STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155596	A. BUILDING -- B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKELAND REHAB AND HEALTHCARE CENTER	500 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: 07/08/24 Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510 At this Emergency Preparedness survey, Lakeland Rehab and Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 75 certified beds. At the time of the survey, the census was 62. Quality Review completed on 07/15/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/08/24 Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510 At this Life Safety Code survey, Lakeland Rehab	K 0000	/p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey Floyd	Executive Director	07/26/2024

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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LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

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	and Healthcare 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, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The resident rooms on the 300-hall and 400-hall had hard wired smoke detectors. The resident rooms on the 200-hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered. Quality Review completed on 07/15/24		/p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p>	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 means of egress were	K 0211	The facility requests paper compliance for this citation.	07/27/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect visitors, staff and residents in 1 of 3 smoke compartments. Findings include: Based on observation with the Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., floor cleaning equipment was not in use and stored in the corridor outside of the kitchen and laundry areas. Based on interview at the time of the observations, the Senior Maintenance Director agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director and Senior Maintenance Director during the exit conference. 3.1-19(b)		*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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that 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 (Attachment A) and the noted obstructions have been moved to a storage area. 4) How the corrective action will be monitored: The Maintenance Director/designee will present a	

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			weekly audit of path of egress monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5) Date of Compliance: 27 July 2024	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits. LSC 19.2.8 states Means of egress shall be illuminated in accordance with Section 7.8. Section 7.8.1.2.1 states Artificial lighting shall be employed at such locations and for such periods of time as are necessary to maintain the illumination to the minimum criteria values herein specified. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps,	K 0281	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 agreement 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

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	escalators, walkways and exit passageways leading to a public way. This deficient practice could affect up to 40 residents when occupied. Findings include: Based on observation with the Senior Maintenance Director on 07/08/24 at 12:44 p.m., during a tour of the facility, the exit discharge sidewalk from the 200 Hall exit, did not have egress lighting for approximately 80 feet of the sidewalk from the exit to the public way. Based on interview at the time of observations, the Senior Maintenance Director advised he was planning to order new lighting for the 200 Hall exit discharge, the Senior Maintenance Director also confirmed there were no other lighting devices illuminating the sidewalk for approximately 80 feet. This finding was reviewed with the Senior Maintenance Director during tour of the facility. 3.1-19(b)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿* 1)Immediate actions taken for those residents identified:¿ No resident was found to be affected by the finding.¿ 2)How the facility identified other residents:¿ Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ Lighting has been added at intervals to illuminate complete path of egress to a public way. 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 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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			indicated.¿ ¿ 5) Date of Compliance: 27 July 2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			

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	1.) Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Main Dining Room. This deficient practice could affect visitors, staff and residents in 1 of 3 smoke compartments. Findings include: Based on observation with the Executive Director and Senior Maintenance Director and interview with Activity Aide 1 on 07/08/24 at 12:40 p.m., the Main Dining Room contained a hot oil popcorn popper that was occasionally used in the main dining room. The Main Dining Room was open to the corridor. 2.) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous area, an activity storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect visitors, staff and residents in 1 of 3 smoke compartments. Findings include: Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24 at 1:48 p.m., during a tour of the facility, the corridor door to the Activity storage room in the corridor outside of the Main Dining Room did not self-close into the door frame. This room was being used for storage of cardboard boxes and paper goods. Based on interview at the time of observation, the Executive Director and Senior Maintenance Director acknowledged the aforementioned condition.	K 0321	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because 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 that reside at the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ The soiled laundry room latching hardware has been repaired and is fully functional. Activities staff and all staff were educated 7/9/24 (Attachment A) on proper popcorn machine usage. Door closure has been added to the Activity Office	07/27/2024

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	3.) Based on observation and interview, the facility failed to ensure 1 of 2 hazardous area corridor doors to the laundry area, would self-close completely and latch into the door frame. This deficient practice could affect visitors, staff and residents in the main dining room. Findings include: Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., the soiled laundry door to the corridor was sticking on the floor when opened fully. The Senior Maintenance Director opened the door fully 3 times; however, the door failed to self-close and latch each time. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		Door. 4)How the corrective action will be monitored:¿ The Maintenance Director/designee will present a weekly audit of the latching mechanisms of five doors to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated.¿ ¿ 5) Date of Compliance: 27 July 2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under			

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	18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect staff and five residents in the therapy gym. Findings include: Based on observation with the Executive Director	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 of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside at the community have the potential to be affected by the alleged deficient practice.	07/27/2024

