129, 6, 130, 23, 12, 177, 17, 7, 9, 2, 82, 179, 180, 25, 20, 79, 14, 11, 1, 24, 13, 81, 4, 10, and 8.) Findings include: On 5/4/2021 at 8:30 a.m. until 8:45 a.m., observed a document titled Nursing 24 Hour Report, undated, indicated a list of residents, the resident's room number and Physician diet order The list was taped on the wall next to the medication cart and across from the dining room. The following information was visible on the posted list: Room (number) Resident 127 (name) room tray, regular diet Room (number) Resident 5 (name) room tray, regular diet Room (number) Resident 3 (name) mechanical soft diet. Room (number) Resident 21 (name) room tray,	F 0583	The list that was taped above the nurses' cart was removed, immediately. Any Resident with special needs could be affected. All staff will be in serviced to identify and remove any document that violates our Residents Privacy. All dietary information will be placed in a binder and stored in the pantry just off the dining room to ensure residents correct diet is being followed. Each Department Manager will audit their own area 2 times a week for 3 weeks 1 time a week for 3 weeks, until there is no evidence of privacy issues. Then once monthly thereafter. Department Managers responsible, Administrator to monitor and report to QA Committee. 5/28/2021 Completion date	05/28/2021

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	regular diet, LCS (low concentrated sweets) Room (number) Resident 128 (name) room tray, regular diet, LCS Room (number) Resident 129 (name) mechanical soft diet Room (number) Resident 6 (name) room tray, regular diet Room (number) Resident 130 (name) puree diet Room (number) Resident 23 (name) room tray, regular diet Room (number) Resident 12 (name) room tray, regular diet Room (number) Resident 177 (name) mechanical diet Room (number) Resident 17 (name) regular diet, LCS, NAS (no added salt) Room (number) Resident 7 (name) regular diet Room (number) Resident 9 (name) regular diet Room (number) Resident 2 (name) mechanical soft diet Room (number) Resident 82 (name) mechanical soft diet Room (number) Resident 179 (name) regular diet, LCS, Nas Room (number) Resident 180 (name) puree diet Room (number) Resident 25 (name) mechanical soft diet Room (number) Resident 20 (name) mechanical soft diet Room (number) Resident 79 (name) regular diet Room (number) Resident 14 (name) regular diet Room (number) Resident 11 (name) regular diet, LCS, NAS Room (number) Resident 1 (name) regular diet, NAS, double protein Room (number) Resident 24 (name) puree diet Room (number) Resident 13 (name) mechanical soft diet Room (number) Resident 81 (name) regular diet, LCS, NAS			

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	Room (number) Resident 4 (name) regular diet Room (number) Resident 10 (name) regular diet Room (number) Resident 8 (name) puree diet During an interview, on 5/4/2021 at 11:33 a.m., the Director of Nursing indicated, the posted information should not have been hanging on the wall. "That information is confidential." Observed the Director of Nursing remove the document from the wall. On 5/3/2021 at 10:56 a.m., the Administrator provided a policy titled Resident Rights, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated, " ...Privacy and Confidentiality. You have a right to personal privacy and confidentiality of your personal and medical records. You have a right to secure and confidential personal and medical records." 3.1-3(o)			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure a resident with dementia was free of a restraint for 1 of 2 residents reviewed for restraints. (Resident 8) Findings include: During a tour of the facility, on 5/2/2021 at 9:55 a.m., Resident 8 was sitting in a wheelchair, which had a seat belt bolted onto the chair. The seat belt was observed to be loosely secured around Resident 8's waist. On 5/5/2021 at 8:30 a.m., observed Resident 8 in his wheelchair with the seatbelt restraint loosely, secured around his waist. Resident was not observed to self release and or try to get out of the seatbelt. During an interview, on 5/2/2021 at 10:08 a.m., Certified Nursing Assistant (CNA) 2 indicated "most people that work with him know to put that belt on him because if we don't, he will fall. We	F 0604	F-604 The chair that resident 8 was in, had the restraint belt removed and thrown away. An order was written for therapy to assess for proper seating for Resident 8. Any recommendations will be care planned accordingly. Any time a new wheelchair or chair is brought into the building, the resident specific order will be directed by the therapy department or the Medical Director. All nursing staff were in serviced regarding this being a Restraint Free Zone. If they see a restraint being used they are to immediately contact the DON. The DON/designee will review each wheelchair one time a week	05/28/2021

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	just undo it when we have to fix him up." During an interview, on 5/2/2021 at 10:48 a.m., CNA 3 indicated "If we don't put that [seatbelt] on him, he will just fall. We release it when we change him or lay him down for bed." On 5/3/2021 at 11:22 a.m., the clinical record for Resident 8 was reviewed. Diagnosis included, but were not limited to, dementia with Lewy bodies. An admission Minimum Data Set (MDS) assessment, dated 12/10/2021, indicated Resident 8 required 2 person, extensive assist with bed mobility. Resident 8's cognitive status was severely impaired - never/rarely made decisions. The clinical record lacked a Physician's order for a restraint. The clinical record lacked any care, services, or instructions for the restraint. During an interview, on 5/4/2021 at 1:38 p.m., The Administrator indicated, "there is no care plan because the patient should not have had the restraint on his wheelchair. The restraint will be removed from the wheelchair." On 5/5/2021 at 1:26 PM, The Director of Nursing provided a policy titled Physical and Chemical restraint dated December 2009, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...the resident has the right to be free from any physical... restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms."		for 3 weeks until all chairs have been identified appropriate for use. The Administrator will Monitor and review with the QA team.	

