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	12/10/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00447844. Complaint IN00447844: Deficiency related to the allegation was F600. Survey dates: December 4, 5, 8, 9, and 10, 2024. Facility number: 000426 Provider number: 155449 AIM number: 100275480 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 2 Medicaid: 45 Other: 38 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 11, 2024.	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. Please accept this plan as our credible allegation of compliance for our recertification & state licensure survey. We respectfully request desk review and paper compliance determination on all citations.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, interview, and record review the facility failed to ensure privacy of protected health information for 1 of 24 residents reviewed (Resident 44).	F 0583	The Director of Nursing re-instructed all nursing employees including Nurses, QMAs, and Nurse Aides about Protecting Resident Private Health	01/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dee Anna Smallman	Administrator	12/30/2024

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	Findings include: During an observation, on 12/4/24 at 9:34 AM, a worksheet with resident information visible was uncovered on top of a medication cart in the hallway. No staff member was in the area. Unidentified residents were present in the hallway near the cart. Protected health information including nursing assessments, vital signs and behavior notes were visible on the worksheet. During an observation, on 12/4/24 at 11:38 AM, Licensed Practical Nurse (LPN) 30 walked away from the medication cart leaving the computer screen open. Resident information was visible on the screen. During an observation, on 12/4/24 at 1:41 PM, LPN 30 was observed standing at the nurses' station with other staff. The computer screen on the medication cart was open to Resident 44's chart with protected health information visible on the screen. Five additional staff members walked past the cart and took no action to conceal the resident information. During an interview, on 12/4/24 at 1:44 PM, LPN 30 indicated a button on the computer to hide the screen should have been pushed before she walked away from the medication cart. She indicated Resident information should not be visible on the computer screen when the computer is unattended. Resident 44's record was reviewed on 12/9/24 at 9:58 AM. Diagnoses included unspecified subluxation of right hip, subsequent encounter, type 2 diabetes mellitus with hyperglycemia, and essential (primary) hypertension.		Information during medication pass, at nurse's stations, and any public location. In addition, the administrator conducted re-instruction to all department managers on Protecting Resident Private Health Information, and each manager conducted re-instruction on Protecting Resident Private Health Information to each non-nursing departments. The Director of Nursing or Designee are conducting a daily audit x 14 days to ensure that resident private health information is being protected across all 3 shifts. The findings are being reviewed during our weekly QA Compliance Meeting. If 100% compliance is achieved and maintained, the QA Committee will recommend going to the next phase of compliance which is 3 X weekly x one week across all shifts, and if 100% compliance maintained, one final observation will be completed for all Nurses & QMAs across all shifts. To ensure ongoing compliance this audit will be added to our Quarterly QA review throughout 2025. The role of the QA Program is to review and substantiate 100% compliance is sustained so this deficiency does not reoccur.	

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	Resident 44's current admission Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). During an interview, on 12/9/24 at 12:02 PM, the Administrator indicated staff should ensure confidential resident information could not be visible on top of the medication cart or nurses' station. Resident information on the computer screen should be kept confidential by closing the computer or hiding the screen. She indicated she was aware staff had left a computer screen open. The nursing report form with confidential information should have information hidden. A current policy, undated, provided by the Administrator on 12/9/24 at 12:33 PM, indicated confidential information including forms and worksheets should not be left on medication carts unattended. The policy indicated medication cart laptops should not be left open with resident information while unattended. 3-1(p)(5)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review the facility failed to ensure residents were free from verbal abuse for 3 of 5 residents reviewed (Resident 15, Resident 18, Resident 44). Findings include: During an interview, on 12/5/24 at 11:18 AM, Resident 15 and Resident 18 indicated Resident 15	F 0600	The administrator was notified immediately of the allegations of abuse, and the facility Policy & Procedure for Abuse Prohibition was followed as written. The administrator did complete a full investigation and notified the Indiana Department of Health per facility policy and IDOH Guidelines. The Charge Nurse	01/08/2025

