

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/11/2015
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NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/11/15</p> <p>Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340</p> <p>At this Life Safety Code survey, Lowell Healthcare Center 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 facility was built as a two story building over a partial basement with a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. The facility refers to the levels as the first, second, third and fourth floors. The construction was determined to be of Type II (111) construction and was fully sprinklered.</p>	K 000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.</p>	

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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K 025 SS=D Bldg. 01	<p>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 detector. The facility has the capacity for 86 and had a census of 78 at the time of this survey.</p> <p>All areas accessible to residents and all areas providing facility services are sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the opening in a smoke partition, such as a ceiling, was sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could any visitors and staff on the basement level with no resident access.</p> <p>Findings include:</p>	K 025	<p>K025 Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The facility has sealed the perimeter of theduct penetration through the laundry ceiling behind the dryers. Howother residents having the potential to be affected by the</p>	06/02/2015

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	<p>Based on observation with the maintenance director on 05/11/15 at 1:10 p.m., the perimeter of a six inch duct penetration through the laundry ceiling behind the dryers was unsealed leaving a one inch gap into the space above the laundry ceiling. The maintenance director said at the time of observation, he hadn't known the penetration was unsealed.</p> <p>3.1-19(b)</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All other ducts in the laundry room were inspected by the maintenance director to assure any ducts going through the ceiling were sealed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director/designee will inspect all walls and ceilings monthly during his PM rounds to ensure they are sealed properly. Any new construction will be inspected by the maintenance director to make sure all ducts are sealed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure the ducts are sealed properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.</p>		

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K 044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure fire doors on 2 of 4 levels were arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect staff, visitors, and 20 or more residents on the first and third floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator between 12:40 p.m. and 1:50 p.m., the function of the self closing devices on fire door sets near resident room 117 on the first floor and near resident room 314 on the third floor were tested twice manually with the maintenance director. One door in each fire door set failed to latch each time the doors were released to close. The doors failed to latch again at 1:50 p.m. when the fire alarm was activated. The maintenance director</p>	K 044	<p>K044 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Both fire doors have been adjusted and now latch properly when released. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. All doors in the facility were tested to assure they latch properly by the maintenance director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director/designee will inspect the fire doors monthly during his monthly fire drill to ensure they latch properly and document on the monthly fire drill form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will</p>	06/02/2015	

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K 069 SS=E Bldg. 01	<p>agreed at the time of observations, there was a problem with the latching mechanisms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, the facility failed to install and maintain cooking facilities in accordance with the requirements of NFPA 96, 3-1 which requires listed grease filters, baffles, or other approved grease removal devices for use with commercial cooking equipment shall be provided. Listed grease filters shall be tested in accordance with UL 1046, Grease Filters for Exhaust Ducts. Mesh filters shall not be used. This deficient practice could affect visitors, staff, and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation of the commercial kitchen range hood with the maintenance director on 05/11/15 at 12:30 p.m., mesh filters were in place to collect grease from cooking vapors. The maintenance</p>	K 069	<p>round with the maintenance director prior to the compliance date to ensure all fire doors latch properly. The Executive Director will review the monthly fire drills performed by the maintenance director monthly and sign off that the checks were completed.</p> <p>K069 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The mesh filters in the kitchen range hood were replaced with approved filters by the maintenance director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential of being affected. There are no other range hoods in the facility to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director/designee will inspect</p>	06/02/2015	

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K 000 Bldg. 03	<p>director said at the time of observation, he did not know mesh filters were not permitted.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/11/15</p> <p>Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 101, Life Safety Code (LSC), and 410</p>	K 000	<p>the kitchen range hood filters monthly during his PM rounds to ensure they are approved filters, not mesh filters.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure the kitchen range filters are approved filters, not mesh filters. The Executive Director will review the preventative maintenance checks performed by the maintenance director on the kitchen range hood filters monthly and sign off that the checks were completed.</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.</p>	

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	<p>IAC 16.2. The 2005 addition of 14 rooms on E wing was surveyed with Chapter 18, New Health Care Facilities.</p> <p>The 2005 addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 86 and had a census of 78 at the time of this survey.</p> <p>At this Life Safety Code survey, Lowell Healthcare Center 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. The 2012 one story addition to the main dining room was surveyed with Chapter 18, New Health Care Facilities.</p> <p>The 2005 addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 86 and had a census of 78 at the time of this survey.</p>			

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K 018 SS=E Bldg. 03	<p>All areas accessible to residents and all areas providing facility services are sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure doors protecting the corridor opening on 1 of 4 floors would resist the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the main first floor dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/11/15 at 11:35 a.m., there was a half inch gap between the double doors to the main dining room at the meeting edges of the doors. The maintenance director acknowledged at the time of observation, a draft was felt passing through the gap when the doors were closed.</p> <p>3.1-19(b)</p>	K 018	<p>K018 Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: Adoor astragal was placed on the dining room doors to prevent smoke from passingthrough by the maintenance director. Adoor coordinator was added to those doors to allow proper closing of the doorsby the maintenance director. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: Allresidents have the potential to be affected. All other doors protecting the corridors were inspected by themaintenance director to assure they resist the passage of smoke. Whatmeasures will be put into</p>	06/02/2015	

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K 056 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.		place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director/designee will check all corridor doors monthly during his PM rounds to assure they resist the passage of smoke. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure the corridor doors resist the passage of smoke. The Executive Director will review the monthly preventative maintenance checks performed by the maintenance director on the corridor doors resisting the passage of smoke and sign off that the checks were completed.	

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	<p>There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in the main dining room in 1 of 3 first floor smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect visitors, staff and 10 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/11/15 at 12:00 p.m., 3 of 12 sprinkler heads protecting the main dining room were identified as the quick response type while the remainder was identified as standard sprinkler heads. The maintenance director said when the sprinklers were each examined and compared to the spare heads in the spare sprinkler cabinet; the identification of the installation of two different types of sprinkler heads was accurate.</p>	K 056	<p>K056</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The sprinkler heads in the main dining room were replaced by the sprinkler system company so all sprinkler heads are the quick response type.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected. All sprinkler heads in each area were inspected by the maintenance director to ensure all were the same type. There are no other areas in the building that have converted sprinklers to the quick response type.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The maintenance director/designee will inspect any new construction areas to ensure they are all the same type of sprinkler head.</p>	06/02/2015

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	3.1-19(b)		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure the sprinkler heads are replaced to the quick response type. The Executive Director will review the preventative maintenance checks performed by the maintenance director on the sprinkler heads monthly and sign off that the checks were completed.		