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	3.1-3(w)			
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to ensure a safe orderly discharge was completed for a resident with latent Tuberculosis (non-infectious) for 1 of 3 residents reviewed for discharge. (Resident G) Findings include: On 5/4/21 at 9:20 a.m., the clinical record for Resident G was reviewed. Diagnosis included, but were not limited to, latent tuberculosis (Tb) infection. A progress note, dated 12/14/21, indicated Resident G was going to be discharged home with family. Resident G was discharged from the facility on 12/23/21. Resident G's clinical record lacked a discharge information, including physician's instructions for the continued treatment of the latent Tb infection. The clinical record lacked documentation regarding notification to the Marion County	F 0624	There was no corrective action required for resident G as he had already discharged 12/2020. All residents have the potential to be affected by this practice. All Nurses were in serviced regarding the proper discharge policy, to include, Dr discharge orders, meds, med sheets, last time of administration, follow-up appointments and notification of local health departments that follow communicable diseases. Nurses will be responsible. Social Service Designee to manage every new discharge to ensure policy is followed. Social Service Designee will report to QA monthly.	05/28/2021

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	Public Health Department of Resident G's discharge to the community. During an interview, on 5/5/21 at 11:00 a.m., Resident G's family member indicated the facility had not provided any discharge paperwork or guidance regarding Resident G's latent Tb infection treatment. During an interview, on 5/5/21/at 2:30 p.m., the Director of Nursing (DON) indicated Resident G's discharge instructions should have been given to the family upon his discharge from the facility. The DON was unable to provide any discharge instructions for Resident G. On 5/5/21 at 2:30 p.m., the DON indicated she was unable to provide a policy for discharge prior to the end of the survey. This Federal tag relates to Complaint IN00351815. 3.1-12(a)(21)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the quarterly Minimum Data Set assessment was coded correctly to reflect the smoking status, for 1 of 2 residents reviewed for smoking, of 24 residents reviewed for accuracy of assessments. (Resident 12) Findings include:	F 0641	A smoking assessment was done on resident 12. Any resident that smokes have the potential to be affected. All residents who smoke will have an assessment completed, initially, if change in condition or/ and quarterly thereafter. MDS coordinator has been replaced. MDS completed will be	05/28/2021

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	On 5/4/21 at 2:45 p.m. observed Resident 12 self-propel his wheel chair outside to smoke cigarettes during supervised smoking. On 5/4/21 at 9:00 a.m., the Director of Nursing provided a current list of residents who smoke. Resident 12 was identified on the list of residents who smoke. Resident 12's clinical record was reviewed on 5/4/21 at 9:56 a.m. Diagnosis included, but was not limited to, chronic obstructive pulmonary disease and dementia. A smoking safety screen tool, dated 8/1/2020, indicated, "does resident have cognitive loss - yes; does resident have any dexterity problems - yes; how many cigarettes does the resident smoke per day - 5-10; resident need for adaptive equipment - supervision; team decision-safe to smoke with supervision." The quarterly Minimum Data Set assessment, dated 1/31/21, did not indicate Resident 12 smoked. During an interview, on 5/4/21 at 3:45 p.m., the Director of Nursing indicated Resident 12's Minimum Data Set assessment, dated 1/31/21, was coded incorrectly as it did not identify the resident smoked. 3.1-31(d)		reviewed for coding errors as change in condition and quarterly MDS are due. All admissions will be assessed upon admission, if change in condition exists and quarterly thereafter per policy. A new MDS coordinator has been hired. Daily change in condition will be identified during Morning meeting care plan and MDS updated as needed. MDS coordinator responsible and DON to monitor.	
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and			

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	implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance			

