An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.

Survey Date: 05/01/18

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 80.

Quality Review completed on 05/09/12 - DA

A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).

Survey Date: 05/01/18

Facility Number: 000361
Provider Number: 155448
AIM Number: 100266340

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

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. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 0741</td>
<td>SS=E</td>
<td>Bldg. 01</td>
<td>All areas accessible to residents and all areas providing facility services are sprinklered.</td>
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</tbody>
</table>

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 facility has the capacity for 86 and had a census of 80 at the time of this survey.

All areas accessible to residents and all areas providing facility services are sprinklered.

Quality Review completed on 05/09/12 - DA

NFPA 101 Smoking Regulations
Smoking regulations shall be adopted and shall include not less than the following provisions:
(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**

155448

**DATE SURVEY COMPLETED:**

05/01/2018

**STATE NAME OF PROVIDER OR SUPPLIER**

LOWELL HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

710 MICHIGAN ST

LOWELL, IN 46356

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>PREFIX</td>
<td>REGULATORY OR LSC IDENTIFYING INFORMATION</td>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<tr>
<td>K 0741</td>
<td>Based on record review, observation and interview; the facility failed to ensure cigarette butts were placed into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking is permitted. This deficient practice could affect staff outside the south entrance of the facility.</td>
<td>K741</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The cigarette butts on the ground were picked up and disposed of properly.</td>
<td>05/31/2018</td>
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<tr>
<td></td>
<td>Findings include:</td>
<td></td>
<td>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. The area around the building was inspected and all cigarette butts have been picked up and disposed of properly.</td>
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**LOCATION:**

Based on record review, observation and interview; the facility failed to ensure cigarette butts were placed into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking is permitted. This deficient practice could affect staff outside the south entrance of the facility.

Findings include:

During a tour of the facility with the Clinical Education Coordinator and the Director of Maintenance on 05/01/18 at 11:47 a.m., more than 20 cigarette butts were observed on the ground outside of the designated smoking area. Based on observation at the time of observation, the Director...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
LOWELL HEALTHCARE
710 MICHIGAN ST
LOWELL, IN 46356

ID: 155448   PREFIX: K0753   TAG: SS=E   Bldg. 01

MULTIPLE CONSTRUCTION
A. BUILDING 01
B. WING

STATEMENT OF DEFICIENCIES

3.1 - 19(b)

Summary: of Maintenance agreed that there were more than 20 cigarette butts on the ground.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

All staff will be educated on designated smoking areas and how to properly dispose of a cigarette butt. The maintenance supervisor/designee will check the grounds for cigarette butts monthly during his PM rounds to assure they are disposed of properly.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director will round with the maintenance director prior to the compliance date to ensure the cigarette butts are disposed of properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director/designee monthly and sign off that the checks were completed.

By what date the systemic changes will be completed:
Compliance Date: 5/31/18
for product.

- Decorations meet NFPA 701.
- Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.
- Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).
- The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.

19.7.5.6

Based on observation and interview, the facility failed to ensure 2 of 2 staff offices was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff only.

Findings include:

Based on a facility tour with the Clinical Education Coordinator and the Director of Maintenance on 05/01/18 a candle with a wick was found in the Clinical Education Coordinator's Office at 12:33 p.m.; additionally, at 12:36 p.m., a candle with a wick was found in the Therapy Manager's office.

Based on interview at the time of observation, the Clinical Education Coordinator and the Director of Maintenance, acknowledged the aforementioned condition and agreed that there were candles with wicks in the staff offices.

3.1-19(b)
combustible decorations. 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 resident rooms and offices are free from combustible decorations. The Executive Director will review the preventative maintenance checks performed by the maintenance director/designee monthly and sign off that the checks were completed.

By what date the systemic changes will be completed:
Compliance Date: 5/31/18

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.

Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.
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| K 0363 | SS=E   | Bldg. 02| 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 facility has the capacity for 86 and had a census of 80 at the time of this survey. All areas accessible to residents and all areas providing facility services are sprinklered. Quality Review completed on 05/09/12 - DA NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors...
to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or 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 3 of 20 resident room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice
could affect staff and up to 18 residents in the South 100 Hall smoke compartment.

Findings include:

During a tour of the facility with the Clinical Education Coordinator and the Director of Maintenance on 05/01/18 between 11:32 a.m. and 11:42 a.m., the following was found:

a) At 11:32 a.m. Resident Room 125 did not latch.
b) At 11:41 a.m. Resident Room 121 did not latch.
c) At 11:42 a.m. Resident Room 120 did not latch.

Each door was attempted several times. Based on interview at the time of observation, the Clinical Education Coordinator and the Director of Maintenance confirmed and acknowledged that the doors would not latch.

3.1-19(b)
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<td>SS=E</td>
<td>Bldg. 02</td>
<td>NFPA 101</td>
<td>K 0920</td>
<td>K920</td>
<td>05/31/2018</td>
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<tr>
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<td></td>
<td>Electrical Equipment - Power Cords and Extens</td>
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<td></td>
<td></td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</td>
<td>05/31/2018</td>
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<td>Electrical Equipment - Power Cords and Extension Cords</td>
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<td></td>
<td>The power strip was removed from room 303 and the nebulizer was plugged directly into the wall.</td>
<td>05/31/2018</td>
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<td>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 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</td>
<td>05/31/2018</td>
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examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect staff and up to 24 residents in the adjacent smoke compartment.

Findings include:

During a facility tour with the Clinical Education Coordinator and the Director of Maintenance on 05/02/18 at 12:06, it could not be assured the power strip used in Resident Room 303 to power a nebulizer in the patient care vicinity met UL 1363A or UL60601-1. Based on interview at the time of observation, the Clinical Education Coordinator and the Director of Maintenance acknowledged it could not be assured the aforementioned power strip met UL 1363A or UL60601-1.

3.1-19(b)

action(s) will be taken:
All residents have the potential to affected. All other rooms were inspected for power strips. They were removed as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be educated prior to the compliance date on the improper use of cords. The maintenance supervisor/designee will check the rooms for improper cords monthly during his PM rounds to assure all devices are plugged in properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure all items are plugged in properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director/designee monthly and sign off that the checks were completed.

By what date the systemic changes will be completed:
Compliance Date: 5/31/18
A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).

Survey Date: 05/01/18

Facility Number: 000361
Provider Number: 155448
AIM Number: 10026340

At this Life Safety Code survey, Lowell Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 facility has the capacity for 86 and had a census of 80 at the time of this survey.

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## Statement of Deficiencies and Plan of Correction

### Identification Number
- **State:** MULTIPLE CONSTRUCTION
- **Type:** A. BUILDING 03
  - B. WING

### Date Survey Completed
- **Date:** 05/01/2018

### Name of Provider or Supplier
- **Provider:** LOWELL HEALTHCARE
- **Address:** 710 MICHIGAN ST, LOWELL, IN 46356

### Summary Statement of Deficiencies
- Quality Review completed on 05/09/12 - DA

### Provider's Plan of Correction
- **ID:** 155448
- **Prefix:** 03
- **Tag:** 03

### Completion Date
- **Date:** 05/01/2018

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**Event ID:** 59DT21  **Facility ID:** 000361  **If continuation sheet:** Page 13 of 13