PRINTED:	12/01/2021
FORM API	PROVED

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/15/2021 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/15/2021 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Emergency Preparedness survey, Lowell Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 75. Quality Review completed on 11/17/21 K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 The creation and submission of Licensure was conducted by the Indiana this plan of correction does not Department of Health in accordance with 42 CFR constitute an admission by the 483.90(a). provider of any conclusion set forth in the statement of deficiencies, or Survey Date: 11/15/2021 of any violation of regulations. Facility Number: 000361 Lowell Healthcare respectfully Provider Number: 155448 requests paper compliance due to AIM Number: 100266340 the low scope and severity of citations. At this Life Safety Code survey, Lowell Healthcare was found not in compliance with

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

TITLE

(X6) DATE

Any defiencystatement 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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155448 B. WING 11/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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. Building 01 was built as a two story building over a partial basement; Building 02 is a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. Building 03 is a dining room connected to Building 02. The facility refers to the levels as the first, second, third and fourth floors. The construction of Building 01 was determined to be 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 75 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 11/17/21 K 0291 **NFPA 101** SS=C **Emergency Lighting** Bldg. 01 **Emergency Lighting** 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, observation and What corrective action will be K 0291 11/28/2021 interview; the facility failed to ensure accomplished by the facility for 6GCU21 Event ID: Facility ID: 000361 Page 2 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED:

