STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING -- B. WING	02/19/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/19/2024 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Emergency Preparedness survey, Lowell Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 74. Quality Review completed on 2/22/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/19/2024 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 At this Life Safety Code survey, Lowell Healthcare was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bailey	Executive Director	03/07/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155448	A. BUILDING 01 B. WING	02/19/2024

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Building 01 was built as a two story building over a partial basement; Building 02 is a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. Building 03 is a dining room connected to Building 02. The facility refers to the levels as the first, second, third and fourth floors. The construction of Building 01 was determined to be of Type II (111) construction and was fully sprinklered. The construction type for the entire facility was V(111) and is fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detectors. The building is partially protected by a 230 kW diesel-powered generator. The facility has the capacity for 86 and had a census of 74 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 2/22/24			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance,			

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	155448	A. BUILDING 01 B. WING	02/19/2024

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	inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 2 antifreeze automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect approximately 40 residents and staff. Findings include: Based on record review with the Maintenance Director on 02/19/24 between 09:29 a.m. and 11:58 a.m., the fifth year sprinkler inspection titled "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler System" dated 4/27/23, a	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 related to the antifreeze is completed on 03/06/2024. **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:** No other repairs were recommended during the last sprinkler inspection. **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 was educated regarding follow up of sprinkler inspection reports. The Maintenance Director will review all Deficiencies noted during annual sprinkler inspections and	03/06/2024

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	deficiency for one antifreeze system was found. Under the "Deficiency Summary" on page 1, the sprinkler company indicated that "small 15 gallon system failed its antifreeze testing and needs the antifreeze replaced." The deficiency was noted as "non-critical" and had an "open" status. Based on interview at the time of record review, the Maintenance Director was initially unaware if the antifreeze had been replaced. Later during the survey, the Maintenance Director confirmed that the deficiency still has not been fixed. He stated that a quote was sent to the facility, but originally the quote had been denied for unknown reasons. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		ensure follow up is completed as 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 put into place:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all sprinkler inspection report recommendations are followed up on. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 9 resident room corridor doors on the South wing of first floor were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 123 Findings include: Based on observation with the Maintenance Director on 02/19/24 between 12:05 p.m. and 2:05 p.m., the corridor door to resident room 123 did not latch into the frame when tested three times. Based on interview at the time of observation, the	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Maintenance Director has fixed room 123 door and now latches **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:** House room audit was completed to check every resident door. Room 125 found to also not latch. It is now corrected.	03/06/2024

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	Maintenance Director agreed that the door did not latch and would get it fixed. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance director was educated on ensuring all fire doors latch. **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 review with the maintenance director prior to the compliance date to ensure all doors latch appropriately. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks have been completed.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview, the facility failed to ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/19/24 between 09:29 a.m. and 11:58 a.m., the Generator Maintenance Report dated 12/27/23 stated "unit needs John Deere to scan it to figure out what is causing a cylinder 6 fault warning." Upon observation during a tour of the facility, the generator annunciator panel had a light illuminated for a "common warning" alert. Based on interview at the time of record review and observation, the Maintenance Director	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Vendor came out to inspect and clear sensor causing “common warning” on control panel on 02/28/2024. **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:** No other generators errors were found. Vendor found the generator to be in full working order with only the sensor needing cleared.	03/06/2024

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	confirmed the annunciator panel lights were illuminated due to a fault. He further stated that the generator company had replaced some parts on the generator previously and thought that fixed it but the lights were illuminated. He was unaware about the issue on the generator report. The generator company had indicated that the unit was operational at the time of service. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**What measures will be put into 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 not 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 put into place:** /p>	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed			

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	wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/19/24 between 12:05 p.m. and 2:05 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the central supply office in the basement. Furthermore, another refrigerator was plugged into and supplied power by a power strip in the employee break room area. Both locations were in the basement. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned issue and unplugged the refrigerators. Findings were reviewed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0920	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of Lowell Healthcare to ensure that no high-power draw equipment is plugged into a power strip. Break room in basement and 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 potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all resident care vicinities did not have any other high-power draw equipment plugged into a power strip. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Education was provided to staff who use those areas about the type of power strip or extension cords allowed and what can or	03/06/2024

