STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE C A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY  COMPLETED  06/15/2023	
	PROVIDER OR SUPPLIE	IEALTHCARE CENTER	STREET 500 N ANGO		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	T 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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
E 0000 Bldg	conducted by the I accordance with 4.  Survey Date: 06/1  Facility Number: 0  Provider Number: AIM Number: 100  At this Emergency Rehab and Health compliance with E Requirements for Participating Provides 3.73  The facility has 75 the survey, the cert Quality Review conductive with the survey of	5/23  000474 155596 0290510  Preparedness survey, Lakeland care Center was found not in imergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR  Certified beds. At the time of issus was 63.  Impleted on 06/19/23  16.54(d)(2), 418.113(d)(2), 32.15(d)(2), 483.475(d)(2), 4.102(d)(2), 485.625(d)(2), 5.727(d)(2), 485.920(d)(2), 61.12(d)(2), 494.62(d)(2) (irements 148.113(d)(2), §441.184(d)(2), 182.15(d)(2), §483.73(d)(2), 3484.102(d)(2), §485.68(d)(2), 3485.727(d)(2), §485.920(d)	E 0000	This facility request paper compliance of all citations This Plan of Correction is center's credible allegation compliance. Preparation a execution of this plan of correction does not constitute admission or agreement by provider of the truth of the alleged or conclusions set in the statement of deficient The plan of correction is prepared and/or executed because it is required by the provisions of federal and staw.	the n of nd/or itute y the e facts t forth ncies. solely he
LABORATOI  Jennifer B		OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE AIT	TITLE	(X6) DATE 06/29/2023

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

Event ID: Facility ID:

continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155596		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/15/2023	
	PROVIDER OR SUPPLIEF	EALTHCARE CENTER		500 N V	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION RD Excilition at \$404.621		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
IAU	§491.12, and ESF  (2) Testing. The [fexercises to test to annually. The [factor following:  (i) Participate in a community-based (A) When a commont accessible, confunctional exercism (B) If the [factor functional exercism activation of the exempt from endommunity-based functional exercism actual event.  (ii) Conduct an additional exercism actual event.  (iii) Conduct an additional exercism actual event.  (ii) Conduct an additional exercism actual event.  (ii) Conduct an additional exercism actual event.  (ii) A second full-scommunity-based functional exercism actual e	RD Facilities at §494.62]: facility] must conduct the emergency plan ility] must do all of the  full-scale exercise that is every 2 years; or munity-based exercise is induct a facility-based e every 2 years; or fility] experiences an actual ade emergency that requires mergency plan, the [facility] igaging in its next required or individual, facility-based e following the onset of the  ditional exercise at least cosite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or		IAU			DATE
	discussion using a clinically-relevant set of problem sta messages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and em	a narrated, emergency scenario, and a tements, directed pared questions designed					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	CATION NUMBER A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/15/2023	
	PROVIDER OR SUPPLIEI	R EALTHCARE CENTER		500 N W	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` <i>'</i>	ospices that provide care in					
	1	e. The hospice must					
	conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is						
		l every 2 years; or					
	(A) When a comn	nunity based exercise is not					
		ıct an individual facility					
		exercise every 2 years; or					
	(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full						
		based exercise or individual					
	I -	ctional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	1 ' '	ne year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is o	conducted, that may					
		limited to the following:					
	1 ' '	-scale exercise that is					
	1	l or a facility based					
	functional exercis	·					
	(B) A mock disas						
		ercise or workshop that is and includes a group					
	discussion using	<del>-</del> -					
	_	emergency scenario, and a					
	I -	atements, directed					
		pared questions designed					
	to challenge an e						
	, · ,	spices that provide inpatient					
		hospice must conduct					
		the emergency plan twice					
		spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/15/2023	
	PROVIDER OR SUPPLIE	R EALTHCARE CENTER		500 N W	DDRESS, CITY, STATE, ZIP COD IILLIAMS ST A, IN 46703			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	that is community	R LSC IDENTIFYING INFORMATIONbased; or		TAG	DEFICIENCY)		DATE	
	(A) When a comn accessible, condu							
	facility-based fund							
	-	experiences a natural or						
	man-made emerg	gency that requires activation						
		plan, the hospice is						
	exempt from enga							
	full-scale community based or facility-based functional exercise following the onset of the emergency event.  (ii) Conduct an additional annual exercise that may include, but is not limited to the							
	following:							
		-scale exercise that is						
	-	l or a facility based						
	functional exercis (B) A mock disas							
	` '	ercise or workshop led by a						
	1 ' '	udes a group discussion						
		clinically-relevant						
	emergency scena	ario, and a set of problem						
		ted messages, or prepared						
		ed to challenge an						
	emergency plan.	nospice's response to and						
	1 ` '	ntation of all drills, tabletop						
		nergency events and revise						
		ergency plan, as needed.						
	*IFor PRFTs at &	441.184(d), Hospitals at						
	§482.15(d), CAH							
	- ' '	PRTF, Hospital, CAH] must						
		s to test the emergency						
	1	ar. The [PRTF, Hospital,						
	CAH] must do the	_						
		an annual full-scale exercise						
	that is community	/-based; or nunity-based exercise is not						
	I (A) WHEH a COMM	idiniy-based excidise is 110t	1					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY  COMPLETED  06/15/2023	
	PROVIDER OR SUPPLIEI	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP CO WILLIAMS ST LA, IN 46703	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEPARTMENT OF DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION
TAG	accessible, condu- facility-based fund (B) If the [PRTF, I- an actual natural that requires activ plan, the [facility] its next required f or individual, facil following the onse (ii) Conduct exercise or and th limited to the follo (A) A second full- community-based facility-based fund (B) A mo (C) A tableto is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or pre to challenge an er (iii) Analyze t and maintain door tabletop exercises and revise the [far needed.  *[For PACE at §4 (2) Testing. The F conduct exercises plan at least annu- organization must (i) Participate in a that is community (A) When a community (A) When a community	escale exercise that is or individual, a ctional exercise; or ock disaster drill; or or exercise or workshop that tor and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. The [facility's] response to the umentation of all drills, is, and emergency events cility's] emergency plan, as considered to the state of the emergency exercise to the test the emergency exally. The PACE of the following: an annual full-scale exercise	TAG			DATE

