**Emily Bailey** 

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

03/07/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/19/2024		
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	02/10/2021	
LOWELL	HEALTHCARE		LOWEL	L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE	_
Bldg	conducted by the Inaccordance with 42		E 0000			
	Healthcare was four Emergency Prepared Medicare and Medic and Suppliers, 42 C	20361 55448 66340 Preparedness survey, Lowell and in compliance with dness Requirements for caid Participating Providers FR 483.73 Certified beds. At the time of us was 74.				
IX 0000						
K 0000						
Bldg. 01	Licensure was cond Department of Heal 483.90(a). Survey Date: 02/19/ Facility Number: 00	00361	K 0000			
LANCE		66340 Code survey, Lowell and not in compliance with		THE S		
LABORATOR	LY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AYKY21 Facility ID: 000361 If continuation sheet Page 1 of 21

**Executive Director** 

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

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155448	A. BUILDING B. WING	<u>01</u>	COMPLETED 02/19/2024	
	PROVIDER OR SUPPLIER HEALTHCARE		710 M	ADDRESS, CITY, STATE, ZIP COD ICHIGAN ST LL, IN 46356		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE CONTENTION	
TAG	Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa Building 01 was but a partial basement; addition offset and o structure by a stairw Building 03 is a din Building 02. The fa	articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Although the article of the original dray prior to March 1, 2003. The cellity refers to the levels as the and fourth floors. The	TAG	DEFICIENCY)	DATE	
	construction of Buil of Type II (111) cor sprinklered. The corfacility was V(111) facility has a fire also smoke detection in a areas. Resident roo powered smoke detection protected by a 230 k. The facility has the census of 74 at the tenses of 74 at the tenses of the correction of	ding 01 was determined to be astruction and was fully astruction type for the entire and is fully sprinklered. The arm system with hard wired the corridors and common are provided with battery ectors. The building is partially at W diesel-powered generator. capacity for 86 and had a				
	providing facility se Quality Review con	ervices are sprinklered.				
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance,				

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

Event ID:

AYKY21

Facility ID: 000361

If continuation sheet

Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  02/19/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	b) Who provided  c) Water system  Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record revialled to maintain 1 sprinkler systems in LSC 9.7.5 requires inspected, tested, ar with NFPA 25, Star Testing, and Mainte Protection Systems. Section 4.1.4.1 state designated represent deficiencies or impathe inspection, test at this standard. Correperformed by qualified contractor records shall be made availating jurisdiction upon recould affect approx.  Findings include:  Based on record revial process of the contractor of the contracto	supply source  RKS information on non-required or partial er system.	K 0353	K353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Sprinkler inspection repairs reto the antifreeze is completed 03/06/2024. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other repairs were recommended during the last sprinkler inspection. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated regarding follow up a sprinkler inspection reports. The Maintenance Director will revie all Deficiencies noted during annual sprinkler inspections a	lated on the e be e

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 3 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  02/19/2024		
	ROVIDER OR SUPPLIER		7	710 MIC	DDRESS, CITY, STATE, ZIP COD :HIGAN ST L, IN 46356		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG. DEFICIENCY		TE	(X5) COMPLETION
TAG	deficiency for one a Under the "Deficier sprinkler company is system failed its and antifreeze replaced. "non-critical" and h interview at the tim Maintenance Direct antifreeze had been survey, the Mainten the deficiency still I that a quote was ser the quote had been of	ntifreeze system was found. Incy Summary" on page 1, the indicated that "small 15 gallon diffreeze testing and needs the "The deficiency was noted as ad an "open" status. Based on the of record review, the for was initially unaware if the replaced. Later during the lance Director confirmed that has not been fixed. He stated at to the facility, but originally denied for unknown reasons.  Install DENTIFYING INFORMATION INFORMATION  Install DENTIFYING INFORMATION  Install DENTIFY INFORMATION  Instal		FAG	ensure follow up is completed part of the preventative maintenance program.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  The Executive Director will row with the maintenance director to the compliance date to ensure all sprinkler inspection report recommendations are followed on. The Executive Director wireview the preventative maintenance checks performed the maintenance director mon and sign off that the checks we completed.	he  ut  und prior ure d up II	DATE
K 0363 SS=D Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller lace CMS regulation. Tapply to auxiliary solidammable or compartments are passage of smoke to rooms containing combustible materials.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain					

