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	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lowell Healthcare	710 Michigan St Lowell, IN 46356

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to an uncovered urinary catheter bag for 1 of 2 residents reviewed for dignity. (Resident 8)Finding includes:On 2/9/26 at 3:10 p.m. Resident 8 was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway.On 2/10/26 at 10:24 a.m. Resident 8 was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway.On 2/11/26 at 11:07 a.m. Resident 8 was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway.Record review for Resident 8 was completed on 2/11/26 at 11:26 a.m. Diagnoses included, but were not limited to, hypertension, osteoarthritis, and obstructive uropathy.The Quarterly Minimum Data Set (MDS) assessment, dated 1/20/26, indicated the resident was cognitively impaired and had an indwelling urinary catheter.A Care Plan, updated 1/28/26, indicated the resident required an indwelling urinary catheter related to obstructive uropathy. An intervention indicated to store the collection bag inside of a protective dignity pouch.During an interview on 2/11/26 at 11:17 a.m., the Director of Nursing was made aware the urinary catheter bag was visible from the hallway. She indicated the facility had dignity covers the staff were to use.3.1-3(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 60)Finding includes:On 2/11/26 at 9:12 a.m., LPN 1 was observed preparing Resident 60's medications, which included Miralax (polyethylene glycol, a laxative medication) 17 grams. She dissolved the medication in a cup of water and entered the resident's room to administer the medications. The resident took his pills and drank a few sips of the Miralax then set the cup on his bedside table. LPN 1 indicated she would come back later and assist him with finishing the Miralax. She completed administering the resident's other medications, exited the room, and returned to the Nurse's Station. She left the Miralax in the resident's room and had not stayed with the resident to ensure the medication was taken. Record review for Resident 60 was completed on 2/11/26 at 12:08 p.m. Diagnoses included, but were not limited to, hypertension, general anxiety disorder, and major depressive disorder.The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/26, indicated the resident was cognitively impaired.There was a lack of any Physician's Orders for self-administration of medications or any assessment for self-administration of medications.During an interview on 2/11/26 at 11:17 a.m., the Director of Nursing was made aware LPN 1 had left the medication in the resident's room. No further information was provided.A facility policy, titled Self-Administration of Medications, indicated, .If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the self-administration of medication assessment observation. A physician order will be obtained specifying the resident's ability to self-administer medications and if necessary, listing which medications will be included in the self-administration plan .3.1-11(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to removing facial hair for female residents for 1 of 2 residents reviewed for ADL care. (Resident 45)Finding includes: On 2/9/26 at 11:29 a.m., Resident 45 was observed sitting in her wheelchair watching television. The resident had facial hair observed on her chin. On 2/11/26 at 9:43 a.m. and 11:42 a.m., Resident 45 was observed with facial hair on her chin. Resident 45's record was reviewed on 2/12/26 at 3:18 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. A Care Plan, dated 9/7/16, indicated the resident required assistance with activities of daily living. Interventions included, but were not limited to, assist with bathing as needed, assist with showers twice weekly in the morning and partial bath in between per resident's preference. The Quarterly Minimum Data Set (MDS) assessment, dated 10/17/25, indicated the resident was severely cognitively impaired and required partial/moderate assistance with personal hygiene and substantial/maximal assistance with bathing. The Shower Sheets were reviewed for the last 60 days and indicated the resident had been assisted with shaving last on 2/3/26. She had received a bed bath or shower on 2/5/26 and 2/10/26 and there were no refusals for shaving documented. During an interview on 2/13/26 at 11:47 a.m., the Assistant Director of Nursing indicated the resident frequently refused assistance with shaving, but it had not been cared planned. During an interview on 2/13/26 at 3:25 p.m., the Administrator indicated the staff were supposed to document refusals on the shower sheets, however that was not completed. A facility policy titled, AM Care, indicated, .Procedure Steps .8. Shave resident, if needed or requested .16. Document the procedure. 