DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	2) MULTIPLE CONSTRUCTION BUILDING <b>01, 02, 03</b>			E SURVEY PLETED	
		155448	B. WING			R 04/13/2023		
NAME OF PR	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.		
					710 MICHIGAN ST			
LOWELL	IEALTHCARE				LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	LD BE COMPLETION		
{K 000}	INITIAL COMMENTS A Post-Survey Revise Code Recertification a	it (PSR) to the Life Safety	{K (	000				
	conducted on 02/27/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).							
	Survey Date: 04/13/23							
	Facility Number: 0003 Provider Number: 155 AIM Number: 100266	5448						
	in compliance with Re in Medicare/Medicaid Life Safety from Fire a National Fire Protection Life Safety Code (LSC	owell Healthcare was found equirements for Participation , 42 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing acies and 410 IAC 16.2.						
	a partial basement; B addition offset and co structure by a stairwa Building 03 is a dining 02. The facility refers second, third and four of Building 01 was de (111) construction and construction type for f and is fully sprinklered alarm system with ha the corridors and corr rooms are provided w detectors. The buildin 230 kW diesel-power	as a two story building over uilding 02 is a two story nnected to the original y prior to March 1, 2003. g room connected to Building to the levels as the first, rth floors. The construction termined to be of Type II d was fully sprinklered. The the entire facility was V(111) d. The facility has a fire rd wired smoke detection in mon areas. Resident with battery powered smoke ig is partially protected by a ed generator. The facility 6 and had a census of 78 at						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	=		TITLE		(X6) DATE	

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

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.

PRINTED: 04/18/2023

TITLE

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/20 FORM APPROV OMB NO. 0938-03		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01, 02, 03	(X3) DATE SURVEY COMPLETED		
		155448	B. WING		R 04/13/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LOWELL H	<b>IEALTHCARE</b>			710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETIC		
{K 000}	Continued From page the time of this surve		{K 000	)}			
	All areas accessible t providing facility serv	to residents and all areas ices are sprinklered.					
{K 000}	Quality Review comp		{K 000	)}			
	Code Recertification conducted on 02/27/2	it (PSR) to the Life Safety and State Licensure 23 was conducted by the of Health in accordance with					
	Survey Date: 04/13/2	3					
	Facility Number: 0003 Provider Number: 155 AIM Number: 100266	5448					
	in compliance with Re in Medicare/Medicaid Life Safety from Fire National Fire Protecti Life Safety Code (LS	owell Healthcare was found equirements for Participation I, 42 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing ncies and 410 IAC 16.2.					
	a partial basement; B addition offset and co structure by a stairwa Building 03 is a dining 02. The facility refers second, third and fou of Building 01 was de (111) construction and	as a two story building over Building 02 is a two story onnected to the original ay prior to March 1, 2003. g room connected to Building s to the levels as the first, rth floors. The construction etermined to be of Type II d was fully sprinklered. The the entire facility was V(111)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000361

If continuation sheet Page 2 of 4

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/18/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 02, 03</b>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155448	B. WING				r. 13/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOWELL HEALTHCARE					10 MICHIGAN ST .OWELL, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
PREFIX TAG   (EACH DEFICIENCY REGULATORY OR L     {K 000}   Continued From page and is fully sprinklered alarm system with har the corridors and com rooms are provided w detectors. The building 230 kW diesel-powere has the capacity for 80 the time of this survey     All areas accessible to providing facility servid     Quality Review compl INITIAL COMMENTS     A Post-Survey Revisi Code Recertification a conducted on 02/27/2 Indiana Department o 42 CFR 483.90(a).     Survey Date: 04/13/23     Facility Number: 0003 Provider Number: 155		d. The facility has a fire rd wired smoke detection in mon areas. Resident vith battery powered smoke by is partially protected by a ed generator. The facility 66 and had a census of 78 at y. o residents and all areas ices are sprinklered. leted on 04/17/23 it (PSR) to the Life Safety and State Licensure 23 was conducted by the of Health in accordance with 3 361 5448	PREFIX				
	in compliance with Re in Medicare/Medicaid Life Safety from Fire National Fire Protecti Life Safety Code (LS	owell Healthcare was found equirements for Participation 4 42 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing ncies and 410 IAC 16.2.					
	a partial basement; B	as a two story building over uilding 02 is a two story onnected to the original					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01, 02, 03	(X3) DATE SURVEY COMPLETED		
		155448 B. WING				04/13/2023		
NAME OF PROVIDER OR SUPPLIER			•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
LOWELL HEALTHCARE				710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID   (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE			
{K 000}	structure by a stairwa Building 03 is a dining 02. The facility refers second, third and four of Building 01 was de (111) construction and construction type for t and is fully sprinklered alarm system with ha the corridors and corr rooms are provided w detectors. The buildin 230 kW diesel-power has the capacity for 8 the time of this survey	by prior to March 1, 2003. g room connected to Building is to the levels as the first, rth floors. The construction termined to be of Type II d was fully sprinklered. The the entire facility was V(111) d. The facility has a fire rd wired smoke detection in mon areas. Resident with battery powered smoke the generator. The facility 6 and had a census of 78 at y.	{K (	000}	}			

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If continuation sheet Page 4 of 4

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