STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2011
NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN46703	

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F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: 10/4, 5, 6 and 11/2011 Facility number: 000426 Provider number: 155449 AIM number: 100275480 Survey team: Carol Miller, RN (10/4-7/2011) Ellen Ruppel, RN Ann Armey, RN (10/5-7 and 10/11/2011) Census bed type: SNF: 6 SNF/NF: 77 Total: 83 Census payor type: Medicare: 12 Medicaid: 44 Other: 27 Total: 83 Sample: 17 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/13/11	F0000	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individulas who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Included is the Plan of Correction for our Annual Recertification & State Licensure Survey for Northern Lakes Nursing & Rehabilitation Center. The Plan of Correction is also to serve as our Credible Allegation of Compliance. Northern Lakes respectfully requests that substantial compliance be established through all paperwork submitted with this plan of correction.This facility respectfully requests that with the submission of attachments that our plan of correction receive a desk review. _____	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	Cathy Emswiller RN			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview, record review and, the facility failed to follow the care plan and facility policy for prevention of constipation for 1 of 2 residents with constipation issues in a sample of 17. Resident #90 Findings include: The clinical record of Resident #90 was reviewed, on 10/4/11 at 10:15 a.m., and indicated the resident had been admitted to the facility on 2/25/10. His diagnoses included, but were not limited to: hypertension, thrombocytopenia, seizures and cerebrovascular accident (stroke). The Minimum Data Set (MDS) assessment, of 9/5/11, indicated the resident was unable to get to the bathroom without assistance and was unable to toilet himself.	F0309	F 309 Facility was unable to take any further action on resident #90. All bowel movement records were reviewed for all in-house residents by the Director of Nursing on October 10, 2011 (see attached initial audit), and if indicated bowel assessments completed and physician notified. All nurses and nurse aides have been re-educated on Bowel Protocol by the Director of Nursing (see attached inservice log). Nursing 24-hour Report was updated and now includes "Bowel Protocol Initiated". (see attached sample report) The Director of Nursing is completing audit of BM records every Monday, Wednesday, and Friday for 4 weeks (see attached audit form) and present findings to the QA Committee weekly. Then the Director of Nursing will complete audit every Monday and Thursday (see attached audit form) for 2 weeks and present to QA	11/04/2011

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	Nurses notes of 8/26/11 at 10:00 p.m., indicated the resident refused to be assessed. During an interview with the Director of Nursing (DoN), on 10/5/11 at 11:00 a.m., indicated the resident was not able to cleanse himself after a bowel movement and would have needed the help of a staff member. She indicated he frequently refused both medications and overall assessment. The nurses notes, dated 9/14/11 at 5:00 p.m., indicated "Resident given Miralax in prune juice c (with) dinner d/t (due to) 0 (no) BM (bowel movement) X (times) 7 days." Review of the flow sheet completed by aides indicated the resident had a medium bowel movement on 9/13/11. There were no nurses notes from 9/14/11 to 9/30/11. There was no documentation to indicate the resident's abdomen had been assessed or he had been offered the Miralax and had refused it until 9/21/11, when he accepted it. The bowel movement record also indicated Resident #90 had gone from having a bowel movement on 9/21/11 to 9/30/11. Physician's progress notes, dated 9/20/11, indicated "Abdomen is soft and		weekly. If continued compliance is maintained the BM record audit will be placed on QA schedule to continue monitoring Quarterly.	

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	non tender. No masses." The physician was interviewed, on 10/4/11 at 11:15 a.m., and indicated he was aware the resident was frequently refusing medications, nursing assessments and just wanted to be left alone to die. Review of physician's orders, dated 2/22/11 indicated 17 Grams (Gm) of Miralax powder in 8 oz of juice was to be given as needed for constipation. The order was clarified, on 9/15/11 for the Miralax to be given daily if needed. The MAR (medication administration record) indicated the Miralax had been given on 9/21/11, with no results. Review of the care plan, related to constipation, with no starting date specified indicated, "BM (bowel movement) q (every) 1-3 days thru next review. Nursing will monitor for s/s (signs and symptoms) of constipation thru next review." The review date was listed as 12/11. The approach was to give Miralax as ordered, 4 oz prune juice daily as needed and bran mix at breakfast as needed. There was no documentation to indicated the Miralax was offered/given as ordered or the prune juice was provided daily when the resident had no bowel			

