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	01/31/2023

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 IN00400155. Complaint IN00400155 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580 and F684. Survey date: January 31, 2023 Facility number: 000426 Provider number: 155449 AIM number: 100275480 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 3 Medicaid: 50 Other: 29 Total: 82 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 2, 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician of a resident's significant change in condition for 1 of 3 residents reviewed (Resident D). Findings include: On 1/31/23 at 10:29 A.M., Resident D's record was reviewed. Diagnoses included paraplegia and right sided inguinal hernia. A quarterly MDS (Minimum Data Set) assessment, dated 11/2/22, indicated the resident had no cognitive impairment and no mood indicators or behaviors. He required extensive assistance from 2 staff members for bed mobility, transfers, toileting, dressing, and personal hygiene. A care plan, dated 5/16/17, indicated the resident had a diagnosis of GERD (acid reflux) with history of nausea and vomiting. Interventions were to assess frequency, color, character, consistency, odor, and amount of emesis and/or stool; check abdomen for rebound tenderness; and monitor for evidence of gastrointestinal bleed such as coffee ground emesis and or black tarry stools and report immediately. A Medication Administration Record (MAR), dated January 2023, and nurse progress notes indicated the following: -1/12/23 at 11:33 p.m., Resident D was given Imodium anti-diarrheal medication for 2 loose stools.	F 0580	F580 Nurse #4 involved in resident D change of condition has been reinstructed on notification of physician and resident representative of any change of condition, nurse #4 will receive ongoing training by the Director of Nursing or designee on notifications as indicated for resident changes, and documentation for the next 3 months. All nurses have been reinstructed on facility policy for change of condition, notification requirements and documentation requirements by the Director of Nursing & Nurse Management Team. The nurses have been instructed to notify the Director of Nursing or Assistant Director of Nursing during normal working hours, after hours to notify the scheduled nurse manager on call for all condition changes, the nurse manager will ensure that all notifications have been made per facility policy, the nurse managers will notify the administrator after hours of any change of condition, actions or orders received, and notifications.	03/01/2023

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	-1/13/23 at 4:20 a.m., the resident was given Imodium anti-diarrheal medication for 2 loose stools and Zofran anti-emetic medication for nausea and vomiting. -1/13/23 at 3:03 p.m., he was given Ibuprofen for complaints of headache. -1/14/23 at 3:13 a.m., the resident had a large emesis which required him to be showered and complete bed change done. He denied nausea after vomiting. -1/14/23 at 7:13 a.m., the resident complained of nausea and was given Zofran as ordered. -1/14/23 at 12:57 p.m., the resident complained of a headache and was given Ibuprofen as ordered. -1/14/23 at 2:08 p.m., the resident had requested to speak with the nurse, indicated he had an upset stomach and was nauseated. He was given PRN (as needed) Zofran which he said helped. He refused his afternoon pills but requested PRN Ibuprofen for a headache which he was given. The nurse was called to his room, he was heard with audible congestion in his throat and chest. He was encouraged to try and cough to bring up the congestion. He was repositioned and then began vomiting dark brown/black emesis. The nurse went to call EMS to transfer to the hospital and when returned to the room, observed the resident to be very pale, unresponsive, and with no pulse. 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.		QMA #2 has been reinstructed on protocol for administration of PRN medications. QMA #2 will have ongoing competency training on QMA Scope of Practice monthly for 3 months. All QMAs will receive retraining on their scope of practice with special focus on administration of PRN medications, communication with nurses on any changes noted with resident, documentation of PRN medications. Retraining will be completed with all QMAs by 2/15/23. The administrator will complete ongoing audits of all change of conditions noted during morning clinical meeting by reviewing 24 hour Change of Condition form (see attached), 24-hour Nursing Report, Progress note report, Stop & Watch Forms, and then will review documentation to ensure notifications have been made per policy daily for 2 weeks, and reviewed with the QA team weekly, if 100% compliance is 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 2023 to ensure we maintain & sustain our compliance with this deficiency.	

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	QMA 2 indicated she had told the nurse about his headache prior to giving him the medication but hadn't known if the nurse had assessed him. She couldn't remember who the nurse was that she'd reported to. On 1/31/23 at 2:09 P.M., LPN 4 (Licensed Practical Nurse) was interviewed. She indicated she cared for the resident on 1/14/23 and had not been made aware the resident had loose stools, nausea and vomiting on 1/13/23. On 1/14/23, she was given report from night shift and had been told the resident had a large emesis during the night. LPN 4 was told by an aide the resident wanted to go to the hospital. She checked on him and he indicated he wanted to go to the hospital due to vomiting. She gave him Zofran for complaints of nausea. She checked on him after lunch and observed he'd only eaten a few bites of lunch. He refused his afternoon medications and requested Ibuprofen for a headache which she gave him. He then indicated that whatever she had just given him had "made it worse" and wanted to go to the hospital. She left the room and went to the nurse's station to call the EMS. She returned to his room and observed him seated upright in bed with dark emesis on him and he was unresponsive with no pulse. She had not contacted the doctor to report the resident's request to go to the hospital due to vomiting. There was no documentation completed to indicate the physician had been notified of the resident's loose stools, nausea and vomiting, or the resident had requested to go to the hospital on 1/13 or 1/14/23. On 1/31/23 at 3:14 P.M., the Director of Nursing provided a current copy of the facility policy, titled "Change of Condition" which stated the			