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	was assisted onto the commode (toilet) by Certified Nurse Aide (CNA) 2. Resident 18 indicated CNA 2 told Resident 15 to put on her call light when finished on the commode. Resident 15 indicated when CNA 2 was getting ready to exit the room, Resident 15 told CNA 2 she was finished on the commode. Resident 15 indicated CNA 2 responded to turn on her call light. Resident 18 indicated Resident 15 was frustrated so Resident 18 told Licensed Practical Nurse (LPN) 3 of Resident 15's requested assistance. Resident 18 indicated she then observed CNA 2 return to the resident's room and overheard yelling. Resident 18 indicated she also observed CNA 2 exit the resident's room. An investigation file was provided by the Director of Nursing (DON) on 12/6/24 at 11:30 AM. The file included the following: A facility reported incident (FRI), dated 11/23/24, indicated on 11/22/24 CNA 2 and Resident 15 were overheard yelling at each other. The FRI indicated the Administrator suspended CNA 2 and then interviewed 5 residents. CNA 2's file indicated CNA 2 verbally abused a resident by saying "if you're going to act like that then someone else can f****** get you." The file indicated other residents also heard CNA 2 in the hallway using foul language. The investigation file included the following interviews: Resident 15's interview with the Administrator indicated the incident occurred on 11/22/24 around 8 PM. Resident 15 indicated she was frustrated with CNA 2. Resident 15 indicated CNA 2 was rude and a B*** towards Resident 15. Resident 18's interview with the Administrator indicated CNA 2 entered the room and assisted her roommate, Resident 15, onto the commode. Prior to leaving the room CNA 2 told Resident 15		followed facility policy including notifying the administrator of this incident and had the employee leave the facility pending notification and investigation. The employee was suspended and at the conclusion of the investigation was terminated from employment with Northern Lakes Nursing & Rehabilitation Center. The IDOH surveyors completed interviews with employees, and they were able to state who they would report suspected abuse to. All employees were re-instructed on Abuse Prohibition, Reporting Abuse, types of abuse. Social Services will conduct a weekly meeting with residents x 2 weeks specific to Abuse to ensure no further allegations are made. If 100% compliance is maintained, a twice monthly meeting will be held with the residents x 2 months. If we maintain 100% compliance, this will be added to our monthly Resident Council Meeting and reported to the Quality Assurance Committee Quarterly. To ensure ongoing compliance this audit will be added to our Quarterly QA review throughout 2025. The role of the QA Program is to review and substantiate 100% compliance is sustained so this deficiency does not reoccur.	

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	she would return. Resident 18 indicated she overheard Resident 15 tell CNA 2 twice she was finished on the commode. Resident 18 indicated CNA 2 left Resident 15 on the commode and left the room. Resident 18 indicated she overheard Resident 15 yell she was finished, and the door was shut. Resident 18 indicated she notified LPN 3 of Resident 15's requested assistance. Resident 18 indicated she then observed CNA 2 return to their room and closed the door. Resident 18 indicated she overheard CNA 2 and Resident 15 yelling at each other. Resident 18 indicated she then observed CNA 2 leave the room and told LPN 3 "just because I didn't get back to her room as quickly as she wanted me to, she threw stuff on the floor, and I am not cleaning it up." Resident 44's interview with the Administrator indicated she overheard Resident 15 yelling on 11/22/24 in the evening for assistance. Resident 44 indicated she overheard CNA 2 indicate "something about a f**** fool" in the hallway. During an interview, on 12/6/24 at 11:15 AM, CNA 4 indicated staff should never yell at any residents. CNA 4 indicated when a resident was frustrated with staff and needs weren't met, the nurse was notified. A record review was completed on 12/6/24 at 11:49 AM. Diagnosis included: major depressive disorder and hemiplegia/hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side. Resident 15's quarterly assessment, dated 10/11/24, indicated Resident 15 had a Brief Interview Mental Status (BIMS) score of 14/15 (cognitively intact). A record review was completed on 12/6/24 at 2:40			