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet Page 4 of 21

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  02/19/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	doors complying wif provided with a control the door closed with a control the door closed with a door closed with a meeting of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glassiassemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rational devices, etc. Based on observation failed to ensure 1 of doors on the South provided with a medoor closed, had no latching and would This deficient pract 2 residents in room  Findings include:  Based on observation failed to ensure 1 of doors on the South provided with a medoor closed, had no latching and would This deficient pract 2 residents in room  Findings include:	fire window assemblies are a sprinklered compartments of the sor frames in window  Parts 403, 418, 460, 482,  So details of doors such as angs, automatics closing  on and interview, the facility of 9 resident room corridor wing of first floor were ans suitable for keeping the impediment to closing, resist the passage of smoke.	K 0363	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice: Maintenance Director has fix room 123 door and now latch How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: House room audit was completed to check every resident door. Room 125 found to also not late it is now corrected.	ed es the ne be ve	

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

Event ID:

AYKY21

Facility ID: 000361

If continuation sheet

Page 5 of 21

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

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMPLETED 02/19/2024	
	PROVIDER OR SUPPLIER HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE	
	latch and would get  The finding was rev	for agreed that the door did not it fixed.  Fiewed with the Executive aintenance Director during the		What measures will be place or what systemic changes will be made to ensure that the deficient practice does not recur Maintenance director was educated on ensuring all latch.  How the corrective active will be monitored to ensuring the deficient practice will not recur, i.e., what quality assurance program will into place:  The Executive Director will not the compliance date to all doors latch appropriate Executive Director will repreventative maintenance performed by the maintenance director monthly and significant to the checks have been continued.	o nt :: as I fire doors on(s) sure the ot I be put will review rector prior o ensure tely. The eview the be checks enance n off that	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable be within 10 seconds. If the n is not met during the brocess shall be provided to his capability for the life branches. Maintenance generator and transfer brimed in accordance with e inspected weekly, and 30 minutes 12 times a				

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet Page 6 of 21

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155448	B. W	NG		02/19/2024	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CHIGAN ST		
	. HEALTHCARE				L, IN 46356		
LOVVLLL	. IILALIIIOANL				, +0000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	year in 20-40 day	intervals, and exercised					
		onths for 4 continuous hours.					
	Scheduled test un	nder load conditions include					
	a complete simula	ated cold start and					
		ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
	_	ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for i						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view, observation and	K 0	918	What corrective action(s) wil	I	03/06/2024
		ty failed to ensure the			be accomplished for those		
	_	ty and integrity of 1 of 1			residents found to have been	n	
		ors. This deficient practice			affected by the deficient		
	could affect all occi	upants.			practice:		
	Diadiana' 1 1				Vendor came out to inspect a		
	Findings include:				clear sensor causing "commo	n	
	Dogad or massed	view with the Maintenance			warning" on control panel on		
		24 between 09:29 a.m. and 11:58			02/28/2024.	the	
					How other residents having to		
		Maintenance Report dated it needs John Deere to scan it			potential to be affected by the		
					same deficient practice will be		
		s causing a cylinder 6 fault			identified and what correctiv	е	
		servation during a tour of the			action(s) will be taken:		
		or annunciator panel had a			No other generators errors we		
		r a "common warning" alert. at the time of record review			found. Vendor found the gene		
					to be in full working order with	only	
I	and observation, the	e Maintenance Director	1		the sensor needing cleared.		I

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet Page 7 of 21

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

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/19/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	illuminated due to a the generator compa on the generator pre fixed it but the light unaware about the i The generator comp unit was operationa The finding was rev	nciator panel lights were I fault. He further stated that any had replaced some parts eviously and thought that Is were illuminated. He was essue on the generator report. Evany had indicated that the I at the time of service.  Triewed with the Executive eintenance Director during the			What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:  Maintenance director was educated on 02/28/2024 to address any inspection results meeting requirements are addressed timely.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printed place:  /p>	not he	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vi- non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard used with general	ent - Power Cords and ent - Power ent					

