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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING -- B. WING	07/22/2021

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 05/26/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/22/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this PSR to the Emergency Preparedness survey, Lynhurst Healthcare was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 40 certified beds. At the time of the survey, the census was 35. Quality Review completed on 07/26/21 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	We respectfully request a paper compliance. 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. We respectfully request a paper compliance.	
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2),			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.			

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	(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents	E 0006	1. Corrective action for those residents found to be have been affected by the deficient practice. A Kaiser Permanente assessment was completed. 2. 2How other residents have	08/13/2021

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	and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director from 9:35 a.m. to 10:30 a.m. on 07/22/21, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. Based on interview at the time of record review, the Maintenance Director stated she thought the facility-based and community-based risk assessment had been updated to address emerging infectious disease (EID) threats but agreed an updated risk assessment was not available for review at the time of the PSR revisit. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. We have the Assessment Tool to track our hazards and will develop policies to ensure the safety of our residents. All 3. What measures will be made to ensure that the deficient practice does not recur: The Kaiser assessment is a working tool to guide us to the policies needed for a safe community. All new procedures will be in serviced to all employees. 4. How the corrective action will be monitored to ensure deficient practice will not recur, "What quality assurance program will be put into place: The total responsibility is that of he administrator. After an incident the assessment will be updated and presented to the QAPI for review and approval. In addition the assessment will be reviewed and updated Annual. 5. Date by which each deficiency will be corrected. 8/10/21 Documents for EID are included as well as a copy of the assessment.	

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K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/26/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/22/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this PSR survey, Lynhurst Healthcare was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, constructed in two sections, is fully sprinklered. The oldest section, a former two story private residence with a basement and the newer section, a one story addition were both determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 40 and had a census of 35 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services which are	K 0000	We respectfully request a paper compliance. 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. We respectfully request a paper compliance.	

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	the laundry building and a metal storage shed which were each not sprinklered. Quality Review completed on 07/26/21			
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge stairs was provided with handrails. LSC 7.2.2.4.1.1 states stairs shall have handrails on both sides, unless otherwise complying with 7.2.2.4.1.5 or 7.2.2.4.1.6. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility using the northwest exit discharge stairs. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the northwest exit from the facility is marked as a facility exit with an exit sign. The exit discharge for the northwest exit consisted of a set of six steps made of concrete creating a stair which was not provided with handrails. Based on interview at the time of the observations, the Maintenance Director stated the former handrail in the exit discharge was removed to reconstruct the stairs, a handrail was not reinstalled and agreed the aforementioned exit discharge stairs was not provided with handrails. This finding was reviewed with the Maintenance	K 0225	1. Corrective action for those residents found to be have been affected by the deficient practice. The hand rails were installed on 8/6/2021, according to citation. One on each side of the steps. A third handrail is being installed today for down the middle, based on the door location. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this practice. Handrails were installed. On outdoor rounds, maintenance will view to insure stability. 3. What measures will be made to ensure that the deficient practice does not recur: During outside rounds Maintenance will view to insure stability. 4. How the corrective action will be monitored to ensure deficient practice will not recur, "What quality assurance program will be put into place: Maintenance	08/10/2021

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	Director and the Director of Nursing during the exit conference. 3.1-19(b)		will view on outside rounds to insure the stability. This will appear on the Maintenance daily round sheets. Any deviation will be reported to the administrator for prompt repair. 5. Date by which each deficiency will be corrected. 8/10/2021	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 1 sets of stairs for 1 of 4 exit discharge was maintained free of obstructions. LSC Section 7.7.4 states doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. LSC Section 7.2.2.1.1 states stairs used as a component in the means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.2, unless otherwise specified in 7.2.2.1.2. Section 7.2.2.2.1.1(2) states existing stairs shall be permitted to remain in use, provided that they meet the requirements for existing stairs shown in Table 7.2.2.2.1.1(b).	K 0271	Corrective action for those residents found to be have been affected by the deficient practice. The hand rails were installed on 8/6/2021, according to citation. One on each side of the steps. A third handrail is being installed today for down the middle, based on the door location. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this practice. Handrails were installed. On outdoor rounds,	08/10/2021