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	PM for Resident 18. Resident 18's admission assessment, dated 9/23/24, indicated Resident 18 had a BIMS score of 15/15 (cognitively intact). intact). A record review was completed on 12/6/24 at 2:41 PM for Resident 44. Resident 44's admission assessment, dated 11/12/24, indicated Resident 44 had a BIMS score of 15/15 (cognitively intact) A policy, last reviewed/updated 1/1/2023, titled "Abuse Prohibition," was provided by the Administrator on 12/4/24 at 10 AM. The policy indicated "verbal abuse: use of oral or gestured language that willfully includes disparaging and derogatory terms to residents or within hearing distance, regardless of the resident's ability to comprehend." This finding is related to Complaint IN00447844. 3.1-27(a)(b)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview and record review the facility failed to ensure orders were entered and followed for 1 of 3 residents reviewed (Resident 15). During an interview on 12/5/24 at 11:34 AM, Resident 15 indicated she had a history of a stroke with left side affected. Resident 15 indicated she was discharged from therapy and recommended to use a splint for her left hand. Resident 15 indicated the staff no longer placed the splint on her hand.	F 0688	The Director of Nursing & Therapy Director reviewed all current orders, care plans, and therapy communication forms to ensure that we have appropriate nursing orders. Nursing department was reinstructed on the use of devices such as palm protectors, splints and other preventative/restorative type devices.	01/08/2025

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	During an observation on 12/5/24 at 11:34 AM, Resident 15 did not have a splint on her left hand. During an observation on 12/5/24 at 1:30 PM, a palmor hand splint was in a bag by Resident 15's bed. An upside-down paper indicated Resident to wear splint daily/nightly, remove for AM/PM and reapply after care. The paper indicated recommendations provided by Occupational Therapist. During an interview on 12/5/24 at 1:12 PM, Certified Nurse Aide (CNA) 6 indicated Resident 15 wore a hand splint for 4 hours a day, between 6 AM - 10 AM. CNA 6 indicated Resident 15's splint was located in a bag by her bed. During an interview on 12/5/24 at 1:32 PM, Registered Nurse (RN) 5 indicated Resident 15 wore a hand splint per the instructions on the wall by her bed. RN 5 indicated the signage indicated Resident 15 to wear daily/nightly, remove for AM/PM and reapply after care. RN 5 indicated the instructions were signed by occupational therapy. RN 5 indicated Resident 15 did not have an order listed in her chart for the splint, but that staff shared the instructions in the report. RN 5 indicated there should be an order for Resident 15's splint with instructions in her chart. During an interview on 12/5/24 at 1:42 PM, the Director of Nursing (DON) indicated Resident 15 did not have a splint/palmer protector order listed. The DON indicated Resident 15 should have a splint order with included instructions/preferences. A record review was completed on 12/6/24 at 11:49 AM. Diagnosis included: hemiplegia and		The Director of Nursing & Therapy Director will conduct 3 times weekly x 2 weeks observations to ensure orders are followed. The findings will be reviewed in the weekly QA Meeting and if 100% compliance is achieved for the two-week observation, the QA Compliance Committee will recommend continued observation weekly for two more weeks and review each week at the weekly QA Compliance Meeting. If we maintain 100% compliance during each review the Director of Nursing will add to our ongoing QA review. The role of the ongoing QA Calendar is to review and substantiate 100% compliance is sustained so this deficiency does not reoccur.	

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hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, contracture of left hand, and contracture of left wrist.

Resident 15's quarterly assessment, dated 10/11/24, indicated Resident 15 had a Brief Interview Mental Status score of 14/15 (cognitively intact).

Resident 15's current care plan, dated 8/24, last reviewed 11/11/24 indicated Resident 15 "wore a palm protector to my left hand." Resident 15's care plan also indicated Resident 15 was "admitted to the facility with a contracture to my left wrist and left-hand r/t cerebral vascular accident (CVA). I am at risk for further contracture to these areas and increased pain."

Resident 15's orders were reviewed. There were no orders for a splint or palm protector.

Resident 15's Occupational Therapy discharge summary, dated 7/10/24 - 9/3/24 was provided by the DON on 12/6/24 at 11:30 AM. The documentation indicated discharge recommendations: palmor protector for skin breakdown protector.

A policy, dated 9/2024, titled "Therapy Communication and Recommendations," was provided by the DON on 12/6/24 at 11:30 AM. The policy indicated "therapist will complete an order for discharge recommendations including: resident indications, summary of recommendations/interventions, start/end date, therapeutic goals and ongoing precautions."