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 8 of 21

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/19/2024
LOWELL	PROVIDER OR SUPPLIER		710 MI	STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	temporarily are relected completion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (NFPA 70), 400 (N	moved immediately upon purpose for which it was as the conditions of 10.2.4.  (a), 10.2.4 (NFPA 99), 400-8. (b) (NFPA 70), TIA 12-5 on and interview, the facility of 2 power strips were not used exed wiring to provide power gh current draw.  (b) 8 state unless specifically elexible cords and cables shall as a substitute for fixed wiring. See could affect approximately own number of residents.  (c) 205 p.m., a refrigerator equipment) was plugged into by a power strip in the central basement. Furthermore, was plugged into and a power strip in the employee of the locations were in the interview at the time of intenance Director confirmed issue and unplugged the wed with the Maintenance tive Director at exit conference.	K 0920	What corrective action (s) we accomplished for those residents found to have been affected by the deficient practice?  It's the policy of Lowell Healt to ensure that no high-power equipment is plugged into a strip. Break room in basemed in central supply office was corrected on 02/19/2024 to be plugged directly into the wall outlet.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take All residents could be affected the deficient practice. An environmental walkthrough we completed to ensure all residenter high-power draw equiping plugged into a power strip.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Education was provided to stow of the power strip or extension cords allowed and what can	hcare draw power int and de  tial  ten? d by was lent ny ment into

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 9 of 21

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

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155448 B. WING		JILDING	<u>01</u>		SURVEY ETED /2024	
		100110	<i>D.</i> W1	_	ADDRESS, CITY, STATE, ZIP COD	02/19/	- LULT
	PROVIDER OR SUPPLIE . HEALTHCARE	R		710 MI	CHIGAN ST L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  cannot be plugged into them.	ATE	(X5) COMPLETION DATE
					How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program to be put into place?  The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool atta for 4 different locations week! 4 weeks, monthly for 6 month and quarterly thereafter for or compliance. Any identified issues/trends will be corrected upon discovery and logged or facility QAPI tracking log. The facility QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum months and until the facility maintains 95% compliance for days.	will e ched y for s ngoing d n the e inely re re n of 6	
K 0000							
Bldg. 02	Licensure was con	000361 155448	K 00	000	The creation and submission this plan of correction does constitute an admission by a provider of any conclusion so forth in the statement of deficiencies, or of any violat of regulation	not this set	

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 10 of 21

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

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	ì	UILDING	NSTRUCTION 02	(X3) DATE COMPI 02/19	ETED
	PROVIDER OR SUPPLIER HEALTHCARE	ξ		710 MIC	DDRESS, CITY, STATE, ZIP COD CHIGAN ST L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
K 0100	Healthcare was fou Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup Building 01 was but a partial basement; addition offset and structure by a stairve Building 03 is a direct Building 02. The first, second, third a construction of Building 05 Type II (111) consprinklered. The confacility was V(111) facility has a fire also smoke detection in areas. Resident roopowered smoke detection in areas.	I, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.  It as a two story building over Building 02 is a two story connected to the original way prior to March 1, 2003. Sing room connected to acility refers to the levels as the and fourth floors. The lding 01 was determined to be instruction and was fully instruction type for the entire and is fully sprinklered. The arm system with hard wired the corridors and common ones are provided with battery sectors. The building is partially kW diesel-powered generator. capacity for 86 and had a time of this survey.					
SS=E Bldg. 02	Section 18.1 and that are not addre						

