STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155448	B. WING		02/27/2023		
			CTREET	ADDRESS CITY STATE ZIR SOD			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
LOWELL HEALTHOADE				CHIGAN ST			
LOWELL	HEALTHCARE		LOWE	LOWELL, IN 46356			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 0000	Please accept the following	as		
		diana Department of Health in		the facility's credible allegati			
	accordance with 42	-		of compliance. This plan of			
				correction does not constitu	te		
	Survey Date: 02/27	7/23		an admission of guilt or liabi			
	•			by the facility and is submitt	- I		
	Facility Number: 00	00361		only in response to the			
	Provider Number: 1	55448		regulatory requirement. We			
	AIM Number: 1002	66340		respectfully request			
				consideration for desk review	w.		
	At this Emergency I	Preparedness survey, Lowell					
	Healthcare was four	nd in compliance with					
	Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73						
	The facility has 86 of	certified beds. At the time of					
	the survey, the cens	us was 77.					
	Quality Review con	npleted on 03/01/23					
K 0000							
Bldg. 01							
	•	Recertification and State	K 0000	Please accept the following			
		ucted by the Indiana		the facility's credible allegation	on		
	Department of Heal	th in accordance with 42 CFR		of compliance. This plan of			
	483.90(a).			correction does not constitu	••		
				an admission of guilt or liabi	=		
	Survey Date: 02/27/	/23		by the facility and is submitt	ed		
				only in response to the			
	Facility Number: 00			regulatory requirement. We			
	Provider Number: 1			respectfully request			
	AIM Number: 1002	66340		consideration for desk review	w.		
		Code survey, Lowell					
	Healthcare was four	nd not in compliance with					
				1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Emily Bailey Executive Director 03/17/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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AND PLAN OF CORRECTION IDEN'		IDENTIFICATION NUMBER 155448	A. BUILDING B. WING	01	COMPLETED 02/27/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupated Building 01 was built a partial basement; I addition offset and ostructure by a stairw Building 03 is a diminibuilding 02. The faffirst, second, third a construction of Built of Type II (111) consprinklered. The confacility was V(111) facility has a fire alasmoke detection in the areas. Resident room powered smoke detection in the facility has the census of 77 at the total All areas accessible	articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Alt as a two story building over Building 02 is a two story connected to the original ray prior to March 1, 2003. The ding of the levels as the and fourth floors. The ding 01 was determined to be astruction and was fully anstruction type for the entire and is fully sprinklered. The arm system with hard wired the corridors and common are provided with battery sectors. The building is partially the wires and the correct of the sectors of the sectors of the sectors. The building is partially the diesel-powered generator.						
	Quality Review con	npleted on 03/01/23						
K 0300 SS=F Bldg. 01	Section 18.3 and 1 requirements that provided K-tags, b information, along	KS section any LSC 19.3 Protection are not addressed by the ut are deficient. This with the applicable Life FPA standard citation,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023		
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION should be included on Form CMS-2567.			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Based on observation failed to ensure all 1 in resident rooms w 4.6.12.3 states exist to the public, if not maintained. NFPA Signaling Code, 20 fire-warning equipment tested in accordance published instruction of Chapter 14. Sective testing, and mainten the requirements of equipment manufact Section 14.4.8.1 state recommended by the instructions, singlealarms shall be replained to operability tests I longer than 10 year. This deficient pract staff, and visitors. Findings include: Based on observation from 1:45 p.m. to 3 Director on 02/27/2 detectors mounted in #125 were inspected manufactured on M than 10 years old. Endowed the manufactured dealarms and would commoke alarms in the smoke alarms i	on Form CMS-2567. On and interview; the facility beattery-operated smoke alarms frere maintained. NFPA 101 in ing life safety features obvious required by the Code, shall be 72, National Fire Alarm and 10 Edition, Section 29.10 states ment shall be maintained and e with the manufacturer's one and per the requirements ion 14.2.1.1.1 Inspection, nance programs shall satisfy this Code and conform to the sturer's published instructions. It is unless otherwise the manufacturer's published and multiple-station smoke acced when they fail to respond but shall not remain in service is from the date of manufacture. It is could affect all residents, on during a tour of the facility soo p.m. with Maintenance 3, the battery-operated smoke in resident rooms #123 and id. The smoke detectors were farch 12, 2012 and were more dased on interview at the time oned observations, the sor stated he was unaware of the single action smoke theck every battery operated to 41 resident rooms for and replace if necessary.	K 0	300	What corrective action (s) wibe accomplished for those residents found to have been affected by the deficient practice? It's the policy of Lowell Health to ensure all battery-operated smoke alarms in residents roowere maintained. A house aud was completed on 02/28/2023 identify the 41 battery-backup: needed replaced. All show as functioning with no errors durit audit. On March 9th, order was placed for replacements to me requirements of being replace every 10 years. Anticipated delivery date of 03/24/2023. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be take All residents could be affected the deficient practice. A house audit was completed on 02/28/2023 to identify the 41 battery-backups needed replated on March 9th, order was placefor replacements to meet requirements of being replaced every 10 years. Anticipated delivery date of 03/24/2023. What measures will be put into place or what systemic changes you will make to	care oms dit to s ng s eet d	03/24/2023

