STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLET					
		155596	B. WI	NG		07/28/	2022
	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	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
L 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/28/22		E 00	000			
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	155596					
	At this Emergency Preparedness survey, Lakeland Rehab and Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73						
	The facility has 75 c the survey, the cens	certified beds. At the time of us was 64.					
	Quality Review con	npleted on 07/29/22					
E 0015 SS=C Bldg	(1), 482.15(b)(1), 4 485.625(b)(1) Subsistence Need §403.748(b)(1), §4 §441.184(b)(1), §4	3.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), 485 staff and Patients 418.113(b)(6)(iii), 460.84(b)(1), §482.15(b)(1), 483.475(b)(1), §485.625(b)(1)					
	must develop and preparedness poli- on the emergency (a) of this section, paragraph (a)(1) o	rocedures. [Facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this					

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

TITLE (X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UHW321 Facility ID: 000474 If continuation sheet Page 1 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155596	B. W	ING		07/28/	2022
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					VILLIAMS ST		
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER		ANGOL	A, IN 46703		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC 11		DATE
		cies and procedures must updated every 2 years					
	[annually for LTC facilities]. At a minimum,						
	the policies and procedures must address the following: (1) The provision of subsistence needs for						
	, ,	whether they evacuate or					
	·	nclude, but are not limited					
	to the following:						
	(i) Food, water, m	edical and pharmaceutical					
	supplies						
	, ,	ces of energy to maintain					
	the following:						
	, ,	to protect patient health					
	storage of provision	the safe and sanitary					
	(B) Emergency lig						
	, ,	, extinguishing, and alarm					
	systems.						
	(D) Sewage and v	vaste disposal.					
	*[For Inpatient Ho	spice at §418.113(b)(6)(iii):]					
	Policies and proce						
	(6) The following a	are additional requirements					
		ted inpatient care facilities					
		and procedures must					
	address the follow	_					
	, ,	of subsistence needs for					
		es and patients, whether shelter in place, include, but					
	are not limited to t	•					
		nedical, and pharmaceutical					
	supplies.	,					
		ces of energy to maintain					
	the following:						
	(1) Temperatures to protect patient health						
		the safe and sanitary					
	storage of provision						
	(2) Emergency lighting.						

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 2 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155996 NAME OF PROVIDER OR SUPPLIER LAKELAND REHAB AND HEALTHCARE CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (IACH DEPTICENCY MUST BE PRECEDED BY PULL AGE (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA, IN 46703 (IACH DEPTICENCY MUST BE PRECEDED BY PULL ANGOLA MUST BE PRECEDED B	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU	JRVEY	
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(i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Based on records review with the Maintenance Director and Administrator on 07/28/22 at 11:50 a.m. and at 2:00 p.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for sewage and waste disposal was not available for review. Based on interview at the time of records review, the Maintenance Director and Administrator stated the sewage and waste disposal policy could not be found. 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 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: 1) Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice and updated its Emergency Preparedness Plan to include documentation related to a sewage and waste disposal			-					
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PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155596	A. BUILDING B. WING		COMPLETED 07/28/2022
	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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
E 0037 SS=F Bldg	403.748(d)(1), 416 441.184(d)(1), 482 483.73(d)(1), 485 486.360(d)(1), 496 EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §485.68(d)(1), §4 §485.68(d)(1), §4 (1), §485.920(d)(1) §491.12(d)(1). *[For RNCHIs at §	6.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1), 1.12(d)(1) am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)		updates have been completed with Staff, Residents, and necessary visitors. 4) How the corrective action will be monitored: The Maintenance Director/designee will preset the Emergency Preparedne Plan monthly to the QAPI Committee during QAPI Meetings to ensure complet of any new necessary updat and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 08/12/2022.	s ent ss tion tes / for ne any e the

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 4 of 21

PRINTED: 08/16/2022 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC		OMB NO. 0938-039				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 	l í	(X3) DATE SURVEY COMPLETED	
		155596	B. WING		07/28	/2022	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	•		
LAKELA	ND REHAB AND H	IEALTHCARE CENTER		VILLIAMS ST .A, IN 46703			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		(X5)	
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FORM CMS-2567(02-99) Previous Versions Obsolete

preparedness training.

