CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	LETED	
		155596	B. W			07/08		
				_		0.700		
NAME OF E	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
			500 N WILLIAMS ST					
LAKELA	ND REHAB AND HE	EALTHCARE CENTER		ANGOL	_A, IN 46703			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)			
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	DATE	
E 0000								
_ 0000								
Bldg								
Diag.	An Emergency Pres	paredness Survey was	E 0	200				
		ndiana Department of Health in		300				
	accordance with 42	-						
	accordance with 42	CFR 483.73.						
	Survey Date: 07/08	/24						
	Survey Date. 07/06.	/24						
	Facility Number: 00	00474						
	Provider Number: 1							
	AIM Number: 1002							
	Alivi Nullioei. 1002	290310						
	At this Emergency	Preparedness survey, Lakeland						
		are Center was found in						
		nergency Preparedness						
	_	Medicare and Medicaid						
		ders and Suppliers, 42 CFR						
	483.73							
	The feetiles to 25	4:6:-11-1- A441-4:						
	I -	certified beds. At the time of						
	the survey, the cens	sus was 62.						
	O I'M D '	1 4 1 07/15/24						
	Quality Review cor	mpleted on 07/15/24						
K 0000								
1 0000								
Bldg. 01								
Diag. 01	A Life Sofety Code	Recertification and State	17.0	000	Ins			
	I	vas conducted by the Indiana	K 0	000	/p>			
		lth in accordance with 42 CFR			/p>			
		ith in accordance with 42 CFR			/p>			
	483.90(a).				/p>			
	g D . 07/00	/2.4			/p>			
	Survey Date: 07/08	/24			/p>			
		00.454			/p>			
	Facility Number: 00				/p>			
	Provider Number: 1				/p>			
	AIM Number: 1002	290510			/p>			
					/p>			
	At this Life Safety	Code survey, Lakeland Rehab			/p>			

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

TITLE (X6) DATE

Lindsey Floyd Executive Director 07/26/2024

Any defiency statement 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 disclodays 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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2024			
	ROVIDER 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 APPROPRI DEFICIENCY)	SHOULD BE COMPLETION	
	Medicare/Medicaid. Life Safety from Fir National Fire Protect Life Safety Code (L Care Occupancies a This one-story facility Type V (111) constructions from the corridor 300-hall and 400-had detectors. The residuatery operated sm a capacity of 75 and of this survey.  All areas where the access were sprinkle detached shed provides.	quirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC) Chapter 19, Existing Health and 410 IAC 16.2.  The was determined to be of ruction and was fully illity has a fire alarm system on in the corridors and areas as. The resident rooms on the ll had hard wired smoke ent rooms on the 200-hall had oke detectors. The facility has a had a census of 62 at the time residents have customary ered. The facility had a ding facility services are supplies that was not		/p>		
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - Means of Egress - Aisles, passagewardischarges, exit lo in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation	General General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2	K 0211	The facility requests paper compliance for this citation.	07/27/2024	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		155596	B. W	ING		07/08/	2024
			<u> </u>	OTENTE	ADDRESS CITY STATE TO SEE		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
	UD DELLAD AND LI				VILLIAMS ST		
LAKELAI	ND KEHAB 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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	continuously maint	ained free of all obstructions			This plan of correction is the		
	or impediments to f	full instant use in the case of			facility's credible allegation of		
	fire or other emerge	ency. This deficient practice			compliance.		
	could affect visitors	s, staff and residents in 1 of 3					
	smoke compartmen	its.			Preparation and/or execution	of	
					this plan of correction does no	ot	
	Findings include:				constitute admission or agreei		
					by the provider of the truth of t		
	Based on observation	on with the Senior			facts alleged or conclusions so		
	Maintenance Director on 07/08/24 during a tour of				forth in the statement of		
	the facility from 12	:12 p.m. to 2:28 p.m., floor			deficiencies. The plan of		
	cleaning equipment	t was not in use and stored in			correction is prepared and/or		
	the corridor outside	of the kitchen and laundry			executed solely because it is		
	areas. Based on into	erview at the time of the			required by the provisions of		
	observations, the Se	enior Maintenance Director			federal and state law.		
	agreed the aforement	ntioned means of egress was					
	not continuously m	aintained free of all			1)Immediate actions taken for		
	obstructions or imp	ediments to full instant use in			those residents identified:		
	the case of fire or o	ther emergency.			No resident was found to be		
					affected by the finding.		
	This finding was re	viewed with the Executive					
	Director and Senior	r Maintenance Director during			2) How the facility identified ot	her	
	the exit conference.				residents:		
					Visitors, staff, and residents th	nat	
	3.1-19(b)				reside in the community have	the	
					potential to be affected by the		
					alleged deficient practice.		
					3) Measures put into		
					place/System changes		
					Staff were educated on 7/9/24	on	
					means of egress requirements	3	
					(Attachment A) and the noted		
					obstructions have been moved	d to a	
					storage area.		
					4) How the corrective action w	/ill be	
					monitored:		
					The Maintenance		
					Director/designee will present	а	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/08/2024
	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
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Me. Illumination of me. discharge, is arrar and shall be eithe or capable of auto manual intervention 18.2.8, 19.2.8 Based on observation	ans of Egress ans of Egress ans of egress, including exit aged in accordance with 7.8 ar continuously in operation matic operation without on. on and interview, the facility tinuity of egress lighting for 2	K 0281	weekly audit of path of egress monthly to the QAPI Committed during QAPI Meetings to ensure completion of any new necess updates and compliance. The report will be reviewed in Quant Assurance Meeting monthly for months or until 100% compliant is achieved. The QA Committed will identify any trends or pattern and make recommendations to revise the plan of correction as indicated.  5) Date of Compliance: 27 July 2024  The facility requests paper compliance for this citation. ¿	ee ure sary lity or 6 nce ee eens oo
	of 2 exits. LSC 19. be illuminated in ac Section 7.8.1.2.1 statemployed at such loof time as are neces illumination to the properties. For the properties of	2.8 states Means of egress shall cordance with Section 7.8. ates Artificial lighting shall be exations and for such periods sary to maintain the minimum criteria values herein carposes of this requirement, lude only designated stairs,		This plan of correction is the facility's credible allegation of compliance.; ¿ Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of	of ot ment the

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only designated stairs, aisles, corridors, ramps,

