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 _____	R **08/23/2021**

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
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the PSR conducted on 07/22/21 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: 08/23/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 At this PSR to the Emergency Preparedness survey, Lynhurst Healthcare was found in 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 36. Quality Review completed on 08/23/21	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the PSR conducted on 07/22/21 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: 08/23/21 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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 _____	R **08/23/2021**

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
{K 000}	Continued From page 1 At this PSR survey, Lynhurst Healthcare was found 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 36 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 the laundry building and a metal storage shed which were each not sprinklered. Quality Review completed on 08/23/21	{K 000}		