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	and Senior Maintenance Director on 07/08/24 at 1:16 p.m., there was a cooktop in the therapy area that was separated from the corridor, but the cooktop was not able to be deactivated from within the cooking facility. A sign in the 400 Hall electrical/breaker room provided instructions for shutting off power to the cooktop inside the therapy area. A sign that read: "Breaker location in 400 hall Breaker room" was posted on the cabinet next to the cooktop. This would require staff to leave the cooking facility to deactivate the cooktop. Based on interview at the time of exit, the Maintenance Director and Administrator stated that staff had been trained on the location of the breaker and the procedures to shut off the breaker. This finding was reviewed with the Executive Director and Senior Maintenance Director during the exit conference. 3.1-19(b)		3)Measures put into place/System changes Power cord to oven/range top has been removed making unit inoperable. All staff educated and notified of this change on 7/9/24 (Attachment A). 4)How the corrective action will be monitored: The Maintenance Director/designee will present records of compliance monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5_Date of Compliance: 27 July 2024	
K 0342 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Initiation Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or			

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	other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 Based on observation and interview, the facility failed to ensure 1 of 9 fire alarm manual pull stations was visible and continuously accessible. LSC Section 19.3.4.2.2 Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that both of the following criteria are met: (1) Such manual fire alarm boxes are visible and continuously accessible. (2) Travel distances required by 9.6.2.5 are not exceeded. This deficient practice could affect visitors, staff and 20 residents in the 200 hall. Findings include: Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., a food and beverage cart obstructed visibility and accessibility to the fire alarm pull station located near the entrance of the 200 Hall across from the nurses station. The cart was removed during observation. The Executive Director and Senior Maintenance Director confirmed the cart blocked the aforementioned device. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)	K 0342	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes All staff were educated 7/9/24 (Attachment A) on maintaining	07/27/2024

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			clear paths to fire pull station, extinguishers, and other fire protection equipment. 4)How the corrective action will be monitored: The Maintenance Director/designee will present a weekly audit of all fire protection devices and obstructions monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5)Date of Compliance: 27 July 2024	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit			

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(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
	sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 3 of 3 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all visitors, staff and residents in the facility. Findings include: Based on observation with the Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., four displaced escutcheons allowed for annular space around a sprinkler, one in the riser room in the 200 Hall, one in the shower room on the 300 Hall, one in resident room 308, and one in the Therapy room on the 400 Hall. Based on interview at the time of observation, the Senior Maintenance Director confirmed the escutcheons was displaced allowing for annular space around the sprinklers. The escutcheons were repositioned on the sprinklers during observation. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference.	K 0351	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside at the community have the potential to be affected by the alleged deficient practice.	07/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155596	A. BUILDING 01 B. WING	07/08/2024

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	3.1-19(b)		3)Measures put into place/System changes Escutcheons have been refitted and are placed correctly and flush. 4)How the corrective action will be monitored: The Maintenance Director/designee will present an audit of 5 escutcheons weekly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5) Date of Compliance: 27 July 2024	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 23 portable fire extinguishers were kept in their designated place and were readily accessible and immediately available. NFPA 10, the Standard 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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	Extinguishers, at Section 6.1.2 states portable fire extinguishers shall be maintained in a fully charged and operable condition and shall be kept in their designated places at all times when they are not being used. This deficient practice could affect visitors, staff and 42 residents in two smoke compartments. Findings include: Based on observation with the Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., two fire extinguisher cabinets did not contain a fire extinguisher. One cabinet located next to resident room 216 was clearly marked as containing a fire extinguisher but no fire extinguisher was present. A second cabinet located in the corridor outside of the kitchen also was clearly marked as containing a fire extinguisher, but no fire extinguisher was present. The Senior Maintenance Director confirmed the fire extinguishers were not present. The Senior Maintenance Director explained that the fire extinguishers had been discharged but not yet replaced. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes Fire extinguishers in question were refilled and placed back in their assigned areas before the end of the survey. All staff were 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: The Maintenance Director/designee will present an	

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			audit of 5 portable fire extinguishers weekly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5)Date of Compliance: 27 July 2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping			

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	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 failed to ensure 1 of 16 resident sleeping room corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect staff and 20 residents in one smoke compartment. Findings include: Based on observation with the Senior Maintenance Director on 07/08/24 at 1:01 p.m., 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 penetrate through the door and was due to the switching of the door handles. This finding was reviewed with the Executive	K 0363	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿*	07/27/2024

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	Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		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 that reside at the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ Penetration has been filled and repaired. An audit was completed facility wide to ensure no other doors were affected. 4) How the corrective action will be monitored:¿ The Maintenance Director/designee will present an audit of the inspection of 10 doors weekly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated.¿ ¿ 5) Date of Compliance: 27 July 2024	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments	K 0511	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside in the community have the potential to be affected by the alleged deficient practice.	07/27/2024