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facility-based functional exercise; or

(B) If the PACE experiences an actual natural

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	l	COMPLETED	
		155596	B. W	ING		06/15	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			VILLIAMS ST			
LAKELA	ND REHAB AND HI	EALTHCARE CENTER			A, IN 46703			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		ergency that requires						
		mergency plan, the PACE						
	is exempt from engaging in its next required							
		nity based or individual,						
		ctional exercise following the						
	onset of the emer							
	` '	in additional exercise every						
		the year the full-scale or						
		e under paragraph (d)(2)(i)						
		conducted that may include,						
	but is not limited to							
	(A) A second full-scale exercise that is							
	community-based or individual, a facility based functional exercise; or							
		•						
	(B) A mock disas	ercise or workshop that is						
		and includes a group						
	discussion, using							
	_	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er	·						
	_	PACE's response to and						
	. ,	ntation of all drills, tabletop						
		nergency events and revise						
		gency plan, as needed.						
		go, ao						
	*[For LTC Facilitie	es at §483.73(d):]						
	(2) The [LTC facili	ity] must conduct exercises						
	to test the emerge	ency plan at least twice per						
	year, including un	announced staff drills using						
	the emergency pr	ocedures. The [LTC facility,						
	ICF/IID] must do t	he following:						
	(i) Participate in a	an annual full-scale exercise						
	that is community	-based; or						
	(A) When a comm	nunity-based exercise is not						
	accessible, condu	ıct an annual individual,						
	facility-based fund	ctional exercise.						
	(B) If the [LTC fac	ility] facility experiences an						
	· · ·	nan-made emergency that						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		155596	B. W	ING		06/15/	/2023
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VILLIAMS ST		
LAKELAI	ND REHAB AND HI	EALTHCARE CENTER			A, IN 46703		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	-	n of the emergency plan, the					
	_	mpt from engaging its next					
	-	lle community-based or					
	_	based functional exercise					
	1	et of the emergency event.					
	1 ' '	dditional annual exercise					
		but is not limited to the					
	following:	scale exercise that is					
	. ,	or an individual, facility					
	based functional						
	(B) A mock disas	•					
	1 ' '	ercise or workshop that is					
	led by a facilitator						
	discussion, using	• .					
	_	emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the [l	LTC facility] facility's					
	response to and n	naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	· · · -					
	. ,	CF/IID must conduct					
		he emergency plan at least					
	1	e ICF/IID must do the					
	following:						
		n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	1	ıct an annual individual,					
	1	ctional exercise; or.					
		experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	iuii-scaie commur	nity-based or individual,					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155596		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/15/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD	_		
LAKELAI	ND REHAB AND H	EALTHCARE CENTER			/ILLIAMS ST A, IN 46703			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1	ctional exercise following the						
	onset of the emergency event.  (ii) Conduct an additional annual exercise that may include, but is not limited to the following:							
		scale exercise that is						
	community-based							
	1	ctional exercise; or						
	(B) A mock disast	ter drill; or						
		ercise or workshop that is						
		and includes a group						
	discussion, using							
	clinically-relevant emergency scenario, and a set of problem statements, directed							
		pared questions designed						
	to challenge an e							
	_	CF/IID's response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
		rgency plan, as needed.						
	*[For HHAs at §48	84.102]						
	(d)(2) Testing. Th	e HHA must conduct						
		he emergency plan at						
		e HHA must do the						
	following:							
		full-scale exercise that is						
	community-based							
	, ,	community-based exercise conduct an annual						
		based functional exercise						
	every 2 years; or.							
	1 .	A experiences an actual						
		ade emergency that requires						
		mergency plan, the HHA is						
	exempt from enga	aging in its next required						
		nity-based or individual,						
		ctional exercise following the						
	onset of the emer	<del>-</del>						
	(ii) Conduct an ad	lditional exercise every 2						

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PRINTED: 07/05/2023
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>		LETED	
		155596	B. W	ING		06/15	5/2023	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					VILLIAMS ST			
LAKELA	ND REHAB AND H	EALTHCARE CENTER		ANGOL	A, IN 46703			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		ne year the full-scale or						
		se under paragraph (d)(2)(i)						
	of this section is	•						
		t limited to the following:						
	, ,	I full-scale exercise that is						
	community-based							
	-	ctional exercise; or						
	1 ' '	lisaster drill; or						
	` '	p exercise or workshop that						
	,	tor and includes a group						
	discussion, using a narrated,							
	-	emergency scenario, and a						
	set of problem statements, directed							
		pared questions designed						
	to challenge an e							
	, ,	IHA's response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
	the HHA's emerg	ency plan, as needed.						
	*[For OPOs at §4	86.3601						
	-	e OPO must conduct						
	, , , ,	the emergency plan. The						
	OPO must do the	- · ·						
		er-based, tabletop exercise						
	,,,	ast annually. A tabletop						
	•	a facilitator and includes a						
	-	, using a narrated, clinically						
		ncy scenario, and a set of						
	_	nts, directed messages, or						
	°	ns designed to challenge an						
	1 ' '	If the OPO experiences an						
		man-made emergency that						
		n of the emergency plan, the						
		om engaging in its next						
		exercise following the onset						
	of the emergency	_						
		PO's response to and						
		ntation of all tabletop						

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exercises, and emergency events, and revise

