STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155240	A. BUILDING 00 B. WING	02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LYONS HEALTH AND LIVING CENTER	2417 S COUNTY ROAD 800 W LYONS, IN 47443

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 5, 6, 7, 8, and 12, 2017 Facility number: 000144 Provide number: 155240 AIM number: 100266760 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 5 Medicaid: 32 Other: 8 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 14, 2018.	F 0000	The plan of correction is to serve as Lyons Health and Living Center's allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Center or its management company that the allegations contained in the survey report is 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.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

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

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	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to keep an indwelling catheter (flexible tube which is positioned into the bladder to drain urine) drainage bag from touching the floor for 1 of 1 resident observed for urinary catheter use. (Resident 30) Finding include: On 2/718 at 10:55 A.M., Resident 30 was observed in his room, seated in his wheelchair, with his catheter drainage bag touching the floor. On 2/718 at 11:30 A.M., Resident 30 was observed in his room, seated in his wheelchair, with his catheter drainage bag touching the floor.	F 0690	**I. The corrective action to be accomplished for the resident found to have been affected by the deficient practice.** Resident # 30 has agreed to utilize leg bag when he gets up for the day and will utilize catheter bag when	02/23/2018

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	On 2/12/18 at 10:30 A.M., Resident 30 was observed in his room, seated in his wheelchair, with his catheter drainage bag touching the floor. On 2/718 at 11:15 A.M., Resident 30 was observed in his room, seated in his wheelchair, with his catheter drainage bag touching the floor. On 2/718 at 12:15 P.M., Resident 30 was observed in his room, seated in his wheelchair, with his catheter drainage bag touching the floor. During an interview, on 2/12/18 at 3:40 P.M., the Director of Nursing indicated the resident's catheter bag should not be touching the floor at any point and the clip holding the bag might have been broken. No part of the catheter drainage system should ever touch the floor. On 2/12/18 at 3:50 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but not limited to obstructive reflux uropathy and vesicoureteric reflux. A physician's order, dated 10/15/17, indicated the resident is to have a suprapubic catheter secondary to diagnoses of vesicoureteric reflux and obstructive reflux uropathy. 3.1-41(a)(2)		he decides he is ready to go to bed at HS. **II. The facility will identify other residents that may potentially be affected by the practice.** Residents have been reviewed and there are no other residents residing in the facility with catheters. No other residents are affected. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The systemic change includes any new resident admitted to facility with foley catheter with appropriate diagnosis will be educated to utilize leg bag throughout day when up and/or extra clasps will be utilized to keep foley catheter tubing from falling/touching floor. Education will be given to facility staff regarding foley catheters in	

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			facility. **IV. The facility will monitor the corrective action by implementing the following measures.** A quality assurance tool will be utilized by the DON or designee, to audit Foley Catheter/Catheters tubing to ensure foley catheter tubing is properly placed. The DON, or designee, will audit Foley Catheter/Catheters daily for 4 weeks, then weekly for 4 weeks, then monthly for 10 months for a total of 12 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%. Compliance date 2/23/2018	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on interview and record review, the facility failed to obtain a 2-step tuberculin skin test (a test to determine one is free from tuberculosis) for 2 of 5 newly hired employees reviewed for tuberculin testing (Dietary Aide 1 and Housekeeper 1).	F 0880	**I. The corrective action to be accomplished for the staff found to have been affected by the deficient practice.**	02/23/2018

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	Findings include: 1.) On 2/12/18 at 10:00 a.m., the employee records were reviewed. The records indicated the following: Dietary Aide 1 had a hire date of 12/27/17. The employee's record indicated a tuberculin step 2 given on 1/20/18, and lacked documentation of a step 1 being administered. During an interview, on 2/12/18 2:30 p.m., Human Resources indicated the tuberculin step 1 record for Dietary Aide 1 was missing from her employee file and could not be located. On 2/12/18 at 3:15 p.m., the Clinical Specialist indicated the facility did not have a policy in regard to tuberculin testing. 2.) Housekeeper 1 had a hire date of 8/9/17. The employee's record indicated an administration of a tuberculin step 1 given on 8/15/17 and a step 2 being administered on 11/7/17. During an interview, on 2/12/18 2:30 p.m., Human Resources did not deny Housekeeper 1's tuberculin step 2 was administered late (not within 1 to 3 weeks after the step 1). On 2/12/18 at 3:15 p.m., the Clinical Specialist indicated the facility did not have a policy in regard to tuberculin testing. 3.1-18(a)		Dietary Aide #1 record for 1st Step PPD was given on 12/22/2017 and read on 12/25/2017. 2nd Step PPD was given on 1/5/2018 and read on 1/8/2018. 1st and 2nd Step PPD negative and proper documentation was found afterSurvey Event ID V7Y711 was completed. Housekeeper #1 1st step PPD was given 2/20/2018 and 2nd step will be given 3/5/2018. **II. The facility will identify other staff that may potentially be affected by the practice.** All staff currently employed/volunteers at facility have been audited for current and up to date PPD compliance with 100% compliance noted. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The systemic change includes any new Employees/Volunteers will report to SDC/ADON or	

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			Designee to have 1st step PPD given then she/he will set up 2nd step PPD with new Employee/Volunteer. SDC/ADON or designee will then make copy and turn into HR to put into Employee/Volunteer File. **IV. The facility will monitor the corrective action by implementing the following measures.** A quality assurance tool will be utilized by the DON or designee to review all new Employees/Volunteers to ensure all PPD'S are given timely. The DON, or designee, will audit new Employee/Volunteer PPD'S daily for 4 weeks, then weekly for 4 weeks, then monthly for 10 months for a total of 12 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%.	

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			Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance 2/23/2018	