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deficiencies.¿ The plan of

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07/30/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 07/08/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE escalators, walkways and exit passageways correction is prepared and/or leading to a public way. This deficient practice executed solely because it is could affect up to 40 residents when occupied. required by the provisions of federal and state law. ¿. Findings include: 1)Immediate actions taken for Based on observation with the Senior those residents identified:¿ Maintenance Director on 07/08/24 at 12:44 p.m., No resident was found to be during a tour of the facility, the exit discharge affected by the finding.¿ sidewalk from the 200 Hall exit, did not have egress lighting for approximately 80 feet of the 2)How the facility identified other sidewalk from the exit to the public way. Based on residents:¿ interview at the time of observations, the Senior Visitors, staff, and residents that Maintenance Director advised he was planning to reside at the community have the order new lighting for the 200 Hall exit discharge, potential to be affected by the the Senior Maintenance Director also confirmed alleged deficient practice.¿ there were no other lighting devices illuminating the sidewalk for approximately 80 feet. 3)Measures put into place/System changes; This finding was reviewed with the Senior Lighting has been added at Maintenance Director during tour of the facility. intervals to illuminate complete path of egress to a public way. 3.1-19(b) 4)How the corrective action will be monitored:¿ The Maintenance Director/designee will present a weekly audit of means of egress to the QAPI Committee during **QAPI** Meetings to ensure completion of any new necessary updates and compliance. The

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report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155596	B. W	ING		07/08/	2024
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	•	500 N V	ADDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	lE	DATE
					indicated.¿		
					¿ 5) Date of Compliance: 27 July 2024	/	
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas						
Ĭ		are protected by a fire					
		our fire resistance rating					
	(with 3/4 hour fire	rated doors) or an					
		nguishing system in					
		.7.1 or 19.3.5.9. When the					
		ic fire extinguishing system					
	•	areas shall be separated					
	-	by smoke resisting					
	•	rs in accordance with 8.4.					
	Doors shall be self	•					
	_	and permitted to have					
		applied protective plates that inches from the bottom of					
	the door.	inches from the bottom of					
		and zone locations of					
		hat are deficient in					
	REMARKS.	ilat are delicient in					
	19.3.2.1, 19.3.5.9						
	10.0.2.1, 10.0.0.0						
	Area	Automatic Sprinkler					
	Separation						
	-	-Fired Heater Rooms					
	b. Laundries (large	er than 100 square feet)					
	c. Repair, Mainten	ance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection	n Rooms					
	(exceeding 64 gall	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	- '	classified as Severe					
	Hazard - see K322	2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155596	B. WI	NG		07/08/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	8			WILLIAMS ST	
LAKELAN	ND REHAB AND HI	EALTHCARE CENTER			_A, IN 46703	
ı			1		T	1
(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)	
TAG		R LSC IDENTIFYING INFORMATION vation and interview, the	IZ O	TAG		DATE 07/27/2024
	· ·	intain protection of 1 of 1 hot	K 0.	321	The facility requests paper	07/27/2024
	-	in the Main Dining Room.			compliance for this citation.¿	
		This deficient practice could affect visitors, staff			This plan of correction is the	
	and residents in 1 of 3 smoke compartments.				facility's credible allegation of	
	and residents in 1 o	and residents in 1 of 5 smoke compartments.			compliance. ¿	
	Findings include:  Based on observation with the Executive Director and Senior Maintenance Director and interview				¿	
					Preparation and/or execution	of
					this plan of correction does no	
					constitute admission or agree	
	with Activity Aide 1 on 07/08/24 at 12:40 p.m., the				by the provider of the truth of t	
	Main Dining Room contained a hot oil popcorn				facts alleged or conclusions se	
	popper that was occasionally used in the main				forth in the statement of	
	dining room. The Main Dining Room was open to				deficiencies.¿ The plan of	
	the corridor.				correction is prepared and/or	
					executed solely because it is	
		vation and interview, the			required by the provisions of	
	-	sure the corridor door to 1 of 1			federal and state law. ¿	
		activity storage room of				
		es over 50 square feet in size,			1)Immediate actions taken for	
	-	a self-closing device which			those residents identified:¿	
		or to automatically close and			No resident was found to be	
		frame. This deficient practice			affected by the finding.¿	
		s, staff and residents in 1 of 3				
	smoke compartmen	ts.			2)How the facility identified oth	ner
	T. 1 1 1				residents:	
	Findings include:				Visitors, staff, and residents th	
	Dagad on abaamiati	on with the Executive Director			reside at the community have	
		ance Director on 07/08/24 at			potential to be affected by the	
		tour of the facility, the corridor			alleged deficient practice.¿	
		storage room in the corridor			3)Measures put into place/Sys	otom
	-	Dining Room did not				stem
		oor frame. This room was			changes¿ The soiled laundry room latchi	ing
		age of cardboard boxes and			hardware has been repaired a	•
		on interview at the time of			fully functional. Activities staff	
		ecutive Director and Senior			all staff were educated 7/9/24	unu
		tor acknowledged the			(Attachment A) on proper pop	corn
	aforementioned cor				machine usage. Door closure	
		**			been added to the Activity Offi	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 07/08/2024				
		155596	B. WII			07/08/2	.024
	PROVIDER OR SUPPLIER	EALTHCARE CENTER		500 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST .A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECUIDED ON AN OF CODDECTION	T	(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.) Based on observ	ration and interview, the			Door.		
		sure 1 of 2 hazardous area					
		e laundry area, would		4)How the corrective action will be			
		ly and latch into the door			monitored:¿		
		nt practice could affect visitors,					
	staff and residents i	n the main dining room.			The Maintenance		
	Findings include:  Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24				Director/designee will present weekly audit of the latching		
					mechanisms of five doors to the QAPI Committee during QAPI		
		facility from 12:12 p.m. to 2:28			Meetings to ensure completion any new necessary updates a		
	1	ndry door to the corridor was			compliance. The report will be		
		r when opened fully. The			reviewed in Quality Assurance		
		e Director opened the door			Meeting monthly for 6 months		
		ver, the door failed to self-close			until 100% compliance is		
	and latch each time				achieved. The QA Committee	will	
					identify any trends or patterns		
	This finding was re	viewed with the Executive			make recommendations to rev		
	Director and Senior	Maintenance Director at the			the plan of correction as		
	exit conference.				indicated.¿		
	3.1-19(b)				と 5) Date of Compliance: 27 Jul	y	
					2024		
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01	Cooking Facilities						
	Cooking equipmen	nt is protected in					
		IFPA 96, Standard for					
	Ventilation Contro	l and Fire Protection of					
	Commercial Cook	ing Operations, unless:					
		ng equipment (i.e., small					
	1	s microwaves, hot plates,					
	l '	l for food warming or limited					
		ance with 18.3.2.5.2,					
	19.3.2.5.2						
	_	open to the corridor in					
		ents with 30 or fewer					
	I patients comply w	ith the conditions under	I				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/08/2024	
	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 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
	with 30 or fewer p conditions under 1 Cooking facilities   NFPA 96 per 9.2.3 enclosed as hazal be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure staff switch for 1 of 1 co LSC 19.3.2.5.4 state residential or commis used to prepare m shall be permitted, pfacility complies with conditions:  (1) The space contains is not a sleeping room (2) The space contains not a sleeping room (2) The space contains not a sleeping room (3) The requirement and (13) are met.  19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, in facility that deactive (b) The switch is used or range whenever the supervision.  This deficient practice residents in the there.	in smoke compartments 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  19.9.2.3, TIA 12-2  19.10 and interview, the facility of had access to the shutoff ok tops in the therapy gym. The session of the second of the following the cooking equipment that the seals for 30 or fewer persons provided that the cooking the all of the following the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. Its of 19.3.2.5.3(1) through (10)  A switch meeting all of the ed:  1. The second of the cooking equipment from the corridor by partitions 2.6.2 through 19.3.6.5. Its of 19.3.2.5.3(1) through (10)  A switch meeting all of the ed:  1. The second of the ed:  1. The second of the cooking equipment from the cooking all of the ed:  2. The second of the ed:  2. The second of the ed:  3. The second of the ed:  4. The second of the ed:  4. The second of the ed:  5. The second of the ed:  6. The second of the ed:  6. The second of the ed:  7. The second of the ed:  8. The second of the ed:  9.	K 0324	The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of a 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 off residents: Visitors, staff, and residents the reside at the community have potential to be affected by the alleged deficient practice.	of ot ment the et  her nat the