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			cannot be plugged into them. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached for 4 different locations weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets routinely and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/19/2024 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation**	

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	At this Life Safety Code survey, Lowell Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Building 01 was built as a two story building over a partial basement; Building 02 is a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. Building 03 is a dining room connected to Building 02. The facility refers to the levels as the first, second, third and fourth floors. The construction of Building 01 was determined to be of Type II (111) construction and was fully sprinklered. The construction type for the entire facility was V(111) and is fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detectors. The building is partially protected by a 230 kW diesel-powered generator. The facility has the capacity for 86 and had a census of 74 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 2/22/24			
K 0100 SS=E Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information,			

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	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 failed to maintain structural integrity of 1 of 4 exit stairs. LSC 101 2012 edition, section 4.2.2 states structural integrity shall be maintained for the time needed to evacuate, relocate, or defend in place occupants who are not intimate with the initial fire development. This deficient practice could affect approximately 5 residents and staff within the physical therapy area. Based on observation during a tour of the facility between 12:05 p.m. and 2:05 p.m. on 02/19/24 with the Maintenance Director, an emergency exit stairway and platform were leading out of the physical therapy area. Upon observation under the platform, approximately six support joists were found to be severely deconditioned and had excessive weathering that compromised the structural integrity of the exit stairs and platform. One joist had an approximate one foot section broken off which compromised the support beam. Numerous other beams had see-through holes and penetrations also compromising the structural integrity of the other support beams. Earlier upon investigation of the platform for the emergency exit stairs, the Maintenance Director had warned the surveyor about the condition of the stairs in which he advised not to stand out on the platform. He then stated that the exit had been "condemned" by the facility in which they placed caution tape across the handrails at the end of the staircase. Based on interview at the time of observations, the Maintenance Director further clarified that to his knowledge, the staircase and platform have been like that since his start of employment. Later during the exit conference, the Executive Director stated that quotes have been	K 0100	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 Exit Stairs- Facility requesting a temporary life safety waiver request to ensure that the 2nd floor landing can be replaced. 2 Latching hardware Smoke Barrier doors- Contractor installed latching hardware on 02/29/2024. **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 All residents have the potential to be affected by the deficient practice. Maint. Dir and ED toured entire facility to identify all areas that have exit stairs to ensure integrity and safety. 2 Maint Dir. and ED toured facility and tested all fire doors to ensure they have latching hardware and are functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** 1 Maint Dir. /ED will review plans to ensure integrity during construction. 2 Maint Dir. was educated on	09/05/2024

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	pushed through and will be in the process of getting the platform and staircase fixed at some point. The stairs were marked with an exit sign and the Maintenance Director stated that if the need were to arise, the last resort for exit would be that staircase. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 2 smoke barrier doors in the 2nd and 4th floor. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 10 staff and an unknown number of residents Findings include: Based on observation with the Maintenance Director on 02/19/24 between 12:05 p.m. and 2:05 p.m., the sets of smoke barrier doors next to physical therapy on the second floor and the other doors on the fourth floor were provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director stated that the doors were recently put in due to an issue cited with the fire marshal's office but did already know that the doors were not properly latching. He further acknowledged that the doors contained latching hardware. The finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		ensuring all fire doors latch and have functioning hardware. **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:** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met.	