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	15E667	A. BUILDING 00 B. WING	05/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to ensure a person centered care plan for 4 residents, a resident with latent tuberculosis (182), a resident who smoked (12), a resident on oxygen (12), and for a resident receiving dialysis (128) of 24 residents reviewed for development of a care plan. Findings include: 1. On 5/4/21 at 9:20 a.m., the clinical record for Resident 182 was reviewed. Diagnoses included, but were not limited to, latent tuberculosis infection. Review of Resident 182's Discharge Minimum Data Set assessment (MDS), dated 12/30/20, indicated he had been diagnosed with tuberculosis. The clinical record lacked a Plan of Care (POC) that addressed the diagnoses and interventions regarding tuberculosis. Interview, on 5/5/21 at 2:30 p.m., the Director of Nursing (DON) indicated she was unable to provide a care plan or interventions in reference to Resident 182's diagnoses of latent tuberculosis. 2. On 5/2/21 at 1:20 p.m., observed Resident 12 resting on his bed with oxygen being administered at 2 liters per minute, per nasal cannula. During an interview, at that time, Resident 12 indicated he used oxygen all the time except when he went outside to smoke. On 5/4/21 at 2:45 p.m., observed Resident 12	F 0656	Residents 12 and 128 have had care plans updated to include smoking, oxygen use and dialysis. Resident 182 was discharged, and the corrective action was stated under F624 to prevent future occurrences. All residents are potentially affected by these deficient practices. Care plans will be reviewed updated annually, quarterly and with any change in condition. A new MDS coordinator has been hired. All changes in condition and/or orders will be reviewed daily In morning meeting. All updates to care plans will be done at that time, as needed. MDS and DON responsible and Administrator will monitor. Results shared with QA committee.	05/28/2021

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	self-propel his wheel chair outside to smoke cigarettes during supervised smoking. Resident 12's clinical record was reviewed on 5/4/21 at 9:56 a.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease and dementia. The quarterly Minimum Data Set assessment, dated 1/31/21, indicated Resident 12 was cognitively intact. A smoking safety screen tool, dated 8/1/2020, indicated, "does resident have cognitive loss - yes; does resident have any dexterity problems - yes; how many cigarettes does the resident smoke per day - 5-10; resident need for adaptive equipment - supervision; team decision-safe to smoke with supervision." Resident 12's clinical record lacked a care plan for smoking. During an interview, on 5/4/21 at 3:45 p.m., the Director of Nursing indicated Resident 12 did not have a care plan for smoking and smoking should have been care planned. On 5/4/21 at 9:00 a.m., the Director of Nursing provided a current list of residents who smoke. Resident 12 was identified on the list of smokers. On 5/4/21 at 3:50 p.m., the Director of Nursing provided a copy of the Smoking Policy - Residents, dated July 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...this facility shall establish and maintain safe resident smoking practices...any smoking-related privileges,			

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	restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan..." 3. On 5/2/21 at 1:20 p.m. observed Resident 12 resting on his bed with oxygen being administered at 2 liters per minute, per nasal cannula. During an interview, at that time, Resident 12 indicated he used oxygen all the time. On 5/3/21 at 3:45 p.m., observed Resident 12 in his room watching TV while he sat in his wheel chair with oxygen being administered at 2 liters per minute, per nasal cannula. Resident 12's clinical record was reviewed on 5/4/21 at 9:56 a.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease and dementia. The May 2021 Doctor's orders, with a start date of 12/12/2019 with no end date, indicated "oxygen at 2 lpm [liters per minute] per nasal cannula." The quarterly Minimum Data Set assessment, dated 1/31/21, indicated Resident 12 was cognitively intact. The quarterly Minimum Data Set assessment, dated 11/2/2020, indicated Resident 12 received oxygen therapy. Resident 12's clinical record lacked a care plan for oxygen therapy. During an interview, on 5/4/21 at 3:45 p.m., the Director of Nursing indicated Resident 12 did not have a care plan for oxygen therapy and it			

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	should have been care planned. 4. On 5/2/21 at 2:14 p.m., observed Resident 128 resting on his bed. During an interview, at that time, Resident 128 indicated he was admitted to the facility "about 2 months ago and goes to dialysis 3 days a week since before he was admitted to the facility." The clinical record was reviewed on 5/4/21 at 2:48 p.m. Diagnosis included, but were not limited to, dependence on renal dialysis and chronic kidney disease. The new admission Minimum Data Set assessment, dated 3/26/21, indicated Resident 128 was cognitively intact and received dialysis services. Resident 128's clinical record lacked a care plan for dialysis. During an interview, on 5/4/21 at 3:08 p.m., the Director of Nursing indicated Resident 128 did not have a care plan for dialysis and it should have been care planned. On 5/5/21 at 10:08 a.m., the Director of Nursing provided an undated copy of the Lynhurst Healthcare Care Plan policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Focus: the team will conduct necessary reviews and develop/implement/monitor/modify the necessary interventions...Assessments: the assessment of the residents overall condition and risk factors must identify the resident's risk for avoidable accidents, evaluate and analyze any risk, implement interventions...the care plan must include all interventions which have been			

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	developed and implemented to try to prevent avoidable accidents, based on the resident's risks..." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure treatment and services for an assessed scabbed area on the bony prominence (right foot) of a dementia resident for 1 of 2 residents reviewed for quality of skin care. (Resident 8) Findings include: On 5/3/2021 at 2:00 p.m., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. An admission Minimum Data Set (MDS) assessment, dated 12/10/2021, indicated Resident 8 required 2 person, extensive assist with bed mobility. Resident 8's cognitive status was severely impaired he never/rarely made decisions. A care plan, undated, indicated Resident 8 had	F 0684	F684 Resident 8 was referred to the MD in May. MD indicated the area was a callous and asked him to see the podiatrist. The nurse who got the first report is no longer employed. The area is not open, and we are awaiting our in house service to schedule a visit. Resident 8 is not exhibiting pain or discomfort from the callous. All residents are at risk of being affected by this practice. Nursing staff educated on the importance of accurate and timely skin sheets being done with showers. Skin assessment policy updated and available. Weekly skin assessments have been placed in all resident's charts and will be	05/28/2021