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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	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  07/08/2024	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	1:16 p.m., there was that was separated foodstop was not abwithin the cooking electrical/breaker reshutting off power therapy area. A signin 400 hall Breaker cabinet next to the cabinet next to the cabinet next to the cooktop. Based on in Maintenance Direct that staff had been the breaker and the probreaker.	ance Director on 07/08/24 at a cooktop in the therapy area from the corridor, but the let to be deactivated from facility. A sign in the 400 Hall from provided instructions for to the cooktop inside the a that read: "Breaker location from" was posted on the cooktop. This would require ooking facility to deactivate the interview at the time of exit, the for and Administrator stated frained on the location of the codures to shut off the codures to shut off the codured with the Executive Maintenance Director during		3)Measures put into place/Sychanges Power cord to oven/range to been removed making unit inoperable. All staff educated notified of this change on 7/9 (Attachment A).  4)How the corrective action with monitored: The Maintenance Director/designee will preserved of compliance month the QAPI Committee during of Meetings to ensure completion any new necessary updates compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 month until 100% compliance is achieved. The QA Committee identify any trends or pattern make recommendations to rethe plan of correction as indicated.  5_Date of Compliance: 27 Ju 2024	o has I and I/24  vill be  It Illy to QAPI on of and e e e s or e will s and evise
K 0342 SS=E Bldg. 01	manual means an system alarm, det system. Manual al the path of egress Manual alarm box shall not be requir				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T2I721

Facility ID: 000474

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155596	B. W	ING		07/08	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			WILLIAMS 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 DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		y attended staff location,					
	provided alarm bo						
	distance is not ex	essible, and 200' travel					
	18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5						
		on and interview, the facility	$ _{K0}$	342	The facility requests paper		07/27/2024
	failed to ensure 1 of 9 fire alarm manual pull		110	3 12	compliance for this citation.		07/27/2021
		and continuously accessible.			This plan of correction is the		
		.2.2 Manual fire alarm boxes in			facility's credible allegation of		
	patient sleeping are	as shall not be required at exits			compliance.		
	if located at all nurs	ses' control stations or other					
	continuously attend	led staff location, provided			Preparation and/or execution	of	
	that both of the foll	owing criteria are met:			this plan of correction does no	ot	
	` '	e alarm boxes are visible and			constitute admission or agree	ment	
	continuously access				by the provider of the truth of		
		s required by 9.6.2.5 are not			facts alleged or conclusions s	et	
	exceeded.				forth in the statement of		
	_	ice could affect visitors, staff			deficiencies. The plan of		
	and 20 residents in	the 200 hall.			correction is prepared and/or		
	Findings indude.				executed solely because it is		
	Findings include:				required by the provisions of		
	Raced on observation	on with the Executive Director			federal and state law.		
		nance Director on 07/08/24			1)Immediate actions taken for		
		facility from 12:12 p.m. to 2:28			those residents identified:		
		verage cart obstructed			No resident was found to be		
	*	sibility to the fire alarm pull			affected by the finding.		
	<u>-</u>	the entrance of the 200 Hall					
		ses station. The cart was			2)How the facility identified otl	her	
	removed during obs	servation. The Executive			residents:		
		Maintenance Director			Visitors, staff, and residents th	nat	
	confirmed the cart l	blocked the aforementioned			reside in the community have		
	device.				potential to be affected by the		
					alleged deficient practice.		
	_	viewed with the Executive					
		Maintenance Director at the			3)Measures put into place/Sys	stem	
	exit conference.				changes		
	2.1.10.03				All staff were educated 7/9/24		
	3.1-19(b)				(Attachment A) on maintaining	9	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	ľ	JILDING	ONSTRUCTION 01	(X3) DATE COMPL <b>07/08</b> /	ETED
	PROVIDER 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 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					clear paths to fire pull station, extinguishers, and other fire protection equipment.  4)How the corrective action will monitored: The Maintenance Director/designee will present weekly audit of all fire protection devices and obstructions monito the QAPI Committee during QAPI Meetings to ensure completion of any new necess updates and compliance. The report will be reviewed in Qual Assurance Meeting monthly formonths or until 100% compliar is achieved. The QA Committee will identify any trends or patter and make recommendations to revise the plan of correction as indicated.	a  bn  thly  ary  ity  r 6  nce  ee  erns	
K 0351 SS=F Bldg. 01	by construction ty throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II co	Installation  nd hospitals where required			5)Date of Compliance: 27 July 2024		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

substituted for sprinkler protection in specific areas where state or local regulations prohibit