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	following: "All staff members shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation. 1. The resident's primary physician or assigned alternate will be notified immediately of any change in resident's physical or mental condition...Notification of physicians and/or responsible parties shall be documented in the clinical record...Procedure: 1. When the nurse is notified of a change of condition, she/he must immediately assess the resident, this would include vital signs, lung sounds, and other assessments indicated by the change...The following is a list of some significant changes of condition...nausea and vomiting, diarrhea, loss of appetite...." This Federal tag relates to Complaint IN00400155. 3.1-5(a)(2)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to assess, monitor, and notify the physician of an acute change in condition that led to a delay in treatment, and decline in condition for 1 of 3 residents reviewed (Resident D). Findings include:	F 0684	F 684 The MDS Coordinator reviewed and updated care plan for all residents with a diagnosis of a Hernia (all types).	03/01/2023

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	On 1/31/23 at 10:29 A.M., Resident D's record was reviewed. Diagnoses included paraplegia and right sided inguinal hernia (a bulging of the contents of the abdomen through a weak area in the lower abdominal wall which most often contain fat or part of the small intestine). Physician notes indicated the resident was being monitored by a general surgeon and his primary care physician (PCP) for a right sided inguinal hernia, bothersome to the resident. He was last seen by the surgeon on 11/3/22 and it was agreed that the hernia would be monitored for enlargement, pain, tenderness and incarceration (part of the bowel becomes trapped in the abdominal muscles creating a blockage with symptoms of nausea, vomiting, abdominal pain, fever). He was visited by the PCP on 1/11/23 and continued to complain of the hernia. On exam, the PCP indicated the resident's abdomen was soft and the hernia visible but not emergent. A quarterly MDS (Minimum Data Set) assessment, dated 11/2/22, indicated the resident had no cognitive impairment and no mood indicators or behaviors. He required extensive assistance from 2 staff members for bed mobility, transfers, toileting, dressing, and personal hygiene. A care plan, dated 5/16/17, indicated the resident had a diagnosis of GERD (acid reflux) with history of nausea and vomiting. Interventions were to assess frequency, color, character, consistency, odor, and amount of emesis and/or stool; check abdomen for rebound tenderness; and monitor for evidence of gastrointestinal bleed such as coffee ground emesis and or black tarry stools and report immediately. The care plan didn't indicate the		The Interdisciplinary team and medical records did a facility wide audit of all resident diagnosis and care plans to ensure all have been addressed. Upon admission, readmission, and ongoing based on MDS schedule, Medical Records designee will audit care plan against diagnosis to ensure all current diagnosis have been addressed. Audit reports will be provided to the QA committee weekly x 4 weeks for further recommendations if needed, if 100% compliance is maintained during this time, this will be an ongoing audit process that will be reported to the QA Committee at each scheduled QA meeting but no less than Quarterly throughout the remainder of 2023. If 100% compliance is not maintained during 2023, this will be reported to the administrator for process review. MDS Coordinator was reinstructed by the administrator on initiating and updating care plan with new diagnosis. Medical record Designee is conducting new admission/readmission audits for diagnosis & care plan review daily x 2 weeks and reporting findings to the QA Committee weekly, if 100% compliance maintained, this audit will be completed weekly x 2	

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	resident had a right inguinal hernia, how to assess and monitor the hernia or signs and symptoms of complications. A Medication Administration Record (MAR), dated January 2023, and nurse progress notes indicated the following: -1/12/23 at 11:33 p.m., Resident D was given Imodium anti-diarrheal medication for 2 loose stools. -1/13/23 at 4:20 a.m., the resident was given Imodium anti-diarrheal medication for 2 loose stools. The physicinan was notified. Zofran (an anti-emetic medication) was ordered and given for nausea and vomiting. The physician indicated to notify him if there was further change in condition. -1/13/23 at 3:03 p.m., he was given Ibuprofen for complaints of headache. -1/14/23 at 3:13 a.m., the resident had a large emesis which required him to be showered and complete bed change done. He denied nausea after vomiting. -1/14/23 at 7:13 a.m., the resident complained of nausea and was given Zofran as ordered. -1/14/23 at 12:57 p.m., the resident complained of a headache and was given Ibuprofen as ordered. -1/14/23 at 2:08 p.m., the resident had requested to speak with the nurse, indicated he had an upset stomach and was nauseated. He was given PRN (as needed) Zofran. He refused his afternoon pills but requested PRN Ibuprofen for a headache which he was given. The nurse was called to his		weeks and reported to the QA Committee. If 100% compliance is maintained, this has been added to the ongoing audit conducted in conjunction with the MDS Schedule to ensure ongoing compliance with this deficiency and results reviewed in Quarterly QA committee meetings throughout 2023. Nurse #4 involved in resident D change of condition has been reinstructed on notification of physician and resident representative of any change of condition, nurse #4 will receive ongoing training by the Director of Nursing or designee on notifications as indicated for resident changes for the next 3 months. All nurses have been reinstructed on facility policy for change of condition, notification requirements and documentation requirements by the Director of Nursing & Nurse Management Team. The nurses have been instructed to notify the Director of Nursing or Assistant Director of Nursing during normal working hours, after hours to notify the scheduled nurse manager on call for all condition changes, the nurse manager will ensure that all notifications have been made per	

