

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/09/14</p> <p>Facility Number: 000144 Provider Number: 155240 AIM Number: 100266760</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lyons Health and Living Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery</p>	K010000		

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.

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K010130 SS=E	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 85 and had a census of 57 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage used as a maintenance shop and maintenance storage, and two small sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 12 of 39 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life</p>	K010130	This plan of correction is to serve as Lyon's Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyon's Health and Living Community or it's management company that the allegations contained in this	01/22/2014

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	<p>safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect 14 residents, as well as staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Battery Operated Smoke Detector testing log on 01/09/14 at 12:00 p.m. with the Maintenance Supervisor present, the batteries in the battery operated smoke detectors located in the following resident sleeping rooms have not been replaced during the past twelve months: 104, 105, 107, 108, 113, 116, 206, 208, 210, 311, 312, and 316. Based on interview at the time of record review, the Maintenance Supervisor said the batteries in the smoke detectors were replaced when they made a beeping sound. Based on observations on 01/09/14 between 9:15 a.m. and 11:15 a.m. during a tour of the facility with the Maintenance Supervisor, battery operated smoke detectors were observed in all resident sleeping rooms.</p> <p>3.1-19(b)</p>		<p>survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Maintenance Director audited rooms, 104,105,107,108,113,116,206,208,210,311,312, and 316. All smoke detectors were functioning properly. Maintenance Director audited the rest of the building and all smoke detectors were functioning properly. A new form was instituted to monitor the smoke detectors weekly per guidelines The administrator/designee will review the log weekly for 6 months and forward to the Q.A. committee for review.</p>		

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the Emergency Power Supply (EPS) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include: Based on review of the facility's</p>	K010144	The Maintenance Director tested the generator and found that it was functioning per the required guidelines of K-0144. The maintenance Director calculated the percentage of the load capacity of the generator and recorded it in the TELS monitoring system. Maintenance director was re-inserviced on the formula for calculating the percentage of the generator's load capacity. The generator will be tested weekly by the Maintenance Director/Designee and the percentage recorded in the TELS monitoring log. The Administrator will review the log weekly for 6 months and the results will be forwarded to the Q.A. Committee for review for 6 months.	01/22/2014			

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	<p>Generator log on 01/09/14 at 12:20 p.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested monthly under load, however, there was no accurate documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the Emergency Power Supply (EPS) nameplate rating for a minimum of 30 minutes during the past twelve months. The generator log form was provided with the question; "Load" with the answer varying from "NA %", "greater than 70 %", or "less than 70 %". During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include accurate documentation the generator was exercised under operating conditions or not less than 30 percent of the Emergency Power Supply (EPS) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>				