12/01/2021

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPL	
		155448	B. WING		11/15/	/2021
JAME OF I	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CO	D	
OWELL	HEALTHCARE			MICHIGAN ST /ELL, IN 46356		
	1					
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR		(X5)
REFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		functional annual testing of		those residents to hav		
		ts was complete. Section		affected by the deficie	nt	
		es functional testing shall be		practice:		
		, with a minimum of 3 weeks		The identified battery-op		
		5 weeks between tests, for not		emergency light was re	placed	
		ls, (3) Functional testing shall		immediately by the Mair	ntenance	
	be conducted annu	ally for a minimum of $1 \ 1/2$		Director.		
	hours if the emerge	ency lighting system is battery		How residents having	the	
	powered and (5) W	ritten records of visual		potential to be affected	l by the	
	inspections and tes	ts shall be kept by the owner		identified deficient pra	ctice	
	for inspection by the	ne authority having		will be corrected:		
		leficient practice could affect all		Maintenance Director c	ompleted	
	residents, staff and			an audit of all facility ba	•	
	,			operated emergency lig	-	
	Findings include:			there were no additiona		
	8			Measures put in place	-	
	Based on review of	f Direct Supply TELS Logbook		systemic changes mad		
		mergency and Exit Lighting:		ensure deficient practi		
		of exit lighting and exit signs"		not recur:	ce ubes	
		h the Maintenance Director		Maintenance Director /	Decignoo	
		w from 9:30 a.m. to 12:25 p.m.			-	
	-	-		will test all facility batter	• •	
		l 90 minute battery operated		emergency lights month		
		sumentation for the most recent		preventative maintenan		
	-	od was not itemized by location.		to ensure compliance w		
		at the time of record review,		Section 7.9.2.6; 7.9.2.7		
		irector stated he was hired		Battery operated emerg		
		ould not speak to work		testing was added to the	-	
	· ·	his hire. The Maintenance		QAPI calendar. Executi		
	Director agreed the			will monitor the calenda		
		licated the annual 90 minute		that the monthly battery		
		mpleted for all lights on		emergency lights test is		
		nual 90 minute battery		completed.		
		esting documentation for the		How the corrective act		
		month period was not itemized		be monitored to ensur	e the	
	by the light locatio	n. During a tour of the facility		deficient practice does	not	
	with the Maintenar	ce Director, battery operated		recur i.e. what quality		
		vere observed in the facility.		will be put in place:		
		-		Results of the monthly		
	This finding was re	eviewed with the Executive		battery-operated emerg	ency lights	
	-	enance Director during the exit		test will be reviewed in		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
		155448	B. WING				5/2021
	PROVIDER OR SUPPLIE	R	7	10 MICH	DDRESS, CITY, STATE, ZIP COD HIGAN ST		
LOWELI	HEALTHCARE		L	.OWELL	, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETION DATE
	conference.				committee. An action plan v implemented if 100% thresh not met.		
< 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testin Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8 Based on record re interview; the facil documentation of s accordance with N NFPA 25, Standar and Maintenance of Systems, 2011 Edi gauges on wet pipo inspected monthly condition and that is being maintained and fire department inspected, tested, a	RKS information on non-required or partial er system. 8, and NFPA 25 view, observation and	K 0353		K353 Sprinkler System What corrective action will accomplished by the facilit those residents to have be affected by the deficient practice: Maintenance Director was in-serviced by the Corporate Maintenance Director regard 353 Sprinkler System Maintenance and Testing for NFPA 25. How residents having the potential to be affected by	y for en Field ling K r K353	11/28/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	. ,	E SURVEY LETED
		155448	B. WING	<u>.</u>	11/15/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD CHIGAN ST		
LOWELI	HEALTHCARE		LOWE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	COMPLETION DATE
		weekly. Section 4.3.1 states		identified deficient pract	ice	
		ade for all inspections, tests,		will be corrected:		
		of the system and its		The required monthly spri		
	-	hall be made available to the		system maintenance and	-	
		risdiction upon request. This		was placed on the month	ly QAPI	
	-	could affect all residents and		calendar.		
	staff in the facility			Measures put in place of		
	Findings include:			systemic changes made ensure deficient practice		
	Based on review of	f Direct Supply: TELS		not recur: Executive Director will mo	nitor the	
		the Monthly Sprinkler Gauge		QAPI calendar to ensure		
		e Maintenance Director during		required monthly sprinkle		
	-	n 9:30 a.m. to 12:25 p.m. on		maintenance and testing	-	
		sprinkler gauge inspection		completed.	15	
		October 2020 through to July		How the corrective actio	n will	
		as readings. Documentation for		be monitored to ensure		
		ovember 2021 had gauge		deficient practice does r		
	-	logged. Based on interview at		recur i.e. what quality m		
		review, the Maintenance		will be put in place:	casare	
		was hired August 2021 and		Results of the monthly sp	rinkler	
		work performed prior to his		system maintenance and		
	-	e aforementioned months		will be reviewed in month	•	
		prinkler gauge readings. Based		committee. An action plar	-	
		the Maintenance Director		implemented if a threshol		
		e facility from 12:55 p.m. to 2:45		100% is not met.	u ui	
	-	the facility has a wet sprinkler		100% is not met.		
		e pressure gauges.				
	This finding was r	eviewed with the Executive				
	-	tenance Director at the exit				
	conference.					
	3.1-19(b)					
0355	NFPA 101					
SS=D	Portable Fire Ext	inquishers				
Bldg. 01	Portable Fire Ext	-				
		nguishers are selected,				
		ed, and maintained in				
		ou, and maintaineu in		1		1

	NT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>01</u>	COM	(X3) DATE SURVEY COMPLETED 11/15/2021	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	Portable Fire Ext 18.3.5.12, 19.3.5 Based on observat failed to inspect 1 in the elevator equ NFPA 10, Standar Section 7.2.1.2 sta inspected either m electronic device / intervals. Section 7 or electronic moni include a check of (1) Location in des (2) No obstruction (3) Pressure gauge operable range or (4) Fullness deterr self expelling-type cartridge-operated (5) Condition of ti nozzle for wheeled (6) Indicator for ne using pushto-test p Section 7.2.4.1 sta inspections shall k extinguishers insp require corrective where at least mor conducted, the dat performed and the performing the ins Section 7.2.4.4 rec are conducted, rec shall be kept on a extinguisher, on an maintained on file Section 7.2.4.5 rec demonstrate that a	2.12, NFPA 10 ion and interview, the facility of 1 portable fire extinguishers import room each month. d for Portable Fire Extinguishers, tes fire extinguishers shall be anually or by means of an system at a minimum of 30-day 7.2.2 states periodic inspection toring of fire extinguishers shall at least the following items: signated place to access or visibility ereading or indicator in the position nined by weighing or hefting for e extinguishers, extinguishers, and pump tanks res, wheels, carriage, hose, and	K 0355	<ul> <li>What corrective action accomplished by the fat those residents to have affected by the deficien practice:</li> <li>The identified fire exting the elevator room was in and dated by the Maintee Director as required by INFPA 10, Section 7.2.1 Section 7.2.2, Section 7</li> <li>Section 7.2.4.3., Section 7</li> <li>Section 7.2.4.5.</li> <li>How residents having a potential to be affected identified deficient prawill be corrected:</li> <li>Maintenance Director we in-serviced by the Corpor Maintenance Director ref F355, NFPA 10, Section 7.2.2., Section 7.2.4.1., Section 7.2.2., Section 7.2.4.3, 7.2.4.4., Section 7.2.4.5 fire extinguishers were i during the Survey inspet there were no other ider deficiencies.</li> <li>Measures put in place systemic changes made ensure the deficient pradoes not recur:</li> <li>Maintenance Director was independent of the section 7.2.4.5 for the section 7.2.5 for the section 7.2.5 for the section 7</li></ul>	acility for e been nt uisher in hspected enance F355, .2, .2.4.1., h 7.2.4.4., he I by the ctice as orate Field egarding h 7.2.1.2. tion . Section . All other nspected ction and htified or le to actice will inspect shers in	11/28/2021	