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	movement every 1-3 days. There was no documentation the monitoring for signs of constipation was being done from 9/14/11 when the Miralax was given to 9/20/11, when the physician wrote the progress note indicating the abdomen was soft and non tender. No nursing notes were documented from the 9/14/11 note until 9/30/11. The resident was sent to the emergency room, on 9/30/11, with an acute right hemispheric hemorrhage. 3.1-37(a)			
F0364 SS=E	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interviews, facility failed to assure food being served to residents in their rooms was hot. This deficiency affected 8 of 23, who	F0364	F 364 The Dietary Manager interviewed all alert residents during a resident group meeting on October 11, 2011 (see initial resident meeting notes) to ensure that food	11/07/2011

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	received room trays of 23 present during the group meeting. (Unique identifiers given to provide confidentiality of residents Residents #100, #101, #102, #103, #104, #105, #106 and #107). This affected residents #108 , #109 and #110 who received room trays and did not attend the group meeting and wished to remain unidentified. Findings include: On 10/5/11, at 10:45 a.m., resident council minutes were reviewed. Resident Council minutes indicated the following concerns: On 6/3/11, that the meals being served in the rooms were not hot. The minutes indicated, "... Hot meals should be served hot... (room trays)..." On 7/25/11, residents complained the soup was cold. On 9/27/11, "... Meals are cold when ... residents get floor trays..." On 10/5/11 at 10:15 a.m., during the group meeting, with residents identified as interviewable by the facility, 8 of 23 residents expressed concern about cold food. The concern indicated the trays arrived on the unit, during the evening meal, but were not served promptly, as a result the food was cold.		temperatures are still being maintained especially on hall carts. The Dietary Manager or designee also has test tray on evening hall cart and is obtaining & logging temperatures per facility policy (see attached temp log). Temperatures have been maintained as they had during survey. The Dietary Manager will interview a sample of resident families to monitor for meal service concerns weekly for 4 weeks (see attached audit) and report findings to the QA committee. Dietary staff and nursing staff have been re-educated on maintaining proper temperatures of food served (see attached inservice). Continued food temperature audits will be obtained for evening shift hall carts weekly on each hall for 4 weeks (see attached log) and log will be presented to the Quality Assurance Committee weekly for 4 weeks. If we maintain compliance with temperatures the Dietary Manager or designee will then check test tray every two weeks for one month and present findings to the QA Committee and if temperatures continue to be maintained we will add to QA Schedule for Quarterly review (see attached QA Schedule). Dietary Satisfaction will continue to be part of Resident Council Meetings.	

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	On 10/5/11 at 4:45 p.m., a test tray was requested for the room trays. On 10/5/11 at 5:10 p.m., the temperature of the food on the test tray was checked by the dietary manager and was warm (beef stew was 161 degrees Fahrenheit). On 10/5/11 at 5:15 p.m., a family member of Resident #71, who was feeding his wife, indicated the meals "were beautiful and wonderful, last evening and this evening but before that the soup, stew and other food was cold." The family member indicated this had been a frequent concern for six months. On 10/5/11 at 5:15 p.m., two residents, (Residents #108 and #109) who had receive room trays and who chose not to be identified, were interviewed. One of the residents (#108) indicated, "It's feast or famine around here. Tonight it's a feast, but often it's famine with cold food." A second resident (#106) indicated the food was good and warm but usually the food on the room trays was cold and the soup was also cold at times. During an interview on 10/7/11 at 2:15 p.m., the Food Service Supervisor (FSS) indicated, she had been checking the food temperatures on the room trays as a response to the resident council minutes			

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	of 9/27/11. Review of monitoring logs, on 10/7/11 at 2:20 p.m., indicated the meals being monitored were for the noon meals, rather than the evening meals about which the residents had concerns. Review of the 1998 food temperature policy, on 10/7/11 at 2:20 p.m., provided by the administrator indicated, in part: "7. Temperatures will be monitored weekly by the Food Service Supervisor for trays delivered to rooms or hall areas." During an interview with the FSS, on 10/11/11 at 3:15 p.m., she indicated a total of 18 residents received trays in their rooms and she had been monitoring temperatures of room trays, but had not recorded them. She indicated she thought the problem had been solved on 9/27/11, after three days of monitoring. 3.1-21(a)(2)			

