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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING -- B. WING	11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LOWELL HEALTHCARE	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
E 0000 Bldg. --	An Emergency Preparedness Survey was 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	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/15/2021 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell Healthcare was found not in compliance with	K 0000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. Lowell Healthcare respectfully requests paper compliance due to the low scope and severity of citations.	

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.

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	155448	A. BUILDING 01 B. WING	11/15/2021

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	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 SS=C Bldg. 01	NFPA 101 Emergency Lighting 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 interview; the facility failed to ensure	K 0291	**What corrective action will be accomplished by the facility for**	11/28/2021

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	documentation for functional annual testing of battery backup lights was complete. 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 review of Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting: Check illumination of exit lighting and exit signs" documentation with the Maintenance Director during record review from 9:30 a.m. to 12:25 p.m. on 11/15/21, annual 90 minute battery operated lighting testing documentation for the most recent twelve month period was not itemized by location. Based on interview at the time of record review, the Maintenance Director stated he was hired August 2021 and could not speak to work performed prior to his hire. The Maintenance Director agreed the TELS Logbook Documentation indicated the annual 90 minute testing task was completed for all lights on 04/22/21 but the annual 90 minute battery operated lighting testing documentation for the most recent twelve month period was not itemized by the light location. During a tour of the facility with the Maintenance Director, battery operated emergency lights were observed in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit		**those residents to have been affected by the deficient practice:** The identified battery-operated emergency light was replaced immediately by the Maintenance Director. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Maintenance Director completed an audit of all facility battery operated emergency lights and there were no additional findings. **Measures put in place or systemic changes made to ensure deficient practice does not recur:** Maintenance Director /Designee will test all facility battery operated emergency lights monthly during preventative maintenance rounds to ensure compliance with K291 Section 7.9.2.6; 7.9.2.7. Battery operated emergency lights testing was added to the monthly QAPI calendar. Executive Director will monitor the calendar to ensure that the monthly battery-operated emergency lights test is completed. **How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality measure will be put in place:** Results of the monthly battery-operated emergency lights test will be reviewed in QAPI	

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	conference.		committee. An action plan will be implemented if 100% threshold is not met.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in 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 record review, observation and interview; the facility failed provided documentation of sprinkler system inspections in accordance with NFPA 25, but it was incomplete. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves	K 0353	**K353 Sprinkler System** **What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice:** Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding K 353 Sprinkler System Maintenance and Testing for K353 NFPA 25. **How residents having the potential to be affected by the**	11/28/2021

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	shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on review of Direct Supply: TELS documentation for the Monthly Sprinkler Gauge inspection with the Maintenance Director during record review from 9:30 a.m. to 12:25 p.m. on 11/15/21, monthly sprinkler gauge inspection documentation for October 2020 through to July 2021 indicated 'na' as readings. Documentation for August 2021 to November 2021 had gauge pressure readings logged. Based on interview at the time of record review, the Maintenance Director stated he was hired August 2021 and could not speak to work performed prior to his hire, but agreed the aforementioned months indicated 'na' for sprinkler gauge readings. Based on observation with the Maintenance Director during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 11/15/21, the facility has a wet sprinkler system and had five pressure gauges. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**identified deficient practice will be corrected:** The required monthly sprinkler system maintenance and testing was placed on the monthly QAPI calendar. **Measures put in place or systemic changes made to ensure deficient practice does not recur:** Executive Director will monitor the QAPI calendar to ensure the required monthly sprinkler system maintenance and testing is completed. **How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality measure will be put in place:** Results of the monthly sprinkler system maintenance and testing will be reviewed in monthly QAPI committee. An action plan will be implemented if a threshold of 100% is not met.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the elevator equipment room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient	K 0355	**What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice:** The identified fire extinguisher in the elevator room was inspected and dated by the Maintenance Director as required by F355, NFPA 10, Section 7.2.1.2, Section 7.2.2, Section 7.2.4.1., Section 7.2.4.3., Section 7.2.4.4., Section 7.2.4.5. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding F355, NFPA 10, Section 7.2.1.2. and Section 7.2.2., Section 7.2.4.1., Section 7.2.4.3., Section 7.2.4.4., Section 7.2.4.5. All other fire extinguishers were inspected during the Survey inspection and there were no other identified deficiencies. **Measures put in place or systemic changes made to ensure the deficient practice does not recur:** Maintenance Director will inspect all portable fire extinguishers in monthly Preventative Maintenance	11/28/2021