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155596	B. W	NG		06/15/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			WILLIAMS ST		
LAKELA	ND REHAB AND HI	EALTHCARE CENTER		ANGOL	_A, IN 46703		
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	OPO's] emergency plan, as					
	needed.						
	*[ RNCHIs at §403.748]:						
		e RNHCI must conduct					
	exercises to test the emergency plan. The						
	RNHCI must do th	<u> </u>					
		er-based, tabletop exercise A tabletop exercise is a					
	1	led by a facilitator, using a					
		· · · · · · · · · · · · · · · · · · ·					
	narrated, clinically-relevant emergency scenario, and a set of problem statements,						
		es, or prepared questions					
	_	enge an emergency plan.					
	_	NHCI's response to and					
	. , , .	ntation of all tabletop					
	exercises, and en	nergency events, and revise					
	the RNHCI's eme	rgency plan, as needed.					
		view and interview, the facility	E 00	)39	E039 EP Testing Requiremen	ts	06/29/2023
		tercises to test the emergency			The facility requests paper		
	plan at least twice p				compliance for this citation.		
		drills using the emergency					
	_	C facility must do the			This plan of correction is the		
	following:	1011 1 1 1			facility's credible allegation of		
	is community-based	annual full-scale exercise that			compliance.		
		ity-based exercise is not					
		an annual individual,					
	facility-based funct				Preparation and/or execution	of	
	•	ty experiences an actual natural			this plan of correction does no		
		gency that requires activation			constitute admission or agree		
	of the emergency p	lan, the LTC facility is exempt			by the provider of the truth of t		
	from engaging its n	ext required full-scale in a			facts alleged or conclusions se	et	
	I -	or individual, facility-based			forth in the statement of		
		l exercise for 1 year following			deficiencies. The plan of		
	the onset of the actu				correction is prepared and/or		
		itional exercise that may			executed solely because it is		
		imited to the following:			required by the provisions of		
	a. A second full-sca				federal and state law.		
	community-based of	or an individual, facility-based					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB	NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		 UILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  06/15/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST		
LAKELA	ND REHAB AND H	IEALTHCARE CENTER	ANGO	LA, IN 46703		
	SUMMARY (EACH DEFICIE REGULATORY O functional exercise b. A mock disaster c. A tabletop exerc facilitator that incl a narrated, clinical and a set of proble messages, or prepa challenge an emery (iii) Analyze the L maintain documen exercises, and eme LTC facility's eme accordance with 42 deficient practice of Findings include:  Based on record re and the Maintenan a.m., no document annual exercise, ar emergency, or an a functional exercise available was avail	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION OR OR OTHER TOTAL STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION OR OTHER TOTAL STATEMENT OF DEFICIENCIE OTHER TOTAL STATEMENT OF D			er at ng nto	(X5) COMPLETION DATE
	review. Based on i review, the Mainte required exercises within the last 12 r	ast year was not available for interview at the time of records chance Director stated both have not been conducted months.  eviewed with the Administrator Director during the exit		to ensure compliance.  4)How the corrective action will monitored:  The Maintenance Director/designee will present t EP Testing, as well as weekly audits, monthly to the QAPI Committee during QAPI Meetin to ensure completion of any ne necessary updates and compliance. The report will be reviewed in Quality Assurance	he	

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Meeting monthly for 6 months or

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

PRINTED: 07/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155596		 JILDING	NSTRUCTION	COMPL 06/15/	ETED	
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N V	ADDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
				until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rev the plan of correction as indicated.	and	
				5_Date of Compliance: 29 Jun 2023	e	
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.6 (e) Emergency and The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator generator must be the location require Care Facilities Cool Interim Amendment 12-4, TIA 12-5, and	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	_	COMPI	ETED
		155596	B. WING		·	06/15	/2023
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
1 A1751 A	ND DELLAD AND LU				VILLIAMS ST		
LAKELAND REHAB AND HEALTHCARE CENTER		Ar	NGOL	A, IN 46703			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREI	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)	\\L	DATE
	Amendments TIA	12-1, TIA 12-2, TIA 12-3,					
	and TIA 12-4), and	d NFPA 110, when a new					
		r when an existing					
	structure or building	•					
	482.15(e)(2), §483	3.73(e)(2), §485.625(e)(2)					
		rator inspection and testing.					
		H and LTC facility] must					
		ergency power system					
		յ, and [maintenance]					
		nd in the Health Care					
	Facilities Code, NFPA 110, and Life Safety						
	Code.	,					
	482.15(e)(3), §483	3.73(e)(3), §485.625(e)(3)					
		rator fuel. [Hospitals, CAHs					
		that maintain an onsite fuel					
		emergency generators must					
	· ·	ow it will keep emergency					
		perational during the					
	emergency, unles	_					
	*[For hospitals at	§482.15(h), LTC at					
		CAHs §485.625(g):]					
		corporated by reference in					
		oproved for incorporation by					
		Director of the Office of the					
	1	in accordance with 5 U.S.C.					
		R part 51. You may obtain					
	, ,	the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
		ARA, call 202-741-6030, or					
		ANA, Gali 202-74 1-0030, Ol					
	go to:						
	nttp://www.archive	es.gov/federal_register/code					İ

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\_of\_federal\_regulations/ibr\_locations.html. If any changes in this edition of the Code are

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 06/15/2023			ETED		
	PROVIDER OR SUPPLIEI	EALTHCARE CENTER		500 N V	ADDRESS, CITY, STATE, ZIP COD VILLIAMS ST .A, IN 46703		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO		TE .	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	incorporated by redocument in the Fannounce the char (1) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Liedition, issued Au (viii) TIA 12-1 to NI 1, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013.	eference, CMS will publish a Federal Register to inges. Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					
	Standby Power S	standard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,					
	failed to implement requirements found Code, NFPA 110, a accordance with 42	eview and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This could affect all occupants.	E 00	041	E041 Hospital CAH and LTC Emergency Power The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of		06/29/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2023		
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST DLA, IN 46703	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and Maintenance D a.m., the generator required by LSC an interview at the tim Maintenance Direct missing some of the			Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for those residents identified:  No resident was found to be affected by the finding.  2)How the facility identified or residents:  Visitors, staff, and residents to reside at the community have potential to be affected by the alleged deficient practice.  3)Measures put into place/Sychanges  Generator testing has been keen current and proper oversight been put into place to ensure compliance is in place for more load testing.	ot ement it the set it

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

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	OF CORRECTION	IDENTIFICATION NUMBER  155596	A. BUILDING B. WING	INSTRUCTION	COMPLETED 06/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703		
(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
				monitored:  The Maintenance Director/designee will present Generator testing logs monthly the QAPI Committee during Q Meetings to ensure completion any new necessary updates a compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rev the plan of correction as indicated.  5_Date of Compliance: 29 Jur 2023	y to API n of nd e or will and
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/15 Facility Number: 06 Provider Number: AIM Number: 1000	00474 155596	K 0000	This facility request paper compliance of all citations This Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constituadmission or agreement by a provider of the truth of the falleged or conclusions set for in the statement of deficience.	of Nor te the acts orth