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet Page 11 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/19/2024 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility K 0100 09/05/2024 What corrective action(s) will failed to maintain structural integrity of 1 of 4 exit be accomplished for those stairs. LSC 101 2012 edition, section 4.2.2 states residents found to have been structural integrity shall be maintained for the time affected by the deficient needed to evacuate, relocate, or defend in place practice: occupants who are not intimate with the initial fire Exit Stairs- Facility development. This deficient practice could affect requesting a temporary life safety approximately 5 residents and staff within the waiver request to ensure that the physical therapy area. 2nd floor landing can be replaced. Latching hardware Smoke Based on observation during a tour of the facility Barrier doors- Contractor installed between 12:05 p.m. and 2:05 p.m. on 02/19/24 with latching hardware on 02/29/2024. the Maintenance Director, an emergency exit How other residents having the stairway and platform were leading out of the potential to be affected by the physical therapy area. Upon observation under same deficient practice will be the platform, approximately six support joists were identified and what corrective found to be severely deconditioned and had action(s) will be taken: excessive weathering that compromised the All residents have the structural integrity of the exit stairs and platform. potential to be affected by the One joist had an approximate one foot section deficient practice. Maint. Dir and broken off which compromised the support beam. ED toured entire facility to identify Numerous other beams had see-through holes all areas that have exit stairs to and penetrations also compromising the structural ensure integrity and safety. integrity of the other support beams. Earlier upon Maint Dir. and ED toured investigation of the platform for the emergency facility and tested all fire doors to exit stairs, the Maintenance Director had warned ensure they have latching the surveyor about the condition of the stairs in hardware and are functioning which he advised not to stand out on the properly. platform. He then stated that the exit had been What measures will be put into "condemned" by the facility in which they placed place or what systemic caution tape across the handrails at the end of the changes will be made to staircase. Based on interview at the time of ensure that the deficient observations, the Maintenance Director further practice does not recur: clarified that to his knowledge, the staircase and Maint Dir. /ED will review platform have been like that since his start of plans to ensure integrity during employment. Later during the exit conference, the construction. Executive Director stated that quotes have been Maint Dir. was educated on

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 02/19/2024	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION WILL be in the process of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CONTROL OF CONTROL OF CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE COMPLETION DATE	
	getting the platform point. The stairs we the Maintenance Di were to arise, the la staircase.  Findings were discurbirector and Execurbirector and Executbirector and Executibility and Executibil	will be in the process of and staircase fixed at some re marked with an exit sign and rector stated that if the need st resort for exit would be that assed with the Maintenance tive Director at exit conference.  Attion and interview, the facility atching hardware on 2 of 2 in the 2nd and 4th floor. LSC isting life safety features it if not required by the Code, tained or removed. This bould affect approximately 10 ion number of residents  On with the Maintenance 4 between 12:05 p.m. and 2:05 ioke barrier doors next to the second floor and the fourth floor were provided with bout failed to latch when tested. In at the time of observation, the for stated that the doors were to an issue cited with the fire did already know that the berly latching. He further the doors contained latching where we with the Executive		ensuring all fire doors latch have functioning hardware. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place:  Maintenance director will me to ensure compliance is me will report results to QAPI to with an action plan in place compliance is not met.	(s) re the e put conitor et and eam	
		enance Director during the exit				

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 13 of 21

AND PLAN OF CORRECTION IDENTIFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  02/19/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0225 SS=F Bldg. 02	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4, Based on observation failed to maintain 2 with NFPA 101 - 20 Tread and Landing treads and landings perforations, unless 7.2.2.3.3.4. 7.2.2.3. 7.2.2.3.3.1 shall not grated stair treads an occupancies: (1) As otherwise provided Detention and corresponded Industrial occupance Chapter 40 This deficient practical residents, staff and Based on observation Director on 02/19/2 p.m. then again between the external emerge floor consisted of m surfaces. The landing measured 1-1/2 incl Furthermore, the for also contained open same size at landing consisted of metal vinch diameter circles.	19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility of 4 exit stairs in accordance 012 edition, Sections 7.2.2.3.3 Surfaces. 7.2.2.3.3.1 Stair shall be solid, without otherwise permitted in 3.4 The requirement of apply to noncombustible and landings in the following sembly occupancies as in Chapters 12 and 13 (2) ctional occupancies as in Chapters 22 and 23 (3) ites as otherwise provided in	K 022	25	K225 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility requesting a temporary safety waiver request to ensure that all exit stairs have proper treads. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential be affected by the deficient practice. Maint. Dir and ED toured entire facility to identify areas that have exit stairs have proper treads. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Maint Dir. /ED will review plansensure 2nd floor landing is completed. How the corrective action(s) will be monitored to ensure the	y life e e e e ul to all e tto	09/05/2024