(v) Maintain documentation of all emergency

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1	JILDING		COMPL	
		155596	B. W	ING		07/28	/2022
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUFFLIER			500 N V	VILLIAMS ST		
LAKELAI	ND REHAB AND HI	EALTHCARE CENTER		ANGOL	A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the						
	1	_					
	updated policies a procedures.	ariu					
	procedures.						
	*[For PRTFs at §4	141.184(d):] (1) Training					
		TF must do all of the					
	following:						
	,,	n emergency preparedness					
		edures to all new and					
		viduals providing services					
		nt, and volunteers,					
		eir expected roles.					
	, ,	ning, provide emergency					
		ning every 2 years.					
	' '	staff knowledge of					
	emergency proce	mentation of all emergency					
	preparedness trai						
		cy preparedness policies					
		re significantly updated, the					
		uct training on the updated					
	policies and proce						
	-	60.84(d):] (1) The PACE					
	_	do all of the following:					
	1 ' ,	n emergency preparedness					
		edures to all new and					
	_	viduals providing on-site					
		rangement, contractors,					
		volunteers, consistent with					
	their expected role						
		ency preparedness training					
	at least every 2 ye						
	' '	staff knowledge of dures, including informing					
		at to do, where to go, and					
		n case of an emergency.					
		mentation of all training.					

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet Page 6 of 21

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		ì	UILDING	NSTRUCTION	(X3) DATE COMP. 07/28			
	PROVIDER OR SUPPLIEF	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	and procedures a	ncy preparedness policies re significantly updated, the uct training on the updated edures.						
	Training Program of the following: (i) Initial training ir policies and proce existing staff, indivunder arrangement consistent with the (ii) Provide emergat least annually. (iii) Maintain docu preparedness trait (iv) Demonstrate emergency proced* [For CORFs at & CORF must do all (i) Provide initial training proparedness policy of the following proparedness of the following procedure in the follo	mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The						
	services under an consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docu (iv) Demonstrate	rangement, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of						
	must be oriented a responsibilities regemergency plan wworkday. The traininstruction in the lasystems and signal equipment.	dures. All new personnel and assigned specific garding the CORF's vithin 2 weeks of their first ning program must include ocation and use of alarm als and firefighting ency preparedness policies						

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet Page 7 of 21

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596			ILDING	NSTRUCTION	(X3) DATE : COMPL 07/28 /	ETED	
	DER OR SUPPLIER	EALTHCARE CENTER		500 N V	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG		ΓE	(X5) COMPLETION
TAG and CO poli *[Fo pro follo (i) I poli rep pro of pre and exist und corr (ii) at I (iii) (iv) em (v) and CA poli *[Fo The em pro indi	I procedures are RF must conductions and procedures and procedures are CAHs at §48 gram. The CAF owing: nitial training in incides and procedures and procedures and procedures are rangement in the conduction of the conduction o	re significantly updated, the cuct training on the updated edures. 85.625(d):] (1) Training H must do all of the a emergency preparedness edures, including prompt inguishing of fires, incre necessary, evacuation innel, and guests, fire properation with firefighting prities, to all new and viduals providing services int, and volunteers, eir expected roles. Hency preparedness training ears. Interpretation of the training ears. Interpretation of the training ears. Interpretation of the updated edures. 1485.920(d):] (1) Training. Interpretation of the updated edures. 1485.920(d):] (1) Training. Interpretation of the updated edures. 1485.920(d):] (1) Training. Interpretation of edures and early staff, ing services under		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
the doc mu	ir expected role cumentation of st demonstrate	volunteers, consistent with es, and maintain the training. The CMHC staff knowledge of					
CM pre	HC must provi paredness train	dures. Thereafter, the de emergency ning at least every 2 years. view and interview, the facility	E 00)37	E037 Emergency Preparedne	ess	08/12/2022