T2I721

Facility ID: 000474

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COMPLE			LETED
		155596	B. W	ING		07/08	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			VILLIAMS ST		
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER			A, IN 46703		
							T
(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		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE
	sprinklers.	Idama and makenancina diin					
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
		sprinkler coverage covers t as required by NFPA 13,					
		llation of Sprinkler					
	Systems.	manon or opinine					
	'	, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	The facility requests paper		07/27/2024
		ne ceiling construction in 3 of 3	100	331	compliance for this citation.		
		ts in accordance with NFPA			This plan of correction is the		
	13, Standard for the Installation of Sprinkler				facility's credible allegation of		
		, 2010 edition, Section 6.2.7.1			compliance.		
	states plates, escute	heons, or other devices used			,		
	to cover the annular	r space around a sprinkler shall			Preparation and/or execution	of	
	be metallic or shall	be listed for use around a			this plan of correction does no	ot	
	sprinkler. This defic	cient practice could affect all			constitute admission or agree	ment	
	visitors, staff and re	esidents in the facility.			by the provider of the truth of	the	
					facts alleged or conclusions s	et	
	Findings include:				forth in the statement of		
					deficiencies. The plan of		
	Based on observation				correction is prepared and/or		
		tor on 07/08/24 during a tour of			executed solely because it is		
	-	:12 p.m. to 2:28 p.m., four			required by the provisions of		
		ons allowed for annular space			federal and state law.		
		one in the riser room in the 200					
		wer room on the 300 Hall, one			1)Immediate actions taken for	•	
		8, and one in the Therapy room			those residents identified:		
		sed on interview at the time of			No resident was found to be		
		nior Maintenance Director			affected by the finding.		
		cheons was displaced r space around the sprinklers.			2) How the facility identified at	hor	
	-	ere repositioned on the			2)How the facility identified others:	IICI	
	sprinklers during of	-			Visitors, staff, and residents the	nat	
	sprinkiers during of	oser varion.			reside at the community have		
	This finding was re	viewed with the Executive			potential to be affected by the		
		: Maintenance Director at the			alleged deficient practice.		
	exit conference.	2 i de la constante de la cons			anogod donoloni pradiloc.		
			- 1		1		I

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Event ID:

T2I721

Facility ID: 000474

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155596		A. BUILDING  B. WING	01	COMPLETED 07/08/2024		
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	DATE	
	3.1-19(b)			3)Measures put into place/Syschanges     Escutcheons have been refitted and are placed correctly and flush.		
				4)How the corrective action wimonitored: The Maintenance Director/designee will present audit of 5 escutcheons weekly 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 revithe plan of correction as indicated.  5) Date of Compliance: 27 July 2024	an to API n of nd or will and rise	
K 0355 SS=E Bldg. 01	installed, inspected accordance with N Portable Fire Extin 18.3.5.12, 19.3.5.1	guishers guishers are selected, d, and maintained in IFPA 10, Standard for guishers. I2, NFPA 10				
	failed to ensure 2 of were kept in their de readily accessible an	n and interview, the facility 23 portable fire extinguishers esignated place and were and immediately available. ard for Portable Fire	K 0355	The facility requests paper compliance for this citation.  This plan of correction is the facility's credible allegation of compliance.	07/27/2024	

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Event ID:

T2I721

Facility ID: 000474

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07/30/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 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 07/08/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Extinguishers, at Section 6.1.2 states portable fire extinguishers shall be maintained in a fully Preparation and/or execution of charged and operable condition and shall be kept this plan of correction does not in their designated places at all times when they constitute admission or agreement are not being used. This deficient practice could by the provider of the truth of the affect visitors, staff and 42 residents in two smoke facts alleged or conclusions set compartments. forth in the statement of deficiencies. The plan of Findings include: correction is prepared and/or executed solely because it is Based on observation with the Senior required by the provisions of Maintenance Director on 07/08/24 during a tour of federal and state law. the facility from 12:12 p.m. to 2:28 p.m., two fire extinguisher cabinets did not contain a fire 1)Immediate actions taken for extinguisher. One cabinet located next to resident those residents identified: room 216 was clearly marked as containing a fire No resident was found to be extinguisher but no fire extinguisher was present. affected by the finding. A second cabinet located in the corridor outside of the kitchen also was clearly marked as 2)How the facility identified other containing a fire extinguisher, but no fire residents: extinguisher was present. The Senior Visitors, staff, and residents that Maintenance Director confirmed the fire reside in the community have the extinguishers were not present. The Senior potential to be affected by the Maintenance Director explained that the fire alleged deficient practice. extinguishers had been discharged but not yet replaced. 3)Measures put into place/System changes This finding was reviewed with the Executive Fire extinguishers in question Director and Senior Maintenance Director at the were refilled and placed back in exit conference. their assigned areas before the end of the survey. All staff were 3.1-19(b) educated on 7/9/24 on the importance of ensuring fire extinguishers are always in assigned areas (Attachment A). 4)How the corrective action will be monitored:

Director/designee will present an

The Maintenance

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

(X2) MULTIPLE CONST  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/08/2024	
STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703			
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
au ex Co to ne cc re M ur ac ide m th inc	udit of 5 portable fire kinguishers weekly to the Quamittee during QAPI Meet ensure completion of any necessary updates and empliance. The report will be eviewed in Quality Assurance eeting monthly for 6 months intil 100% compliance is chieved. The QA Committee entify any trends or patterns ake recommendations to releptant of correction as dicated.	API tings new e e e s or e will s and vise	
	STREET ADD 500 N WIL ANGOLA,  ID PREFIX TAG  CC to ne cc ree  M un ac id m th in 55)	B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  500 N WILLIAMS ST  ANGOLA, IN 46703  ID  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	

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Event ID:

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07/30/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 07/08/2024 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483. and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 07/27/2024 The facility requests paper failed to ensure 1 of 16 resident sleeping room compliance for this citation.; corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. This plan of correction is the This deficient practice could affect staff and 20 facility's credible allegation of residents in one smoke compartment. compliance. ¿. Findings include: Preparation and/or execution of this plan of correction does not Based on observation with the Senior constitute admission or agreement Maintenance Director on 07/08/24 at 1:01 p.m., by the provider of the truth of the

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resident room 413 corridor door had a pencil size

hole that went through the door. Based on

interview at the time of observation, the

Maintenance Director stated the hole did

switching of the door handles.

penetrate through the door and was due to the

This finding was reviewed with the Executive

Event ID:

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facts alleged or conclusions set

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. ¿

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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 AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155596		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/08/2024			
	PROVIDER OR SUPPLIEI	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, 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 CROSS-REFERENCED TO THE APPROID DEFICIENCY)	BE COMPLETION		
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION  The Maintenance Director at the	TAG	1)Immediate actions taken those residents identified: No resident was found to be affected by the finding.  2)How the facility identified residents:  Visitors, staff, and residents reside at the community has potential to be affected by the alleged deficient practice.  3)Measures put into place/stanges.  Penetration has been filler repaired. An audit was comfacility wide to ensure no of doors were affected.  4) How the corrective action monitored:  The Maintenance Director/designee will prese audit of the inspection of 10 weekly to the QAPI Commiduring QAPI Meetings to encompletion of any new necoupdates and compliance. To report will be reviewed in Question of the plan of correction indicated.  5) Date of Compliance: 27 2024	for e  other s that ve the the  System d and apleted ther  n will be  ent an 0 doors ttee assary the duality y for 6 bliance nittee atterns as to n as		

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Event ID:

T2I721

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 01 COMPLE  B. WING 07/08/2			LETED			
		155596	B. WI	B. WING			07/08/2024	
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		DATE	
K 0511	NFPA 101							
SS=E	Utilities - Gas and	Electric						
Bldg. 01	Utilities - Gas and	Electric						
	Equipment using g	gas or related gas piping						
	-	PA 54, National Fuel Gas						
		ring and equipment						
	-	PA 70, National Electric						
	•	tallations can continue in						
	service provided n							
	18.5.1.1, 19.5.1.1,		17.0	<b>511</b>	The facility requests namer		07/07/0004	ı
	Based on observation and interview, the facility failed to ensure 1 of 1 wet locations were provided		K 0	511	The facility requests paper		07/27/2024	
		rcuit interrupter (GFCI)			compliance for this citation.  This plan of correction is the			
	-	lectric shock. LSC 19.5.1.1			facility's credible allegation of			
		nply with Section 9.1. LSC			compliance.			
	-	ical wiring and equipment to			Compliance.			
	_	70, National Electrical Code.			Preparation and/or execution of	n <i>f</i>		
		1 Edition at 210.8 Ground-Fault			this plan of correction does no			
		Protection for Personnel,			constitute admission or agreer			
	_	circuit-interruption for			by the provider of the truth of t			
	-	rovided as required in			facts alleged or conclusions se			
	210.8(A) through (C	C). The ground-fault			forth in the statement of			
	circuit-interrupter sl	nall be installed in a readily			deficiencies. The plan of			
	accessible location.	(B) Other Than Dwelling			correction is prepared and/or			
	Units. All 125-volt,	, single-phase, 15- and			executed solely because it is			
		les installed in the locations			required by the provisions of			
	-	3)(1) through (8) shall have			federal and state law.			
	ground-fault circuit-	interrupter protection for						
	personnel.				1)Immediate actions taken for			
	(1) Bathrooms				those residents identified:			
	(2) Kitchens				No resident was found to be			
	(3) Rooftops				affected by the finding.			
	(4) Outdoors	(3) and (4): Receptacles that are			2)How the facility identified oth	or		
	_	le and are supplied by a			l '	ier		
		ated to electric snow-melting,			residents: Visitors, staff, and residents th	at		
		and vessel heating equipment			reside in the community have			
		be installed in accordance			potential to be affected by the	u IC		
	with 426.28 or 427.2				alleged deficient practice.			
		(4): In industrial establishments			a 2 god donoioni praotioo.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/08/2024		
NAME OF PROVIDER OF LAKELAND REHA		EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703				
PREFIX (EAC	H 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)	TE	(X5) COMPLETION DATE
only, wh supervision are involuted to conducte shall be poutlets uncreate a graph having a protection (5) Sinks 1.8 m (6) Exception receptable removal shazard	ere the core on ensure ved, an assor program permitted for suppressed to	ditions of maintenance and that only qualified personnel sured equipment grounding as specified in 590.6(B)(2) for only those receptacle oly equipment that would ard if power is interrupted or t is not compatible with GFCI exceptacles are installed within outside edge of the sink.  (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without  (5): For receptacles located in its of general care or critical care facilities other than those protection shall not be required.		IAU	3)Measures put into place/Syschanges GFCI replaced and tested to ensure functionality.  4)How the corrective action wimonitored: The Maintenance Director/designee will present weekly audit of 5 GFCI receptacles monthly to the QA Committee during QAPI Meeti 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 revite plan of correction as indicated.  5)Date of Compliance: 27 July 2024	II be  a PI ngs ew or will and rise	DATE
			- 1				

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PRINTED: 07/30/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/08/2024	
	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0521 SS=F Bldg. 01	Based on observation and Senior Mainten during a tour of the p.m., there was one feet of the sink in the electric receptacle of the sink in the electric receptacle of ault circuit interrupt function properly windicated "bad grout tested multiple times Senior Maintenance observation.  This finding was reduced by the properties of the sink of the properties of the propert	on with the Executive Director ance Director on 07/08/24 facility from 12:12 p.m. to 2:28 electric receptacle within three are pantry on the 300 Hall The was provided with aground oter (GFCI), but the failed to then tested. The GFCI tester and and would not trip when so This was confirmed by the Director at the time of the wiewed with the Executive Maintenance Director at the manufacturer's p.2. The manufacturer's p.2. The manufacture in the facility of 20 fire dampers in the facility of 20 fire dampe	K 0521	The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.  Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions set forth in the statement of	of toment he

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Doors and Other Opening Protectives. NFPA 80,

