STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 / B. WING	06/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/01/16 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was built as a two story building over a partial basement with a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. The facility refers to the levels as the first, second, third and fourth floors. The construction was determined to be of Type II (111) construction and was fully sprinklered.	K 0000	**Thecreation and submission of this plan of correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation.** **Dueto the relative low scope and severity of this survey, the facilityrespectfully requests a desk review in lieu of a post-survey revisit.**	

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 determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155448		06/01/2016

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	The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detector. The facility has the capacity for 86 and had a census of 78 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 06/03/16 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			

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	Based on observation and interview, the facility failed to ensure 1 of 41 resident room corridor doors closed and latched into the door frame. This deficient practice could affect staff and up to 16 residents. Findings include: Based on observation and interview on 06/01/16 at 1:20 p.m., the Executive Director and the Maintenance Supervisor acknowledged the corridor door to resident room 122 failed to latch into the frame when tested. 3.1-19(b)	K 0018	**K018 Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The facility has adjusted the resident roomdoors for 122 and 301 so they latch into the frame. The Activity Storage manual latch wasreplaced so the door positively latches into the frame. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: Allresidents have the potential to be affected. All other doors were inspected by the maintenance director to assure alldoors and double doors latch into the frame. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Themaintenance director/designee will inspect doors monthly during his PM roundsto ensure they latch into the frame properly. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: TheExecutive Director will round with the maintenance**	07/01/2016

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			director prior to thecompliance date to ensure the doors latch properly. The Executive Director will review thepreventative maintenance checks performed by the maintenance director monthlyand sign off that the checks were completed.	
K 0066 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 2 area where smoking was permitted for staff and residents were maintained. This deficient practice could affect staff only.	K 0066	**K066** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Thecigarette butts on the**	07/01/2016

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	Findings include: Based on observations with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:22 p.m., there were at least 50 cigarette butts on the ground in the designated staff smoke area and near the generator. Additionally, there were at least 50 cigarette butts in a trash can with trash included. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**ground were picked up and disposed of properly.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **Allresidents have the potential to affected. The area around the building was inspected and all cigarette butts havebeen picked up and disposed of properly.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **All staff will be educated ondesignated smoking areas and how to properly dispose of a cigarette butt. The maintenance supervisor/designee willcheck the grounds for cigarette butts monthly during his PM rounds to assurethey are disposed of properly.** **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:** **TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure the cigarette butts are disposed of properly.** **The Executive Director will review thepreventative**	

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	155448		06/01/2016

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			maintenance checks performed by the maintenance director/designeemonthly and sign off that the checks were completed.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:00 p.m., a surge protector was powering another surge protector powering a digital video recorder in the 3rd floor IT room. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0147	**K147** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Thesurge protectors were separated and plugged into the wall properly. The extension cord in room 107 was removedand the lights were plugged into the wall directly.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **Allresidents have the potential to affected. All other rooms were inspected for surge protectors plugged into anothersurge protector and extension cords. They were removed as needed.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **The maintenance**	07/01/2016

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			supervisor/designeewill check the rooms/offices for improper cords monthly during his PM rounds toassure all devices are plugged in properly. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure all items are plugged in properly. The Executive Director will review thepreventative maintenance checks performed by the maintenance director/designeemonthly and sign off that the checks were completed.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/01/16 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell	K 0000	**Thecreation and submission of this plan of correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation. Dueto the relative low scope and severity of this survey, the facilityrespectfully requests a desk review in lieu of a post-survey revisit.**	

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was built as a two story building over a partial basement with a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. The facility refers to the levels as the first, second, third and fourth floors. The construction was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detector. The facility has the capacity for 86 and had a census of 78 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 06/03/16 - DA			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
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K 0018 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 1. Based on observation and interview, the facility failed to ensure 1 of 41 resident room corridor doors closed and latched into the door frame. This deficient practice could affect staff and up to 24 residents. Findings include: Based on observation and interview on 06/01/16 at 11:35 a.m., the Executive Director and the Maintenance Supervisor acknowledged the corridor door to resident room 301 failed to latch into the frame when tested.	K 0018	**K018 Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The facility has adjusted the resident roomdoors for 122 and 301 so they latch into the frame. The Activity Storage manual latch wasreplaced so the door positively latches into the frame. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:**	07/01/2016