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F0368 SS=E	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interviews, record review and observation, the facility failed to offer residents a snack at bedtime. This deficiency affected 23 of 23 residents attending the resident group meeting, and potentially affected 66 non-diabetic residents in the facility of 83 residents. Residents #32, 69, 11, 75, 19, 77, 76, 22, 35, 67, 29, 70, 18, 83, 30, 65, 81, 1, 17, 23, 78, 7, and 28. Findings include: During the resident group meeting, on 10/5/11 at 10:15 a.m., 23 residents (Residents #32, 69, 11, 75, 19, 77, 76, 22, 35, 67, 29, 70, 18, 83, 30, 65, 81, 1, 17, 23, 78, 7, and 28), who had been identified as alert and interviewable by facility staff attended.	F0368	F 368 IDR (INFORMAL DISPUTE RESOLUTION) Interviewable residents were questioned by the Dietary Manager about receiving HS Snacks at a group meeting on October 10, 2011. During resident group meeting on October 18, 2011 it was agreed by all interviewable residents that they would sign that they were offered a snack and accepted or refused and they all agreed. Dietary Manager has the evening shift cook place date on snack basket as well as drink containers. The snack baskets are collected each morning and restocked with snacks, and new date. The Dietary Manager has re-educated dietary staff and nursing staff on offering and obtaining signatures of interviewable residents for HS Snacks every night (see attached	11/10/2011

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	When queried about being offered a snack at bedtime all of the residents present indicated they were not offered something each night at bedtime. Two of the residents (who asked not to be identified) indicated if residents wanted something to eat at bedtime, they had to go to the desk and ask for it. They indicated the diabetic residents were usually given something, but the remainder of the residents were not offered anything. The two food pantries in the facility were observed, with the Director of Nursing (DoN) on 10/6/11 at 9:10 a.m. The West area of the facility had no drinks present in the refrigerator and a plastic container of graham crackers, saltines and single packaged cookies was observed to have enough items to cover the bottom of the container. The East area refrigerator had two full containers of lemonade and half a pitcher of apple juice in it. The containers were dated 10/5/11. There was a container of crackers and cookies was one third full. No date was on the container. LPN #3 was interviewed about snack records, on 10/6/11 at 9:30 a.m. She indicated she thought the bedtime snacks were recorded on the medication or treatment sheets. Review of the current		inservice). Dietary Manager and Director of Nursing is completing interviews daily with residents to ensure they received HS Snack the night before, and they are meeting with interviewable residents weekly (see attached resident group meeting minutes), this will be reported to the Quality Assurance Committee meeting weekly, if 100% satisfaction obtained thru interview process then they will interview weekly for two weeks and report to QA Committee, if satisfaction is maintained we will add this to Monthly Resident Council Discussion and the Quarterly QA Schedule for continued compliance.	

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	Medication Administration Records (MARS) and current Treatment Administration Records (TARS), of the sampled 17 residents, (Residents 49, 90, 13, 7, 23, 3, 29, 78, 20, 24, 50, 22, 21, 36, 89, 92 and 91) on 10/6/11 at 9:45 a.m., indicated no record of snacks present on either record. The food consumption records were also checked and no records of bedtime snacks were present on the records. The Dietary Manager was queried, on 10/6/11 at 10:00 a.m., about the provision of snacks. She indicated the snacks were sent out at 7:00 p.m., each night by kitchen staff and nursing was to serve the snacks at bedtime. Certified Nursing Assistant (CNA) #5, who worked evenings, was queried, on 10/6/11 at 1:30 p.m., about bedtime snacks for residents. He indicated "several months ago" snacks were given out at bedtime, but the aides had not been offering snacks until the evening of 10/5/11, when the issue was brought up. He indicated many of the residents were going to bed before the snacks were brought out. During an interview with the Administrator, on 10/6/11 at 1:45 p.m., she indicated there had been a break down			

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	in the bedtime snack provision, and measures were underway to correct the issue. She indicated, starting the evening of 10/5/11, all residents were being offered snacks and the amounts they were eating would be recorded. 3.1-21(e)			
F0456 SS=E	The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1. Based on observation, interview and record review, the facility failed to assure the window screens in 2 of 17 sampled resident's rooms and one additional resident room were in good condition to prevent flies from being present. This deficiency affected 3 of 17 resident rooms potentially affecting 4 of 4 residents. (Residents #13 and #36 and supplemental residents #72 and #73) 2. Based on observation, interviews and record review, the facility failed to ensure the glucose monitoring devices in the	F0456	F 456 IDR (INFORMAL DISPUTE RESOLUTION) Maintenance staff replaced all screens identified by surveyors immediately, and then inspected all window screens and replaced as indicated (see attached inspection logs). The Maintenance Director and Environmental Director has updated daily cleaning schedule, deep clean schedule, and preventative maintenance schedule to include inspection of window screens (see attached) The administrator re-educated Maintenance and Environmental Director on Federal Regulations on maintaining all essential	11/10/2011