T2I721

Facility ID: 000474

deficiencies. The plan of

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì ′		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	01	COMPLETED	
		155596	B. WIN	<u> </u>		07/08/2024	
NAME OF P	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD		
					VILLIAMS ST		
LAKELAN	ND KEHAB AND H	EALTHCARE CENTER		ANGOL	.A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	1
PREFIX	,	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		on 19.4.1 states each damper			correction is prepared and/or		
	shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and				executed solely because it is required by the provisions of		
	inspection frequency shall then be every 4 years				federal and state law.		
	except for hospitals where the frequency is every				rederar and state law.		
	6 years. If the damper is equipped with a fusible				1)Immediate actions taken for		
		be removed for testing to ensure			those residents identified:		
		k-in-place if so equipped. The			No resident was found to be		
		blocked from closure in any			affected by the finding.		
	way. All inspection	ns and testing shall be					
	documented, indica	ting the location of the fire			2)How the facility identified oth	ner	
	damper, date of inspection, name of inspector and				residents:		
	deficiencies discovered. The documentation shall				Visitors, staff, and residents th	at	
	-	cate when and how the			reside in the community have	the	
		orrected. This deficient			potential to be affected by the		
	-	t all visitors, staff and			alleged deficient practice.		
	residents.						
					3)Measures put into place/Sys	tem	
	Findings include:				changes		
	D 1 1				Damper inspections have bee		
		eview and interview with the			completed by certified contrac	tor.	
		and Senior Maintenance 4 from 9:42 a.m. to 11:48 a.m.,			4) Llow the corrective estion w	ll bo	
		nper Maintenance Record			4)How the corrective action with monitored:	ii ne	
		e dampers throughout the			The Maintenance		
		led maintenance on 06/11/20,			Director/designee will present	an	
	• •	sceeding the four year			audit of damper inspections	uii	
	*	ement. During records review			monthly to the QAPI Committee	ee	
	•	enior Maintenance Director			during QAPI Meetings to ensu		
		as scheduled but the service			completion of any new necess		
		ow-up. The lack of four-year			updates and compliance. The	<b>,</b>	
		cted on fire dampers was			report will be reviewed in Qua	ity	
		or Maintenance Director at the			Assurance Meeting monthly for	-	
	time of record revie	ew.			months or until 100% complia		
					is achieved. The QA Committe		
	This finding was re	viewed with the Executive			will identify any trends or patte	erns	
		Maintenance Director at the			and make recommendations t	o	
	exit conference.				revise the plan of correction a	s	
					indicated.		
	3.1-19(b)					1	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X:	O7/08/2024
	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 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and R Evacuation and R There is a written patients and for th of an emergency. Employees are pe kept informed with and a copy of the with telephone op plan addresses th of staff per 18/19. of the fire safety p 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2 Based on record rev failed to provide 1 esafety plan that inco NFPA 101, Section 1. Use of alarms. 2. Transmission of 3. Emergency phot 4. Response to alar 5. Isolation of fire. 6. Evacuation of sr	elocation Plan elocation Plan plan for the protection of all leir evacuation in the event eriodically instructed and in their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all elan components per 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 12, 19.7.2.3  view and interview, the facility of 1 written emergency fire proporated all items listed in 19.7.2.2.  falarms to fire department the call to fire department ms.	K 0711	The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.  Preparation and/or execution of this plan of correction does not constitute admission or agreeme by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	07/27/2024
	residents in the eve	ice affects all visitors, staff and		correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for these residents identified:	
I	Based on records re	eview and interview with the	1	those residents identified:	I

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  07/08/2024	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	-
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER	ANG		
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	Director on 07/08/2 the facility's fire saf	and Senior Maintenance 4 from 9:42 a.m. to 11:48 a.m., ety plan labeled Fire Safety n did not address evacuation tents.		No resident was found to be affected by the finding.  2)How the facility identified or residents:	other
		viewed with the Executive Maintenance Director at the		Visitors, staff, and residents reside in the community have potential to be affected by the alleged deficient practice.	e the
	3.1-19(b)			3)Measures put into place/Sichanges Smoke compartment evacual policy addendum has been updated in the EPP to addresevacuation of individual smocompartments (Attachment Estaff was educated on this addendum on 7/9/24 (Attach A).	ss ke 3). All
				4)How the corrective action of monitored: The Maintenance Director/designee will preser audit of the EPP smoke compartment policy monthly the QAPI Committee during Meetings to ensure completi any new necessary updates compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 month until 100% compliance is achieved. The QA Committee identify any trends or pattern make recommendations to rethe plan of correction as indicated.	to QAPI on of and oe ce is or e will is and

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Event ID:

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Facility ID: 000474

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMP		COMPL	ETED	
		155596	B. WI			07/08/	07/08/2024	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			WILLIAMS ST			
IVKELVI	ND BEHAR AND HE	EALTHCARE CENTER			A, IN 46703			
LANLLAI	ND INCHAD AND HE	LALITIOANE CENTER		ANGOL				
(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	
					5)Date of Compliance: 27 July	!		
					2024			
K 0712	NFPA 101							
SS=F	Fire Drills							
Bldg. 01	Fire Drills							
		the transmission of a fire						
	-	simulation of emergency fire						
		ills are held at expected						
		mes under varying						
		t quarterly on each shift.						
		r with procedures and is						
		re part of established						
		rills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms.	10.7.4.7						
	19.7.1.4 through 1	view and interview, the facility	17.0	710	The feeiliby negroests negro		07/27/2024	
		tions at unexpected times	K 0	/12	The facility requests paper		07/27/2024	
		second shift for 4 of 4			compliance for this citation.  This plan of correction is the			
		1.6 states drills shall be			facility's credible allegation of			
	-	on each shift to familiarize			compliance.			
		nurses, interns, maintenance			Compliance.			
		inistrative staff) with the			Preparation and/or execution of	of		
		ncy action required under			this plan of correction does no			
	-	This deficient practice affects			constitute admission or agree			
	all visitors, staff and	-			by the provider of the truth of t			
					facts alleged or conclusions se			
	Findings include:				forth in the statement of			
	J				deficiencies. The plan of			
	Based on records re	eview with the Senior			correction is prepared and/or			
	Maintenance Direct	tor on 07/08/24 from 9:42 a.m.			executed solely because it is			
	to 11:48 a.m., the fo	ollowing fire drills were			required by the provisions of			
	documented:				federal and state law.			
	a) A second shift fir	re drill in the first quarter						
	01/29/24 at 3:03 p.r	n.			1)Immediate actions taken for			
	b) A second shift fir	re drill in the second quarter			those residents identified:			
	04/29/24 at 2:27 p.r	n.			No resident was found to be			
	c) A second shift fir	re drill in the third quarter			affected by the finding.			