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	Section 7.2.2.2.1.1(3) states approved existing stairs shall be permitted to be rebuilt in accordance with the following: (a) Dimensional criteria of Table 7.2.2.2.1.1(b) (b) Other stair requirements of 7.2.2 LSC 7.2.2.4.1.1 states stairs shall have handrails on both sides, unless otherwise complying with 7.2.2.4.1.5 or 7.2.2.4.1.6. This deficient practice could affect over 20 residents if needing to exit the facility using the exit discharge stairs for the northwest exit of the facility. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the northwest exit from the facility is marked as a facility exit with an exit sign. The exit discharge for the northwest exit consisted of a set of six steps made of concrete creating a stair which was not provided with handrails. Based on interview at the time of the observations, the Maintenance Director stated the former handrail in the exit discharge was removed to reconstruct the stairs, a handrail was not reinstalled and agreed the aforementioned exit discharge stairs was not provided with handrails. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		maintenance will view to insure stability. 3. What measures will be made to ensure that the deficient practice does not recur: During outside rounds Maintenance will view to insure stability. 4. How the corrective action will be monitored to ensure deficient practice will not recur, "What quality assurance program will be put into place: Maintenance will view on outside rounds to insure the stability. This will appear on the Maintenance daily round sheets. Any deviation will be reported to the administrator for prompt repair. 5. Date by which each deficiency will be corrected. 8/10/2021	

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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 1. Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the battery operated lighting system outside the facility by the emergency generator location failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned battery powered emergency light failed to illuminate when it was tested to illuminate multiple times. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The	K 0291	1. Corrective action for those residents found to be have been affected by the deficient practice. The 1 light in question has been replaced with a battery operated emergency light with a reliable type of rechargeable battery provided with suitable facilities for maintaining them in properly charged condition. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents, staff and visitor could be affected by this deficient practice. 3. What measures will be made to ensure that the deficient practice does not recur: On the daily, weekly monitoring to ensure outside lights are functional. At the time of the resurvey we had not had the tool available. Maintenance will replace any light not operation. Maintenance has been instructed to keep one of each light on hand for back up. 4. How the corrective action will be monitored to ensure deficient practice will not recur,	08/10/2021

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	facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 6 of 6 battery backup lights were tested monthly and annually during the most recent twelve month period 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, staff and visitors. Findings include: Based on review of "Battery-Operated Emergency Lights - Test Log" for 2020 and 2021 with the Administrator and the Maintenance Director during record review from 9:10 a.m. to 12:25 p.m. on 05/26/21, monthly battery operated light testing documentation for January 2021 through May 2021 was not itemized by location. In addition, monthly and annual testing documentation within the most recent twelve month period did not state the duration of the test. The documentation indicated the initials of the person performing the test or a checkmark that the test was completed but it did not state the completed test was for 30 seconds or 90		"What quality assurance program will be put into place: Maintenance will advise in morning meeting an light that will be replaced. Maintenance responsible and Administrator to monitor. 5. Date by which each deficiency will be corrected. 8/10/21	

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	minutes. Based on interview at the time of record review, the Maintenance Director agreed the battery operated light testing documentation did not state the duration of the test completed and was not itemized by location for the 2021 documentation. Based on record review with the Maintenance Director from 9:35 a.m. to 10:30 a.m. on 07/22/21, monthly battery light testing documentation for June 2021 was not available for review. In addition, annual battery operated light testing documentation within the most recent twelve month period did not state the duration of the test. Based on interview at the time of record review, the Maintenance Director stated the facility has not performed or documented any battery light testing on or after 05/26/21. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated			

