

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 01/13/2015
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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: 01/13/15</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, 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</p>	K010000		
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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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K010038 SS=E	<p>rooms. The facility has a capacity of 82 and had a census of 54 at the time of this 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 by Dennis Austill, Life Safety Code Specialist on 01/15/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 Based on observation and interview, the facility failed to ensure 1 of 6 exit door electromagnetic locks unlocked when the fire alarm was activated. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires that all emergency exits</p>	K010038	This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or 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	01/23/2015			

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K010062 SS=B	<p>connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect up to 20 residents, as well as staff and visitors while in the 100 hall plus any residents while in the Activity room.</p> <p>Findings include:</p> <p>Based on observation on 01/13/15 at 11:20 a.m. during a tour of the facility with the Maintenance Director, the fire alarm system was activated by a pull station and all magnetically locked exit doors released except the 100 hall exit door. The 100 hall exit door did release when the four digit code was pushed. Based on interview during the time of observation, the Maintenance Director acknowledged the magnetically locked 100 hall exit door did not release when the fire alarm system was activated.</p> <p>3.1-19(b)</p> <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</p>	K010062	<p>services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Lyons health and Living Community respectfully request paper compliance for this survey. K 0038 Integrated Electronics was in and fixed the 100 hall fire door so it unlocks when the fire alarm is triggered. There were no residents, visitors or staff affected. The 100 hall fire door will be tested for unlocking when fire alarm is triggered 2xs a week for three months and then weekly for a year. The results of these test will be recorded on an audit sheet. The maintenance director or designee will perform the test and record the results. The results will be forwarded to the Q.A. monthly for any negative findings and further actions if needed. The administrator is responsible for compliance .</p> <p>K 0062 The automatic sprinkler heads have been ordered to</p>	01/23/2015			

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K010064 SS=B	<p>facility failed to ensure 1 of 1 automatic sprinkler head storage cabinet was provided with at least two of each type of sprinkler head 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 residents, as well as staff and visitors while using the 200 hall shower room and Physical Therapy room.</p> <p>Findings include:</p> <p>Based on observations on 01/13/15 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with Maintenance Director, the spare sprinkler head cabinets in the facility had six spare sprinkler heads, however, there were no spare quick response pendent type heads. Quick response heads was observed in the 100 hall shower room and Physical Therapy room. This was acknowledged by the Maintenance Director at the time of observations, furthermore, the Maintenance Director said there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all</p>		<p>comply with NFPA 25,2-4.1.4 There were no residents ,visitors or staff affected. The maintenance director or designee will perform an audit weekly to ensure the sprinkler heads are available if/when needed. This audit will be completed once a week for thirty days and then monthly for a year and then ongoing. The results will forwarded to the Q.A. monthly meeting for further action as needed. The administrator is responsible for compliance.</p>		

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	<p>health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect mostly staff while working in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 01/13/15 at 10:50 a.m. during a tour of the facility with the Maintenance Director, there was a Class K portable fire extinguisher in the</p>	K010064	K 0064 The portable fire extinguisher in the kitchen cooking area has a placard that meets the requirements of NFPA 10, 2-3.2. There were no residents, visitors or staff affected. The maintenance director or designee will audit twice a week for 30 days and then monthly there after to ensure the placard is in place. Results of the audit will be forwarded to the Q.A. monthly meeting for further recommendations as needed. The administrator is responsible for compliance.	01/23/2015

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K010130 SS=B	<p>kitchen which lacked a placard. Based on interview at the time of observation, the Maintenance Director acknowledged the Class K portable fire extinguisher lacked a placard.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room and kitchen</p>	K010130	K 0130 The rolling fire door had been inspected and now has the inspecting tag on it. There were no residents, staff or visitors were affected. The maintenance director or designee will audit two times a week for 30 days and then weekly for a year and then ongoing to ensure the tag is on the rolling window and replaced with the new inspection tag as it comes due. The results will be forwarded to the Q.A. committee monthly and further recommendations made as needed. The administrator is responsible for compliance	01/23/2015

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K010147 SS=E	<p>staff.</p> <p>Findings include:</p> <p>Based on observation on 01/13/15 at 10:48 a.m. during a tour of the facility with the Maintenance Director, the metal rolling fire door was without a current inspection tag protecting the opening from the kitchen to the Dining Room. The most recent tag/sticker on the metal rolling fire door was dated 05/13. Based on interview at the time of observation, this was confirmed by the Maintenance Director, furthermore, the Maintenance Director stated there was no additional documentation of an annual inspection or test for the kitchen rolling fire door to check for proper operation and full closure of the metal curtain since the 05/13 inspection tag/sticker.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure power strips and multi plug adaptors were not used as a substitute for fixed wiring in 2 of 41 resident rooms, plus the Activity room. LSC 19.5.1 requires utilities to comply</p>	K010147	Room 106 has refrigerator plugged directly into wall socket.family was notified of LSC 9.1.2 and asked to come in and pick up their multi socket outlet. Activity room has microwave plugged directly into wall socket and education provided to the	01/23/2015			

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	<p>with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents in rooms 106 and 117, plus residents, staff and visitors while in the Activity room.</p> <p>Findings include:</p> <p>Based on observations on 01/13/15 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <ol style="list-style-type: none"> 1. Room 106 had a refrigerator plugged into a multi plug adaptor 2. The Activity room had a microwave plugged into a power strip 3. Room 117 had a bed, nebulizer, and microwave plugged into two power strips and a multi plug adaptor. <p>At the time of each observation, the Maintenance Director acknowledged the use of the power strips and multi adaptors in the previously mentioned rooms.</p> <p>3.1-19(b)</p>		<p>activity director on the LSC requirement. Room 117 has all equipment plugged into electrical plug ins that meet LSC 9.1.2. The family has been provided education on LSC 9.1.2. The maintenance director or designee will audit building weekly for a month and check that all equipment is plugged in according to LSC 9.1.2, then monthly ongoing . Results will be forwarded to Q.A. monthly for any follow as needed. The administrator is responsible for compliance.</p>				