Event ID: 6GCU21 Facility ID: 000361

If continuation sheet Page 6 of 18

ENTERS FO				NONGERIA		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		. ,	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01		PLETED
		155448	B. WING		11/1	5/2021
NAME OF	PROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP COL	)	
				ICHIGAN ST		
LOWELL	HEALTHCARE		LOWE	ELL, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	ROPRIATE	DATE
	practice could affe	ect up to 3 staff in the vicinity of		rounds. Executive Direct	or will	
	-	ator equipment room.		review the monthly porta		
		ator equipment room.		extinguisher Preventative		
	Eindinge includer			-		
	Findings include:			Maintenance checks to e	ensure	
				timely completion.		
		vation with the Maintenance				
		21 at 2:25 p.m., the monthly		How the corrective action	on will	
		he fire extinguisher located in		be monitored to ensure	the	
	the basement eleva	ator equipment room lacked		deficient practice does	not	
	documentation of	a monthly inspections for		recue I.E what quality		
	August through N	ovember of 2021. Annual fire		measures will be put in	place:	
		ce took place July 2021. Based		Results of monthly check		
	-	time of observation, the		reviewed in the monthly		
		ctor agreed monthly inspections		committee. An action pla		
		ucted on the fire extinguisher in		-		
		-		implemented if a thresho		
	the basement eleva	ator equipment room.		100% is not met.		
	This finding was r	eviewed with the Executive				
		tenance Director at the exit				
		tenance Director at the exit				
	conference.					
	2.1.10(h)					
	3.1-19(b)					
< 0000						
Bldg. 02	A Life Safety Cad	e Recertification and State	V 0000			
			K 0000			
		ducted by the Indiana				
	-	alth in accordance with 42 CFR				
	483.90(a).					
	Survey Date: 11/1	5/2021				
	Equility Number (	000261				
	Facility Number: (					
	Provider Number:					
	AIM Number: 100	0266340				
	At this I if Safety	Code survey, Lowell				
		und not in compliance with				
		-				
	Requirements for 1	ганногранон ш	1			1