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155596	B. W	ING		06/15/	2023
NAME OF P	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD		
					VILLIAMS ST		
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER		ANGOL	.A, IN 46703		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ter was found not in equirements for Participation in			prepared and/or executed so	-	
	•	, 42 CFR Subpart 483.90(a),			because it is required by the provisions of federal and sta		
	Life Safety from Fire and the 2012 edition of the				law.	ite	
		etion Association (NFPA) 101,			NAW.		
		SC) Chapter 19, Existing Health					
	Care Occupancies a	and 410 IAC 16.2.					
	This one story facility was determined to be of						
		ruction and was fully					
		cility has a fire alarm system					
	with smoke detection	on in the corridors and areas					
	-	s. The resident rooms on the					
		all had hard wired smoke					
		ent rooms on the 200-hall had					
		oke detectors. The facility and had a census of 63 at the					
	time of this survey.	and had a census of 03 at the					
	unite of this survey.						
	All areas where the	residents have customary					
	-	ered. The facility had a					
	_	iding facility services					
	-	nce supplies that was not					
	sprinklered.						
	Quality Review con	npleted on 06/19/23					
K 0222	NFPA 101						
SS=B	Egress Doors						
Bldg. 01	Egress Doors						
		d means of egress shall not					
		a latch or a lock that					
	•	f a tool or key from the susing one of the following					
	special locking arr	9					
		OR SECURITY THREAT					
	LOCKING	· · · · · · · · · · · · · ·					
		king arrangements for the					
	·	eds of the patient are					
	used, only one loc	king device shall be					

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i ´		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155596	B. WING		06/15/2023
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		WILLIAMS ST	
LAKELA	ND REHAB AND HI	EALTHCARE CENTER	ANGO	LA, IN 46703	
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	I .	n door and provisions shall			
		apid removal of occupants			
	1 -	l of locks; keying of all			
	-	ied by staff at all times; or			
		e means available to the			
	staff at all times.	226 4022254			
		.2.2.6, 19.2.2.2.5.1,			
	19.2.2.2.6 SPECIAL NEEDS	ST OCKING			
	ARRANGEMENT				
		king arrangements for the			
	· ·	e patient are used, all of			
	-	curity Locking requirements			
		addition, the locks must be			
		at fail safely so as to			
		of power to the device; the			
	-	ed by a supervised			
		er system and the locked			
	space is protected	d by a complete smoke			
	detection system	(or is constantly monitored			
	at an attended loc	cation within the locked			
		the sprinkler and detection			
	1 -	nged to unlock the doors			
	upon activation.				
	18.2.2.2.5.2, 19.2				
	DELAYED-EGRE				
	ARRANGEMENT				
		delayed-egress locking			
	1 -	in accordance with			
		permitted on door			
		ng low and ordinary hazard			
		ngs protected throughout by ervised automatic fire			
		or an approved, supervised			
	automatic sprinkle				
	18.2.2.2.4, 19.2.2	_			
		ROLLED EGRESS			
	LOCKING ARRAI				
		d Egress Door assemblies			
		dance with 7.2.1.6.2 shall			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/15/2023 155596 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 500 N WILLIAMS ST LAKELAND REHAB AND HEALTHCARE CENTER ANGOLA. IN 46703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE be permitted. 18.2.2.2.4, 19.2.2.2.4 **ELEVATOR LOBBY EXIT ACCESS** LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility K 0222 **K222 Egress Doors** 06/29/2023 failed to ensure the means of egress through 1 of The facility requests paper 2 exits with special locking arrangements for the compliance for this citation. clinical security needs of the residents were This plan of correction is the readily accessible by remote control of locks; keys facility's credible allegation of carried by staff at all times; or other such reliable compliance. means available to the staff at all times. This deficient practice could affect 25 residents in the Preparation and/or execution of 200-hall. this plan of correction does not constitute admission or Findings include: agreement by the provider of the truth of the facts alleged or Based on observation with the Maintenance conclusions set forth in the Director on 06/15/23 at 11:50 a.m., the 200-hall exit statement of deficiencies. The plan of correction is prepared door was locked, could be opened by entering a four-digit code, and the hall had special locking and/or executed solely because arrangements for residents with clinical security it is required by the provisions needs; but when the code was entered the door of federal and state law. did not release. Based on interview at the time of 1)Immediate actions taken for observation, the Maintenance Director stated the those residents identified: keypad was not functioning properly and within No resident was found to be 10 minutes the keypad was repaired and opened affected by the finding. the door with the code. 2)How the facility identified other residents: This finding was reviewed with the Administrator Visitors, staff, and residents and Maintenance Director during the exit that reside at the community conference. have the potential to be affected by the alleged

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	OF CORRECTION	IDENTIFICATION NUMBER  155596	A. BUILDING B. WING	01	COMPLETED 06/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N \	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST _A, IN 46703	
(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
	3.1-19(b)			deficient practice.  3)Measures put into place/System changes The door code has been changed and will be checked weekly to ensure proper functioning of the egress do Staff have been educated on the egress door and the code 4)How the corrective action to be monitored: The Maintenance Director/designee will present the Egress door testing mon to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurant Meeting monthly for 6 month or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated.  5_Date of Compliance: 29 Jul 2023	or. e. will  nt thly og  pe ce as
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour d automatically in	K 0291	K291 Emergency Lighting	06/29/2023