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet Page 14 of 21

PRINTED: 03/08/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155448			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  02/19/2024	
	PROVIDER OR SUPPLIER	·		710 MIC	ADDRESS, CITY, STATE, ZIP COD CHIGAN ST L, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	Maintenance Direct aforementioned isst staircases had meta Maintenance Direct were indicated with	for confirmed the less and agreed that the less and agreed that the lopen grating stair treads. For also confirmed the stairs exit signs.			deficient practice will not recur, i.e., what quality assurance program will be printo place:  Maintenance director will monito ensure compliance is met al will report results to QAPI team with an action plan in place if compliance is not met.	<b>ut</b> itor nd	
K 0353 SS=E Bldg. 02	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of syster inspection and tes secure location ar	<u> </u>					
	Provide in REMAI coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record refailed to maintain 1 sprinkler systems in LSC 9.7.5 requires inspected, tested, au with NFPA 25, States	RKS information on non-required or partial er system.	K 03	353	K353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Sprinkler inspection repairs rel	1	

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

Protection Systems. NFPA 25, 2011 Edition,

Event ID:

AYKY21

Facility ID: 000361

to the antifreeze is completed on

If continuation sheet

Page 15 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED		
		155448	B. WING 02/19/2024			2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	8						
	HEALTHCARE		710 MICHIGAN ST LOWELL, IN 46356					
LOVVELL	. HEALHIUARE			LOVVELL, IIV 40000				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE	
		es the property owner or			03/06/2024.			
		tative shall correct or repair			How other residents having t			
	_	airments that are found during			potential to be affected by th			
	_	and maintenance required by			same deficient practice will b			
		ections and repairs shall be			identified and what correctiv	е		
		fied maintenance personnel or			action(s) will be taken:			
	-	or. NFPA 25, 4.3.1 requires			No other repairs were			
		de for all inspections, tests,			recommended during the last			
		the system components and			sprinkler inspection.			
		able to the authority having			What measures will be put in	ito		
	jurisdiction upon request. This deficient practice				place or what systemic			
	could affect approximately 40 residents and staff.				changes will be made to			
	77' 1' ' 1 1				ensure that the deficient			
	Findings include:		practice does not recur:					
	Dogad on massaud may	view with the Maintenance		The Maintenance Director was				
		4 between 09:29 a.m. and 11:58	educated regarding follow up of sprinkler inspection reports. The					
		sprinkler inspection titled			Maintenance Director will review			
	-	on, Testing and Maintenance of			all Deficiencies noted during	ew		
	_	nkler System" dated 4/27/23, a	annual sprinkler inspections and		nd			
		antifreeze system was found.		ensure follow up is completed as				
	_	ncy Summary" on page 1, the			part of the preventative	as		
		indicated that "small 15 gallon			maintenance program.			
		tifreeze testing and needs the			How the corrective action(s)			
	_ ·	" The deficiency was noted as			will be monitored to ensure t			
	_	ad an "open" status. Based on			deficient practice will not	.116		
		e of record review, the			recur, i.e., what quality			
		tor was initially unaware if the			assurance program will be p	ut		
		replaced. Later during the			into place:			
		nance Director confirmed that			The Executive Director will rou	und		
	-	has not been fixed. He stated			with the maintenance director prior			
	-	nt to the facility, but originally			to the compliance date to ensure			
	•	denied for unknown reasons.			all sprinkler inspection report			
					recommendations are followed	d up		
	Findings were discu	assed with the Maintenance			on. The Executive Director wi	-		
		tive Director at exit conference.			review the preventative			
					maintenance checks performe	ed by		
	3.1-19(b)				the maintenance director mon	-		
					and sign off that the checks w	-		
				completed				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 02/19/2024				
	ROVIDER OR SUPPLIER HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under love year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are corpersonnel. Mainte energy power sou accordance with N circuit breakers and program for period components is est manufacturer requiof maintenance ar and readily availat and circuits are mainted and separate from Minimizing the pos- emergency power consideration for re-	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised exercised in this for 4 continuous hours. It der load conditions include the ted cold start and the last transfer of all EES inducted by competent exercised exercised in the source and testing of stored forces (Type 3 EES) are in the life and all transfer of all in the life and the life						
		riew, observation and ty failed to ensure the	K 0918	What corrective action(s) will be accomplished for those	03/06/2024			

