STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155449		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       01/31/2023				LETED	
	PROVIDER OR SUPPLIER	NG AND REHABILITATION CEN	NTER	516 N	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST ILA, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
F 0000							
Bldg. 00	IN00400155.  Complaint IN00400 Federal/state deficie allegations are cited survey date: Januar Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type Medicare: 3 Medicaid: 50 Other: 29 Total: 82	1 at F580 and F684.  ry 31, 2023  10426 55449 75480  : ects State Findings cited in	F 00	000	This Plan of Correction is submitted under Federal and regulations and status applicate to long term care providers.  This Plan of Correction does constitute an admission of lia on the part of the facility and liability is hereby denied. The submission of this plan does constitute agreement by the facility that the surveyor's find or conclusions are accurate, the findings constitute a deficiency, or that the scope severity regarding any of the deficiencies are cited corrections.	not bility such not dings that	
		apleted February 2, 2023					
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must i resident; consult v physician; and no	(Injury/Decline/Room, etc.) otification of Changes. mmediately inform the					

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

(A) An accident involving the resident which

TITLE (X6) DATE

Dee Anna Smallman Administrator 02/20/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MYD211 Facility ID: 000426 If continuation sheet Page 1 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155449	B. WI	NG		01/31	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENT	ER	ANGOL	A, IN 46703		
(X4) ID	SUMMARY	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
		nd has the potential for					
	requiring physicial						
	, , -	hange in the resident's or psychosocial status					
		ation in health, mental, or					
		us in either life-threatening					
		cal complications);					
		r treatment significantly					
	` '	discontinue an existing					
	form of treatment	_					
		to commence a new form					
	of treatment); or						
		ransfer or discharge the					
	, ,	facility as specified in					
	§483.15(c)(1)(ii).	•					
	(ii) When making ı	notification under paragraph					
	(g)(14)(i) of this se	ection, the facility must					
	ensure that all per	tinent information specified					
	in §483.15(c)(2) is	s available and provided					
	upon request to th	ne physician.					
	(iii) The facility mu	ıst also promptly notify the					
	resident and the re	esident representative, if					
	any, when there is	S-					
	(A) A change in ro						
	-	ecified in §483.10(e)(6); or					
		esident rights under Federal					
	_	gulations as specified in					
	paragraph (e)(10)						
	, ,	ust record and periodically					
		ss (mailing and email) and					
	phone number of						
	representative(s).						
	§483.10(g)(15)						
		mposite distinct part. A					
		mposite distinct part (as					
	•	must disclose in its					
	admission agreem						
	_	uding the various locations					
	_	composite distinct part					İ

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

Event ID:

MYD211 Facility ID: 000426

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155449		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 01/31/2023					
	PROVIDER OR SUPPLIEF	R NG AND REHABILITATION CEN	ITER	516 N \	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST LA, IN 46703		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
PREFIX TAG	and must specify room changes bet under §483.15(c)( Based on interview failed to notify the significant change is reviewed (Resident Findings include:  On 1/31/23 at 10:29 reviewed. Diagnose right sided inguinal A quarterly MDS (I assessment, dated 1 had no cognitive in indicators or behave assistance from 2 st transfers, toileting, hygiene.  A care plan, dated 5 had a diagnosis of 6 of nausea and vomi assess frequency, codor, and amount of abdomen for rebourd evidence of gastroing ground emesis and immediately.  A Medication Adm	the policies that apply to tween its different locations (9).  and record review, the facility physician of a resident's in condition for 1 of 3 residents (D).  A.M., Resident D's record was be included paraplegia and thernia.  Minimum Data Set) (1/2/22, indicated the resident apairment and no mood thors. He required extensive that aff members for bed mobility, dressing, and personal (5/16/17, indicated the resident apairment and no mood the single paraplegia and personal (5/16/17, indicated the resident apairment and personal (	F 0.	TAG	F580  Nurse #4 involved in resident change of condition has been reinstructed on notification of physician and resident representative of any change condition, nurse #4 will receive ongoing training by the Director Nursing or designee on notifications as indicated for resident changes, and documentation for the next 3 months.  All nurses have been reinstruction facility policy for change of condition, notification requirements and documentative requirements by the Director of Nursing & Nurse Management Team.  The nurses have been instruction notify the Director of Nursing during normal working hours, a hours to notify the scheduled nurse manager on call for all condition changes, the nurse manager will ensure that all	of e or of t ted g or after	O3/01/2023
	indicated the follow -1/12/23 at 11:33 p.	, and nurse progress notes ving: .m., Resident D was given heal medication for 2 loose			notifications have been made facility policy, the nurse manage will notify the administrator afte hours of any change of condition actions or orders received, and	gers er ion,	