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	facility were monitored for accuracy. This deficiency had the potential to affect 22 of 22 diabetic residents in the facility. Findings include: 1. a. On 10/6/11 at 2:45 p.m., Resident #13 was observed in bed and was unresponsive to voice. On 10/6/11 at 2:45 p.m., CNA #4 was notified that there were flies in Resident #13's room. On 10/6/11 at 2:55 p.m., Resident #13 was observed. Five flies were in the room and were on the resident's face, hands and bedding. The window in the room was open and the screen was bowed away from the frame allowing flies to enter the room. During an interview on 10/7/11 at 2:10 p.m., the Administrator indicated the screen was repaired. b. During an interview with the family member of Resident #36, on 10/6/11 at 1:45 p.m. During observation at that time, the screen in the window was observed pushed out, leaving a gap between the screen and window sill. The window was open and no flies were present in the		equipment, window screen monitoring, Pest Control (see attached inservice). All maintenance and environmental staff were educated to new cleaning schedules, preventative maintenance schedules, monitoring and reporting reapirs and maintenance (see attached inservice). Maintenance staff will inspect window screens every two weeks for one month and report to Quality Assurance Committee weekly, then monthly for 3 months, if compliance is maintained window screen inspections will be placed on QA Schedule for ongoing quarterly inspections (see attached inspection logs) The Director of Nursing immediately performed Control Solution Test on all Glucometers. Central Supply has been instructed to place sticker on all test strip boxes reminding nurses to complete control test on glucometer when opening new box. Third shift routinely completes Control Test on all glucometers. Nurses have be re-educated on Control Solution Testing including new glucose meter; new box of test strips; suspect that the test results are not accurate, they were instructed if they drop or expose the meter to liquids other than blood samples that they need to obtain new meter (see attached inservice). The Director of Nursing completes audit every Monday, Wednesday, and Friday	

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	room. c . Observation of the room of (Residents #71 and #72) on 10/5/11 at 1:05 p.m., the window screen was pushed out, leaving a gap between the screen and window sill. No flies were observed and the window which was open. 2. During the environmental observation of the medication room covering two units in the facility, on 10/7/11 at 1:15 p.m., LPN#6 was queried about the system of calibrating the glucose testing equipment. LPN #6 indicated the facility had new devices, which had been in use for two months. When the logs provided by the DoN, on 10/7/11 at 2:00 p.m., for monitoring the testing of the meters was reviewed, the dates on the sheets indicated last test of a meter on the Sandy Shore unit had been 8/7/10, the meter on the Piers unit was last checked 1/8/11 and the one on the Coves unit was last checked on 10/16/10. There was no record for the Island Park unit. The Director of Nursing (DoN) was queried about the date the new Presto meters had been placed in service. She indicated the new one was placed on the Sandy Shores unit on 9/5/11, the one on		on Coves hall that has the majority of our Diabetics, and all other halls weekly for one month (see attached audits), and report findings to the Quality Assurance Committee weekly. If substantial compliance maintained this will be placed on QA Schedule for Quarterly reviews for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2011
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	the Piers unit on 9/1/11 the one on the Coves unit on 9/22/11 and the one on Island Park on 8/20/11. She indicated, on 10/11/11 at 3:00 p.m., the facility housed 22 residents who were being checked with the meters. Review of the information supplied by the manufacturer, on 10/7/11 at 2:15 p.m., indicated, "Control solution tests should be performed when you: [1] First get the WaveSense Presto Pro Meter. [2] Begin using a new vial of WaveSense Presto Test Strips. [3] Suspect that the WaveSense Presto Pro Meter or WaveSense Presto Test Strips are not working properly. [4] Think that the test results are not accurate. [5] Have dropped or damaged the meter or exposed the meter to liquids other than blood samples. [6] May have exposed the WaveSense Presto Test Strips to temperatures blow 46 (degrees) F (8 degrees C) or above 86 F (30 C) or humidity above 90%." During an interview with the DoN, on 10/7/11 at 2:30 p.m., she indicated there had been no inservice related to the new glucose monitors, and there was no			

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	documentation any testing had been done. 3.1-19(bb)			