10/11/2024

						1 10114	1ED. 10/11/2021	
DEPARTMENT	FORM APPROVED							
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (2)			(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED		
		155596	B. WING		09/24/2024			
NAME OF PROVIDER OR SUPPLIER LAKELAND REHAB AND HEALTHCARE 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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	

LAKELA	ND REHAB AND HEALTHCARE CENTER	ANGC	ANGOLA, IN 46703			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
0000						
Bldg. 02						
	An investigation of Complaint Number	K 0000	/p>			
	IN00443208 was conducted by the Indiana		/p>			
	Department of Health in accordance with 42 CFR		/p>			
	483.90(a).		/p>			
			/p>			
	Complaint Number IN00443208 - A Federal/State		/p>			
	deficiency related to the allegation was cited at		/p>			
	K0511.		/p>			
			/p>			
	Survey Date: 09/24/24		/p>			
			/p>			
	Facility Number: 000474		/p>			
	Provider Number: 155596		/p>			
	AIM Number: 100290510		/p>			
			/p>			
	At this Complaint survey, Lakeland Rehab and		/p>			
	Healthcare Center was found not in compliance		/p>			
	with Requirements for Participation in		/p>			
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),		/p>			
	Life Safety from Fire and the 2012 edition of the		/p>			
	National Fire Protection Association (NFPA) 101,		/p>			
	Life Safety Code (LSC), Chapter 19, Existing		/p>			
	Health Care Occupancies and 410 IAC 16.2.		/p>			
			/p>			
	This one-story facility was determined to be of		="" p="">			
	Type V (111) construction and was fully		="" p="">			
	sprinklered. The facility has a fire alarm system		="" p="">			
	with smoke detection in the corridors and areas		="" p="">			
	open to the corridors. The resident rooms on the		="" p="">			
	300-hall and 400-hall had hard wired smoke		="" p="">			
	detectors. The resident rooms on the 200-hall had		="" p="">			
	battery operated smoke detectors. The facility has		="" p="">			
	a capacity of 75 and had a census of 67 at the time		="" p="">			
	of this survey.		="" p="">			
			="" p="">			
	All areas where the residents have customary		="" p="">			
	access were sprinklered. The facility had a		="" p="">			

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

TITLE (X6) DATE

Lindsey Floyd 10/07/2024

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 09/24/2024			
		.0000		ADDRESS, CITY, STATE, ZIP COD	30/2 1/202 1		
NAME OF I	PROVIDER OR SUPPLIE	R		WILLIAMS ST			
LAKELAI	ND REHAB AND H	EALTHCARE CENTER	ANGOLA, IN 46703				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		viding facility services		="" p="">			
	sprinklered.	ance supplies, that was not		="" p="">			
	sprinklered.			="" p=""> ="" p="">			
	Ouality Review co	mpleted on 09/25/24		="" p="">			
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	p. 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,		="" p="">			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W1IT21

Facility ID: 000474

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 10/11/2024
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
l i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED		
		155596	B. WING		09/24/2024		
			<u> </u>				
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD			
	White of Trovider or soft elek			WILLIAMS ST			
LAKELAI	ND REHAB AND HI	EALTHCARE CENTER	ANGO	_A, IN 46703			
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE	ID	I	(X5)		
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(A3)		
PREFIX	*	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE		
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Event ID:

W1IT21

Facility ID: 000474

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

PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED		
		155596	B. WING 09/24/2024					
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 500 N WILLIAMS ST ANGOLA, IN 46703					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDERIC DI ANI OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
					="" p="">			
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and	Electric						
2.13. 01	failed to ensure 1 of resident room 309 w Edition. Article 406 Receptacles shall be terminals are not ex	on and interview, the facility 1 electrical junction box in was protected. NFPA 70, 2011 1.5 (F) Exposed Terminals, 2 enclosed so that live wiring posed to contact. This bull affect staff and 1 resident	K 0.	511	K511 Utilities – Gas and Electric The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation compliance.		10/10/2024	

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Facility ID: 000474

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Preparation and/or execution of

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STATEMENT OF DEFICIENCIES X1) PH		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED			
155596		155596	B. W.	ING		09/24/2024			
<u> </u>				CTREET	ADDRESS SITY STATE TIP SOD				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
LAKELAND DELLAD AND LIEAL THOADE OF NED				500 N WILLIAMS ST					
LAKELAI	ND KEHAB AND HI	EALTHCARE CENTER		ANGOLA, IN 46703					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE			
Findings include:					this plan of correction does	not			
					constitute admission or				
	Based on observation	on and interview with the			agreement by the provider o	f			
	Executive Director	on 9/24/24 at 1:22 p.m., there			the truth of the facts alleged	or			
	was electrical wirin	ng hanging from an open			conclusions set forth in the				
	junction box withou	ut a cover plate near the smoke			statement of deficiencies. T	'he			
	alarm on the ceiling	g. Based on interview at the			plan of correction is prepare	ed			
	time of observation	, the Executive Director did not			and/or executed solely beca	use			
	know what the wiri	ng was for and did not know			it is required by the provisio	ns			
	why it was like that	but did acknowledge the			of federal and state law.				
	junction box was of	pen with exposed wires			1)Immediate actions taken fo	or			
	hanging.				those residents identified:				
					No resident was found to be				
	This finding was reviewed with the Executive				affected by the finding.				
	Director at the exit conference.				2)How the facility identified				
					other residents:				
	3.1-19(b)				Visitors, staff, and residents				
					that reside in the community	,			
	_	ates to complaint number			have the potential to be				
	IN00443208.				affected by the alleged				
					deficient practice.				
					3)Measures put into				
					place/System changes				
					Wiring for outdated fire				
					detection device was remove				
					and penetration was filled ar	nd			
					patched.				
					4)How the corrective action	will			
					be monitored:				
					The Maintenance				
					Director/designee will preser	nt			
					a weekly audit of 5 room				
					inspections monthly to the				
					QAPI Committee during QAF				
					Meetings to ensure completi				
					of any new necessary update	es			
					and compliance. The report				
					will be reviewed in Quality	_			
					Assurance Meeting monthly	for			
					6 months or until 100%				

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155596	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		<u>02</u>	(X3) DATE SURVEY COMPLETED 09/24/2024	
NAME OF PROVIDER OR SUPPLIER LAKELAND REHAB AND HEALTHCARE CENTER			500 N WILLIAMS ST ANGOLA, IN 46703				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
					compliance is achieved. The QA Committee will identify at trends or patterns and make recommendations to revise t plan of correction as indicated. 5) Date of Compliance: 10 October 2024	-	

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