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

stools.

Event ID:

MYD211

Facility ID: 000426

notifications.

If continuation sheet

Page 3 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/31/2023 155449 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 516 N WILLIAMS ST NORTHERN LAKES NURSING AND REHABILITATION CENTER ANGOLA. IN 46703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE -1/13/23 at 4:20 a.m., the resident was given QMA #2 has been reinstructed on Imodium anti-diarrheal medication for 2 loose protocol for administration of PRN stools and Zofran anti-emetic medication for medications. QMA #2 will have nausea and vomiting. ongoing competency training on QMA Scope of Practice monthly -1/13/23 at 3:03 p.m., he was given Ibuprofen for for 3 months. All QMAs will complaints of headache. receive retraining on their scope of practice with special focus on -1/14/23 at 3:13 a.m., the resident had a large administration of PRN emesis which required him to be showered and medications, communication with complete bed change done. He denied nausea nurses on any changes noted with after vomiting. resident, documentation of PRN medications. Retraining will be -1/14/23 at 7:13 a.m., the resident complained of completed with all QMAs by nausea and was given Zofran as ordered. 2/15/23. -1/14/23 at 12:57 p.m., the resident complained of a headache and was given Ibuprofen as ordered. The administrator will complete ongoing audits of all change of -1/14/23 at 2:08 p.m., the resident had requested to conditions noted during morning speak with the nurse, indicated he had an upset clinical meeting by reviewing 24 stomach and was nauseated. He was given PRN hour Change of Condition form (as needed) Zofran which he said helped. He (see attached), 24-hour Nursing refused his afternoon pills but requested PRN Report, Progress note report, Stop Ibuprofen for a headache which he was given. & Watch Forms, and then will The nurse was called to his room, he was heard review documentation to ensure with audible congestion in his throat and chest. notifications have been made per He was encouraged to try and cough to bring up policy daily for 2 weeks, and the congestion. He was repositioned and then reviewed with the QA team began vomiting dark brown/black emesis. The weekly, if 100% compliance is

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

no pulse.

nurse went to call EMS to transfer to the hospital

resident to be very pale, unresponsive, and with

and when returned to the room, observed the

On 1/31/23 at 1:59 P.M., QMA 2 (Qualified

Medication Aide) was interviewed. She indicated

she had administered Ibuprofen to Resident D on

1/13/23 at 3:03 p.m. for complaints of a headache.

Event ID:

MYD211

Facility ID: 000426

deficiency.