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	from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous areas such as boiler and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Janitor's Closet by the kitchen. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m.	K 0321	1. Corrective action for those residents found to be have been affected by the deficient practice. Doors have been repaired to maintain smoke integrity 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents could be affected by this deficient practice. All doors were reviewed for auto closure and smoke integrity. 3. What measures will be	08/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 01 B. WING	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	on 07/22/21, the corridor door to the Janitor's Closet was equipped with a self closing device but the door failed to latch into the latching plate on the door frame when tested to close multiple times. A natural gas fired water heater was located in the Main Mechanical Room which was open to the Janitor's Closet. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous areas such as soiled linen and trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Soiled Utility Room by Room 16. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, a one inch gap was noted in between the face of the door and the door stop		made to ensure that the deficient practice does not recur: On daily walking rounds doors will be assessed randomly to insure smoke integrity and self closing. Maintenance will repair any door not closing properly. 4. How the corrective action will be monitored to ensure deficient practice will not recur, “What quality assurance program will be put into place: Maintenance will review on walking rounds and report to the Administrator if any door is at risk of not providing smoke integrity. Maintenance responsible, Administrator to monitor. to 5. Date by which each deficiency will be corrected. 8/10/21	

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	15E667	A. BUILDING 01 B. WING	07/22/2021

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	near the latching mechanism for the corridor door to the Soiled Utility Room by Room 16. The gap appeared to be created by gouging out the wood of the door near the latching mechanism. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give			

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	15E667	A. BUILDING 01 B. WING	07/22/2021

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	the rating _____________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls for 1 of 1 main Dining Rooms was constructed to resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the corridor door to the Nutrition Room in the main Dining Room had a three foot by one foot grill installed in the door near the floor. The main Dining Room was open to the corridor. Based on interview at the time of the observations, the Maintenance Director stated the facility has a replacement door on order but agreed the aforementioned opening in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0362	1. Corrective action for those residents found to be have been affected by the deficient practice. A new door was ordered and has not been delivered to date. To secure the smoke barrier a piece of wood has been drilled into the door, until the door arrives. A small a/c unit has been utilized to keep the pantry cool for the ice machine. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this practice 3. What measures will be made to ensure that the deficient practice does not recur: Current maintenance team are aware there can be no openings into the corridor for smoke barrier doors. That all doors must close completely with no gaps. 4. How the corrective action will be monitored to ensure deficient practice will not recur, “What quality assurance program will be put into place: All doors will be viewed during maintenance	08/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 01 B. WING	07/22/2021

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

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			rounding. All corrections will be made immediately. During QAPI Maintenance will report rounding report. Maintenance resposible Administrator to monitor. 5. Date by which each deficiency will be corrected.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

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	15E667	A. BUILDING 01 B. WING	07/22/2021

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 5 of over 25 corridor doors had no impediment to closing and latching into the door frame or would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the following was noted: a. a one inch gap was noted in between the face of the door and the door stop near the door handle for the corridor door to Room 1. b. a one inch gap was noted in between the face of the door and the door stop near the top of the corridor door to Room 12. c. a one inch gap was noted in between the face of the door and the door stop near the latching mechanism for the corridor door to the Soiled Utility Room by Room 16. The gap appeared to be created by gouging out the wood near the latching mechanism. d. the corridor door to the Janitor's Closet was equipped with a self closing device but the door failed to latch into the latching plate on the door	K 0363	1. Corrective action for those residents found to be have been affected by the deficient practice. All five doors have been repaired to latch into the door frame to resist passage of smoke. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: all residents could be affected by this deficient practice. 3. What measures will be made to ensure that the deficient practice does not recur: On walking rounds by Maintenance doors will be viewed randomly to insure all doors are closing properly. 4. How the corrective action will be monitored to ensure deficient practice will not recur, “What quality assurance program	08/10/2021

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	15E667	A. BUILDING 01 B. WING	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	frame when tested to close multiple times. e. the corridor door to the kitchen by the Janitor's Closet was equipped with a thumb twist lock and was not equipped with a positive latching device. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		will be put into place: Maintenance will observe door closure on walking rounds randomly. They will be repaired immediately. Report will occur at morning meeting. Maintenance responsible Administrator to Monito 5. Date by which each deficiency will be corrected. 8/10/21	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 2 ceiling	K 0372	1. Corrective action for those residents found to be have been	08/10/2021