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	155448	A. BUILDING 02 B. WING	02/19/2024

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K 0225 SS=F Bldg. 02	3.1-19(b) NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to maintain 2 of 4 exit stairs in accordance with NFPA 101 - 2012 edition, Sections 7.2.2.3.3 Tread and Landing Surfaces. 7.2.2.3.3.1 Stair treads and landings shall be solid, without perforations, unless otherwise permitted in 7.2.2.3.3.4. 7.2.2.3.3.4 The requirement of 7.2.2.3.3.1 shall not apply to noncombustible grated stair treads and landings in the following occupancies: (1) Assembly occupancies as otherwise provided in Chapters 12 and 13 (2) Detention and correctional occupancies as otherwise provided in Chapters 22 and 23 (3) Industrial occupancies as otherwise provided in Chapter 40 This deficient practice could affect approximately all residents, staff and visitors. Based on observation with the Maintenance Director on 02/19/24 between 12:05 p.m. and 2:05 p.m. then again between 3:00 p.m. and 4:15 p.m., the external emergency exit stairway for the third floor consisted of metal open grate walking surfaces. The landing and all of the stair treads measured 1-1/2 inches by 4 inch squares. Furthermore, the fourth floor emergency exit stairs also contained open grating approximately the same size at landings, however the stair tread consisted of metal which had approximately 1-1/2 inch diameter circles on each step. Based on interview at the time of observation, the	K 0225	**K225** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility requesting a temporary life 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 to be affected by the deficient practice. Maint. Dir and ED toured entire facility to identify all areas that have exit stairs have proper treads. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maint Dir. /ED will review plans to ensure 2nd floor landing is completed. **How the corrective action(s) will be monitored to ensure the**	09/05/2024

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	Maintenance Director confirmed the aforementioned issues and agreed that the staircases had metal open grating stair treads. Maintenance Director also confirmed the stairs were indicated with exit signs. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met.	
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 2 antifreeze automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition,	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 related to the antifreeze is completed on	03/06/2024

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	Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect approximately 40 residents and staff. Findings include: Based on record review with the Maintenance Director on 02/19/24 between 09:29 a.m. and 11:58 a.m., the fifth year sprinkler inspection titled "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler System" dated 4/27/23, a deficiency for one antifreeze system was found. Under the "Deficiency Summary" on page 1, the sprinkler company indicated that "small 15 gallon system failed its antifreeze testing and needs the antifreeze replaced." The deficiency was noted as "non-critical" and had an "open" status. Based on interview at the time of record review, the Maintenance Director was initially unaware if the antifreeze had been replaced. Later during the survey, the Maintenance Director confirmed that the deficiency still has not been fixed. He stated that a quote was sent to the facility, but originally the quote had been denied for unknown reasons. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		03/06/2024. **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:** No other repairs were recommended during the last sprinkler inspection. **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 was educated regarding follow up of sprinkler inspection reports. The Maintenance Director will review all Deficiencies noted during annual sprinkler inspections and ensure follow up is completed as 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 put into place:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all sprinkler inspection report recommendations are followed up on. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	

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K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review, observation and interview, the facility failed to ensure the	K 0918	**What corrective action(s) will be accomplished for those**	03/06/2024

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	continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/19/24 between 09:29 a.m. and 11:58 a.m., the Generator Maintenance Report dated 12/27/23 stated "unit needs John Deere to scan it to figure out what is causing a cylinder 6 fault warning." Upon observation during a tour of the facility, the generator annunciator panel had a light illuminated for a "common warning" alert. Based on interview at the time of record review and observation, the Maintenance Director confirmed the annunciator panel lights were illuminated due to a fault. He further stated that the generator company had replaced some parts on the generator previously and thought that fixed it but the lights were illuminated. He was unaware about the issue on the generator report. The generator company had indicated that the unit was operational at the time of service. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** Vendor came out to inspect and clear sensor causing “common warning” on control panel on 02/28/2024. **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:** No other generators errors were found. Vendor found the generator to be in full working order with only the sensor needing cleared. **What measures will be put into 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 not 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 put into place:** /p>	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000		

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	483.90(a). Survey Date: 02/19/2024 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. Building 01 was built as a two story building over a partial basement; Building 02 is a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. Building 03 is a dining room connected to Building 02. The facility refers to the levels as the first, second, third and fourth floors. The construction of Building 01 was determined to be of Type II (111) construction and was fully sprinklered. The construction type for the entire facility was V(111) and is fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detectors. The building is partially protected by a 230 kW diesel-powered generator. The facility has the capacity for 86 and had a census of 74 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 2/22/24			

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