ENTERS FOR	R MEDICARE & MEDI					0.0	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155448	B. WING			11/15/2021	
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ER		710 MICHIGAN ST			
LOWELL	HEALTHCARE			LOWEL	L, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	DATE
		d, 42 CFR Subpart 483.90(a),					
		Fire and the 2012 edition of the					
	-	ection Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
		pancies and 410 IAC 16.2.					
		Junetes and 110 1110 10.2.					
	Building 01 was b						
	a partial basement						
	addition offset and						
	structure by a stair						
	Building 03 is a di	ning room connected to					
	Building 02. The	facility refers to the levels as the					
	first, second, third	and fourth floors. The					
	construction of Bu	ilding 01 was determined to be					
		onstruction and was fully					
		onstruction type for the entire					
	-	) and is fully sprinklered. The					
		larm system with hard wired					
	smoke detection in						
		oms are provided with battery					
		etectors. The building is partially					
	-						
		kW diesel-powered generator.					
		e capacity for 86 and had a					
	census of 75 at the	time of this survey.					
	All areas accessibl	e to residents and all areas					
	providing facility	services are sprinklered.					
	Quality Review co	ompleted on 11/17/21					
0291	NFPA 101						
SS=D	Emergency Light	ing					
Bldg. 02	Emergency Light	-					
Diay. UZ		-					
		ng of at least 1-1/2-hour					
		led automatically in					
	accordance with						
	18.2.9.1, 19.2.9.1						
		ion and interview, the facility	K 02	291	What corrective action will		11/28/202
		of 1 battery powered emergency			accomplished by the facility those residents to have been		
		oom were maintained in					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION (2	X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPLETED	
		155448	B. WI	NG		11/15/2	021
	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
		IK			CHIGAN ST		
LOWELL	- HEALTHCARE		LOWELL, IN 46356				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		SC 7.9. LSC 7.9.2.6 states			affected by the deficient		
		mergency lights shall use only			practice:		
	• •	chargeable batteries provided			Maintenance Director was		
		ities for maintaining them in			in-serviced by the Corporate Fie		
		condition. Batteries used in			Maintenance Director regarding	jК	
	-	s shall be approved for their			291 Emergency Lighting and		
		hall comply with NFPA 70			required documentation for		
		Code. LSC 7.9.2.7 states the			functional testing of battery		
		g system shall be either be			backup lights according to K291	1	
		peration or shall be capable of			Section 7.9.3.1.1.		
	-	e operation without manual			How residents having the		
	intervention. This	deficient practice could affect			potential to be affected by the		
	staff when in the r	iser room.			identified deficient practice		
					will be corrected:		
	Findings include:				Functional annual testing of		
					battery backup lights was place	d	
	Based on observat	ion with the Maintenance			on the April 2022 QAPI calenda	ar	
	Director on 11/15/	21 during a tour of the facility			for completion according to		
	from 12:55 p.m. to	2:45 p.m., the battery operated			requirements as specified in K2	91	
	emergency light in	the riser room failed to function			Section 7.9.3.1.1.		
	when its respective	e test button was pushed three			Measures put in place or		
	times. Based on in	terview at the time of the			systemic changes made to		
	observation, the M	laintenance Director stated			ensure deficient practice does	6	
	battery operated li	ghts in the facility are tested			not recur:		
	monthly and woul	d replace the one in the riser			Executive Director will monitor		
	room that failed to	function when the test button			monthly QAPI calendar to ensu	re	
	was pushed.				the scheduled annual backup		
					battery lights testing and require	ed	
	This finding was r	eviewed with the Executive			documentation is completed as		
		tenance Director at the exit			specified in K291v 7.9.3.1.1.		
	conference.				How the corrective action will		
					be monitored to ensure the		
	3.1-19(b)				deficient practice does not		
					recur i.e. what quality measure	e	
					will be put in place:		
					Results of the required Battery		
					Backup testing and		
					documentation will be reviewed	in	
					April 2022 QAPI committee and		
					an action plan will be implemen		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	identification number 155448	A. BUILDING B. WING	02	COMPLETED 11/15/2021	
	PROVIDER OR SUPPLIE	R	710 M	ADDRESS, CITY, STATE, ZIP COD ICHIGAN ST ILL, IN 46356		
				LL, IN 40330		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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	
				if a 100% threshold is not met.		