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155596   B. WING   D1   COMPLETED   07/08/2024    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP COD   500 N WILLIAMS ST   ANGOLA, IN 46703    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIE   ID   PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE    (X5)   COMPLETION   DATE   COMPLETED   COMPLETED   COMPLETED   COMPLETION   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE    (X5)   COMPLETION   COMPLETION   COMPLETION   COMPLETION   COMPLETION   DATE   COMPLETION   DATE   COMPLETION   COMPLETION   DATE   COMPLETION   DATE   COMPLETION   DATE   COMPLETION   COMPLETION   DATE   COMPLETION   COMPLETION   DATE   COMPL	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHAB AND HEALTHCARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  d) A second shift fire drill in the fourth quarter  10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the  Maintenance Director acknowledged the fire drills  STREET ADDRESS, CITY, STATE, ZIP COD  500 N WILLIAMS ST  ANGOLA, IN 46703  (X5)  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION  DATE  2) How the facility identified other residents:  Visitors, staff, and residents that reside in the community have the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPI		LETED		
LAKELAND REHAB AND HEALTHCARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  (A) A second shift fire drill in the fourth quarter 10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  (X5)  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (A) PREFIX  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (A) A second shift fire drill in the fourth quarter residents:  Usitors, staff, and residents that reside in the community have the			155596	B. W	B. WING 07/08/2024			/2024	
LAKELAND REHAB AND HEALTHCARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  (A) A second shift fire drill in the fourth quarter 10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  (X5)  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (A) PREFIX  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (A) A second shift fire drill in the fourth quarter residents:  Usitors, staff, and residents that reside in the community have the					STREET A	ADDRESS, CITY, STATE, ZIP COD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  O7/31/23 at 2:17 p.m.  d) A second shift fire drill in the fourth quarter 10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  (X5) PREFIX CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFER	NAME OF P	PROVIDER OR SUPPLIEI	R						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (COMPLETION DATE  2) How the facility identified other residents: Visitors, staff, and residents that reside in the community have the	LAKELAN	ND REHAB AND H	EALTHCARE CENTER						
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  O7/31/23 at 2:17 p.m.  d) A second shift fire drill in the fourth quarter 10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  CROSS-REFERENCED TO THE APPROPRIATE DATE  CROSS-REFERENCED TO THE APPROPRIATE DATE  2)How the facility identified other residents:  Visitors, staff, and residents that reside in the community have the		SUMMARY	STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION			
07/31/23 at 2:17 p.m. d) A second shift fire drill in the fourth quarter 10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  2)How the facility identified other residents:  Visitors, staff, and residents that reside in the community have the					CROSS-REFERENCED TO THE APPR		ΙΤΕ		
d) A second shift fire drill in the fourth quarter  10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  2)How the facility identified other residents:  Visitors, staff, and residents that reside in the community have the	TAG			-	TAG	DEFICIENCY)		DATE	
10/12/23 at 2:15 p.m.  Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  residents:  Visitors, staff, and residents that reside in the community have the		_				0)	L		
Based on interview at the time of exit, the Maintenance Director acknowledged the fire drills  Visitors, staff, and residents that reside in the community have the		10/12/23 at 2:15 p.m.				, ·	ner		
Maintenance Director acknowledged the fire drills reside in the community have the							not.		
I were conducted in the last few days of each I I notential to be affected by the I		were conducted in the last few days of each month and all within the same 1-hour time frame.  This finding was reviewed with the Executive Director and Senior Maintenance Director at the				potential to be affected by the			
						1 ·			
anogod donoton practice.						anogod donoioni praetice.			
This finding was reviewed with the Executive 3)Measures put into place/System						3)Measures put into place/Sys	stem		
						1			
exit conference.  Measures have been put into		exit conference.				_			
place to ensure variation in times						place to ensure variation in tin	nes		
3.1-19(b) for future fire drills. Maintenance		3.1-19(b)				for future fire drills. Maintenan	ce		
3.1-51(c) team/designee have been		3.1-51(c)				_			
educated on importance to vary						T	ry		
time for fire drills.						time for fire drills.			
4)How the corrective action will be						1 .	ill be		
monitored:									
The Maintenance									
Director/designee will present an						-			
audit of fire drills monthly to the						-			
QAPI Committee during QAPI  Meetings to ensure completion of						_			
any new necessary updates and						_			
compliance. The report will be						1 -			
reviewed in Quality Assurance						1			
Meeting monthly for 6 months or						<u>-</u>			
until 100% compliance is							=		
achieved. The QA Committee will						•	will		
identify any trends or patterns and						identify any trends or patterns	and		
make recommendations to revise						make recommendations to rev	vise		
the plan of correction as						the plan of correction as			
indicated.						indicated.			
5)Date of Compliance: 27 July 2024						' · · · · · · · · · · · · · · · · · ·	/		
K 0020 NEDA 404	K 0020	NEDA 404							
K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and			ent - Power Cords and						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155596	B. WING 07/08/2024			2024	
			<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				VILLIAMS ST		
IAKEIAN		EALTHCARE CENTER					
LANELAN	ND REHAD AND HE	EALTHCARE CENTER		ANGOL	A, IN 46703		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
Bldg. 01	Extens						
	Electrical Equipme	ent - Power Cords and					
	<b>Extension Cords</b>						
	Power strips in a p	patient care vicinity are only					
	used for compone	nts of movable					
	patient-care-relate	d electrical equipment					
	(PCREE) assembl	es that have been					
	, ,	lified personnel and meet					
	the conditions of 1	0.2.3.6. Power strips in					
		cinity may not be used for					
	non-PCREE (e.g.,	personal electronics),					
	except in long-terr	n care resident rooms that					
	do not use PCRE	E. Power strips for PCREE					
	meet UL 1363A or	UL 60601-1. Power strips					
	for non-PCREE in	the patient care rooms					
	(outside of vicinity	) meet UL 1363. In					
	non-patient care re	ooms, power strips meet					
	other UL standard	s. All power strips are					
	used with general	precautions. Extension					
	cords are not used	d as a substitute for fixed					
	wiring of a structur	re. Extension cords used					
	temporarily are rea	moved immediately upon					
	completion of the	purpose for which it was					
	installed and meet	s the conditions of 10.2.4.					
	10.2.3.6 (NFPA 99	9), 10.2.4 (NFPA 99), 400-8					
	(NFPA 70), 590.3(	D) (NFPA 70), TIA 12-5					
	Based on observation	on and interview, the facility	K 09	920	The facility requests paper		07/27/2024
	failed to ensure 1 of	42 resident rooms. did not use			compliance for this citation.		
	flexible cords as a s	ubstitute for fixed wiring. LSC			This plan of correction is the		
	9.1.2 requires electr	ical wiring and equipment shall			facility's credible allegation of		
		th NFPA 70, National			compliance.		
	Electrical Code. NF	PA 70, 2011 Edition, Article					
	400.8 requires that,	unless specifically permitted,			Preparation and/or execution of	of	
		ables shall not be used as a			this plan of correction does no	t	
		wiring of a structure. This			constitute admission or agreer	nent	
	-	fects staff and up to 20			by the provider of the truth of t	he	
	residents in the 200	Hall smoke compartment.			facts alleged or conclusions se	∍t	
					forth in the statement of		
	Findings include:				deficiencies. The plan of		
					correction is prepared and/or		

