

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 01/11/2016
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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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K 0000 Bldg. 01	<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: 01/11/16</p> <p>Facility Number: 000144 Provider Number: 155240 AIM Number: 100266760</p> <p>At this Life Safety Code survey, Lyons Health and Living Center, Inc. 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 spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 82 and had a census of 59 at the time of this</p>	K 0000	<p>This plan of correction is to serve as Lyons Health and Living Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Center of its management company that the allegations contained in the 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.</p>	
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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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K 0025 SS=E Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered, and 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 completed 01/12/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect up to 21 residents in the 200 hall plus any number of residents, as well as staff and visitors while in the Nurses' Station area where the 100, 200 and 300 halls meet.</p>	K 0025	<p>K025 NFPA 101 LIFESAFETY CODE STANDARD</p> <p>1.The hole has been repaired and fire caulked withapproval rated drywall and NFPA rated fire caulk as of 1/12/2016.</p> <p>2.An interior audit above the drop ceiling at allfire/smoke doors has been conducted and no other areas have been found.</p> <p>3.The systemic change includes that beginningimmediately any</p>	01/12/2016

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K 0038 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 01/11/16 at 1:30 p.m. during a tour of the facility with the Maintenance Director, the smoke barrier wall above the smoke barrier doors in the 200 hall had a two foot by one foot hole through the wall above an air duct and wire bundles. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>		<p>time a contractor does work in the building; the area in use will be inspected by the Facility Director to determine if any holes or breaches have been made regarding fire protection. Any discrepancy found will be properly sealed before the contractor is released. Education will be provided to the Maintenance Director regarding the systemic change.</p> <p>4. A quality assurance audit will be completed by the Maintenance Director or designee, daily during any contractor work in the building that could breach fire protection during the contractor's presence and immediately after their exit. Any concerns will be addressed at the time of the breach.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>Based on observation and interview, the facility failed to ensure a way of exit was well maintained for 3 of 5 exits. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 01/11/16 between 12:15 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, the sidewalks to the front parking lot from the 100, 200 and 300 hall exits were covered with up to an inch of snow and ice which would not be easily traversed in the event of an evacuation. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>	K 0038	<p>K038 NFPA 101 LIFESAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 1. The walk ways were cleared 1/11/2016. 2. All walkways were cleared during the survey process and are kept cleared to be easily traversed in the event of an evacuation 3. The systemic change includes that there will be a visual inspection by the Facility Maintenance Director, or designee, of all emergency exit sidewalks during and after snow or ice fall to visualize that they remain clear and free of ice and snow. The Maintenance Director was offered education regarding the systemic change. 4. A quality assurance audit tool will be completed by the Maintenance Director or designee, during times of snow or ice at least twice a day, 7 days a week to review that walkways are cleared to be easily traversed in the event of an evacuation. This audit will continue twice a day, 7 days a week during snow or ice for 30 days, then daily, 5 days a week for 30 days, and then weekly for a duration of 12 months of monitoring if the weather includes snow and ice. <p>The Results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting</p>	01/12/2016	

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K 0062 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler heads used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/11/16 at 12:40 p.m. during a tour of the facility with the Maintenance Director, the spare sprinkler head cabinets in the sprinkler riser room had over twelve spare sprinkler heads, however, there were no spare quick response pendent type heads</p>	K 0062	<p>monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>K062 NFPA LIFE SAFETY CODE STANDARD</p> <p>1. Spare sprinkler heads have been ordered through P.I.P.E. who is the Fire sprinkler contractor.</p> <p>2. 2 of each type of sprinkler heads used in the facility will be maintained and stored in a cabinet, including quick response pendent type sprinkler heads with red glass tubes.</p> <p>3. The systemic change includes that a monthly audit/inventory of the spare sprinkler heads will be conducted by the Facility Director and added to the TELS maintenance system. Education will be provided to the Maintenance Director regarding the systemic change.</p> <p>4. A quality assurance audit tool will be completed by the Maintenance Director or designee to review for the presence of the appropriate spare sprinkler heads in the cabinet daily, five days a week for 30 days, and then weekly</p>	02/10/2016	

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K 0144 SS=C Bldg. 01	<p>with red glass tubes. Quick response pendent type sprinkler heads with red glass tubes were observed during the tour with the Maintenance Director between 12:15 p.m. and 1:45 p.m. in the Maintenance Office where the fire alarm panel was located, the Physical Therapy Gym, and the Medical Records Room. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director said there were no other spare sprinkler heads in the facility that he could find.</p> <p>3-1.19(b)</p> <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, observation and interview; the facility failed to ensure documentation for 1 of 1 emergency generators showed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown</p>	K 0144	<p>for a duration of 12 months of monitoring. The results of these reviews will bediscussed at the monthly facility Quality Assurance Committee meeting monthlyfor 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%.</p> <p>K144 NFPA 101 LIFESAFETY CODE STANDARD 1.Documentation was completed for the emergencygenerator showing a 5 minute cool down period after a load test. 2.The 5 minute cool down period after a load testis being completed and recorded on the generator log sheet weekly. 3.The systemic change includes that documentation willbe completed for the emergency generator showing a 5 minute</p>	01/12/2016

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	<p>requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator weekly testing log on 01/11/16 at 10:55 a.m. with the Maintenance Director present, the generator log form documented the generator was tested weekly for 60 minutes under load, however, the TELS form had a question asking "Cool Down Time:" with the answer being "NA Minutes" during each weekly test. Based on observation at 1:40 p.m. with the Maintenance Director, the Generator Transfer Switch was identified with having a clock set up to perform a 10 minute cool down time after each load test. During an interview at the time of observation, the Maintenance Director confirmed the weekly generator log did not include documentation of a cool down time being recorded, but indicated a 10 minute cool down time does take</p>		<p>cool down period after a load test weekly and be tracked by the TELS maintenance system. Education will be provided to the Maintenance Director regarding the systemic change.</p> <p>4. A quality assurance audit tool will be completed by the Maintenance Director or designee weekly for documentation of the 5 minute cool down period after a load test of the emergency generator weekly. This audit tool will continue weekly for a duration of twelve months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>				

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

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	place after each weekly load test. 3.1-19(b)				