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	potential for pressure ulcer development related to decreased physical mobility, incontinence of bowel and bladder, and cognitive impairment. The goal indicated the resident's will have intact skin, free of redness, blisters or discoloration through review date (not indicated). Interventions included, but were not limited to: monitor/document/report any changes in skin status: appearance, color, signs and symptoms of infection, or presence of skin breakdown. A progress note, dated 3/4/2021 at 2:29 p.m., indicated, "during shower [Resident 8] staff notified writer res [resident] has 2 x 2 [2 cm x 2 cm] open area on R [right] side of foot. No drainage or foul odor noted, writer applied dressing to area, will notify wound doc [physician] when in building." The clinical record, dated 3/4/2021 to May 3, 2021, lacked any other documentation regarding the Physician being notified. The clinical record, dated 3/4/2021 to May 3, 2021, lacked any treatment order for the open area identified on March 4 2021. A weekly skin assessment, dated 1/7/2021, indicated Resident 8 did not have any open skin areas. The clinical record, lacked subsequent skin assessments. Shower sheets, dated 2/8/21, 3/7/21, 3/11/21,3/25/21,3/28/21, 4/1/21, 4/5/21, 4/9/21, 4/20/21, 4/27/21 and 4/29/21 indicated Resident 8 had no skin issues. During an observation, on 5/4/2021 at 10:08		triggered to be completed weekly. Inservice on proper skin assessment and wound identification completed with all nursing staff. Nursing staff responsible, DON to monitor 5xweek for 3 weeks, 3xweekly for 2 weeks and 1 time per week thereafter. Compliance will be reviewed by QA monthly.	

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	a.m., Certified Nursing Assistant (CNA) 3 removed Resident 8's sock. Resident 8 was observed to have a penny size scab to right side of right foot over a bony prominence. The wound was observed to not have drainage or foul odor. During an interview, on 5/4/2021 at 10:08 a.m., CNA 3 indicated "if I find an open area on a resident, I tell the nurse." During an interview, on 5/4/2021 at 10:10 a.m., Qualified Medication Assistant (QMA) 4 indicated "I am not a nurse, so if I noticed an open area on a resident, I would tell the nurse right away." During an interview, on 5/4/2021 at 10:15 AM, LPN 1 indicated "If I was notified of an open skin area, I would first check to see if it has already been documented, if not, I would do an incident report and get a treatment in place." During a clinical record review, for Resident 8, on 5/5/2021 at 8:45 a.m., the clinical record did not show any assessment, treatment, physician or guardian notification for the open area on right side of residents 8's right foot. During an interview, on 5/5/2021 at 1:28 p.m.,, the Director of Nursing (DON) indicated a report for the open area on Resident 8's foot was not available. The DON also indicated documentation of Physician's notification, was not available. On 5/5/2021 at 2:22 p.m., a review of the facility job description, for staff nurses indicated, the nurse should "Communicate with the medical staff, nursing personnel, and other department supervisors, and adequately plan for			

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	the resident's needs." On 5/6/2021 at 11:35 a.m., the Director of Nursing provided documentation from a Physician's Assistant, dated 5/3/2021 at 11:36 a.m. A review of the Physician's Assistant documentation indicated "no rash, no open areas." The note contained a addendum dated 5/6/2021 at 9:53 a.m., the addendum indicated "right lateral foot callous - cont. [continue] to keep foot clean and dry, area is 1cm x 1.1cm x 0, podiatry to consult in two weeks." On 5/6/2021 at 11:43 p.m., a skin assessment policy was requested from the Director of Nursing and the Administrator. On 5/6/2021 at 2:33 p.m., a skin assessment policy was not provided by the end of the survey. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure all used injection needles were disposed of in a sharps container for safe disposal for 1 of 1 randomly observed accident hazard.	F 0689	The needle and cap were removed from the floor. All residents have a potential to be affected by this practice. The evening nurse who administrated the	05/28/2021