maintained, weekly x 2 weeks and

findings reviewed with the QA

team weekly, and if ongoing

compliance is maintained this review will be reported to the QA

committee Quarterly throughout

sustain our compliance with this

2023 to ensure we maintain &

If continuation sheet

Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155449	B. W	ING		01/31/	1/31/2023	
				CTREET	DDDECC CITY CTATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD VILLIAMS ST			
NODTHE	DN I AVES NI IDSI	NG AND REHABILITATION CENT	ED.		A, IN 46703			
NORTHE	INN LANES NORSI	NG AND REHABILITATION CENT		ANGOL	A, IN 40703			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF			(X5)	
PREFIX	(EACH DEFICIEN	CY 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	
	`	he had told the nurse about his						
		iving him the medication but						
		nurse had assessed him. She						
		who the nurse was that she'd						
	reported to.							
	O: 1/21/22 -+ 2:00	D.M. I DNI 4 (Lineared Durentinal						
		P.M., LPN 4 (Licensed Practical wed. She indicated she cared						
	/	1/14/23 and had not been made						
		nad loose stools, nausea and						
		3. On 1/14/23, she was given						
	-	nift and had been told the						
		emesis during the night. LPN						
		le the resident wanted to go to						
		ecked on him and he indicated						
	-	the hospital due to vomiting.						
		in for complaints of nausea.						
	-	after lunch and observed he'd						
		tes of lunch. He refused his						
	-	ons and requested Ibuprofen						
		ch she gave him. He then						
	indicated that whate	ever she had just given him						
	had "made it worse	" and wanted to go to the						
	hospital. She left th	e room and went to the nurse's						
	station to call the E	MS. She returned to his room						
	and observed him s	eated upright in bed with dark						
	emesis on him and	he was unresponsive with no						
	pulse. She had not o	contacted the doctor to report						
	the resident's reques	st to go to the hospital due to						
	vomiting.							
		mentation completed to						
		an had been notified of the						
		ols, nausea and vomiting, or						
	•	uested to go to the hospital						
	on 1/13 or 1/14/23.							
	O., 1/21/22 + 2.14	D.M. 4h - Dimester, CNL						
		P.M., the Director of Nursing						
	*	copy of the facility policy,						
	utted "Change of C	ondition" which stated the						

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

Event ID:

MYD211 Facility ID: 000426

If continuation sheet Page 5 of 11

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155449	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/31/2023
	ROVIDER OR SUPPLIER	NG AND REHABILITATION CENT	516 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST _A, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  f members shall communicate	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=G Bldg. 00	any information abore appropriate licensed observation. 1. The or assigned alternate of any change in resconditionNotifical responsible parties a clinical recordPronotified of a change immediately assess include vital signs, lassessments indicate following is a list of conditionnausea a appetite"  This Federal tag related as 1.5-5(a)(2)  483.25  Quality of Care § 483.25 Quality of Quality of care is a applies to all treatment facility residents. Ecomprehensive as facility must ensur treatment and care professional stands comprehensive peand the residents' Based on interview failed to assess, more of an acute change in the session of a	put resident status change to personnel immediately upon resident's primary physician will be notified immediately ident's physical or mental tion of physicians and/or shall be documented in the cedure: 1. When the nurse is of condition, she/he must the resident, this would ung sounds, and other ed by the changeThe some significant changes of and vomiting, diarrhea, loss of attes to Complaint IN00400155.  If care a fundamental principle that ment and care provided to assed on the sessment of a resident, the ethat residents receive in accordance with ards of practice, the erson-centered care plan, choices.  and record review, the facility nitor, and notify the physician in condition that led to a delay cline in condition for 1 of 3	F 0684	F 684  The MDS Coordinator review and updated care plan for all residents with a diagnosis of a Hernia (all types).	

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

Event ID:

 $MYD211 \quad \text{ Facility ID:} \quad 000426$ 

If continuation sheet

Page 6 of 11

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155449	B. WI	NG		01/31/	2023
				OTTO FEET	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
NODTUE	DN I AKEC MUDCI	NO AND DELIABILITATION CENT	-D		VILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENT	EK	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
					The Interdisciplinary team and		
	On 1/31/23 at 10:29	A.M., Resident D's record was			medical records did a facility w	/ide	
	reviewed. Diagnose	es included paraplegia and			audit of all resident diagnosis	and	
	right sided inguinal	hernia (a bulging of the			care plans to ensure all have t	peen	
	contents of the abdo	omen through a weak area in			addressed.		
	the lower abdomina	al wall which most often					
	contain fat or part o	of the small intestine).			Upon admission, readmission,	and	
					ongoing based on MDS sched	ule,	
	-	icated the resident was being			Medical Records designee will		
		eral surgeon and his primary			audit care plan against diagno	sis	
		P) for a right sided inguinal			to ensure all current diagnosis		
	·	to the resident. He was last			have been addressed. Audit		
		on 11/3/22 and it was agreed			reports will be provided to the	QA	
	that the hernia woul				committee weekly x 4 weeks for	or	
		tenderness and incarceration			further recommendations if		
	(part of the bowel b	ecomes trapped in the			needed, if 100% compliance is	3	
	abdominal muscles	creating a blockage with			maintained during this time, th	is	
	symptoms of nause	a, vomiting, abdominal pain,			will be an ongoing audit proce	SS	
	fever). He was visit	ed by the PCP on 1/11/23 and			that will be reported to the QA		
	_	ain of the hernia. On exam, the			Committee at each scheduled	QA	
	PCP indicated the re	esident's abdomen was soft			meeting but no less than Quar	terly	
	and the hernia visib	le but not emergent.			throughout the remainder of 20	023.	
					If 100% compliance is not		
	A quarterly MDS (N				maintained during 2023, this w		
		1/2/22, indicated the resident			be reported to the administrate	or for	
	_	npairment and no mood			process review.		
		iors. He required extensive					
	assistance from 2 st	aff members for bed mobility,			MDS Coordinator was reinstru	cted	
	transfers, toileting,	dressing, and personal			by the administrator on initiatir	ng	
	hygiene.				and updating care plan with ne	ew	
					diagnosis.		
	-	5/16/17, indicated the resident					
	_	GERD (acid reflux) with history			Medical record Designee is		
		ting. Interventions were to			conducting new		
		olor, character, consistency,			admission/readmission audits		
		f emesis and/or stool; check			diagnosis & care plan review o	-	
		nd tenderness; and monitor for			x 2 weeks and reporting findin	•	
		ntestinal bleed such as coffee			to the QA Committee weekly,		
		or black tarry stools and report			100% compliance maintained,	this	
	l immediately. The co	are plan didn't indicate the	1		audit will be completed weekly	v 2	

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

Event ID:

MYD211 Facility ID: 000426

If continuation sheet Page 7 of 11

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155449	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION  00	(X3) DATE : COMPL 01/31/	ETED
	PROVIDER OR SUPPLIER	NG AND REHABILITATION CEN	TER	516 N V	ADDRESS, CITY, STATE, ZIP COD WILLIAMS ST _A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	resident had a right and monitor the her complications.  A Medication Adm dated January 2023 indicated the follow -1/12/23 at 11:33 p.	inguinal hernia, how to assess nia or signs and symptoms of inistration Record (MAR), , and nurse progress notes ving: m., Resident D was given			weeks and reported to the Q. Committee. If 100% complia is maintained, this has been added to the ongoing audit conducted in conjunction with MDS Schedule to ensure on compliance with this deficien and results reviewed in Quar QA committee meetings	n the going cy	
	stools.	neal medication for 2 loose  1., the resident was given			hroughout 2023.  Nurse #4 involved in resident change of condition has been		
	Imodium anti-diarri stools. The physicir anti-emetic medicat nausea and vomitin	neal medication for 2 loose nan was notified. Zofran (an tion) was ordered and given for g. The physician indicated to was further change in			reinstructed on notification of physician and resident representative of any change condition, nurse #4 will receive ongoing training by the Direct Nursing or designee on notifications as indicated for	e of ve	
	-1/13/23 at 3:03 p.n complaints of heada	n., he was given Ibuprofen for ache.			resident changes for the next	t 3	
	emesis which required complete bed chang after vomiting.  -1/14/23 at 7:13 a.m.	n., the resident had a large red him to be showered and ge done. He denied nausea n., the resident complained of en Zofran as ordered.			All nurses have been reinstruon facility policy for change of condition, notification requirements and documenta requirements by the Director Nursing & Nurse Manageme Team.	f ation of	
	headache and was g -1/14/23 at 2:08 p.n speak with the nurs stomach and was na (as needed) Zofran. but requested PRN	m., the resident complained of a given Ibuprofen as ordered.  n., the resident had requested to e, indicated he had an upset auseated. He was given PRN He refused his afternoon pills Ibuprofen for a headache			The nurses have been instruto notify the Director of Nursing Assistant Director of Nursing during normal working hours hours to notify the scheduled nurse manager on call for all condition changes, the nurse manager will ensure that all notifications have been made	ng or , after	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155449	B. W	/ING		01/31/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CEN	TER		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		audible congestion in his			facility policy, the nurse mana	_	
		examination. He was			will notify the administrator aft		
		nd cough to bring up the			hours of any change of conditi		
	-	repositioned and then began			actions or orders received, and	d	
	-	n/black emesis. The nurse			notifications.		
		transfer to the hospital and					
		e room, observed the resident			QMA #2 has been reinstructed		
	to be very pale, unro	esponsive, and with no pulse.			protocol for administration of F		
	On 1/21/22 -4 1.50 1	D.M. OMA 2 (On-1:E-1			medications. QMA #2 will have		
		P.M., QMA 2 (Qualified vas interviewed. She indicated			ongoing competency training of QMA Scope of Practice month		
	· ·	ed Ibuprofen to Resident D on			· '	ııy	
		. for complaints of a headache.			for 3 months. All QMAs will receive retraining on their sco	ne of	
	-	m yelling out for help and			practice with special focus on	p <del>e</del> oi	
		eport from the day shift, that			administration of PRN		
	_	out or that he'd had diarrhea,			medications, communication v	vith	
		ng during the night. QMA 2			nurses on any changes noted		
		old the nurse about his			resident, documentation of PR		
		iving him the medication but			medications. Retraining will be		
		nurse had assessed him. She			completed with all QMAs by		
		who the nurse was that she'd			2/15/23.		
	reported to.						
	•						
		P.M., LPN 4 (Licensed Practical			The administrator will complet	е	
	′	wed. She indicated she cared			ongoing audits of all change o	f	
		/14/23, but had not been made			conditions noted during morning	~	
		nad loose stools and nausea			clinical meeting by reviewing 2		
	_	13/23. She hadn't heard the			hour Change of Condition form	n	
	• •	for help. On 1/14/23, she was			(see attached), 24-hour Nursir	-	
		ight shift and had been told			Report, Progress note report,	Stop	
		arge emesis during the night.			& Watch Forms, and then will		
	-	an aide the resident wanted to			review documentation to ensu		
		She checked on him and he			notifications have been made	per	
		I to go to the hospital due to			policy daily for 2 weeks, and		
		him Zofran for complaints of			reviewed with the QA team		
		d on him again after breakfast			weekly, if 100% compliance is		
		eaten a couple bites. He said			maintained, weekly x 2 weeks		
		er and he was given his			findings reviewed with the QA		
	-	ns. When questioned, she			team weekly, and if ongoing		
	indicated she had cl	necked his abdomen and his			compliance is maintained this		

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

Event ID:

MYD211 Facility ID: 000426

If continuation sheet Page 9 of 11

AND PLAN OF CORRECTION  IDSTITUCTOR ON SHIPPLER  NORTHERN LAKES NURSHING AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP COD 516 N WILLLIAMS ST ANGOLA, IN 46703  CV4) ID  SUMMARY STATEMENT OF DEFICIENCE PREFIX (EACH DEFCIENCY MUST BE PRECEDED BY FULL ANG DIGHT AND	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MYD211 Facility ID: 000426

If continuation sheet Page 10 of 11

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

PRINTED: 02/28/2023 FORM APPROVED OMB NO. 0938-039

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING		(X3) DATE SURVEY COMPLETED 01/31/2023				
NAME OF PROVIDER OR SUPPLIER  NORTHERN LAKES NURSING AND REHABILITATION CENTER  THE PROPERTY OF THE PROPERTY O			ΞR	516 N V	NDDRESS, CITY, STATE, ZIP COD VILLIAMS ST 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 TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
	conditionnausea a appetite"	f some significant changes of and vomiting, diarrhea, loss of ates to Complaint IN00400155.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MYD211 Facility ID: 000426 If continuation sheet Page 11 of 11