		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY  COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUM.  155449			B. WING			01/09/2025	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CEN	ITER		LA, IN 46703		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
E 0000							
Bldg	Δn Emergency Pres	paredness Survey was	E 00	000	This Plan of Correction is		
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in			J00	submitted under Federal and	State	
	accordance with 42	-			regulations and status applica		
	G D 01/00	0/25			to long term care providers. This		
	Survey Date: 01/09	9/23			Plan of Correction does not constitute an admission of liability		
	Facility Number: 00	00426			on the part of the facility and such		
	Provider Number: 155449				liability is hereby denied.		
	AIM Number: 1002	275480			The submission of this plan do	200	
	At this Emergency	Preparedness Survey,			not constitute agreement by the		
	Northern Lakes Nursing and Rehabilitation Center				facility that the surveyor's find		
	was found in compliance with Emergency Preparedness Requirements for Medicare and				or conclusions are accurate, the	hat	
					the findings constitute a		
	Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 99 and				deficiency, or that the scope a severity regarding any of the	ina	
	had a census of 85 at the time of this survey.				deficiencies are cited correctly	/.	
		1 . 1 . 01/10/05					
	Quality Review con	mpleted on 01/10/25			We respectfully request a des review and paper compliance	K	
				determination on all citation			
K 0000							
Bldg. 01							
	-	(LSC) Recertification and State	K 0	000	This Plan of Correction is	_	
		vas conducted by the Indiana Ith in accordance with 42 CFR			submitted under Federal and		
	483.90(a).	un in accordance with 42 CFR			regulations and status applica to long term care providers. The		
	.00.50(a).				Plan of Correction does not	1110	
	Survey Date: 01/09	9/25			constitute an admission of liab	-	
	Facility Number: 00	00426			on the part of the facility and s	such	
	Provider Number: 10				liability is hereby denied.		
	AIM Number: 1002				The submission of this plan do	pes	
					not constitute agreement by the	ne	
	At this LSC survey,	, Northern Lakes Nursing and			facility that the surveyor's find	ings	
					-		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Dee Anna Smallman Administrator 01/23/2025

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155449		B. WING 01/09/2029				2025	
NAME OF P	ROVIDER OR SUPPLIER	<del></del>			ADDRESS, CITY, STATE, ZIP COD		
NODTUE	DNI AKES MUDOU	NO AND DEHABILITATION OF IT	ED	1	VILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENT	EK .	ANGOL	.A, IN 46703		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,				or conclusions are accurate, the	nat	
					the findings constitute a		
					deficiency, or that the scope a severity regarding any of the	iiu	
					deficiencies are cited correctly.		
	LSC, Chapter 19, E				denoichoids are older contectly		
	Occupancies and 41	_			We respectfully request a desi	<	
	1				review and paper compliance		
	This one story facili	ity was determined to be of			determination on all citations.		
	Type V (000) const	ruction and was fully					
	_	cility has a fire alarm system					
		on in corridors, areas open to					
	the corridors and battery operated smoke detectors in the resident rooms. The facility has a						
		nad a census of 85 at the time					
	of this survey.						
	All areas where the	residents have customary					
		ered. The facility had a					
	_	ng providing facility services					
		enance office and tools that					
	_	. The facility has an additional					
	off site storage unit including the storage of beds						
	and mattresses that	was not sprinklered.					
	Quality Review con	npleted on 01/10/25					
K 0222	NFPA 101						
SS=E Bldg. 01	Egress Doors						
		on and interview, the facility	K 02	222	="" p="">Human Resources		01/10/2025
		means of egress through 1 of			laminated the four digit code a	nd	
		herapy gym were readily			placed above the access conti	rol	
		ents without a clinical			pad.		
		specialized security measures.			="" p="">All other coded doors	•	
	_	nired means of egress shall not			have been inspected and not		
		latch or lock that requires the			affected by this citation and ar	e in	
		from the egress side unless			compliance.		
	_	1 by LSC 19.2.2.2.4.			="" p="">Maintenance or desig		
	Door-locking arrang	gements shall be permitted in	1		will check to make sure that th	IS	

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Event ID:

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155449	B. WI	NG		01/09/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					VILLIAMS ST		
NORTHERN LAKES NURSING AND REHABILITATION CENTI			FR		A, IN 46703		
110111111	THE DIVINE	THE PRETINE IT THE TOTAL CENTER		711001	71, 114 407 00		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION						DATE
		2.2.2.5.2. This deficient			code is visible and located abo	ve	
	practice could affect	t 5 residents using the therapy		the access control pad.			
	gym.				Administrator reinstructed		
					maintenance department on		
	Findings include:				display of code on emergency		
					egress doors to be visible for		
		on with the Maintenance			emergency evacuation. See		
		5 at 12:13 p.m., the exit in the			attached inservice.		
		arked as a facility exit, was			="" p="">This inspection has b		
		l, and could be opened by			added to the Life Safety Round	sb	
	entering a four-digit code on the access control pad, but the code was not posted by the access control pad. Based on an interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad.				quarterly to ensure 100%		
					compliance with this requireme		
					and is reported to QA Commit	:ee	
					for review.		
	This finding was reviewed with the Administrator						
and Maintenance Director during the exit conference.		frector during the exit					
	21.10(1)						
	3.1-19(b)						
K 0321	224 NEDA 404						
SS=E	NFPA 101 Hazardous Areas	Fralsoure					
Bldg. 01	Hazardous Areas	- Enclosure					
Blug. 01	Dagad on observation	on and interview, the facility	17.0	221	(a) The maintenance staff inst	allad	01/10/2025
		3 rooms on the service hall	K 03	321	(a) The maintenance staff insta		01/10/2025
		are feet and being used for			a self closing door closure to the records office.	IE	
		ounts of combustibles were			records office.		
		ous areas. This deficient			The maintenance staff or design	anoo	
	-	t staff in the service hall.			has ensured that the door is se	_	
	Practice could affect	starr in the service nam.			closing and remains to be self		
	Findings include:				closing and remains to be sen closing. Records office staff ha		
	i manga metude.				been reinstructed on why the		
	Based on observations with the Maintenance				is self closing. See attached	1001	
		histrator on 01/09/25 at 12:05			inservice.		
	p.m., the following						
		ce contained over 25			The maintenance staff inspect	ed	
	* *	supplies, was greater than 50			all other doors and rooms that		
	Illacoula cones of	cappines, was breater than 50	I			ui C	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155449			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/09/2025	
	PROVIDER OR SUPPLIEI	NG AND REHABILITATION CEI	516	EET ADDRESS, CITY, STATE, ZIP O 3 N WILLIAMS ST GOLA, IN 46703	COD	
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF square feet, therefor hazardous area. The protected as a hazar corridor door to the automatic closing. I time of observation agreed the room wa storage, was larger corridor door to the (b) The folding roo hanging clothing, w therefore making the folding room was re area because the co with a door wedge the door. Based on	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  TO making the room a the records office was not redous area because the room was not self-closing or Based on an interview at the state of the maintenance Director as used for combustible than 50 square feet, and the room was not self-closing.  The common maintenance of the room was not self-closing.  The room was not self-closing.  The room a hazardous area. The the room a hazardous area. The room of the room was propped open and had clothes hanging on an interview at the time of	ID PREFI	used for storage and f they were not affected citation and were in coand found that they we closing.  This inspection has be the Life Safety Rounds ensure 100% compliant requirement and is rep QA Committee for review (b) Human Resources Environmental Staff or folding room door can	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  used for storage and found that they were not affected by this citation and were in compliance and found that they were all self closing.  This inspection has been added to the Life Safety Rounds quarterly to ensure 100% compliance with this requirement and is reported to the QA Committee for review.  (b) Human Resources reinstructed Environmental Staff on why the folding room door cannot be propped open or have clothing	
K 0781	observation, the Maintenance Director agreed the room was used for combustible storage, was larger than 50 square feet, and the corridor door to the room was propped open with a door wedge. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b)			inservice.  The maintenance staff all other doors and roc used for storage and f they were not affected citation and were in co and found that they we closing.  The inspection has be the Life Safety Rounds ensure 100% complian requirement and is rep QA Committee for revi	f inspected oms that are ound that by this ompliance ere all self en added to squarterly to noce with this ported to the	
SS=E Bldg. 01	Portable Space H	eaters				

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

PRINTED: 01/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building 01		01	COMPLETED		
		155449	B. WING			01/09/	/2025	
		<u> </u>		OTD DET	ADDRESS OF A STATE SIDE OF	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
NODTUE		NO AND DELIABILITATION CENT	516 N WILLIAMS ST					
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENT	ER ANGOLA, 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 TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION					DATE	
		on and interview, the facility	K 0	781	The maintenance director and	t	01/10/2025	
		f 1 portable space heaters were		designee have inspected		other		
		care areas. This deficient			patient care areas to ensure t	hat		
	•	et up to 20 residents in the	r		no space heaters are being u	e being used.		
	Memory Care Hall.				All staff have all been re-instr			
					on the use of space heaters.			
	Findings include:				They were instructed that spa			
				heaters cannot be used in any		•		
	Based on an observation with the Maintenance				resident care areas and that t	•		
	Director and Administrator on 01/09/25 at 11:00		should always look to ensure that					
	a.m., a portable space heater was sitting on a cart		we do not have any space heaters					
	in the Memory Care Hall nurses' station. Based on				in the resident care areas. See			
	an interview at the time of the observation, the				attached inservice.			
		se stated the space heater is		All care areas have been				
	used in the nurses' station during the night shift.				inspected and are not affecte	•		
	The Maintenance Director agreed a space heater		this citation and are found to be in			be in		
	was in a resident care area and removed the space		compliance.					
	heater.		This inspection has been added					
					to the Life Safety Rounds qua	-		
	This finding was reviewed with the Administrator		to ensure 100% compliance with					
	and Maintenance Director during the exit		this requirement and is reported to					
	conference.				the QA Committee for review			
	3.1-19(b)							

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