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	Findings include: On 5/4/2021 at 9:33 a.m., during a tour of the facility, an uncapped used pen-injector needle was found on the floor across from the dining room, in a heavy traffic area. During an interview, at that time, Licensed Practical Nurse 1 was unaware of the needle that was on the floor. Observed Licensed Practical Nurse (LPN) 1 pick the needle up off of the floor, and put the needle into the sharps container that was on top of the Medication Cart. Interview, at that time, LPN 1 indicated he was not sure where the needle came from. Observed a resident in the area, at that time, with no shoes on his feet. Several residents in the dining room were observed with no shoes on. The residents used the hall, where the needle was observed, to get to the dining room. During an interview, on 5/4/2021 at 10:55 a.m., the Director of Nursing indicated she was not aware of any residents that received insulin injections from a pen-injector. On 5/5/2021 at 8:30 a.m., observed a pen-injector needle cap on the floor next to the medication cart, across from the dining room. During an interview, on 5/5/2021 at 9:00 a.m., the Director of Nursing indicated Resident 128 did have an order for Basaglar KwikPen Solution Pen-injector that required the type of needle that was found on the floor. Review of May 2020, Physician's orders, with a start date of May 2021, indated Resident 128's last dose of Basaglar KwikPen Solution Pen-injector 100 unit/Ml would have given at 10:00 p.m., on 5/4/2021.		Injection was counseled on proper disposal of needles. All nurses were education on the policy for handling and disposing of needles and the hazards, of Improper handling. Nurses to watch as needles are disposed of to insure, they are disposed of correctly, before moving to another task. Each oncoming shift will review the area around their cart to insure items have been disposed of correctly. Nurses responsible, DON to monitor.	

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	On 5/5/2021 at 10:15 a.m., a policy regarding safety and hazards was requested to the Director of Nursing. On 5/6/2021 at 2:33 p.m., a policy regarding safety and hazards was not provided from the facility by the end of the survey. 3.1-45(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review and interview, the facility failed to obtain a Physician's order for a resident receiving oxygen therapy for 1 of 2 residents reviewed for oxygen therapy. (Resident 81) Findings include: During an observation, on 5/5/2021 at 10:15 a.m., Resident 81 in her room sitting on the side of her bed. An oxygen tank was observed next to her bed. During an interview, at that time, the resident indicated she only wears her oxygen at night and sometimes during the day if needed. On 5/5/2021 at 11:00 a.m., Resident 81's	F 0695	Resident 81 has an order in her chart for 02, head of the bed elevated and to monitor q shift. Care plan was updated. Any resident with O2 could be affected. All residents were reviewed for O2 usage and orders. Those residents with orders were care planned as above per policy. MDS nurse has been replaced. All new orders will be reviewed during morning meeting and care plans updated as needed.	05/28/2021

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	clinical record was reviewed. Diagnosis, included but were not limited to, chronic respiratory failure. An annual Minimum Data Set Assessment, dated 2/16/2021, indicated Resident 81 was cognitively intact. A care plan, dated 7/7/2019, indicated Resident 81's was on oxygen therapy as needed due to episodes of shortness of breath. Resident 81's clinical record lacked a Physicians order for oxygen therapy. During an interview, on 5/5/2021 at 11:22 a.m., the Director of Nursing (DON) indicated, Resident 81 should have had an order for oxygen therapy. The DON was unsure why the resident did not have an order for the oxygen. On 5/5/2021 at 11:30 a.m., a policy was requested regarding a Physician's order for oxygen. On 5/6/2021 at 2:33 p.m., a policy regarding a Physician's order for Oxygen, was not provided by the end of the survey. 3.1-47(a)(6)		Nursing and MDS responsible. DON to monitor 3x weekly for 4 weeks, 2x weekly for 2 weeks. and 1 time weekly for 5 weeks or until complete compliance has been attained. Monthly report by DON to QA committee.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each			

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	resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, interview, and record review, the facility failed to ensure staff accurately assessed and notified the Physician of a skin issue, that was reported to the nurse on duty for 1 of 2 residents reviewed for skin issues. (Resident 8) Findings include: On 5/3/2021 at 2:00 p.m., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. An admission Minimum Data Set (MDS)	F 0726	The resident was seen by the physician and a podiatry consult was recommended. The area is not open, does not cause resident discomfort. All residents could be affected by this deficient practice. The nurse who was responsible for this has been terminated. As evidenced by interviews current nursing staff were aware of the policy for newly discovered skin problems, including notifying he	05/28/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 12/10/2021, indicated Resident 8 required 2 person, extensive assist with bed mobility. Resident 8's cognitive status was severely impaired, he never and/or rarely made decisions. A progress note, dated 3/4/2021 at 2:29 p.m., indicated "during shower [Resident 8] staff notified writer res [resident] has 2 x 2 [2 cm x 2 cm] open area on R (right) side foot. No drainage or foul odor noted writer applied dressing to area will notify wound doc [physician] when in building." The clinical record lacked any other documentation regarding the Physician being notified of any skin issues. The clinical record lacked any treatment order for the open area. A weekly skin assessment, dated 1/7/2021, indicated resident 8 did not have any open skin areas. The clinical record lacked subsequent skin assessments after 1/7/2021. During an observation, on 5/4/2021 at 10:08 a.m., observed Certified Nursing Assistant (CNA) 3 remove Resident 8's sock. Observed Resident 8 had a penny size scabbed area to right side of right foot over a bony prominence. The wound was observed not have drainage or foul odor. During an interview, on 5/4/2021 at 10:08 a.m., CNA 3 indicated "if I find an open area on a resident, I tell the nurse."		MD. Skin assessment policy updated and available. Weekly skin assessments have been placed in all resident's charts and will be triggered to be completed weekly. Inservice on proper skin assessment and wound identification completed with all nursing staff. Nursing staff responsible, DON to monitor 5xweek for 3 weeks, 3xweekly for 2 weeks and 1 time per week thereafter. Compliance will be reviewed by QA monthly	

