STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155449	A. BUILDING -- B. WING	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/09/25 Facility Number: 000426 Provider Number: 155449 AIM Number: 100275480 At this Emergency Preparedness Survey, Northern Lakes Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 99 and had a census of 85 at the time of this survey. Quality Review completed on 01/10/25	E 0000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. We respectfully request a desk review and paper compliance determination on all citations.	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/09/25 Facility Number: 000426 Provider Number: 155449 AIM Number: 100275480 At this LSC survey, Northern Lakes Nursing and	K 0000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dee Anna Smallman	Administrator	01/23/2025

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	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, LSC, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 99 and had a census of 85 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a maintenance building providing facility services including the maintenance office and tools that was not sprinklered. The facility has an additional off site storage unit including the storage of beds and mattresses that was not sprinklered. Quality Review completed on 01/10/25		or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. We respectfully request a desk review and paper compliance determination on all citations.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exit doors in the therapy gym were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in	K 0222	=" " p=" ">Human Resources laminated the four digit code and placed above the access control pad. =" " p=" ">All other coded doors have been inspected and not affected by this citation and are in compliance. =" " p=" ">Maintenance or designee will check to make sure that this	01/10/2025

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	accordance with 19.2.2.2.5.2. This deficient practice could affect 5 residents using the therapy gym. Findings include: Based on observation with the Maintenance Director on 01/09/25 at 12:13 p.m., the exit in the therapy gym was marked as a facility exit, was magnetically locked, and could be opened by 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. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		code is visible and located above the access control pad. Administrator reinstructed maintenance department on display of code on emergency egress doors to be visible for emergency evacuation. See attached inservice. ="" p="">This inspection has been added to the Life Safety Rounds quarterly to ensure 100% compliance with this requirement and is reported to QA Committee for review.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of 3 rooms on the service hall greater than 50 square feet and being used for storage of large amounts of combustibles were protected as hazardous areas. This deficient practice could affect staff in the service hall. Findings include: Based on observations with the Maintenance Director and Administrator on 01/09/25 at 12:05 p.m., the following was observed: (a) The records office contained over 25 cardboard boxes of supplies, was greater than 50	K 0321	(a) The maintenance staff installed a self closing door closure to the records office. The maintenance staff or designee has ensured that the door is self closing and remains to be self closing. Records office staff have been reinstructed on why the door is self closing. See attached inservice. The maintenance staff inspected all other doors and rooms that are	01/10/2025

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	square feet, therefore making the room a hazardous area. The records office was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on an interview at the time of 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 not self-closing. (b) The folding room contained large amount of hanging clothing, was greater than 50 square feet, therefore making the room a hazardous area. The folding room was not protected as a hazardous area because the corridor door was propped open with a door wedge and had clothes hanging on the door. Based on an interview at the time of 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)		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 hanging on the door. See attached inservice. The maintenance staff inspected all other doors and rooms that are 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. The 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. ="" p ="" p="">	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters			

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	Based on observation and interview, the facility failed to ensure 1 of 1 portable space heaters were not used in resident care areas. This deficient practice could affect up to 20 residents in the Memory Care Hall. Findings include: Based on an observation with the Maintenance Director and Administrator on 01/09/25 at 11:00 a.m., a portable space heater was sitting on a cart in the Memory Care Hall nurses' station. Based on an interview at the time of the observation, the on-duty charge nurse stated the space heater is used in the nurses' station during the night shift. The Maintenance Director agreed a space heater was in a resident care area and removed the space heater. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0781	The maintenance director and designee have inspected all other patient care areas to ensure that no space heaters are being used. All staff have all been re-instructed on the use of space heaters. They were instructed that space heaters cannot be used in any resident care areas and that they should always look to ensure that we do not have any space heaters in the resident care areas. See attached inservice. All care areas have been inspected and are not affected by this citation and are found to be in compliance. 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.	01/10/2025