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet Page 8 of 21

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/28/2022		
	PROVIDER OR SUPPLIEF	EALTHCARE CENTER	500 N	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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
TAG	failed to conduct an Emergency Prepare facility must do all training in emergen procedures to all ne individuals providin and volunteers, con roles; (ii) Provide e training at least ann documentation of a training; (iv) Demo emergency procedu 483.73(d) (1). This all residents in the factorial fa	nual training for the dness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain all emergency preparedness instrate staff knowledge of the res in accordance with 42 CFR deficient practice could affect facility. View with the Maintenance instrator on 07/28/22 at 11:50 and, no documentation of annual of documentation to show staff knowledge of the EPP was are Based on an interview at the ew, the Maintenance Director tated the EPP training was but could not find the are EPP training or	TAG	Training Plan The facility requests paper compliance for this citation This Plan of Correction is a center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider the truth of the facts alleged conclusions set forth in the statement of deficiencies. plan of correction is preparand/or executed solely bed it is required by the provise of federal and state law. 1) Immediate actions taken those residents identified No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents reside at the community has the potential to be affected the alleged deficient practically has reviewed and updated its Emergency Preparedness Plan. Communication of updates have been completed with Staff, Residents, and neces visitors. Additional trainin will take course as necessal and on a annual basis. 4) How the corrective action	in. the n of fon of s not of ed or e The red cause ions for oe d s that ave by ce //	

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 9 of 21

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155596	A. BUILDING B. WING	JNSTRUCTION	COMPLETED 07/28/2022		
	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 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 0000				will be monitored: The Maintenance Director/designee will present the Emergency Preparednes Plan monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary update and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of compliance: 08/12/2022.	on es for e ny		
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/28 Facility Number: 00 Provider Number: AIM Number: 100 At this Life Safety of and Healthcare Cencompliance with Reference Medicare/Medicaid	00474 155596	K 0000				

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 10 of 21

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155596	B. WI	NG		07/28/2022	
	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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		etion Association (NFPA) 101, SC) Chapter 19, Existing Health and 410 IAC 16.2.					
	This one story facility was determined to be of						
	Type V (111) constr	ruction and was fully					
	sprinklered. The fac	cility has a fire alarm system					
		on in the corridors and areas					
	•	s. The resident rooms on the					
		ll had hard wired smoke					
		lent rooms on the 200 hall had					
	battery operated smoke detectors. The facility has a capacity of 75 and had a census of 64 at the						
	time of this survey.	and had a census of 04 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 con	npleted on 07/29/22					
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	<u>.</u>					

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 11 of 21

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` '			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	G	01	COMPL	
		155596	B. W	ING			07/28/	/2022
NAME OF P	PROVIDER OR SUPPLIER		•	STRE	EET A	DDRESS, CITY, STATE, ZIP COD	•	
						/ILLIAMS ST		
LAKELAN	ND REHAB AND HE	EALTHCARE CENTER		ANG	GOL/	A, IN 46703		
(X4) ID		STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		DEFICIENCY)		DATE
	Provide in REMARKS information on							
	-	non-required or partial						
	automatic sprinkle	<u> </u>						
	9.7.5, 9.7.7, 9.7.8							
		on and interview, the facility	K 0	353		E053 Sprinkler System-		08/12/2022
		of 10 sprinkler heads in the				Maintenance and Testing		
		aded and covered with foreign				The facility requests paper		
		nce with LSC 9.7.5. NFPA 25,				compliance for this citation.		
	· ·	.1.1.1 sprinklers shall not show				This Plan of Correction is the	-	
		all be free of corrosion,				center's credible allegation of	of	
		aint, and physical damage; and				compliance.		
		the correct orientation (e.g.,						
		or sidewall). Furthermore, at				Preparation and/or execution		
		tler that shows signs of any of				this plan of correction does	not	
	_	be replaced: (1) Leakage (2)				constitute admission or		
		ical Damage (4) Loss of fluid in				agreement by the provider of		
	-	responsive element (5)				the truth of the facts alleged	or	
		g unless painted by the				conclusions set forth in the		
	-	arer. This deficient practice				statement of deficiencies. The		
		nd up to 25 residents in one				plan of correction is prepare		
	smoke compartmen	t.				and/or executed solely becare		
						it is required by the provision	ns	
	Findings include:					of federal and state law.		
						1)Immediate actions taken fo	r	
		on with the Maintenance				those residents identified		
		2 at 12:29 p.m., all the sprinkler				No resident was found to be		
		were loaded with dirt and				affected by the finding.		
	-	terview at the time of				2)How the facility identified		
	· · · · · · · · · · · · · · · · · · ·	nintenance Director confirmed				other residents:		
	-	in the kitchen were loaded				Visitors, staff and residents t		
	with dirt and grease					reside at the community have		
	m1					the potential to be affected b	-	
	-	viewed with the Administrator				the alleged deficient practice	•	
		irector during the exit				3) Measures put into place/		
	conference.					System changes:	_	
	2.1.10(1)					10 of 10 sprinkler heads note		
	3.1-19(b)					in the survey were evaluated		
						and cleaned of foreign		
						material.		
1			1		- 1	1) How the corrective actions		I