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	15E667	A. BUILDING 00 B. WING	05/06/2021

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	During an interview, on 5/4/2021 at 10:10 a.m., Qualified Medication Assistant (QMA) 4 indicated "I am not a nurse, so if I noticed an open area on a resident, I would tell the nurse right away." During an interview, on 5/4/2021 at 10:15 AM, LPN 1 indicated "If I was notified of an open skin area, I would first check to see if it has already been documented, if not, I would do an incident report and get a treatment in place." During an interview, on 5/5/2021 at 1:28 p.m., the Director of Nursing (DON) indicated "the facility did not have an incident report for the open area found on Resident 8's foot. The DON also indicated documentation of Physicians notification of the area on Resident 8's foot was not available. Shower sheets, dated 2/8/21, 3/7/21, 3/11/21,3/25/21,3/28/21, 4/1/21, 4/5/21, 4/9/21, 4/20/21, 4/27/21 and 4/29/21 indicated Resident 8 had no skin issues. A care plan, undated, indicated Resident 8 has potential for pressure ulcer development related to decreased physical mobility, incontinence of bowel and bladder, and cognitive impairment. The goal indicated the resident will have intact skin, free of redness, blisters or discoloration through review date. Interventions included, but were not limited to: monitor/document/report any changes in skin status: appearance, color, signs and symptoms of infection, or presence of skin breakdown. The facility job description, for staff nurses indicated, the nurse should "Communicate with the medical staff, nursing personnel, and other			

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	department supervisors, and adequately plan for the resident's needs." On 5/6/2021 at 11:35 a.m., the Director of Nursing provided documentation from a Physician's Assistant, dated 5/3/2021 at 11:36 a.m., The Physician's Assistant report indicated "no rash, no open areas." The note contained an addendum, dated 5/6/2021 at 9:53 a.m., the addendum indicated "right lateral foot callous - continue to keep foot clean and dry, area is 1cm x 1.1cm x 0, podiatry to consult in two weeks." On 5/6/2021 at 11:43 p.m., a skin assessment policy was requested from the Director of Nursing and the Administrator. On 5/6/2021 at 2:33 p.m., a skin assessment policy was not provided by the end of the survey.			
F 0755 SS=B Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure the disposition of medication for a resident that was discharged from the facility for 1 of 3 residents reviewed for discharge (Resident 27) and the the facility failed to ensure and document proof of an accurate reconciliation of controlled medications for 2 of 2 narcotic count verification sheets reviewed for controlled substance monitoring. Findings include: 1. On 05/04/21 at 09:04 a.m., the clinical record of Resident 27 was reviewed. Diagnosis included, but were not limited to, dementia. A Nurses note, dated 3/1/2021 at 1:14 p.m., indicated Resident 27 was discharged to another facility on 5/3/2021. A recapitulation review of Physician's orders, dated May 2021, included but were not limited	F 0755	Resident 27 was transferred to another facility. He did not have any controlled substances. He was a Medicaid resident as per Medicaid policy all medication was sent with him. His discharge order was not clear other than discharge to Alpha Home. The narcotic sheets were before termed two nurses, who we felt could be diverting medication. All residents can be affected by this this practice. Two nurses were terminated. Physician discharge orders will be reviewed to include Medication disposition, location of transfer with appropriate orders. The drug destruction policy has	05/28/2021

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	to: haloperidol 1 mg tablet, propranolol hcl 10 mg, Tenex 1 mg tablet, zinc 50 tablet, vitamin D 1000 units tablet, synthroid 125 mcg, tamsulosin hcl 0.4 mg, thiamine hcl 100 mg, melatonin 5 mg, and folic acid 1 mg. The clinical record lacked a drug destruction log upon discharge. During an interview, on 5/4/2021 at 10:44 a.m., the Director of Nursing, indicated a drug disposition should have been completed upon discharge. A drug disposition for Resident 27 was not available. On 5/4/2021 at 3:30 p.m., a drug disposition policy was requested from the Director of Nursing. On 5/6/2021 at 2:33 p.m., a drug disposition policy had not been provided by the end of the survey. 2. On 5/2/21 at 9:30 p.m., observed medication cart 1 and reviewed the corresponding narcotic count verification sheets for April 2021. The following lacked documentation of narcotic reconciliation: Med Cart 1 4/1/21- missing day and evening shift 4/18/21-missing day and evening shift 4/23/21-missing evening and night shift 4/26/21-missing day shift 4/27/21- missing day shift 4/28/21-missing night shift On 5/2/21 at 9:30 p.m., observed medication cart 2 and the corresponding narcotic count verification sheets for April 2021. The		been revised and the nursing staff were educated. To include two Nurses signing off on med destruction/waste at the end of each 8-hour shift. Nurses responsible DON to monitor and report to QA monthly.	