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PRINTED: 04/05/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155448	A. BUILDING B. WING	01	COMPLETED 02/27/2023		
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		viewed with the Executive enance Director at the exit		ensure that the deficient practice does not recur?			
	3.1-19(c)			To ensure the deficient practiculation does not reoccur, the battery-operated smoke alarm will be monitored by QA tool. Maintenance Director was in-serviced on 02/27/2023 on battery-operated smoke alarm requirements.	s		
				How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program with be put into place? The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attack by selecting ten (10) random locations of the battery-operate smoke detectors weekly for or month and all of them monthly thereafter for three (3) months Any identified issues/trends with corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing	vill ched ed ne dill be		
				compliance minimum of three months and until the facility maintains 95% compliance for days.	(3)		

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

PRINTED: 04/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/27/2023			
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON (X5) BE COMPLETION DATE		
K 0000							
Bldg. 02	Licensure was cond Department of Heal 483.90(a). Survey Date: 02/27. Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety Healthcare was four Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupation of Safety Code (I Health Care Occupation of Safety Requirements of P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupation of Safety Code (I Health Care	200361 55448 266340 Code survey, Lowell and not in compliance with	K 0000	Please accept the following the facility's credible alleg of compliance. This plan correction does not constant an admission of guilt or like by the facility and is submonly in response to the regulatory requirement. We respectfully request consideration for desk revenue.	ation of itute ability nitted		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155448		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/27/2023		
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE			71	STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	The facility has the census of 77 at the t	kW diesel-powered generator. capacity for 86 and had a time of this survey. to residents and all areas						
		ervices are sprinklered. npleted on 03/01/23						
K 0000								
Bldg. 03	Licensure was cond Department of Heal 483.90(a). Survey Date: 02/27/ Facility Number: 00 Provider Number: 1	ey Date: 02/27/23			Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for desk review.			
	Healthcare was four Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) Building 01 was but a partial basement; addition offset and structure by a stairw Building 03 is a din Building 02. The fafirst, second, third a	Code survey, Lowell and not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the ction Association (NFPA) 101, asc), Chapter 19, Existing ancies and 410 IAC 16.2. A two story building over Building 02 is a two story connected to the original way prior to March 1, 2003. The acility refers to the levels as the and fourth floors. The liding 01 was determined to be						

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PRINTED: 04/05/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 02/27/2023		
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	of Type II (111) construction and was fully sprinklered. The construction type for the entire facility was V(111) and is fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detectors. The building is partially protected by a 230 kW diesel-powered generator. The facility has the capacity for 86 and had a census of 77 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 03/01/23						

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