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 17 of 21

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		A. BUILDING <u>02</u> COMPLET		(X3) DATE SURVEY COMPLETED 02/19/2024			
	ROVIDER OR SUPPLIER HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	continuing reliabilitemergency generate could affect all occurrence of the could affect all occurrence occurrence of the could affect all occurrence occu	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  y and integrity of 1 of 1  ors. This deficient practice spants.  iew with the Maintenance 4 between 09:29 a.m. and 11:58  Maintenance Report dated it needs John Deere to scan it 6 causing a cylinder 6 fault fervation during a tour of the for annunciator panel had a 6 a "common warning" alert. at the time of record review 6 Maintenance Director ficiator panel lights were fault. He further stated that fany had replaced some parts for viously and thought that for swere illuminated. He was for sum on the generator report. For samp had indicated that the first at the time of service.  iewed with the Executive finitenance Director during the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION MEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIVE DEFICIENCY)  residents found to have bee affected by the deficient practice:  Vendor came out to inspect a clear sensor causing "commo warning" on control panel on 02/28/2024.  How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken:  No other generators errors we found. Vendor found the generator be in full working order with the sensor needing cleared.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:  Maintenance director was educated on 02/28/2024 to address any inspection result meeting requirements are addressed timely.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place:	n nd nn the ne be ve ere erator in only into		
K 0000				/p>			
Bldg. 03	Licensure was cond	Recertification and State ucted by the Indiana th in accordance with 42 CFR	K 0000				

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

Event ID:

AYKY21 Facility ID: 000361

If continuation sheet

Page 18 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155448		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       03       COMPLETED         B. WING       02/19/2024				ETED	
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU	483.90(a).	X ESC IDENTIFIED INFORMATION		IAU			DATE
	Survey Date: 02/19						
	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 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.						
	a partial basement; addition offset and structure by a stairv Building 03 is a dir Building 02. The first, second, third a construction of Bui of Type II (111) co sprinklered. The co facility was V(111) facility has a fire al smoke detection in areas. Resident roopowered smoke det protected by a 230	connected to the original way prior to March 1, 2003. Sing room connected to the levels as the and fourth floors. The lding 01 was determined to be instruction and was fully instruction type for the entire and is fully sprinklered. The arm system with hard wired the corridors and common ones are provided with battery ectors. The building is partially kW diesel-powered generator. capacity for 86 and had a time of this survey.					
	providing facility so	e to residents and all areas ervices are sprinklered.					
	Quality Review con	npieted on 2/22/24					

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

Event ID: AYKY21 Facility ID: 000361

If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155448		(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 03	(X3) DATE SURVEY COMPLETED 02/19/2024	
	PROVIDER OR SUPPLIER . HEALTHCARE		710 MI	ADDRESS, CITY, STATE, ZIP COD CHIGAN ST LL, IN 46356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
K 0918 SS=F Bldg. 03	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availal and circuits are manufactures requ of maintenance ar and separate from Minimizing the pos- emergency power consideration for re-	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised anths for 4 continuous hours. In der load conditions include the deal transfer of all EES inducted by competent load testing of stored arces (Type 3 EES) are in lifer and all transfer of all EES in lifer and a dically exercising the life ablished according to life ments. Written records and testing are maintained be leed to the second in the			
		riew, observation and ty failed to ensure the	K 0918	What corrective action(s) we be accomplished for those	•

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

Event ID:

AYKY21

Facility ID: 000361

If continuation sheet

Page 20 of 21

STATEMENT OF DEFICIENCIES X1) P.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>03</u>		03	COMPL	ETED
		155448	B. WI	NG		02/19/	2024
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	continuing reliability emergency generated could affect all occurs of the could are could affect at the generator of the generator components of the generator components of the generator components of the generator compunit was operational.	ty and integrity of 1 of 1 ors. This deficient practice		TAG	residents found to have been affected by the deficient practice:  Vendor came out to inspect an clear sensor causing "common warning" on control panel on 02/28/2024.  How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:  No other generators errors were found. Vendor found the gene to be in full working order with the sensor needing cleared.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:  Maintenance director was educated on 02/28/2024 to address any inspection results meeting requirements are addressed timely.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place:  /p>	the the te the tre trator only tho	DATE
			ı				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AYKY21 Facility ID: 000361 If continuation sheet Page 21 of 21