

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 05/29/2014
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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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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/29/14</p> <p>Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lowell Healthcare 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</p>	K010000	<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.</p> <p>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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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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K010046 SS=F	<p>was determined to be of Type II (111) construction and was fully sprinklered. The one story dining room was Type V (III) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in common areas. Resident rooms are provided with battery powered smoke detector. The facility has a capacity of 90 and had a census of 74 at the time of this survey.</p> <p>All areas accessible to residents and all areas providing facility services are sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour</p>				

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	<p>duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure the exterior emergency exit paths for 4 of 4 "floors" were provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance director on 05/29/14 at 11:30 a.m., the exit discharge paths for all exits were not provided with emergency lighting when the emergency generator would not start because the fuel supply was interrupted. The maintenance director acknowledged at the time of observation, the exterior discharge lighting relied on the emergency generator to supply power to the fixtures.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 67 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires</p>	K010046	<p>K046</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. The facility has replaced the emergency generator with a new diesel emergency generator. This will stop the fuel supply from being interrupted. Emergency lighting is powered by the emergency generator.</p> <p>2. The facility replaced the emergency light fixtures on the 3rd floor and in the kitchen with new battery powered lights.</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>1. The emergency generator has been replaced with a new diesel emergency generator. The generator has been tested to ensure it provides emergency powered egress lighting to the exterior emergency exit paths.</p> <p>2. The facility has checked all emergency light fixtures to ensure they all operate.</p> <p>3. The E.D. has re-educated the maintenance director to ensure the generator functions properly and all emergency</p>	06/18/2014	

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	<p>battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, kitchen staff and 10 or more residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance director on 05/29/14 between 10:50 a.m. and 12:00 p.m., the third floor emergency light near resident room 323 and an emergency light in the kitchen each failed to illuminate when tested twice with the maintenance director. The maintenance director said at the times of observation, he had "just changed the batteries" in these fixtures within the past week.</p> <p>3.1-19 (b)</p>		<p>light fixtures operate properly. 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 test the emergency generator weekly to ensure it functions properly and provides emergency powered egress lighting to the exterior emergency paths. The maintenance director/designee will test all emergency light fixtures monthly during his PM rounds to ensure they all operate.</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:</p> <p>The Executive Director will round with the maintenance director prior to the compliance date to ensure the generator operates properly and all emergency lights operate properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director on the generator and emergency lights monthly and sign off that the checks were completed. By what date the systemic changes will be completed:</p> <p>Compliance Date = 6/18/14</p>		

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K010051 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 smoke detectors located in the basement level corridor and connected to the fire alarm system was properly separated from an air supply or return vent. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect 3 or more staff and visitors accessing the basement level service departments.</p>	K010051	<p>K051 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A piece of sheet metal was hung from the basement ceiling between the smoke detector and the air supply to provide separation. 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 smoke detectors were inspected to ensure there was proper separation from an air</p>	06/18/2014			

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	<p>Findings include:</p> <p>Based on observation with the administrator and maintenance director on 05/29/14 at 1:20 p.m., a basement corridor smoke detector located near the laundry was 12 inches from an air return vent. The maintenance director acknowledged at the time of observation, the distance between the vent and smoke detector was less than 36 inches.</p> <p>3.1-19(b)</p>		<p>supply or return vent. The E.D. re-educated the maintenance director to ensure all smoke detectors are separated from an air supply or return vent. 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 smoke detectors monthly during his PM rounds to ensure there is proper separation from an air supply or return vent. 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 all smoke detectors have proper separation from an air supply or return vent. The Executive Director will review the preventative maintenance checks performed by the maintenance director on the smoke detectors monthly and sign off that the checks were completed.</p> <p>By what date the systemic changes will be completed: Compliance Date = 6/18/14</p>		

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler system gauges was replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation of the sprinkler system water gauge with the administrator and maintenance director on 05/29/14 at 11:10 a.m., the sprinkler system water gauge had a 2008 date on the dial. The maintenance director said at the time of observation, he did not remember when the gauge had last been calibrated or changed. During record review of sprinkler system maintenance,</p>	K010062	<p>K062 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The sprinkler system gauge was replaced. 2. A cover has been placed over the tamper switch. 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: 1. The sprinkler gauge was replaced for the sprinkler system. 2. All tamper switches were inspected to ensure proper protection. 3. The E.D. re-educated the maintenance director to ensure all tamper switches are covered and the sprinkler system gauge is replaced every 5 years. 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 sprinkler gauge and tamper switches monthly during his PM rounds to ensure the gauge is replaced every five years and there is proper protection on</p>	06/18/2014
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	<p>inspection, and test records on 05/29/14 at 2:30 p.m., no record of recalibration or replacement was found. The maintenance director immediately contacted the sprinkler system maintenance and testing contractor to request the information. No record was received by the end of the tour on 05/29/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure protection for the tamper switch providing electronic supervision for 1 of 1 automatic sprinkler system water control backflow valves was maintained. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the sprinkler system water gauge with the administrator and maintenance director on 05/29/14 at 11:10 a.m., the sprinkler system backflow was equipped with an electronic supervisory switch. The switch was uncovered exposing the wiring. The maintenance director acknowledged at the time of observation, these tamper switches were usually covered by a protective box. He said he did not know when or why the box had</p>		<p>the tamper switches. 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 gauge is replaced and there is proper protection on the tamper switches. The Executive Director will review the preventative maintenance checks performed by the maintenance director on the gauge and tamper switch monthly and sign off that the checks were completed. By what date the systemic changes will be completed: Compliance Date = 6/18/14</p>		

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K010144 SS=F	<p>been removed and why it was not protected.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators would start and the annunciator panel for the emergency generator would alert staff to generator alarm conditions in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a</p>	K010144	<p>K144</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility has replaced the emergency generator with a new diesel emergency generator.</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>The facility has replaced the emergency generator with a new diesel emergency generator. The E.D. re-educated the maintenance director to ensure the emergency generator operates properly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	06/18/2014	

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	<p>common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.</p> <p>In addition, NFPA 101 at Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code shall be continuously maintained.</p> <p>Furthermore, NFPA 99, 3-5.3.2.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load after a short delay. NFPA 99, 3-4.2.1(d) requires the generator to start and be on line within 10 seconds.</p>		<p>practice does not recur: The maintenance director/designee will test the emergency generator weekly to ensure it functions properly. 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 generator operates properly. The Executive Director will review the weekly preventative maintenance checks performed by the maintenance director on the generator monthly and sign off that the checks were completed.</p> <p>By what date the systemic changes will be completed: Compliance Date = 6/18/14</p>				

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	<p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance director on 5/29/14 at 11:15 a.m., the facility emergency generator annunciator panel was not in it's normal location across from the first floor nurses station. The maintenance director found it at the nurses' station where it had been moved during a renovation. The annunciator panel was on and in the normal operating mode. At 11:30 a.m. on 05/29/14 with the administrator and maintenance director, the emergency generator did not start when tested twice. The maintenance director then did some manipulation to the generator panel and equipment and the generator started within 10 seconds. Asked why the generator had failed previously, the maintenance director said, "I must have forgotten to turn the valve for the natural gas supply back on when I changed the oil this morning."</p> <p>3.1-19(b)</p>						

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

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