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	following lacked documentation of narcotic reconciliation: Med Cart 2 4/9/21- missing night shift 4/22/21-missing night shift 4/23/21-missing day and night shift 4/25/21-missing night shift 4/26/21-missing night shift 4/427/21-missing night shift 428/21-missing night shift 45/29/21- missing night shift 4/30/21-missing evening and night shift Interview, on 5/2/21 at 1:30 p.m., the Director of Nursing indicated the narcotic count should be completed by two nurses at the end of each eight-hour shift. Both nurses must sign and verify the narcotic count verification sheets. On 5/5/21 at 1:30 p.m., requested the medication administration and medication storage policy. The administrator did not provide a policy by the survey exit time. 3.1-25(e)(3) 3.1-25(s)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure kitchen staff conducted hand hygiene between preparing food items and plating the noon the meal. This had the potential to affect 48 of 48 residents residing in the facility who received food from the kitchen. Findings include: On 5/2/21 from 12:15 p.m. to 12:30 p.m., the noon meal was observed being prepared and plated for distribution to the residents. The following was observed: -Cook 5 walked from the Dietary Manager's office to the steam table and donned (put on) plastic gloves. She then began preparing mashed potatoes (taking the hot water from the stove directly behind the steam table and placing it on the steam table counter, reaching into the refrigerator unit located next to the stove to gather additional ingredients, and opening the box of instant potatoes and then began mixing the mashed potatoes). Cook 5 placed the finished product into the steam table unit. -Cook 5 then picked up a Styrofoam food	F 0812	Cook 5 was counseled regarding proper handwashing technique. She did not use the technique that had been taught. All residents have the potential to be affected by this practice. All dietary staff have been educated regarding handwashing and safe food handling, with return demonstration and testing. Monthly there will be an education on handwashing and safe food handling. There will be a post test. The Food Service Manager will observe 5 meals a week for 5 weeks, 4 meals a week for 4 weeks, 3 meals a week for 3 weeks, 2 meals a week for 2 weeks until compliance is met. Dietary Staff is responsible, Food Service Manager will monitor and report to QA monthly till compliance is met.	05/28/2021

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	container (from the adjacent table) and placed it onto the steam table counter, then used tongs to place a hot dog bun into the container. She then used her gloved hands to open the hot dog bun and used another tong utensil to place a hot dog onto the bun. Cook 5 proceed to use separate utensils to plate the remainder of the noon meal food items. Once the foods were placed in the container, Cook 5 closed the container lid and placed it on the adjacent table. Cook 5 repeated the previously mentioned steps during the meal service. During an interview, at that time, Cook 5 indicated hand hygiene was to occur when preparing and changing tasks. Cook 5 indicated, "is takes too long to use tongs to open the hot dog buns so I use my hands." Cook 5 was observed to not conduct hand hygiene prior to donning gloves or change the plastic gloves between tasks. During an interview, on 5/5/21 at 1:20 p.m., the Director of Nursing indicated all residents residing in the facility received food items from the kitchen. The facility census was 48. On 5/5/21 at 1:26 p.m., the Director of Nursing provided an undated copy of the Food Handling policy and indicated it was the current policy in use by the facility. A review of the policy indicate, "...Lynhurst Healthcare procures...prepares, distributes, and serves food under sanitary conditions...the purpose of this policy is to prevent the spread of food borne illness and reduce those practices that result in food contamination and compromised food safety...Sanitary conditions are defined as proper storage, preparation, distribution, and serving of food in order to prevent food borne illness...Dietary department compliance			

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	checklist...does staff use good hygiene practices..." On 5/6/21 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...When to wash hands...during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks...before touching food or food-contact surfaces...before placing gloves on hands..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the ground surrounding the facility's dumpster area was free from rubbish and failed to ensure the dumpster lid was kept closed when not in use. This had the potential to affect 48 of 48 residents residing in the facility. Findings include: On 5/2/21 from 9:15 a.m. to 9:20 a.m., observed the facility's trash dumpster area located adjacent to the parking lot and near the front entrance door. The following was observed at the dumpster area: -The dumpster had 2 separate lids. -One lid was observed to not be closed and partially filled trash bags were visible inside the dumpster.	F 0814	The Maintenance Tech was terminated. The area has been cleaned up around the dumpster. The company was called we added an extra pick up. All residents have the potential to be affected by this practice. The night shift nursing staff will be responsible for checking the lids, closing them if necessary. This will be temporary until we have hired a new maintenance tech. A schedule will be established for the new maintenance tech which includes patrol of the dumpster area and grounds, at 700am each morning. The assistant to the director of nursing will monitor daily. The Administrator is	05/28/2021