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 12 of 21

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		A. BUILDING <u>01</u> COMPLETED		(X3) DATE SURVEY COMPLETED 07/28/2022	
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST ILA, 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
				will be monitored: The Maintenance Director/designee will audit sprinkler heads per week to ensure they are clean of foreign material and bring the audits monthly to the QAPI Committee meeting for revies and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise in plan of correction as indicated. 5) Date of compliance: 08/12/2022.	e w t for e ny
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where and is installed for smoke to the smoke barriers and to the smoke barriers. Describe any medical system in REMAR Based on observation	nall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent ter.) chanical smoke control kKS.	K 0372	K372: Subdivision of Buildin	og 08/12/2022
		penetrations caused by the		Spaces- Smoke Barrier	33,12,2022

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

Event ID:

UHW321

Facility ID: 000474

If continuation sheet

Page 13 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED	
		155596	B. WING 07/28/2022			2022	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WILLIAMS ST		
ΙΔΚΕΙΔΙ	ND REHAR AND HI	EALTHCARE CENTER			A, IN 46703		
LAILLAI		LALITIOANE OLIVIEN		ANGOL			
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		l/or conduit through 2 of 5			Construction		
		s were protected to maintain the			The facility requests paper		
		f each smoke barrier. LSC			compliance for this citation.		
	-	aires penetrations for cables,			This Plan of Correction is th	e	
		s, pipes, tubes, vents, wires,			center's credible allegation of	of	
		accommodate electrical,			compliance.		
		ing, and communications					
		nrough a wall, floor, or			Preparation and/or execution		
	_	bly constructed as a smoke			this plan of correction does	not	
	_	the ceiling membrane of the			constitute admission or		
	_	oke barrier assembly, shall be			agreement by the provider o	f	
		em or material capable of			the truth of the facts alleged	or	
	_	ement of smoke. This deficient			conclusions set forth in the		
	practice could affect	et staff and at least 40 residents		statement of deficiencies. The			
	in three smoke com	partments.		plan of correction is prepared			
					and/or executed solely beca	use	
	Findings include:				it is required by the provisio	ns	
					of federal and state law.		
		ons with the Maintenance			1)Immediate actions taken fo	or	
	Director on 07/28/2	22 at 2:00 p.m. and at 2:10 p.m.,			those residents identified		
	the following unsea	aled penetrations were			No resident was found to be		
	discovered:				affected by the finding.		
		ceiling of the 300-hall smoke			2)How the facility identified		
	wall there were 2 up	nsealed ½ inch gaps around			other residents:		
	wires.				Visitors, staff and residents		
		ceiling of the therapy-hall			reside at the community hav		
		as an inch unsealed gap			the potential to be affected b	у	
		end of a pipe sleeve.			the alleged deficient practice	•	
		at the time of observation, the			3) Measures put into place/		
		tor agreed the aforementioned			System changes:		
	smoke walls contain	ned unsealed penetrations.			Facility has assessed all		
					identified smoke barrier		
	_	viewed with the Administrator			corridor doorways and walls	to	
		rirector during the exit			ensure no penetrations are		
	conference.				present. Any penetrations		
					identified in the audit will be		
	3.1-19(b)				corrected. Areas A and B	3	
					noted in the 2567 have been		
					corrected.		
					4)How the corrective actions	;	

PRINTED: 08/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 01 COMPLETI B. WING 07/28/20			ETED		
	PROVIDER OR SUPPLIE	R EALTHCARE CENTER		500 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST .A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Butarrie Subdivision of Butarrie Subdivision of Butarrier Doors 2012 EXISTING Doors in smoke to solid bonded wood construction that Nonrated protectiare permitted. Dofixed fire window are self-closing or require latching, a in the direction of	illding Spaces - Smoke illding Spaces - Smoke sarriers are 1-3/4-inch thick ad-core doors or of resists fire for 20 minutes. ve plates of unlimited height sors are permitted to have assemblies per 8.5. Doors r automatic-closing, do not and are not required to swing egress travel. Door opening um clear width of 32 inches orizontal doors.			will be monitored: The Maintenance Director/designee will inspessmoke barrier walls and corridor doors monthly for functionality. Completion inspection will be presented the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 08/12/2022	of I to I for e any e the	