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	practice could affect up to 3 staff in the vicinity of the basement elevator equipment room. Findings include: Based on an observation with the Maintenance Director on 11/15/21 at 2:25 p.m., the monthly inspection tag on the fire extinguisher located in the basement elevator equipment room lacked documentation of a monthly inspections for August through November of 2021. Annual fire extinguisher service took place July 2021. Based on interview at the time of observation, the Maintenance Director agreed monthly inspections had not been conducted on the fire extinguisher in the basement elevator equipment room. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		rounds. Executive Director will review the monthly portable fire extinguisher Preventative Maintenance checks to ensure timely completion. **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 be reviewed in the monthly QAPI committee. An action plan will be implemented if a threshold of 100% is not met.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/15/2021 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell Healthcare was found not in compliance with Requirements for Participation in	K 0000		

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	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 SS=D Bldg. 02	NFPA 101 Emergency Lighting 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 observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lights in the riser room were maintained in	K 0291	**What corrective action will be accomplished by the facility for those residents to have been**	11/28/2021

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	accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect staff when in the riser room. Findings include: Based on observation with the Maintenance Director on 11/15/21 during a tour of the facility from 12:55 p.m. to 2:45 p.m., the battery operated emergency light in the riser room failed to function when its respective test button was pushed three times. Based on interview at the time of the observation, the Maintenance Director stated battery operated lights in the facility are tested monthly and would replace the one in the riser room that failed to function when the test button was pushed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**affected by the deficient practice:** Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding K 291 Emergency Lighting and required documentation for functional testing of battery backup lights according to K291 Section 7.9.3.1.1. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Functional annual testing of battery backup lights was placed on the April 2022 QAPI calendar for completion according to requirements as specified in K291 Section 7.9.3.1.1. **Measures put in place or systemic changes made to ensure deficient practice does not recur:** Executive Director will monitor monthly QAPI calendar to ensure the scheduled annual backup battery lights testing and required documentation is completed as specified in K291v 7.9.3.1.1. **How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality measure 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 implemented	

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			if a 100% threshold is not met.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 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 Field Maintenance Director regarding K351 LSC 19.3.5.1. **How residents having the**	11/28/2021

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	sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 11/15/21 during a tour of the facility from 12:55 p.m. to 2:45 p.m., the dry storage room in the kitchen had 4 cardboard boxes of supplies bags of chips stored on top shelves along the walls of the room above the sprinkler head. The top of the boxes were two inches from the ceiling. Based on interview at the time of observation, the Maintenance Director confirmed the measurements and agreed the boxes were stored above the sprinkler heads in the room. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**potential to be affected by the identified deficient practice will be corrected:** Maintenance Director completed an inspection of all facility storage rooms to ensure compliance with K351 LSC 19.3.5.1 and no additional deficiencies were noted. No additional findings were identified during the Survey inspection. **Measures put in place or systemic changes made to ensure deficient practice does not recur:** Maintenance Director/Designee will inspect all facility storage areas weekly for 4 weeks, then monthly for 6 months to ensure ongoing compliance with K351 LSC 19.3.5.1. Executive Director will review the inspection results and sign off those inspections were completed. **How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality measure will be put in place:** Results will be reviewed in monthly QAPI committee. An action plan will be implemented if a threshold of 100% is not met.	
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	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 failed to maintain the ceiling construction in 1 of 1 Mechanical rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 4 residents, staff, and visitors in the vicinity of the Mechanical room by resident room 311. Findings include: Based on observations with the Executive Director and Maintenance Director during a tour of the facility from 12:55 p.m. to 2:45 p.m. on 11/15/2021, a suspended ceiling tiles was missing in the Mechanical room by resident room 311. Ductwork from an HVAC unit in the room penetrated through the suspended ceiling, with	K 0353	**What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice:** The identified missing ceiling tile in the mechanical room was installed immediately. There were no other identified missing ceiling tiles during the Survey inspection. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding K353, NFPA 13, Section 3.3.4.3. and Section 8.5.4.1.1. **Measures put in place or systemic changes made to ensure the deficient practice does not recur:** Maintenance Director will inspect	11/28/2021

