STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155449	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410058 and IN00410262. Complaint IN00410058 - Federal/state deficiencies related to the allegations are cited at F604. Complaint IN00410262 - Federal/state deficiencies related to the allegations are cited at F604. Survey dates: June 15 and 16, 2023. Facility number: 000426 Provider number: 155449 AIM number: 100275480 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 3 Medicaid: 48 Other: 28 Total: 79 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 19, 2023	F 0000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly.	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any			

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

Dee Anna Smallman | Administrator | 06/28/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155449	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 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
	physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview and record review the facility failed to ensure residents were free from physical restraint for 1 of 6 residents reviewed (Resident B). Findings include: An investigation file was provided by the Administrator on 6/15/23 at 2:50 PM. The file included a facility reported incident dated 6/3/23. The report indicated on 6/3/23 Licensed Practical Nurse (LPN) 2 arrived for her shift and noted Resident B had a gait belt around his waist attached to a BRODA (specific wheelchair). LPN 2	F 0604	The facility respectfully requests that a desk review for substantial compliance be conducted for F0604. F 0604 The Director of Nursing and Assistant Director of Nursing immediately reviewed all other residents in the facility to ensure no other residents were affected by this practice of restraint use. The administrator did notify and meet with hospice providers to	07/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155449	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 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
	received report from Registered Nurse (RN) 3. RN 3 indicated she restrained Resident B due to restlessness and fall prevention. RN 3 also indicated she did not obtain an order from the doctor for the restraint. A resident abuse investigation form indicated RN 3 restrained Resident B. The form also indicated RN 3 quit when the facility requested a statement regarding the incident. The file also included statements as follows: LPN 2's statement, dated 6/3/23, indicated she arrived for her shift at 5:45 AM and observed Resident B at the nurses station. LPN 2 indicated Resident B had "a gait belt applied" around his waist and a BRODA chair as a restraint. LPN 2 received report from RN 3. The report included Resident B was "out of control" all evening, fell and the restraint was the only way to keep him from falling again. LPN 2 indicated she immediately removed the restraint, completed a complete body assessment and did not find any marks or redness. Certified Nurse Aide (CNA) 4's statement, dated 6/3/23, indicated Resident B fell on her shift and was restless. CNA 4 indicated they placed a restraint on Resident B, with the use of a gait belt. In an interview on 6/15/23 at 2:40 PM, LPN 2 indicated on 6/3/23 AM she observed Resident B at the nurse's station with his gown mostly off, no blankets and with a gait belt around his chest and his broda chair. LPN 2 indicated she removed the gait belt and performed a skin assessment. She indicated there were no marks or redness. LPN 2 indicated RN 3 did not obtain a doctor's order for the restraint.		establish expectation of support and staff assistance required when we have a resident under hospice that has experienced a change of condition and current plan of care is not resolving the issues. All nurses were informed by the administrator to communicate with hospice providers that they expect a nurse to come to facility and reassess resident. All nurses were reinstructed on Restraint use and facility policy review by the Staff Development Coordinator. The administrator reinstructed the management team on facility policy on restraint use, notification of the administrator, investigation of allegations of abuse and reports of any staff not following facility policy. All staff have been reinstructed on Restraint Policy, Reporting Allegations of Abuse, employees not following facility policy to the administrator, and they were provided the administrators phone number to report any concerns or allegations. The new hire process for nursing staff now includes review of Restraint Use Policy, Notification of Administrator with administrator's phone number (see attached flyer). In addition, we	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155449	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 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
	In an interview on 6/16/23 at 9:40 AM, the Administrator and Director of Nursing (DON) indicated on 6/2/23 Resident B had behaviors and anxiety. The Administrator indicated RN 3 administered as needed medication and spoke with the hospice provider, but no medication was effective. The Administrator indicated RN 3 felt "the only option was to secure the resident to the chair with a restraint." LPN 2 arrived for her shift, noticed the gait belt restraint and removed the restraint. LPN 2 then reported to the DON and Administrator. The DON indicated she received a text message from RN 3 around 5:23 AM. The message indicated Resident B was up all night, as needed medications were not effective and RN 3 seat belted him to his chair with a gait belt. The DON indicated RN 3 also messaged her she was aware the belt was a restraint but it was the "only way to keep him safe." The DON indicated to RN 3 she should have called the DON. In an interview on 6/15/23 at 2:32 PM, LPN 5 indicated a restraint was anything that restricted the resident from movement. LPN 5 indicated if a resident were anxious or being combative, staff offered snacks, drinks, music, the toilet and as needed medications. Resident B's record was reviewed on 6/16/23 at 8:50 AM. Diagnoses included restlessness, agitation and insomnia. A nursing note, dated 6/3/23 at 12:56 AM, indicated Resident B was agitated, combative and confused. RN 3 administered as needed medication and indicated the medication was somewhat effective. Resident B was brought to the nurse's station for one on one monitoring for fall prevention.		have increased our ongoing mandatory inservice calendar to include training on Abuse Prohibition, Reporting, Restraint Use, Notification of Administrator, Notification of Hospice Nurse. The clinical management team that includes the Director of Nursing, Assistant Director of Nursing, Social Services, and Administrator will review previous day progress notes, 24-hour nursing reports, new orders, behavior logs to determine if a resident is experiencing changes in mood, behavior, anxiety, terminal restlessness, restlessness, insomnia and other areas that may cause increased risk of falls or uncontrolled behaviors to ensure appropriate notification of the physician, Behavioral Health NP, or Hospice Nurse has been completed, assessments completed to rule out possible health reasons or med reasons for change and to follow-up to ensure resolution of the issue identified in morning meeting. Residents with changes will be identified for the Behavior Management Team to follow until resolution or stability of the issues identified. This log will be presented to the QA Committee weekly for 4 weeks to review and make further recommendations, if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155449	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 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
	A nursing note, dated 6/3/23 at 2:12 AM, indicated Resident B was at the nurse's station aggressive and angry. RN 3 indicated as needed medication was given with mild effectiveness. A nursing note, dated 6/3/23 at 6 AM, indicated LPN 2 observed Resident B at the nurse's station with a gait belt wrapped around his chest and broda chair. LPN 2 also noted Resident B's gown was off and to the side. LPN 2 removed the belt and completed a skin assessment on Resident B. There were no physician orders, communication or other interventions documented prior to the applied restraint. A policy, undated, titled "Physical Restraints and Maintaing a Restraint Free Environment," indicated "physical restraints are physical or manual devices attached or adjacent to the resident's body which restricted the resident's freedom of normal access or movement." The policy also included "using devices in conjunction with a chair, such as trays, tables, bars or belts, that restricts the resident from rising" is considered a restraint and should not be utilized. This Federal Finding relates to Complaint IN00410058 and IN00410262. 3.1-3(w) 3.1-26		100% compliance is achieved for not only resolution to changes but better managed behavioral disturbances identified and that facility policy was followed, the QA Committee will review twice a month for 3 months and if 100% compliance is maintained, this will be made part of the ongoing Behavior Management Team reviews in QA meetings quarterly through the remainder of 2023.	