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155596	B. WING		06/15/2023	
		10000			36/16/2020	
NAME OF E	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
TOTAL OF I	NO VIDER OR SOLVER	•	500 N	WILLIAMS ST		
LAKELAI	ND REHAB AND HE	EALTHCARE CENTER	ANGC	DLA, IN 46703		
(V4) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE		1	(V5)	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
		ty failed to ensure 10 of 10		The facility requests paper		
		ts were tested monthly and		compliance for this citation.		
	-	7.9.3.1.1 (1) requires functional				
	_	ducted monthly, with a		This plan of correction is the		
		ks and a maximum of 5 weeks		facility's credible allegation of		
		ot less than 30 seconds, (3)		compliance.		
	Functional testing s	hall be conducted annually for				
	a minimum of 1 1/2	2 hours if the emergency lighting				
	system is battery powered and (5) Written records of visual inspections and tests shall be kept by					
				Preparation and/or execution	of	
	the owner for inspection by the authority having			this plan of correction does no	ot	
	jurisdiction. This deficient practice could affect all			constitute admission or agree	ment	
	residents in the faci	lity.		by the provider of the truth of	the	
				facts alleged or conclusions s		
	Findings include:			forth in the statement of		
				deficiencies. The plan of		
	Based on an observ	ation during a tour of the		correction is prepared and/or		
		intenance Director on 06/15/23		executed solely because it is		
	_	and 1:00 p.m., there were 10		required by the provisions of		
		nergency light throughout the		federal and state law.		
		ecords review at 10:10 a.m., the		1.555.01.01.12.51.01.01.01		
	-	test for the battery powered		1)Immediate actions taken for		
	-	as missing for the months of		those residents identified:		
		of 2022, and February of 2023.		those residents identified.		
		-minute test was not		No resident was found to be		
		st 12 months. Based on an		affected by the finding.		
	-	e of record review and		anected by the infully.		
		aintenance Director agreed the		2) Llow the facility identified at	hor	
		th testing was not complete,		2)How the facility identified of	riei	
				residents:		
	_	the monthly test were missed		Visitana atati analonasidanta ti	4	
	and the annual test	was not conducted.		Visitors, staff, and residents the		
	TE1 ' C' 1'	1 14 4 4 1 1 1 1		reside at the community have		
		viewed with the Administrator		potential to be affected by the		
		irector during the exit		alleged deficient practice.		
	conference.					
				3)Measures put into place/Sys	stem	
	3.1-19(b)			changes		
				Battery testing & Powered Lig	hts	

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testing has been kept current and

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155596	B. W	ING		06/15/	/2023
NAMEOFI			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		500 N V	WILLIAMS ST		
LAKELAI	ND REHAB AND HI	EALTHCARE CENTER		ANGOL	_A, IN 46703		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG			DATE
					proper oversight has been put	into	
					place to ensure compliance		
					monthly load testing.		
					4)How the corrective action wi	ll he	
					monitored:	ii bC	
					, menikeredi.		
					The Maintenance		
					Director/designee will present	the	
					Emergency Lighting logs mon	thly	
					to the QAPI Committee during		
					QAPI Meetings to ensure		
					completion of any new necess	ary	
					updates and compliance. The		
					report will be reviewed in Qual	ity	
					Assurance Meeting monthly fo	r 6	
					months or until 100% compliar	nce	
					is achieved. The QA Committe	ee	
					will identify any trends or patte	rns	
					and make recommendations to	)	
					revise the plan of correction as	3	
					indicated.		
					5_Date of Compliance: 29 Jur	ie	
					2023		
K 0300	NFPA 101						
SS=E	Protection - Other						
Bldg. 01	Protection - Other						
ag. 0 i		RKS section any LSC					
	Section 18.3 and						

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requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			ETED		
		155596	B. WING			06/15/	06/15/2023	
				CTREET	ADDRESS SITY STATE ZIR COD			
NAME OF P	ROVIDER OR SUPPLIER	8		l	ADDRESS, CITY, STATE, ZIP COD			
	ID DELLAD AND LIE			l	VILLIAMS ST			
LAKELAI	ND KEHAB AND HE	EALTHCARE CENTER		ANGOL	_A, IN 46703			
(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	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
	Safety Code or NF	FPA standard citation,						
	should be included	d on Form CMS-2567.						
	Based on record rev	view, interview, and	K 0	300	K300 Protection- Other		06/29/2023	
	observation, the fac	ility failed to ensure			The facility requests paper			
		the preventative maintenance			compliance for this citation.			
	of 15 of 15 battery	operated smoke alarms in			·			
	resident rooms was complete. NFPA 101 in				This plan of correction is the			
	4.6.12.3 states existing life safety features obvious				facility's credible allegation of			
	to the public, if not required by the Code, shall be				compliance.			
	maintained. NFPA 72, 29.10 Maintenance and				_			
	Tests. Fire-warning	equipment shall be maintained						
	and tested in accordance with the manufacturer's							
	published instructions and per the requirements				Preparation and/or execution of	of		
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,				this plan of correction does no	t		
	testing, and maintenance programs shall satisfy				constitute admission or agreer	ment		
	the requirements of	this Code and conform to the			by the provider of the truth of t	he		
	equipment manufac	turer's published instructions.		facts alleged or conclusions set		et		
	This deficient pract	ice could affect residents, on			forth in the statement of			
	the 200-hall				deficiencies. The plan of			
					correction is prepared and/or			
	Findings include:				executed solely because it is			
					required by the provisions of			
	Based on records re	eview with the Maintenance			federal and state law.			
	Director and Admir	nistrator on 06/15/23 at 10:31						
	a.m., no completed	itemized list for preventative			1)Immediate actions taken for			
	maintenance for the				those residents identified:			
		noke alarms on the 200-hall was						
	available for review	7. Furthermore, the			No resident was found to be			
	manufacture's docu	mentation requires weekly			affected by the finding.			
	testing. Based on in	nterview at the time of review,						
	the Maintenance Di	rector stated the			2)How the facility identified oth	ner		
	battery-operated sm	noke alarms were not tested			residents:			
	within the last 12 m	nonths.						
					Visitors, staff, and residents th	at		
		viewed with the Administrator			reside the community have the	9		
		irector during the exit			potential to be affected by the			
	conference.				alleged deficient practice.			
	3.1-19(b)				3)Measures put into place/Sys	tem		
					changes			