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	room. There he was audible congestion in his throat and chest on examination. He was encouraged to try and cough to bring up the congestion. He was repositioned and then began vomiting dark brown/black emesis. The nurse went to call EMS to transfer to the hospital and when returned to the room, observed the resident to be very pale, unresponsive, and with no pulse. 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. She hadn't heard him yelling out for help and wasn't told during report from the day shift, that he had been yelling out or that he'd had diarrhea, nausea, and vomiting during the night. QMA 2 indicated she had told the nurse about his headache prior to giving him the medication but hadn't known if the nurse had assessed him. She couldn't remember who the nurse was that she'd reported to. On 1/31/23 at 2:09 P.M., LPN 4 (Licensed Practical Nurse) was interviewed. She indicated she cared for Resident D on 1/14/23, but had not been made aware the resident had loose stools and nausea and vomiting on 1/13/23. She hadn't heard the resident yelling out for help. On 1/14/23, she was given report from night shift and had been told the resident had a large emesis during the night. LPN 4 was told by an aide the resident wanted to go to the hospital. She checked on him and he indicated he wanted to go to the hospital due to vomiting. She gave him Zofran for complaints of nausea. She checked on him again after breakfast and noted he'd only eaten a couple bites. He said his nausea was better and he was given his morning medications. When questioned, she indicated she had checked his abdomen and his		facility policy, the nurse managers will notify the administrator after hours of any change of condition, actions or orders received, and notifications. QMA #2 has been reinstructed on protocol for administration of PRN medications. QMA #2 will have ongoing competency training on QMA Scope of Practice monthly for 3 months. All QMAs will receive retraining on their scope of practice with special focus on administration of PRN medications, communication with nurses on any changes noted with resident, documentation of PRN medications. Retraining will be completed with all QMAs by 2/15/23. The administrator will complete ongoing audits of all change of conditions noted during morning clinical meeting by reviewing 24 hour Change of Condition form (see attached), 24-hour Nursing Report, Progress note report, Stop & Watch Forms, and then will review documentation to ensure notifications have been made per policy daily for 2 weeks, and reviewed with the QA team weekly, if 100% compliance is maintained, weekly x 2 weeks and findings reviewed with the QA team weekly, and if ongoing compliance is maintained this	

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	inguinal hernia and "nothing looked out of the ordinary" but she hadn't documented it. She checked on him after lunch and observed he'd only eaten a few bites of lunch. He refused his afternoon medications and requested Ibuprofen for a headache which she gave him. He then indicated that whatever she had just given him had "made it worse" and wanted to go to the hospital. She left the room and went to the nurses station to call the EMS. She returned to his room and observed him seated upright in bed with dark emesis on him and he was unresponsive with no pulse. She had not contacted the doctor to report the resident's request to go to the hospital due to vomiting. When questioned about the resident's inguinal hernia and complications to watch for, she indicated she didn't know but would expect to find it on his care plan or the facility would have a policy for monitoring of his hernia. According to Lippincott's Manual of Nursing Practice, a strangulated hernia presents with pain, nausea, vomiting, and swelling. On 1/31/23 at 3:14 P.M., the Director of Nursing provided a current copy of the facility policy, titled "Change of Condition" which stated the following: "All staff members shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation. 1. The resident's primary physician or assigned alternate will be notified immediately of any change in resident's physical or mental condition...Notification of physicians and/or responsible parties shall be documented in the clinical record...Procedure: 1. When the nurse is notified of a change of condition, she/he must immediately assess the resident, this would include vital signs, lung sounds, and other assessments indicated by the change...The		review will be reported to the QA committee Quarterly throughout 2023 to ensure we maintain & sustain our compliance with this deficiency.	

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	following is a list of some significant changes of condition...nausea and vomiting, diarrhea, loss of appetite...." This Federal tag relates to Complaint IN00400155. 3.1-37(a)			