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPLETED		
155596		B. WING 07/28/2022			22		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
	ID DELLAD AND LIE				WILLIAMS ST		
LAKELAI	ND KEHAR AND H	EALTHCARE CENTER		ANGOL	_A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
	Based on observation	on and interview, the facility	K 0	374	K374: Subdivision of Buildin	q 0	8/12/2022
	failed to ensure 1 of	f 5 sets of smoke barrier doors		-, -	Spaces- Smoke Barrier Door	-	
	assemblies would re	estrict the movement of smoke			The facility requests paper		
		tes. This deficient practice			compliance for this citation.		
	could affect 30 resid	-			This Plan of Correction is the	e	
	compartments				center's credible allegation of		
	-				compliance.		
	Finding include:						
	8				Preparation and/or execution	n of	
	Based on observation	ons with the Maintenance			this plan of correction does		
		22 at 1:50 p.m., the smoke barrier			constitute admission or		
		herapy had two holes			agreement by the provider o	f	
		n inch that went through the			the truth of the facts alleged		
	-	on an interview at the time of			conclusions set forth in the		
		aintenance Director agreed			statement of deficiencies. T	he	
		rough the smoke door frame.			plan of correction is prepare		
	unoro woro noros un	a cugar une camene u cer munier			and/or executed solely beca		
	This finding was re	viewed with the Administrator			it is required by the provisio		
	-	rirector during the exit			of federal and state law.		
	conference.				1)Immediate actions taken fo	or	
					those residents identified		
	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 at the community hav		
					the potential to be affected b		
					the alleged deficient practice	-	
					3) Measures put into place/		
					System changes:		
					Facility has assessed all		
					identified smoke barrier		
					corridor doorway assemblies	s to	
					ensure proper functionality a		
					no penetrations are present.		
					Any areas of concern identif	ied	
					in the audit will be		
					corrected. The two holes		
					noted in the 2567 on the smo	ke	

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		•			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01	CON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596 NAME OF PROVIDER OR SUPPLIER LAKELAND REHAB AND HEALTHCARE CENTER		A. BUILDIN B. WING STR 500	E CONSTRUCTION G 01 EET ADDRESS, CITY, STATE, ZIP COD N WILLIAMS ST GOLA, IN 46703	COM 07/2	(X3) DATE SURVEY COMPLETED 07/28/2022	
(X4) ID	T	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAC	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	LD BE	COMPLETION DATE
K 0761 SS=E Bldg. 01	failed to maintain a fire door in accordarequires any device condition, arrangen other feature is requ provision of this Co system, condition, a protection, or other maintained unless t maintenance. NFP, assemblies shall be	on and interview, the facility nnual testing of 1 of 1 rolling ance with NFPA 80. LSC 4.5.8 and, equipment, system, nent, level of protection, or any aired for compliance with the ode, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such A 80 5.2.1 requires fire door inspected and tested not less a written record of the	K 0761	barrier door assembly heen corrected. 4)How the corrective act will be monitored: The Maintenance Director/designee will in smoke barrier walls and corridor doors monthly functionality. Completed inspection will be presented QAPI Committee. The port will be reviewed in Quality Assurance Meet monthly for 6 months or 100% compliance is ach The QA Committee will in any trends or patterns a make recommendations revise the plan of correction dicated. 5) Date of compliance: 08/12/2022. K761 Maintenance, Inspection of the facility requests paragraphic paragraphic compliance. Preparation and/or executing plan of correction of constitute admission or agreement by the provice the truth of the facts allegated.	spect for tion of nted to he n ing until ieved. dentify nd to tion as	08/12/2022