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	-On top of the closed dumpster lid were 2 clear plastic trash bags that contained trash. -No staff were observed near the area. During the initial kitchen tour with Cook 5, on 5/2/21 from 10:10 a.m. to 10:20 a.m., the following was observed at the dumpster area: -The dumpster had 2 separate lids. -One lid was observed to not be closed and partially filled trash bags were visible inside the dumpster. -On top of the closed dumpster lid were 2 clear plastic trash bags that contained trash. -On the ground in front of and to the left of the dumpster were 12 used plastic gloves. -On the ground behind the dumpster container were multiple open Styrofoam food containers with unidentifiable food adhered to the food containers. -On the ground behind the dumpster were multiple clear plastic trash bags partially filled with trash. -No staff were observed in the area. -During an interview, at that time, Cook 5 indicated the facility had one dumpster; the lids were to be kept closed; and all trash was to be placed inside the dumpster container. On 5/3/21 from 3:40 p.m. to 3:45 p.m., observed the dumpster area. The following was observed at the dumpster area: -On the ground in front of and to the left of the dumpster were 12 used plastic gloves. -On the ground behind the dumpster were multiple clear plastic trash bags partially filled with trash. -No staff were observed in the area. On 5/4/21 from 8:20 a.m. to 8:23 a.m., observed		responsible.	

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	the dumpster area. The following was observed at the dumpster area: -On top of the closed dumpster lid was a small plastic trash bag filled with trash. -On the ground in front of and to the left of the dumpster was multiple used plastic gloves. -No staff were observed in the area. On 5/4/21 from 9:05 a.m. to 9:10 a.m. observed the dumpster area with the Maintenance Director. The following was observed: -On top of the closed dumpster lid was a small plastic trash bag filled with trash. -On the ground in front of and to the left of the dumpster was multiple used plastic gloves. -No staff were observed in the area. -During an interview, at that time, the Maintenance Director indicated the dumpster area was to be kept clean and free of debris. The dumpster lids were to be kept closed. During an interview, on 5/5/21 at 1:20 p.m., the Director of Nursing indicated all residents residing in the facility received food items from the kitchen. The facility census was 48. On 5/5/21 at 1:26 p.m., the Administrator provided an undated copy of the Disposal of Garbage and Refuse policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Lynhurst Healthcare has procedures to ensure proper disposal of garbage and refuse...containers are maintained in good condition and waste is properly contained in dumpsters...garbage receptacles are kept covered..." On 5/6/21 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements -			

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	Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(5)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a homelike environment for 2 of 3 resident's rooms observed. (Resident 81 and 13). Findings include: 1. During an observation on 5/3/2021 at 10:33 a.m., observed Resident 81's bedside table. The veneer had peeled off of the top of the surface of the table. The center of the table was warped. Observed Resident 81's bathroom door to have an approximate 2" x 3" hole 1/3 of the way up from the bottom of the door. During and interview, at that time, Resident 81 was not sure how long the bedside table had been warped. The resident was also unaware of how long the bathroom door had a hole in it, but indicated "a long time." 2. During an observation, on 5/4/2021 at 9:33 a.m., observed Resident 13's bedside table. The veneer had peeled of the top of the surface of the	F 0921	The resident 81's bedside table was replaced. The bathroom door was repaired. The maintenance tech was terminated. All residents have the potential to be affected. A room-by-room inspection is being done. Each area of concern will be addressed. Items that need replaced will be ordered. A policy of total room inspections will be followed to ensure that all rooms will be given an inspection to identify concerns and repair completed. Housekeeping and Maintenance tech responsible, Administrator to monitor.	05/28/2021

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	table. The center of the table was warped. Observed Resident 13's bathroom door to have an approximate 2" x 3" hole 1/3 of the way up from the bottom of the door. During an interview, on 5/5/2021 at 9:35 a.m., Qualified Medication Aide 4, indicated whenever she would see a maintenance issue she would write it in the maintenance log. During an interview, on 5/5/2021 at 10:00 a.m., the Administrator, indicated if a staff member observed an issue with the resident's environment, or had maintenance issues, they were to write the concern or issue on the Lynhurst Healthcare Maintenance log. On 5/5/2021 at 10:22 a.m., a review of the Lynhurst Maintenance log, dated February 2021, was the only log sheet found in the log binder. No entry's in the log book were regarding Resident 81 or Resident's 13's bedside tables or the residents bathroom door. During an interview, on 05/06/21 10:33 AM During an interview, the Maintenance Director indicated if there is a maintenance issue in the facility, staff would write it in the maintenance log book. On 5/4/2021 at 10:48 a.m., the Administrator provided a policy, undated, titled Maintenance Request, and indicated it was the current policy being used by the facility. A review of the policy, indicated "Maintenance Request, Maintenance request shall be completed in order to establish a priority of maintenance service....1. In order to establish a priority of maintenance service, work orders must be written in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 00 B. WING	05/06/2021

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

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	Maintenance Binder. 2. It shall be the responsibility of the staff to fill out the binder request for the Maintenance Director. 3. A binder is maintained at each nurses station. 4. The binder will be checked daily by the Maintenance Director..." 3.1-19(f)(5)			