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	155448	A. BUILDING 02 B. WING	11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

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	the missing 4" by 8" tile behind it left an opening in the ceiling tile grid which exposed the ceiling above. The room was equipped with one pendant sprinkler installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed the Mechanical Room was missing a section of ceiling tile. This finding was reviewed with the Executive Director and Maintenance Supervisor at the exit conference. 3.1-19(b)		facility ceiling tiles monthly during Preventative Maintenance checks. Any findings will be corrected immediately. Executive Director will review the monthly Preventative Maintenance checks of facility ceiling times monthly. **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 be reviewed in the monthly QAPI committee. An action plan will be implemented if a threshold of 100% is not met.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the lounge each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place	K 0355	**What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice:** The identified K Class fire extinguisher in the Lounge was inspected and dated by the Maintenance Director as required by %355, NFPA 10, section 7.2.1.2., 7.2.2., Section 7.2.4.1.,	11/28/2021

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	(2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect up to 10 residents and staff in the vicinity of the 1st floor lounge by the north nurse's station. Findings include: Based on an observation with the Maintenance Director on 11/15/21 at 1:58 p.m., the monthly inspection tag on the K Class fire extinguisher located in the lounge lacked documentation of a monthly inspections for October and November 2021. Annual fire extinguisher service took place July 2021. Based on interview at the time of observation, the Maintenance Director agreed		Section 7.2.4.3., Section 7.2.4.5. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding F355, NFPA 10, Section 7.2.1.2. and Section 7.2.2., Section 7.2.4.1., Section 7.2.4.3., Section 7.2.4.4., Section 7.2.4.5. All other fire extinguishers were inspected during the Survey inspection and there were no other identified deficiencies. **Measures put in place or systemic changes made to ensure the deficient practice does not recur:** Maintenance Director will inspect all portable fire extinguishers in monthly Preventative Maintenance rounds. Executive Director will review the monthly portable fire extinguisher Preventative Maintenance checks to ensure compliance. **How the corrective action will be monitored to ensure the deficient practice does not recur I.E what quality measures will be put in place:** Results of monthly checks will be reviewed in the monthly QAPI committee. An action plan will be implemented if a threshold of	

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	monthly inspections had not been conducted on 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)		100% is not met.	
K 0363 SS=D Bldg. 02	NFPA 101 Corridor - Doors 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			

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	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 failed to ensure 1 of 1 Employee Break room door to the corridor would completely resist the passage of smoke. This deficient practice could affect staff only. Findings include: Based on observation on 11/15/2021 at 1:05 p.m. during a tour of the facility with the Maintenance Director, the corridor door to the Employee Break Room next to the exterior exit stairs had a one-quarter inch circle shaped hole above the handle to the door that was open to the corridor. A flashlight was used on the corridor side of the hole, which illuminated through the door; making the door not smoke tight. Based on interview at the time of observation, the Maintenance Director agreed there was a circle shaped hole above the handle of the Employee Break room and stated he would fill in the hole. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0363	**What corrective action will be accomplished by the facility for those residents to have been affected by the deficient practice:** The identified door handle in the employee breakroom was replaced immediately by the Maintenance Director. **How residents having the potential to be affected by the identified deficient practice will be corrected:** Maintenance Director completed an audit of all facility door handles and no additional deficiencies were identified. There also were no other identified door handle deficiencies found during the Survey inspection. Maintenance Director was in-serviced by the Corporate Field Maintenance Director regarding K363 and Corridor Doors. **Measures put in place or systemic changes made to**	11/28/2021

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			ensure the deficient practice does not recur: Maintenance Director/Designee will inspect all facility door handles monthly during Preventative Maintenance checks and upon any identified deficient findings, will correct immediately. Executive Director will review the monthly facility door handle Preventative 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 be reviewed in the monthly QAPI committee. An action plan will be implemented if a threshold of 100% is not met.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/15/2021 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340	K 0000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. Lowell Healthcare respectfully requests paper compliance due to the low scope and severity of citations.	

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

FORM APPROVED
OMB NO. 0938-039

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	At this Life Safety Code survey, Lowell Healthcare was found not in 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. 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			