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet

Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/28/2022	
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	500 N \	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST .A, IN 46703	
	SUMMARY (EACH DEFICIENT REGULATORY OF inspection shall be by the AHJ. This do residents in the main Findings include: Based on observation Director on 07/28/2 rolling fire door/windining room. The tain indicated the last ar July 2020. Based on observation, the Material fire door/window he July of 2020. The finding was revenue.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION signed and kept for inspection eficient practice could affect 25	500 N \	WILLIAMS ST	that e ed use ns or ed ee eis e
				Committee. The report will reviewed in Quality Assurant Meeting annually to ensure 100% compliance is achieve The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated.	ce d. tify

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155596					07/28/	/2022	
				OTTO FEET	ADDRESS OF A STATE SIDE OF		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
		TALTUCADE CENTED			VILLIAMS ST		
LAKELAI	ND KEHAB AND HE	EALTHCARE CENTER		ANGOL	A, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					5) Date of compliance:		
					08/12/2022.		
K 0914	NFPA 101						
SS=F	Electrical Systems	s - Maintenance and					
Bldg. 01	Testing						
	Electrical Systems	s - Maintenance and					
	Testing						
		ceptacles at patient bed				ļ	
		re deep sedation or general					
		ninistered, are tested after					
		replacement or servicing.					
	_	is performed at intervals					
	1	ented performance data.					
	1	sted as hospital-grade at					
		e tested at intervals not					
	_	nths. Line isolation monitors					
		are tested at intervals of					
		to 1 month by actuating					
		n per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
		utomated self-testing, this					
		formed at intervals less					
	I -	2 months. LIM circuits are					
	1	.2 after any repair or					
		electric distribution system. tained of required tests and					
	associated repairs	•					
		oom or area tested, and					
	results.	Doill of alea tested, and					
	6.3.4 (NFPA 99)						
		on, record review and	K 09	014	K914: Electrical Systems-	ļ	08/12/2022
		ty failed to ensure non-hospital	15 0	/1 ↑	Maintenance and Testing		00/12/2022
		eptacles at 43 of 43 resident			The facility requests paper		
	_	e tested at least annually.			compliance for this citation.		
	NFPA 99, Health Care Facilities Code 2012 Edition,				This Plan of Correction is the	e	
	· ·	ates receptacles not listed as			center's credible allegation of	•	
		atient bed locations and in			compliance.		
		ep sedation or general				ļ	
		istered, shall be tested at			Preparation and/or execution	າ of	
I	l	,	1		1		I

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

Event ID:

UHW321 Facility ID: 000474

If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) 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 07/28/2022		
	PROVIDER OR SUPPLIER	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ling 12 months. Additionally,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) this plan of correction doe	BE COMPLETION DATE	
	Rooms requires the receptacle shall be of the continuity of the	physical integrity of each confirmed by visual inspection. The grounding circuit in each eshall be verified. Correct		constitute admission or agreement by the provider the truth of the facts alleg- conclusions set forth in the statement of deficiencies.	ed or ne	
	polarity of the hot a each electrical recep retention force of the electrical receptacles	nd neutral connections in otacle shall be confirmed; and he grounding blade of each e(except locking-type		plan of correction is prepa and/or executed solely be it is required by the provis of federal and state law.	ared cause sions	
	receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include:			1)Immediate actions taken those residents identified No resident was found to I affected by the finding. 2)How the facility identified	ре	
	Based on observations during a tour of the facility with the Maintenance Director on 07/28/22 between 12:00 p.m. and 2:00 p.m., the facility's 43			other residents: Visitors, staff and resident reside at the community h the potential to be affected the alleged deficient practi	ave I by	
	resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknow the last			Measures put into place System changes: Facility has completed and testing on 43 of the 43	of .	
				receptacles located in the resident sleeping rooms. 4)How the corrective actio will be monitored: The Maintenance	ns	
	time the annual test This finding was re and Maintenance D			Director/designee will test the 43 noted receptacles monthly and present finding the QAPI Committee during	ngs to	
	conference. 3.1-19(b)			QAPI Meetings to ensure compliance. The report was be reviewed in Quality Assurance Meeting month 6 months or until 100% compliance is achieved. To QA Committee will identify	ly for he	

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ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-0
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED
	155596	B. WING	07/28/2022
		CTREET ADDRESS CITY STATE 7ID COD	

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 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 08/12/2022

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UHW321 Facility ID: 000474 If continuation sheet Page 21 of 21