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	only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include:		3)Measures put into place/System changes GFCI replaced and tested to ensure functionality. 4)How the corrective action will be monitored: The Maintenance Director/designee will present a weekly audit of 5 GFCI receptacles monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5)Date of Compliance: 27 July 2024	

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	Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., there was one electric receptacle within three feet of the sink in the pantry on the 300 Hall The electric receptacle was provided with aground fault circuit interrupter (GFCI), but the failed to function properly when tested. The GFCI tester indicated "bad ground" and would not trip when tested multiple times. This was confirmed by the Senior Maintenance Director at the time of observation. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview; the facility failed to ensure 20 of 20 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80,	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 agreement 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

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	2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all visitors, staff and residents. Findings include: Based on records review and interview with the Executive Director and Senior Maintenance Director on 07/08/24 from 9:42 a.m. to 11:48 a.m., the Fire/Smoke Damper Maintenance Record indicated twenty fire dampers throughout the facility were provided maintenance on 06/11/20, which is a period exceeding the four year maintenance requirement. During records review and interview the Senior Maintenance Director stated the service was scheduled but the service company did not show-up. The lack of four-year maintenance conducted on fire dampers was verified by the Senior Maintenance Director at the time of record review. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1)Immediate actions taken for those residents identified: No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes Damper inspections have been completed by certified contractor. 4)How the corrective action will be monitored: The Maintenance Director/designee will present an audit of damper inspections monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated.	

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K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all visitors, staff and residents in the event of an emergency. Findings include: Based on records review and interview with the	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1)Immediate actions taken for those residents identified:	07/27/2024

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	Executive Director and Senior Maintenance Director on 07/08/24 from 9:42 a.m. to 11:48 a.m., the facility's fire safety plan labeled Fire Safety and Evacuation Plan did not address evacuation of smoke compartments. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes Smoke compartment evacuation policy addendum has been updated in the EPP to address evacuation of individual smoke compartments (Attachment B). All staff was educated on this addendum on 7/9/24 (Attachment A). 4)How the corrective action will be monitored: The Maintenance Director/designee will present an audit of the EPP smoke compartment policy monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated.	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to vary conditions at unexpected times during fire drills on second shift for 4 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all visitors, staff and residents. Findings include: Based on records review with the Senior Maintenance Director on 07/08/24 from 9:42 a.m. to 11:48 a.m., the following fire drills were documented: a) A second shift fire drill in the first quarter 01/29/24 at 3:03 p.m. b) A second shift fire drill in the second quarter 04/29/24 at 2:27 p.m. c) A second shift fire drill in the third quarter	K 0712	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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.	07/27/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

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	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 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 exit conference. 3.1-19(b) 3.1-51(c)		2)How the facility identified other residents: Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes Measures have been put into place to ensure variation in times for future fire drills. Maintenance team/designee have been educated on importance to vary time for fire drills. 4)How the corrective action will 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 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 indicated. 5)Date of Compliance: 27 July 2024	
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. 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 rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 42 resident rooms. did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 20 residents in the 200 Hall smoke compartment. Findings include:	K 0920	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	07/27/2024

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	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 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 and Senior Maintenance Director during the exit conference. 3.1-19(b)		*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 that reside in the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/System changes Extension cord was removed from resident room. All staff were educated on 7/9/24 (Attachment A) on the importance of not using extension cords in patient care areas. 4)How the corrective action will be monitored: The Maintenance Director/designee will present a weekly audit of 5 room checks monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The 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	

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			revise the plan of correction as indicated. 5)Date of Compliance: 27 July 2024	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in			

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	order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 3 of 3 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 42 residents in 2 of 3 smoke compartments. Findings include: Based on observation with the Executive Director and Senior Maintenance Director on 07/08/24 during a tour of the facility from 12:12 p.m. to 2:28 p.m., three 'E' type oxygen cylinders was standing upright on the floor not properly chained or supported in a proper cylinder stand or cart, one cylinder was located behind the nurse's station on the 300 Hall and two cylinders were located in the Therapy area. Based on interview at the time of observation, the Executive Director and Senior Maintenance Director acknowledged the oxygen cylinder located at the nurses station on the 300	K 0923	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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 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 that reside in the community have the potential to be affected by the alleged deficient practice.	07/27/2024

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	hall and 2 oxygen cylinders in the Therapy area were unsupported, not chained, and not in a stand or cart. This finding was reviewed with the Executive Director and Senior Maintenance Director at the exit conference. 3.1-19(b)		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 Meetings to ensure completion of any new necessary updates and compliance. The 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 indicated. 5)Date of Compliance: 27 July 2024	