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155596	B. W	ING		06/15/	/2023
				_			
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
	ID DELLAD AND LIE	TALTILOADE OFNITED			VILLIAMS ST		
LAKELAI	ND REHAB AND HE	EALTHCARE CENTER		ANGOL	A, IN 46703		
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Battery operated smoke detect tracking log has been generated and will be completed weekly Maintenance Director/designed.  4)How the corrective action with monitored:  The Maintenance Director/designee will present Battery Operated Smoke Detectors monthly to the QAPI Committee during QAPI Meeting to ensure completion of any necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to reviewed in Correction as indicated.  5_Date of Compliance: 29 Jur 2023	ed by ee. fill be the ector engs ew or will and vise	
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01	Cooking Facilities Cooking Facilities						
Diag. 01	Cooking Facilities Cooking equipmen						
		NFPA 96, Standard for					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155596	B. WING	B. WING 06/15/2023			/2023
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	50	0 N W	DDRESS, CITY, STATE, ZIP COD /ILLIAMS ST A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
	Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordance accooking in accordance are cooking facilities are comparted patients comply with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities are a Cooking facilities with 19.3.2.5.4 statures and 19.3.2.5.4 statures are a Cooking facility complies with 19.1 and 19.3.2.5.4 statures are a sleeping room (2). The space contains a sleeping room (2). The space contains a sleeping room (2). The space contains a sleeping room (3). The requirement and (13) are met.  19.3.2.5.3(9) states following is provided (a). A locked switch a cooking in accordance are under a cooking in accordance and a cooking in accordance are under a cooking in accordance and a cooking in accordance are under a cooking in accordance and a cooking in accordance are under a cooking in accordance and a co	atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility of had access to the shutoff ok tops in the therapy gym. es within a smoke compartment, arecial cooking equipment that heals for 30 or fewer persons provided that the cooking the all of the following the cooking equipment to m. ining the cooking equipment to m. in the corridor by partitions 3.6.2 through 19.3.6.5. Its of 19.3.2.5.3(1) through (10)	K 0324		K324 Cooking Facilities The facility requests paper compliance for this citation. The plan of correction is the facility credible allegation of compliance. Preparation and/ execution of this plan of correct does not constitute admission agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because is required by the provisions of federal and state law. 1)Immer actions taken for those resident identified: No resident was fout to be affected by the finding 2)How the facility iden	or ction or the se it f diate nts and	06/29/2023

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01 COMPLETED			
		155596	B. W	ING		06/15/	/2023
NAME OF D	DOWNER OF CHIRD IED		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER	C.		500 N V	WILLIAMS ST		
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER		ANGOL	_A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ates the cooktop or range.			other residents: Visitors, staff,	and	
	* *	ed to deactivate the cooktop			residents that reside at the		
	-	the kitchen is not under staff			community have the potential		
	supervision.				be affected by the alleged def	icient	
	-	ice could affect five residents			practice. 3)Measures put into		
	in the therapy gym.				place/System changes Contro		
					measures include staff educat		
	Findings include:				therapy staff access to breake		
					box for cooking facilities powe	r	
		on with the Maintenance			shut-off, and detailed instruction	on	
		3 at 12:44 p.m., there was a			regarding this process. 4)How	the	
	-	py gym that was separated			corrective action will be		
		ut staff were unable to			monitored: The Maintenance		
	deactivate the cook	top from power. Based on			Director/designee will present		
		e of observation, the			records of compliance monthly	y to	
	Maintenance Direct	or was asked if staff were able			the QAPI Committee during Q	API	
	to deactivate the co	oktop and lock the switch.			Meetings to ensure completion	n of	
	The Maintenance di	irector stated the shut off			any new necessary updates a	nd	
	switch is in the elec	trical room in a breaker box,			compliance. The report will be		
	but staff did not hav	ve access to the braker box.			reviewed in Quality Assurance	)	
					Meeting monthly for 6 months	or	
	This finding was re	viewed with the Administrator			until 100% compliance is		
	and Maintenance D	irector during the exit			achieved. The QA Committee	will	
	conference.				identify any trends or patterns	and	
					make recommendations to rev	/ise	
	3.1-19(b)				the plan of correction as		
					indicated. 5_Date of Complia	nce:	
					29 June 2023		
K 0345	NEDA 404						
K 0345 SS=F	NFPA 101	. Tastina and					
	Fire Alarm System	1 - Testing and					
Bldg. 01	Maintenance	<b>-</b>					
	Fire Alarm System	n - Testing and					
	Maintenance						
		m is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
	Records of systen	n acceptance, maintenance					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE         A. BUILDING       01       COMPI         B. WING       06/15			ETED	
	OF PROVIDER OR SUPPLIE	R EALTHCARE CENTER		500 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST _A, IN 46703		
(X4) II PREFI	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY 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)	ATE	(X5) COMPLETION DATE
TAC	and testing are regions. 1.3, 9.6.1.5, No. 1.3, 9.6.1.5, No. 1.5,	view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section hless otherwise permitted by ections shall be performed in e schedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals ators s (e.g. duct detectors, manual eat detectors, smoke detectors, liances pen devices tice affects all occupants in the siew with the Maintenance 23 at 10:26 a.m. no s provided regarding a visual re alarm system six months fire alarm inspection conducted I on interview at the time of Maintenance Director stated a f the fire alarm system six annual fire alarm inspection	K 0	345	K345 Fire Alarm System The facility requests paper compliance for this citation.; plan of correction is the facility credible allegation of compliance.; Preparation a execution of this plan of corredoes not constitute admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies.; The plan of correction is prepared and/or executed solely because is required by the provisions of federal and state law.; 1)Immediate actions ta for those residents identified; resident was found to be affect by the finding.; 2)How the fact identified other residents:; Visitors, staff, and residents that reside at the community have the potential be affected by the alleged def practice.; 3)Measures put implace/System changes; Visual fire alarm inspection shall be performed in accordance with testing requirements and met the time frame provided by law; 4)How the corrective action be monitored:; The Maintena Director/designee will present Visual Fire Alarm Inspection to QAPI Committee during QAPI Meetings to ensure completio any new necessary updates as	nd/or ction or the se it of ken cility to ficient to all the in w.¿ in will cance the other.	06/29/2023