( 0351 SS=E Bldg. 02	by construction ty throughout by an sprinkler system 13, Standard for the Systems. In Type I and II co protection measure substituted for sp areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprint Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, Based on observatification accordance with edition, Section 8.3 located so as to mit discharge as define 8.5.5.3 or additionation ensure adequate co 8.5.5.2 and 8.5.5.3 noncontinuous obs 18 inches below the		K 0351	What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice: The identified boxes in the Culinary dry storage room were removed immediately. Maintenance Director was in-serviced by the Corporate Fie Maintenance Director regarding K351 LSC 19.3.5.1. How residents having the	əld	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATI	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMP	PLETED
		155448	B. WING		11/1	5/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	-	
	_ HEALTHCARE				CHIGAN ST _L, IN 46356		
				LOWEL	_L, IN 40330		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	ERIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	that prevent the spray pattern			potential to be affected by	the	
		ing. This deficient practice			identified deficient practice	)	
	could affect staff o	only.			will be corrected:		
					Maintenance Director compl	eted	
	Findings include:				an inspection of all facility st	orage	
					rooms to ensure compliance	with	
	Based on observat	ion with the Maintenance			K351 LSC 19.3.5.1 and no		
	Director on 11/15/	21 during a tour of the facility			additional deficiencies were	noted.	
		2:45 p.m., the dry storage room			No additional findings were		
	-	4 cardboard boxes of supplies			identified during the Survey		
		d on top shelves along the			inspection.		
		above the sprinkler head. The			Measures put in place or		
		ere two inches from the ceiling.			systemic changes made to		
	-	v at the time of observation, the			ensure deficient practice d		
	Maintenance Direc				not recur:		
		agreed the boxes were stored			Maintenance Director/Design	nee	
		r heads in the room.			will inspect all facility storage		
	above the sprinkle	r heads in the room.			areas weekly for 4 weeks, th		
	This finding was r	eviewed with the Executive			monthly for 6 months to ensit		
		tenance Director at the exit			-		
	conference.	tenance Director at the exit			ongoing compliance with K3		
	conference.				LSC 19.3.5.1. Executive Dire		
	2.1.10(1)				will review the inspection res		
	3.1-19(b)				and sign off those inspection	IS	
					were completed.		
					How the corrective action v		
					be monitored to ensure the		
					deficient practice does not		
					recur i.e. what quality meas	sure	
					will be put in place:		
					Results will be reviewed in		
					monthly QAPI committee. A	า	
					action plan will be implemen	ted if	
					a threshold of 100% is not m	iet.	
)353	NFPA 101						
S=E		Maintonance and Tasting					
		- Maintenance and Testing					
dg. 02		- Maintenance and Testing					
		ler and standpipe systems					
	are inspected, tes	sted, and maintained in			1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 11/15/2021 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility K 0353 11/28/2021 What corrective action will be failed to maintain the ceiling construction in 1 of 1 accomplished by the facility for Mechanical rooms. NFPA 13, 2010 edition, Section those residents to have been 3.3.5.4 defines a smooth ceiling as a continuous affected by the deficient ceiling free from significant irregularities, lumps, or practice: indentations. The ceiling traps hot air and gases The identified missing ceiling tile around the sprinkler and cause the sprinkler to in the mechanical room was operate at a specified temperature. Section installed immediately. There were 8.5.4.1.1 states the distance between the sprinkler no other identified missing ceiling deflector and the ceiling above shall be selected tiles during the Survey inspection. based on the type of sprinkler and the type of How residents having the construction. This deficient practice could affect 4 potential to be affected by the residents, staff, and visitors in the vicinity of the identified deficient practice Mechanical room by resident room 311. will be corrected: Maintenance Director was Findings include: in-serviced by the Corporate Field Maintenance Director regarding Based on observations with the Executive K353, NFPA 13, Section 3.3.4.3. Director and Maintenance Director during a tour and Section 8.5.4.1.1. of the facility from 12:55 p.m. to 2:45 p.m. on Measures put in place or 11/15/2021, a suspended ceiling tiles was missing systemic changes made to in the Mechanical room by resident room 311. ensure the deficient practice Ductwork from an HVAC unit in the room does not recur: penetrated through the suspended ceiling, with Maintenance Director will inspect