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 4th floor Activity Storage corridor doors positively latched into the frame. This deficient practice could affect staff and at least 5 residents. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 11:13 a.m., the 4th floor Activities storage room contained a set of double doors that latched into one another but one door contained manual latching into the frame. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**Allresidents have the potential to be affected. All other doors were inspected by the maintenance director to assure alldoors and double doors latch into the frame. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Themaintenance director/designee will inspect doors monthly during his PM roundsto ensure they latch into the frame properly. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure the doors latch properly. The Executive Director will review thepreventative maintenance checks performed by the maintenance director monthlyand sign off that the checks were completed.**	
K 0025 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated			

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	glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was smoke resistive. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only. Findings include: Based on observations with the Executive Director and the Maintenance Supervisor on 06/01/16 at 11:29 p.m., a five inch by five inch piece of ceiling tile was missing in the 3rd floor Mechanical room. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged and provided the measurements for the unsealed penetration. 3.1-19(b)	K 0025	**K025** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **The facility has replaced the ceiling tile inthe 3rd floor mechanical room.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **Allresidents have the potential to be affected. All other ceiling tiles were inspected by the maintenance director toassure ceiling tiles were sealed properly.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **Themaintenance director/designee will inspect all ceiling tiles monthly during hisPM rounds to ensure they are sealed properly.** **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:** **TheExecutive Director will round with the maintenance director prior to thecompliance**	07/01/2016

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			date to ensure the ceiling tiles are sealed properly. The Executive Director will review thepreventative maintenance checks performed by the maintenance director monthly andsign off that the checks were completed.	
K 0029 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired 3rd floor Air Handler room, a hazardous area, was provided with self-closer and would positively latch into the frame. This deficient practice could affect staff and at least 23 residents. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 11:31 a.m.,the 3rd floor Air Handler room contained fuel fired	K 0029	**K029** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Adoor closer was added to the Dining Room Mechanical .** **Howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** **Allresidents have the potential to be affected. All doors in the facility were tested to assure they self close properlyby the maintenance director.**	07/01/2016

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	appliances and a set of double doors. The double doors did not contain self-closing hardware. One of the two doors had a manual slide latch. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Themaintenance director/designee will inspect the double doors to ensure theyclose properly monthly during his PM rounds. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with themaintenance director prior to the compliance date to ensure all doors closeproperly. The Executive Director willreview the preventative maintenance checks performed by the maintenancedirector monthly and sign off that the checks were completed**	
K 0046 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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 and interview; the facility failed to ensure 1 of 1 Social Service battery operated emergency light in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting	K 0046	**K046** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **The battery operated emergency lightin the Dining**	07/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 06/01/2016
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356	

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	Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. 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 staff and up to 17 residents. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:24 p.m., the battery operated emergency light in the corridor near the 1st floor Social Service office failed to illuminate when tested. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**Room has been removed because other emergency lighting isavailable when the generator is on.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **All residents have the potential ofbeing affected. All other batteryoperated emergency lights have been tested and replaced/removed as needed.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **The maintenance director/designeewill inspect all battery operated emergency lights monthly during his PM roundsto ensure they are functioning.** **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure all battery powered emergency lights arefunctioning. The Executive Director willreview the preventative maintenance**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED
	155448		06/01/2016

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			checks performed by the maintenancedirector on the battery powered emergency lights monthly and sign off that thechecks were completed.	
K 0062 SS=D Bldg. 02	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 Based on observation and interview, the facility failed to replace 1 of 1 1st floor Boiler room sprinkler head. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:36 p.m., one sprinkler head was corroded in the 1st floor Boiler room. Based on interview at the time of	K 0062	**K062** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Thesprinkler head in the 1st floor boiler room was replaced.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **Allresidents have the potential to be affected. All other sprinkler heads have been inspected and replaced as needed.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **Themaintenance director/designee will check all sprinkler heads monthly during hisPM rounds to assure they are not corroded.**	07/01/2016