3.1-38(a)(3)(D)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration and humidity bottles that were outdated for 3 of 3 residents reviewed for respiratory care. (Residents 72, 15, and 10)Findings include: 1. On 2/9/26 at 11:41 a.m., Resident 72 was observed in bed with oxygen on via a nasal cannula. The resident indicated she administered the oxygen when she felt she needed it. The oxygen concentrator was set to 1.5 liters per minute and had a humidity bottle attached that was dated 1/19/26. On 2/11/26 at 9:25 a.m., Resident 72 was observed asleep in bed. She was wearing a nasal cannula attached to the oxygen concentrator set to 1.5 liters per minute. The humidity bottle was dated 1/19/26. Resident 72's record was reviewed on 2/12/26 at 3:36 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease A Physician's Order, dated 8/21/24, indicated change oxygen tubing and humidity once a day on Sunday. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/25, indicated the resident was cognitively intact. A Physician's Order, dated 12/9/21, indicated oxygen at 2 liters per nasal cannula, resident to apply when feeling short of breath. During an interview on 2/13/26 at 11:47 a.m., the Assistant Director of Nursing (ADON) indicated she had no further information to provide. 2. On 2/10/26 at 10:34 a.m., Resident 15 was observed sitting on her bed. She had a nasal cannula sitting on the floor connected to an oxygen concentrator. On 2/11/26 at 9:41 a.m., Resident 15 was sitting on the side of the bed. She had a nasal cannula on connected to a portable concentrator set to 3 liters per minute. On 2/13/26 at 10:55 a.m., Resident 15 was observed sitting up in her bed. She had a nasal cannula on connected to an oxygen concentrator set to 1.5 liters per minute. Resident 15's record was reviewed on 2/11/26 at 11:43 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and respiratory failure. A Care Plan, dated 8/21/20, indicated the resident was at risk for impaired gas exchange related to chronic obstructive pulmonary disease. Interventions included, but were not limited to, oxygen as ordered/needed. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 1/15/26, indicated the resident was moderately impaired for daily decision making and required oxygen therapy. A Physician's Order, dated 2/4/26, indicated oxygen at a 2 liters per minute per nasal cannula every shift. During an interview on 2/13/26 at 11:47 a.m., the Assistant Director of Nursing (ADON) indicated she had no further information to provide. 3. On 2/9/26 at 10:59 a.m., Resident 10 was observed in bed. He was wearing a nasal cannula connected to an oxygen concentrator with a flow rate of 1.5 liters per minute. On 2/11/26 at 9:39 a.m., 2/12/26 at 11:08 a.m., and 2/13/26 at 10:28 a.m., Resident 10 was observed in bed with no oxygen on. Resident 10's record was reviewed on 2/12/26 at 2:59 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and asthma. A Physician's Order, dated 11/24/25, indicated oxygen at 2 liters per nasal cannula every shift. The Quarterly Minimum Data Set (MDS) assessment, dated 12/11/25, indicated the resident was severely cognitively impaired and required oxygen therapy. During an interview on 2/13/26 at 11:47 a.m., the Assistant Director of Nursing (ADON) indicated she had no further information to provide. A facility policy titled, Oxygen Concentrator, indicated, .Procedure 1. Verify and understand the physician's order. 2. Know the flow rate and duration of use .9. Adjust the flow meter control knob to the flow setting prescribed by the physician .Daily Maintenance 1. Check the water level in the humidity bottle. Change the bottle as needed or every 7 days . 3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained, related to staff touching pills during medication administration for 1 of 5 residents observed during medication administration. (Resident 60) Finding includes:On 2/11/26 at 9:12 a.m., LPN 1 was observed preparing Resident 60's medications, which included 10 pills. She popped each pill out of the medication cards one at a time, into her hand, and then put them in a medication cup. She then administered the medications to the resident.During an interview on 2/11/26 at 11:17 a.m., the Director of Nursing was made aware LPN 1 had touched the medications with her hands.A facility policy, titled Medication Administration (Medication Pass Procedure), indicated, .5. Medications are opened without contaminating.3.1-18(b)