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Event ID:

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHAB AND HEALTHCARE CENTER  STREAT ADDRESS, CITY, STATE, ZIP COD SOON WILLIAMS ST ANGOLA, IN 46703  SIMMARY STATEMINT OF DEFICIENCE PREEX TAG  REGULATIONY OR LSC IDENTIFYING INFORMATION  Based on observation with the Senior Maintenance Director on 07/08/24 at 12:40 p.m., an extension cord was found powering a television in resident room 20, Based on interview at the time of observation, the Senior Maintenance Director acknowledged the extension cord was being used to power a television in the resident room.  This finding was reviewed with the Executive Director and Senior Maintenance Director during the exit conference.  3.1-19(b)  STREAT ADDRESS, CITY, STATE, ZIP COD SOON WILLIAMS ST ANGOLA, IN 46703  CXS.  COMPLETION TAG  SECULTED SIDE OF THE APPROCRIATE TAG  SECULTED SIDE OF THE APPROCRIATE TAG  COMPLETION TAG  PREEX TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION OF THE APPROCRIATE TAG  COMPLETION TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION OF THE APPROCRIATE TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION OF THE APPROCRIATE TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION OF THE APPROCRIATE TAG  COMPLETION TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION OF THE APPROCRIATE TAG  COMPLETION TAG  SECULTOR SOLE) DESTRESS AND GROUP THE COMPLETION TAG	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHAB AND HEALTHCARE CENTER  IX4) ID  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGILATORY OR LSC IDENTIFYING INFORMATION  Maintenance Director on 07/08/24 at 12:40 p.m., an extension cord was found powering a television in resident room 209. Based on interview at the time of observation, the Senior Maintenance Director acknowledged the extension cord was being used to power a television in the resident room.  This finding was reviewed with the Executive Director addening the exit conference.  3.1-19(b)  3.1-19(b)  STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703  Deficition of Comments of Commen						01	COMPLETED	
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Assurance Meeting monthly for 6						1 · · · · · · · · · · · · · · · · · · ·		
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months or until 100% compliance						•		
is achieved. The QA Committee								
will identify any trends or patterns and make recommendations to						1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T2I721

Facility ID: 000474

If continuation sheet Page 28 of 31

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/08/2024	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST	
LAKELAI	ND REHAB AND HE	EALTHCARE CENTER		LA, IN 46703	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
				revise the plan of correction a indicated.	S
				5)Date of Compliance: 27 July 2024	′
K 0923	NFPA 101				
SS=E		Cylinder and Container			
Bldg. 01	Storag	-,ac. aa coac.			
	Gas Equipment -	Cylinder and Container			
	Storage				
		qual to 3,000 cubic feet			
	_	are designed, constructed,			
	and ventilated in a	accordance with 5.1.3.3.2			
	>300 but <3,000 d	subjected			
		are outdoors in an			
	_	n an enclosed interior			
		mited- combustible			
		door (or gates outdoors)			
		ed. Oxidizing gases are not			
	stored with flamm	ables, and are separated			
	from combustibles	by 20 feet (5 feet if			
	sprinklered) or en	closed in a cabinet of			
		onstruction having a			
		re protection rating.			
		I to 300 cubic feet			
		compartment, individual			
	_	e for immediate use in			
	•	with an aggregate volume			
		ual to 300 cubic feet are not red in an enclosure.			
	-	handled with precautions			
	as specified in 11.				
	-	ign readable from 5 feet is			
		ate of a cylinder storage			
	_	ign includes the wording as			
		ΓΙΟΝ: OXIDIZING GAS(ES)			
	STORED WITHIN				
		d so cylinders are used in			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T2I721

Facility ID: 000474

If continuation sheet Page 29 of 31

PRINTED: 07/30/2024 FORM APPROVED

ENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
	155596		B. WI	NG		07/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	C		500 N V	WILLIAMS ST		
LAKELAND REHAB AND HEALTHCARE 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	order of which the supplier. Empty of from full cylinders cylinders with interest threshold pressure established. Emp avoid confusion. Care protected from 11.3.1, 11.3.2, 11.99)  Based on observation failed to ensure 3 orgases such as oxygon falling. NFPA 99, 2012 Edition, Section onflammable gase (300 cubic feet) but (3000 cubic feet) but (3000 cubic feet) strugh 11.3.2.3. A cylinder or contained 11.6.2.3. Section 1 cylinders shall be pin a proper cylinder practice could affect residents in 2 of 3 structure.  Based on observation and Senior Maintenduring a tour of the p.m., three 'E' type upright on the floor supported in a proper cylinder was located the 300 Hall and two Therapy area. Base	by are received from the cylinders are segregated  When facility employs gral pressure gauge, a e considered empty is by cylinders are marked to cylinders stored in the open	K 09		The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.  Preparation and/or execution of this plan of correction does not constitute admission or agreed 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 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 other residents: Visitors, staff, and residents the reside in the community have potential to be affected by the	t ment the et	07/27/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Maintenance Director acknowledged the oxygen

cylinder located at the nurses station on the 300

Event ID:

T2I721

Facility ID: 000474

alleged deficient practice.

If continuation sheet

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

PRINTED: 07/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 07/08/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE		PR	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERNCED TO THE APPR DEFICIENCY)  3)Measures put into place changes Gas cylinders removed from the content of the content	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  3)Measures put into place/System changes Gas cylinders removed from areas noted in the 2567 and returned to O2 storage room. All staff were educated on 7/9/24 (Attachment A) on importance of proper O2 storage.  4)How the corrective action will be monitored: The Maintenance Director/designee will present a weekly audit of 5 areas monthly to the QAPI Committee during QAPI		
				compliance. The report w reviewed in Quality Assur Meeting monthly for 6 mo until 100% compliance is achieved. The QA Comm identify any trends or patt make recommendations t the plan of correction as indicated.  5)Date of Compliance: 27 2024	II be ance nths or ttee will erns and o revise		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T2I721 Facility ID: 000474 If continuation sheet Page 31 of 31