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Facility ID: 000474

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 07/05/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596		JILDING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  06/15/2023	
	PROVIDER OR SUPPLIEF	EALTHCARE CENTER		500 N \	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST _A, IN 46703		
(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
					compliance. The report will be reviewed in Quality Assurance. Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indicated. ¿ ¿ 5) Date of Compliance: 29 June 2023	e s or e will s and	
K 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of syster inspection and tes secure location ar a) Date sprinkler b) Who provided						
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record rev failed to maintain 1	RKS information on non-required or partial er system.	K 0	353	K353 Sprinkler System		06/29/2023
	automatic sprinkler and maintained in a Standard for the Ins	systems shall be inspected accordance with NFPA 25, spection, Testing, and atter-Based Fire Protection			The facility requests paper compliance for this citation.¿		

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Systems. NFPA 25, 2011 edition, Table 5.1.1.2

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IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/15/2023
ROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST LA, IN 46703	•
SUMMARY:  (EACH DEFICIEN  REGULATORY OR  indicates the require testing. NFPA 25, 5 pipe sprinkler syste and gauges on dry s inspected weekly to pressure is being ma states valves should valves secured lock shall be permitted to deficient practice co.  Findings include:  Based on records re Director on 06/15/2 monthly wet pipe or system's gauges and months of January a interview at the tim Maintenance Direct gauges and valves f were completed by Director and but was  This finding was re-	EALTHCARE CENTER  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION  End frequency of inspection and 3.2.4.1 states gauges on wet ms shall be inspected monthly systems (5.2.4.2) shall be ensure normal water or air aintained. NFPA 25 13.3.2.1  The be inspected weekly or s or supervised (13.3.2.1.1) To be inspected monthly. This build affect all occupants.  Eview with the Maintenance 3 at 10:42 a.m. there was no r weekly dry pipe sprinkler I valves inspection for the and February 2023. During an the of record review, the for stated the inspection of for January and February 2023  The previous Maintenance			of ement the set  ther that ne
			alleged deficient practice.¿	

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

PRINTED: 07/05/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155596	A. BUILDING  B. WING	01	COMPLETED 06/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST .A, IN 46703	
(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
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  3) Measures put into place/Syschanges;  The monthly inspection on the pipe sprinkler system and gau on the dry system shall be inspected weekly. These will be performed in accordance with testing requirements and met the time frame provided by law 4) How the corrective action with monitored:;  The Maintenance Director/designee will present Sprinkler Gauge Inspections to QAPI Committee during QAPI Meetings to ensure completion any new necessary updates a compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee	completion DATE  stem  wet ges  be the in V.¿  ill be  the o the or of or will
				identify any trends or patterns make recommendations to revente plan of correction as indicated.;  ¿ 5) Date of Compliance: 29 Jun 2023; ¿	rise

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155596		 UILDING	01	COMPL 06/15/	ETED	
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N V	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(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)	TE	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required encl exits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. T apply to auxiliary s flammable or com Clearance betwee covering is not exc doors complying w if provided with a c the door closed wh applied. There is closing of the door release when the opermitted. Nonrate unlimited height ar	orridor openings in other osures of vertical openings, areas resist the passage made of 1 3/4 inch wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or ials have positive latching atches are prohibited by hese requirements do not spaces that do not contain oustible material. In bottom of door and floor seeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the seed protective plates of the permitted. Dutch doors	TAG	DEFICIENCY)		DATE
	frames shall be lat other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In	are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are sprinklered compartments ctions in area or fire				

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587C21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/15/2023 155596 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 500 N WILLIAMS ST LAKELAND REHAB AND HEALTHCARE CENTER ANGOLA. IN 46703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 K 0363 K363 Corridor Doors 06/29/2023 failed to ensure 1 of 1 Nursing Coordinator office corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. The facility requests paper This deficient practice could affect 20 residents in compliance for this citation.¿ one smoke compartments. Findings include: This plan of correction is the Based on an observation with the Maintenance facility's credible allegation of Director on 06/15/23 at 12:14 p.m., the Nursing compliance.¿ Coordinator office corridor door had two half inch holes that went through the door. Based on interview at the time of observation, the Maintenance Director stated the holes were due Preparation and/or execution of the switching of the door handles. this plan of correction does not constitute admission or agreement This finding was reviewed with the Administrator by the provider of the truth of the and Maintenance Director during the exit facts alleged or conclusions set conference. forth in the statement of deficiencies.¿ The plan of 3.1-19(b) correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿ 1)Immediate actions taken for those residents identified:¿

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Facility ID: 000474

No resident was found to be

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE ( A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	r address, city, state, zip cod WILLIAMS ST DLA, IN 46703	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				affected by the finding.¿  2)How the facility identified o	ther
				residents:¿  Visitors, staff, and residents treside the community have the potential to be affected by the alleged deficient practice.¿	rhat ne
				3)Measures put into place/Sy changes;  A new door handle has beer installed the Nursing Coordin office corridor.	1
				4) How the corrective action monitored:¿	will be
				The Maintenance Director/designee will presen audit of the inspection of 10 of weekly to the QAPI Committe during QAPI Meetings to ens completion of any new neces updates and compliance. The report will be reviewed in Qua Assurance Meeting monthly f months or until 100% complia is achieved. The QA Commit will identify any trends or patt	doors ee ure ssary e ality for 6 ance tee

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

PRINTED: 07/05/2023 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION				
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST DLA, IN 46703	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life.	K 0511	and make recommendations to revise the plan of correction as indicated.;  ¿ 5) Date of Compliance: 29 June 2023;  K511 Utilities-Gas and Electric	
	box. LSC 9.1.2 req equipment to compl Electrical Code. Art shall be made in list	dees were made in a junction uires electrical wiring and by with NFPA 70, National ticle 322.56 (A) states splices ted junction boxes. This buld affect 20 residents in one t.		The facility requests paper compliance for this citation.  This plan of correction is the facility's credible allegation of compliance.	
	Director on 06/15/2 switch room there v	on with the Maintenance 3 at 11:10 a.m., in the transfer were wires spliced together light that was not contained		Preparation and/or execution of this plan of correction does not constitute admission or agreem by the provider of the truth of the facts alleged or conclusions se	nent ne

