STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155240	A. BUILDING -- B. WING	03/19/2018

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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E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/19/18 Facility Number: 000144 Provider Number: 155240 AIM Number: 100266760 At this Emergency Preparedness survey, Lyons Health and Living Center Inc. was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 82 certified beds. At the time of the survey, the census was 44. Quality Review completed on 03/21/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0023 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all	E 0023	1.No residents were affected by this deficient practice. 2.A policy and procedure has been developed that preserves resident information, protects confidentiality of resident's information, and secures and maintains the availability of	04/02/2018

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

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	occupants. Findings include: Based on review of the Emergency Disaster Preparedness Manual (EDPM) on 03/19/18 between 12:15 p.m. and 1:15 p.m., there was a tab in the EDPM for policy and procedures for Medical Documents, however, there was no documentation available to indicate the use of a system to preserve resident medical documentation during an emergency. This was confirmed by the Director of Maintenance at the time of record review and interview.		records. We currently use our Matrix Computer system to print off face sheets of all residents. All face sheets are kept in a binder in the ADON office and are updated as needed. 3.The systematic change involves developing and implementing a policy that addresses policies and procedures for medical documentation. The Emergency Disaster Preparedness Manual has a policy and procedure for medical records that indicates the use of a system to preserve resident documentation during an emergency. This policy identifies the use of lanyards that will include resident identification in case of an emergency. 4.Facility will use Matrix system to update face sheets when needed and will print these off to place in binder. 5.This policy remains in effect for the duration. Any changes in policy or procedure will be reviewed and discussed in the quality assurance meeting. 6.Completion date: April 2, 2018.	
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the	E 0037	1.No residents were affected by this deficient practice. 2.Mandatory In-service will be held with all staff on the	04/05/2018

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	following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Disaster Preparedness Manual (EDPM) on 03/19/18 between 12:15 p.m. and 1:15 p.m. with the Director of Maintenance present, there was no documentation to indicate facility staff were trained on the EDPM over the past 12 months. Based on an interview at the time of EDPM review, the Director of Maintenance said the facility has not trained the staff and documented the training on the EDPM.		Emergency Disaster Preparedness Manual on April 5th 2018. 3.The systematic change involves annual training with all staff, on the Emergency Disaster Preparedness Manual and with new staff on hire. The training for new staff will be done by the Maintenance Director and will include fire safety, evacuation, and emergency preparedness. 4.Completion date: April 5th, 2018	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a	E 0039	1.No residents were affected by the deficient practice. 2.A full scale community exercise is scheduled for April 16th 2018 with all staff, and the local fire department. 3.The systematic change includes biannual training on Emergency Disaster Preparedness with two full scale community exercises. 4.Training documentation will be	04/16/2018

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	community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Disaster Preparedness Manual (EDPM) on 03/19/18 between 12:15 p.m. and 1:15 p.m. with the Director of Maintenance present, the facility did provide documentation that a community based emergency preparedness drill was performed, however, the facility was unable to provide documentation that a second drill/exercise was conducted during the past 12 months, such as a table top exercise or another community based emergency preparedness drill. Based on interview at the time of EDPM review, the Director of Maintenance said the facility has not conducted two emergency preparedness exercises during the past 12 months.		placed in our Emergency Preparedness Disaster Manual. Completion date: April 16th, 2018	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/19/18 Facility Number: 000144 Provider Number: 155240 AIM Number: 100266760 At this Life Safety Code survey, Lyons Health and Living Center, Inc. was found in substantial compliance with Requirements for Participation in Medicare/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 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 44 at the time of this survey. 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. Quality Review completed on 03/21/18 - DA			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting			

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	Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly for 30 seconds and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 03/19/18 at 10:45 a.m. with the Director of Maintenance present, there was no monthly inspection documentation to show when the battery powered emergency light was tested. Furthermore, there was no documentation to show the battery operated emergency light was tested annually for 90 minutes. Based on an interview at the time of record review, the Director of Maintenance said the battery powered emergency light was tested weekly, but not for thirty seconds, plus there was no documentation available to show the battery powered emergency light was tested for at least 30	K 0291	1.No residents have been affected by the deficient practice. 2.A functional test of the battery operated back up light was completed. A test will be done monthly for 30seconds and annually for 90 minutes to ensure the light would provide lighting during periods of power outage. 3.An audit tool was implemented and will be completed by the Maintenance supervisor and will be placed in the TELS system. 4.The systematic change includes that a policy was implemented in the facility regarding monthly audits to show battery powered emergency lighting was tested for at least 30 seconds monthly and 90 min annually. This policy has been placed in the facility disaster manual. Staff have been educated regarding this policy. 5.Completion date: April 5 , 2018	04/05/2018

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	seconds monthly and for 90 minute annually during the past twelve months, furthermore, the Director of Maintenance said the battery powered emergency light was just replaced within the past month. 3.1-19(b)			
K 0341 SS=B Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 2 of over 75 total smoke detectors were not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect two staff.	K 0341	1.No residents were affected by the deficient practice. 2.Audit was completed for all facility fire alarms to insure that all smoke alarms are installed where air flow would not adversely affect the alarms operation. No other residents have been affected by this deficient practice. 3.The systematic change includes moving both fire alarms that were found to be within 12 inches from the air supply vent further than 12 inches from the air	03/20/2018

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	Findings include: Based on observations on 03/19/18 between 11:00 a.m. and 12:15 p.m. during a tour of the facility with the Director of Maintenance, the following was noted: a. There was a ceiling mounted battery powered smoke detector in the Admissions Coordinator office within 12 inches of an air supply vent b. There was a ceiling mounted battery powered smoke detector in the Dietary Managers office within 12 inches of an air supply vent Based on interview at the time of each observation, the Director of Maintenance agreed the smoke detectors were within 12 inches of the air supply vents. 3.1-19(b)		supply vent. . 4.Facility Maintenance Director has both alarms moved and has provided pictures to show replacement. 5.Completion date: March 20, 2018	
K 0511 SS=B Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily	K 0511	1.No residents were affected by the deficient practice. 2.The electrical reciprocal in the restroom was removed. 3.Completion date: March 20, 2018.	03/20/2018

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	accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under			

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	210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly staff using the Associate Restroom. Findings include: Based on observation on 03/19/18 at 11:41 a.m. during a tour of the facility with the Director of Maintenance, there was one electric receptacle within two feet of the sink in the Associate Restroom. The electric receptacle was not provided with ground fault circuit interrupters (GFCI). This was confirmed when tested with a GFCI testing device. Based on interview at the time of observation, the Director of Maintenance agreed the receptacle in the Associate Restroom was not GFCI protected. 3.1-19(b)			