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	15E667	A. BUILDING 01 B. WING	07/22/2021

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LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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	smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, a black substance was used to firestop the annular space surrounding three electrical conduits which penetrated the ceiling of the Main Mechanical Room by the main Dining Room. Based on interview at the time of the observations, the Maintenance Director stated fire resistance rating documentation for the black substance was not available for review and agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference.		affected by the deficient practice. Ceiling smoke barrier has been caulked with fire resistance caulk. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident have the potential to be affected by this deficient practice. Ceiling smoke barrier has been caulked with fire resistance caulk. 3. What measures will be made to ensure that the deficient practice does not recur: Per preventative maintenance checklist. Ceiling smoke barriers will be checked on a regular basis. Will be repaired immediately by maintenance. 4. How the corrective action will be monitored to ensure deficient practice will not recur, “What quality assurance program will be put into place: The preventative maintenance checklist will be reviewed monthly in QA. Maintenance responsible and Administrator to monitor. 5. Date by which each deficiency will be corrected. 8/10/21	

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	15E667	A. BUILDING 01 B. WING	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0374	1. Corrective action for those residents found to be have been affected by the deficient practice. The fire smoke doors were repaired and now closes correctly. The gap has now been repaired. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by this practice. The fire smoke doors were repaired and now closes correctly. The gap has	08/10/2021

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	Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, the smoke barrier door set at the top of the ramp in the corridor by Room 6 failed to fully self close when tested to close multiple times. The two doors in the door set each swing in the same direction and was equipped with a door closing coordinator affixed to the top of the door frame near the center of the door frame. The coordinator failed to operate correctly and propped the north door open with a four inch gap in between the meeting edges of the door set. Each door in the door set was held in the fully open position with magnetic holding devices set to release each door to close with fire alarm system activation. Based on interview at the time of the observations, the Maintenance Director agreed the smoke barrier door set failed to fully self close to restrict the passage of smoke due to the closing coordinator not functioning correctly. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference. This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		now been repaired. 3. What measures will be made to ensure that the deficient practice does not recur: The fire doors will be observed during fire drills, randomly 1 time a week and as indicated with the preventative maintenance program. 4. How the corrective action will be monitored to ensure deficient practice will not recur, "What quality assurance program will be put into place: The preventative maintenance program will report monthly at our QAPI meeting. The Maintenance department responsible, administrator to monitor. 5. Date by which each deficiency will be corrected. 8/10/21	
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2			

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	15E667	A. BUILDING 01 B. WING	07/22/2021

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

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	and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 4 of 4 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health	K 0923	1. Corrective action for those residents found to be have been affected by the deficient practice. All improperly secured oxygen	08/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 01 B. WING	07/22/2021

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	Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over one staff and visitor in the Soiled Utility Room by the east exit door set in the facility. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 8:45 a.m. to 9:35 a.m. on 07/22/21, three 'E' type oxygen cylinders were freestanding on the countertop in the Soiled Utility Room by the east exit door set in the facility and were not properly chained or supported in a proper cylinder stand or cart. One additional 'E' type oxygen cylinder was also located in the room and was freestanding on the lid for a red bag waste bin and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Assistant stated the cylinders had been removed from the upper floors of the facility and were awaiting pickup but agreed 4 of 4 oxygen cylinders in the Soiled Utility Room were not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference.		tanks were removed and stored securely and correctly. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents and staff has the potential to be affected. 3. What measures will be made to ensure that the deficient practice does not recur: During morning rounds the DON will make rounds to insure all oxygen tanks are secured. In her absence the charge nurse will do rounds. 4. How the corrective action will be monitored to ensure deficient practice will not recur, “What quality assurance program will be put into place: DON to report daily in morning meeting her findings, DON responsible and Administrator to monitor. 5. Date by which each deficiency will be corrected. 8/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING 01 B. WING	07/22/2021

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

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	This deficiency was cited on 05/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			