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

Event ID:

6GCU21 Facility

Facility ID: 000361

If continuation sheet Pa

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12/01/2021

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>02</u>		OMPLETED 1/15/2021	
	PROVIDER OR SUPPLIE	R	710 N	t address, city, state, zip cod 11CHIGAN ST ELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	in the ceiling tile g above. The room v sprinkler installed Based on interview observations, the N the Mechanical Ro ceiling tile. This finding was r	8" tile behind it left an opening rid which exposed the ceiling vas equipped with one pendant on the suspended ceiling. v at the time of the Maintenance Director agreed bom was missing a section of eviewed with the Executive tenance Supervisor at the exit		facility ceiling tiles monthly of Preventative Maintenance of Any findings will be corrected immediately. Executive Dire will review the monthly Preventative Maintenance of of facility ceiling times month How the corrective action of be monitored to ensure the deficient practice does not recue I.E what quality measures will be put in plat Results of monthly checks w reviewed in the monthly QAI committee. An action plan w implemented if a threshold of 100% is not met.	hecks. d ctor hecks hly. will e vill be Pl vill be		
K 0355 SS=E Bldg. 02	installed, inspect accordance with Portable Fire Ext 18.3.5.12, 19.3.5 Based on observat failed to inspect 1 in the lounge each Portable Fire Extin fire extinguishers a manually or by me system at a minim 7.2.2 states period	inguishers nguishers are selected, ed, and maintained in NFPA 10, Standard for inguishers. .12, NFPA 10 ion and interview, the facility of 1 portable fire extinguishers month. NFPA 10, Standard for nguishers, Section 7.2.1.2 states shall be inspected either eans of an electronic device / um of 30-day intervals. Section ic inspection or electronic extinguishers shall include a e following items:	K 0355	What corrective action will accomplished by the facilit those residents to have be affected by the deficient practice: The identified K Class fire extinguisher in the Lounge v inspected and dated by the Maintenance Director as rec by %355, NFPA 10, section 7.2.1.2., 7.2.2., Section 7.2.4	vas quired	11/28/202	

TERS FU	R MEDICARE & MEDI	CAID SERVICES			-	AB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		î î	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02		LETED
		155448	B. WING		11/18	5/2021
JAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
	_ HEALTHCARE			CHIGAN ST LL, IN 46356		
	1			1		
X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N RE	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	TAG			DATE
		to access or visibility		Section 7.2.4.3., Section 7.2	2.4.5.	
		e reading or indicator in the		How residents having the		
	operable range or	-		potential to be affected by		
		nined by weighing or hefting for		identified deficient practice	e	
	self expelling-type			will be corrected:		
	e .	extinguishers, and pump tanks		Maintenance Director was	<b>-</b>	
		res, wheels, carriage, hose, and		in-serviced by the Corporate		
	nozzle for wheele	6		Maintenance Director regard	0	
		onrechargeable extinguishers		F355, NFPA 10, Section 7.2	2.1.2.	
		pressure indicators.		and Section 7.2.2., Section		
		tes personnel making manual		7.2.4.1., Section 7.2.4.3., Se		
	-	teep records of all fire		7.2.4.4., Section 7.2.4.5. All		
		ected, including those found to		fire extinguishers were inspe		
	-	action. Section 7.2.4.3 requires		during the Survey inspection		
	where at least monthly manual inspections are conducted, the date the manual inspection was		there were no other identifie	ed		
			deficiencies.			
	-	initials of the person				
		spection shall be recorded.		Measures put in place or		
		quires where manual inspections		systemic changes made to		
		ords for manual inspections		ensure the deficient praction	се	
	-	tag or label attached to the fire		does not recur:		
	-	n inspection checklist		Maintenance Director will in	•	
		, or by an electronic method.		all portable fire extinguisher	s in	
		quires records shall be kept to		monthly Preventative Mainte		
		t least the last 12 monthly		rounds. Executive Director v		
	-	been performed. This deficient		review the monthly portable	fire	
	-	ect up to 10 residents and staff		extinguisher Preventative		
		he 1st floor lounge by the north		Maintenance checks to ensu	ure	
	nurse's station.			compliance.		
	Findings include:					
				How the corrective action	will	
	Based on an obser	vation with the Maintenance		be monitored to ensure the		
		/21 at 1:58 p.m., the monthly		deficient practice does not		
		the K Class fire extinguisher		recur I.E what quality meas		
		ige lacked documentation of a		will be put in place:		
		ns for October and November		Results of monthly checks v	vill be	
		extinguisher service took place		reviewed in the monthly QA		
		on interview at the time of		committee. An action plan		
		laintenance Director agreed		implemented if a threshold of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155448 B. WING 11/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE monthly inspections had not been conducted on 100% is not met. the fire extinguisher in the lounge for the aforementioned months. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) K 0363 **NFPA 101** SS=D Corridor - Doors Bldg. 02 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or 6GCU21 Event ID: Facility ID: 000361 Page 15 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 11/15/2021 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 11/28/2021 failed to ensure 1 of 1 Employee Break room door What corrective action will be to the corridor would completely resist the accomplished by the facility for passage of smoke. This deficient practice could those residents to have been affect staff only. affected by the deficient practice: Findings include: The identified door handle in the employee breakroom was Based on observation on 11/15/2021 at 1:05 p.m. replaced immediately by the during a tour of the facility with the Maintenance Maintenance Director. Director, the corridor door to the Employee Break How residents having the Room next to the exterior exit stairs had a potential to be affected by the identified deficient practice one-quarter inch circle shaped hole above the handle to the door that was open to the corridor. will be corrected: A flashlight was used on the corridor side of the Maintenance Director completed hole, which illuminated through the door; making an audit of all facility door handles the door not smoke tight. Based on interview at and no additional deficiencies the time of observation, the Maintenance Director were identified. There also were no agreed there was a circle shaped hole above the other identified door handle handle of the Employee Break room and stated he deficiencies found during the would fill in the hole. Survey inspection. Maintenance Director was in-serviced by the This finding was reviewed with the Executive Corporate Field Maintenance Director and Maintenance Director at the exit Director regarding K363 and conference. Corridor Doors. Measures put in place or 3.1-19(b) systemic changes made to Event ID: 6GCU21 Facility ID: 000361 Page 16 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