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

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	OF CORRECTION	IDENTIFICATION NUMBER  155596	A. BUILDING B. WING	01	COMPLETED 06/15/2023
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST LA, IN 46703	
(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
	time of the observat Director acknowled splices that were no box. This finding was rev	x. Based on interview at the ions, the Maintenance ged there were electrical t protected with a junction viewed with the Administrator frector during the exit		forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for those residents identified:  No resident was found to be affected by the finding.  2)How the facility identified of residents:  Visitors, staff, and residents the residents at the community have potential to be affected by the alleged deficient practice.  3)Measures put into place/Syschanges  A new Emergency light has be installed and all electrical issue have been resolved in-house the Maintenance Director/designee.  4)How the corrective action we monitored:  The Maintenance Director/designee will present weekly testing logs for Emerg Lighting monthly to the QAPI Committee during QAPI Meet to ensure completion of any in necessary updates and	her  nat the  stem  een es by  ill be

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/05/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/15/2023	
	PROVIDER OR SUPPLIEI	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 500 N WILLIAMS ST ANGOLA, IN 46703		COD	
(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)	ιΤΕ	(X5) COMPLETION DATE
					compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to revithe plan of correction as indicated.  5_Date of Compliance: 29 Jur 2023	e or will and vise	
K 0712 SS=F Bldg. 01	alarm signal and a conditions. Fire di and unexpected t conditions, at leas The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through	ay be used instead of	K 0'	712	K 712 Fire Drills		06/29/2023

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Event ID:

failed to conduct fire drills on each shift for 2 of 4

conducted quarterly on each shift to familiarize

quarters. LSC 19.7.1.6 states drills shall be

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The facility requests paper

compliance for this citation. This

plan of correction is the facility's

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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	JILDING	onstruction 01	(X3) DATE S COMPLI 06/15/2	ETED
	PROVIDER OR SUPPLIEF	EALTHCARE CENTER	500 N V	ADDRESS, CITY, STATE, ZIP COD VILLIAMS ST .A, IN 46703		
(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)	ATE	(X5) COMPLETION DATE
	facility personnel (rengineers, and adm signals and emerger varied conditions. Tall staff and residen Findings include:  Based on records re Director on 06/15/2 shifts were missing fire drill: a) A second shift fire 2022. b) A third shift fire 2022. c) A second shift fire 2023. Based on interview the Maintenance Diaforementioned fire	view with the Maintenance 3 at 10:02 a.m., the following documentation of a completed re drill in the fourth quarter of drill in the first quarter of at the time of record review,		credible allegation of compliance. Preparation and execution of this plan of corre does not constitute admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. Th plan of correction is prepared and/or executed solely becau is required by the provisions of federal and state law. 1)Imme actions taken for those reside identified: No resident was for to be affected by the finding. 2)How the facility ider other residents: Visitors, staff, residents that reside at the community have the potential be affected by the alleged definance. 3)Measures put into place/System changes Fire ditesting has been kept current proper oversight has been purplace to ensure compliance. drills will be done on a quarter each shift as per the testing requirement. 4)How the correction will be monitored: The Maintenance Director/designed will present the Fire Drill Logs the QAPI Committee during Compliance. The report will be reviewed in Quality Assurance Meetings to ensure completion any new necessary updates a compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns	ction or the ese it of diate nts und to ficient rill and t into Fire rly on ective ese to DAPI n of and ese or ewill	

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

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AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLL IDENTIFICATION NUMBER  155596				UILDING	nstruction 01	СОМ	e survey pleted 5/2023	
	PROVIDER OR SUPPLIEI	EALTHCARE CENTER	-	500 N V	ADDRESS, CITY, STATE, ZIP VILLIAMS ST A, IN 46703	COD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
					make recommendation the plan of correction indicated. 5_Date of 29 June 2023	as		
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 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							

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  Description:  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  155596		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/15/2023			
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHAB AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRE IX (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE COMPLETION PROPRIATE DATE			
TAG	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 and interview, the facility failed to maintain a complete written record of monthly generator load testing for 8 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.		K 0918	K918 Electrical Systems-Essential Elect Systems The facility requests pap compliance for this citati  This plan of correction is facility's credible allegati compliance.  Preparation and/or exec this plan of correction do constitute admission or a by the provider of the tru facts alleged or conclusi forth in the statement of deficiencies. The plan o	rical  oer on.  the on of  ution of ees not agreement th of the ons set			
	Director and the Ad 10:00 a.m., for the February 2023 the indicate if the 30-m Based on an intervireview, the Mainter Administrator state the months of June were not conducted. The finding was rev	deview with the Maintenance deministrator on 06/15/23 at months of June 2022 through generator load test log did not ainute load test was conducted. The was even at the time of records nance Director and did the monthly load tests for 2022 through February 2023 but are conducted now.		correction is prepared ar executed solely because required by the provision federal and state law.  1)Immediate actions take those residents identified.  No resident was found to affected by the finding.  2)How the facility identified residents:  Visitors, staff, and residents reside the community has potential to be affected by alleged deficient practices.	end/or e it is ens of  en for d: o be  ed other  ents that eve the by the			

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	COMPLETED	
		155596	B. WING 06		06/15/	06/15/2023	
			ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIER	8			VILLIAMS ST		
I DKELVI	ND BEHAB VND HI	EALTHCARE CENTER			A, IN 46703		
LANELAI	AD LIELIND HIND U	LALTHOANE CENTER		ANGUL			
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
IAU	REGULATORY OR	A LSC IDEN HEY ING INFORMATION		IAU	3)Measures put into place/Syschanges  Generator testing has been ke current and proper oversight heen put into place to ensure compliance with the 30-minute load test.  4)How the corrective action with monitored:  The Maintenance Director/designee will present weekly and monthly Emergency Power Generator Logs, as we weekly audits, monthly to the QAPI Committee during QAPI Meetings to ensure completion any new necessary updates a compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rev	ept as  Il be the cy Il as n of nd e or will and	DATE
					the plan of correction as indicated.		
					5_Date of Compliance: 29 Jun 2023	ie	

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