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	observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure the sprinkler heads are not corroded. The Executive Director will review the monthlypreventative maintenance checks performed by the maintenance director on thesprinkler heads and sign off that the checks were completed.**	
K 0147 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 22 residents. Findings include: Based on observation with the Executive	K 0147	**K147** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Thesurge protectors were separated and plugged into the wall properly. The extension cord in room 107 was removedand the lights were plugged into the wall directly.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **Allresidents have the potential**	07/01/2016

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	Director and the Maintenance Supervisor on 06/01/16 at 1:00 p.m., an extension cord was powering a string of green lights in resident room 107. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**to affected. All other rooms were inspected for surge protectors plugged into anothersurge protector and extension cords. They were removed as needed.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **The maintenance supervisor/designeewill check the rooms/offices for improper cords monthly during his PM rounds toassure all devices are plugged in properly.** **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:** **TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure all items are plugged in properly. The Executive Director will review thepreventative maintenance checks performed by the maintenance director/designeemonthly and sign off that the checks were completed.**	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure was conducted by the	K 0000	**Thecreation and submission of this plan of correction does not**	

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	Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/01/16 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 2012 one story addition to the main dining room was surveyed with Chapter 18, New Health Care Facilities. 101, Life Safety Code (LSC), and 410 IAC 16.2. The 2005 addition of 14 rooms on E wing was surveyed with Chapter 18, New Health Care Facilities. The 2005 addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 86 and had a census of 78 at the time		**constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation.** **Dueto the relative low scope and severity of this survey, the facilityrespectfully requests a desk review in lieu of a post-survey revisit.**	

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	of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 06/03/16 - DA			
K 0029 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Dining Room Mechanical room, a hazardous area, was provided with self-closer and would positively latch into the frame. This deficient practice could affect staff and at least 25 residents. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:49 p.m., the Dining Room Mechanical room contained fuel fired appliances. The corridor door did not contain self-closing hardware. Based	K 0029	**K029** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **Adoor closer was added to the Dining Room Mechanical .** **Howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** **Allresidents have the potential to be affected. All doors in the facility were tested to assure they self close properlyby the maintenance director.** **Whatmeasures will be put into place or what systemic**	07/01/2016

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	on interview at the time of the observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**changes will be made to ensurethat the deficient practice does not recur: Themaintenance director/designee will inspect the double doors to ensure theyclose properly monthly during his PM rounds. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with themaintenance director prior to the compliance date to ensure all doors closeproperly. The Executive Director willreview the preventative maintenance checks performed by the maintenancedirector monthly and sign off that the checks were completed**	
K 0046 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD 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 and interview; the facility failed to ensure 1 of 1 Dining Room battery operated emergency light in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day	K 0046	**K046** **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** **The battery operated emergency lightin the Dining Room has been removed because other emergency**	07/01/2016

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	intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. 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 staff and at least 25 residents. Findings include: Based on observation with the Executive Director and the Maintenance Supervisor on 06/01/16 at 12:49 p.m., the battery operated emergency light in the Dining Room failed to illuminate when tested. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**lighting isavailable when the generator is on.** **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** **All residents have the potential ofbeing affected. All other batteryoperated emergency lights have been tested and replaced/removed as needed.** **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** **The maintenance director/designeewill inspect all battery operated emergency lights monthly during his PM roundsto ensure they are functioning.** **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:** **TheExecutive Director will round with the maintenance director prior to thecompliance date to ensure all battery powered emergency lights arefunctioning. The Executive Director willreview the preventative maintenance checks performed by the maintenancedirector on the**	

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			battery powered emergency lights monthly and sign off that thechecks were completed.	