	R MEDICARE & MEDI				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/15/2021	
	PROVIDER OR SUPPLIE	ËR	710 M	address, city, state, zip cod ICHIGAN ST ILL, IN 46356		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		(X5)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure the deficient practice	DATE	
				does not recur: Maintenance Director/Designe will inspect all facility door har monthly during Preventative Maintenance checks and upor any identified deficient finding will correct immediately. Exect Director will review the monthl facility door handle Preventativ Maintenance checks to ensure compliance. How the corrective action will be monitored to ensure the deficient practice does not recue I.E what quality measures will be put in place Results of monthly checks will reviewed in the monthly QAPI committee. An action plan will implemented if a threshold of 100% is not met.	ee ndles n s, utive y ve e II I be	
K 0000						
Bldg. 03	Licensure was cor	000361 155448	К 0000	The creation and submission of this plan of correction does no constitute an admission by the provider of any conclusion set in the statement of deficiencie of any violation of regulations. Lowell Healthcare respectfully requests paper compliance du the low scope and severity of citations.	ot e forth s, or	

AND PLAN OF CORRECTION IDENT		x1) provider/supplier/clia identification number 155448	ENTIFICATION NUMBER A. BUILDING <u>03</u>		(X3) DATE SURVEY COMPLETED 11/15/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE COMPLETION	
TAG	At this Life Safety Healthcare was fou Requirements for I Medicare/Medicaid Life Safety from F National Fire Prote Life Safety Code ( Health Care Occup Building 01 was bu a partial basement; addition offset and structure by a stair Building 03 is a din Building 02. The f first, second, third construction of Bu of Type II (111) cc sprinklered. The cc facility was V(111) facility has a fire a smoke detection in areas. Resident roo powered smoke de protected by a 230 The facility has the census of 75 at the All areas accessibl- providing facility s	R LSC IDENTIFYING INFORMATION         Code survey, Lowell         and not in compliance with         Participation in         d, 42 CFR Subpart 483.90(a),         ire and the 2012 edition of the         extion Association (NFPA) 101,         LSC), Chapter 19, Existing         pancies and 410 IAC 16.2.         uilt as a two story building over         Building 02 is a two story         connected to the original         way prior to March 1, 2003.         ning room connected to         facility refers to the levels as the         and fourth floors. The         tiding 01 was determined to be         onstruction and was fully         postruction type for the entire         and is fully sprinklered. The         larm system with hard wired         the corridors and common         oms are provided with battery         tectors. The building is partially         kW diesel-powered generator.         e capacity for 86 and had a         time of this survey.         e to residents and all areas         ervices are sprinklered.	TAG	DEFICIENCY)	DATE	

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If continuation sheet Page

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