3.1-37

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure a blood sugar meter (glucometer) was properly disinfected between each resident use for 2 of 2 residents reviewed (Resident 59 and Resident 26). Findings include: On 12/5/24 at 11:17 AM, Licensed Practical Nurse (LPN) 20 was observed cleaning a unit glucometer at the medication (med) cart. In an interview, on 12/5/24 at 11:20 AM, LPN 20 indicated the unit glucometer was used to obtain blood sugars for all the diabetic residents on the unit. LPN 20 indicated they cleaned the glucometer between each resident use with an alcohol pad. LPN 20 indicated cleaning the glucometer with alcohol after each use was standard practice. On 12/5/24 at 11:26 AM, items in a unit med cart were observed with LPN 20. The med cart did not contain disposable bleach wipes. On 12/09/24 at11:39 AM, Qualified Medication Aide (QMA) 10 was observed obtaining Resident 59's blood sugar with the unit glucometer. Resident 59's record was reviewed on 12/9/24 at 11:43 AM. Resident 59 had a diagnosis of insulin dependent diabetes. Resident 59's Quarterly Minimum Data Set, (MDS) dated 10/7/24, indicated Resident 59's Brief Interview for Mental Status (BIMS) score was 4	F 0880	The Director of Nursing & Staff Development Coordinator reinstructed all Nurses & QMAs on our Policy & Procedure for sanitizing glucometers between use immediately when this was brought to our attention. Each medication cart was immediately stocked with Sani-Wipes (approved bleach sanitizer) for use. We now utilize two glucometers for each medication cart this allows the Nurses and QMAs to sanitize the glucometer and let it sit for the recommended 4 minutes and utilize the other glucometer that has been sanitized and ready to use. The Director of Nursing or Designee are conducting daily audit x 14 days to ensure that the Nurses & QMAs are utilizing the Sani Wipes (approved bleach sanitizer) and following the facility policy on sanitizing glucometers between each resident use. The findings are being reviewed during our weekly QA Compliance Meeting. If 100% compliance is achieved and maintained, the QA Committee will recommend going to the next phase of compliance which is 3 X weekly x one week across all shifts, and if 100%	01/08/2025

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	(severe cognitive impairment). The MDS indicated Resident 59 received insulin injections 7 days a week. A physician order, dated 10/7/24, indicated Resident 59 was to be administered insulin injections according to a sliding scale (doseage calculated from blood sugar results) 4 times a day. On 12/9/24 at 11:57 AM, QMA 10 was observed wiping the glucometer with an alcohol pad. QMA 10 placed the glucometer on top of the med cart. On 12/9/24 at 12:02 PM, QMA 10 was observed obtaining Resident 26's blood sugar with the unit glucometer. On 12/9/24 at 12:05 PM, QMA 10 was observed wiping the unit glucometer with an alcohol pad. After the glucometer was wiped with alcohol, QMA 20 placed the glucometer on the top of the med cart. In an interview, on 12/9/24 at 12:07 PM, QMA 10 indicated all the residents on the unit used the same glucometer. QMA 10 indicated they sanitized the glucometer between each resident use with an alcohol pad and placed the glucometer on top of the med cart to dry for 2 minutes. QMA indicated they had been trained to clean the glucometers with an alcohol pad between each use. On 12/9/24 at 12:12 PM, items in a unit med cart were observed with QMA 10. The med cart did not contain disposable bleach wipes. Resident 26's record was reviewed on 12/9/24 at 12:15 PM. Resident 26 had a diagnosis of insulin dependent diabetes.		compliance maintained, one final observation will be completed for all Nurses & QMAs across all shifts. To ensure ongoing compliance this audit will be added to our Quarterly QA review throughout 2025. The role of the QA Program is to review and substantiate 100% compliance is sustained so this deficiency does not reoccur.	

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	Resident 26's Annual Minimum Data Set, (MDS) dated 11/7/24, indicated Resident 26's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive impairment). The MDS indicated Resident 26 received insulin injections 7 days a week. A physician order, dated 9/11/24, indicated Resident 26 was to be administered 5 units of insulin with meals every day. A physician order, dated 10/22/24, indicated Resident 26 was to be administered insulin injections according to a sliding scale 4 times a day. In an interview, on 12/9/24 at 3:26 PM, the Director of Nursing (DON) indicated shared glucometers should be cleaned with an approved bleach sanitizer after each resident use. The DON indicated alcohol pads were not recommended as a disinfectant for shared glucometer use (CDC, 2024). The DON indicated each med cart should be supplied with a container of disposable bleach wipes. A current undated facility policy, provided by the DON on 12/9/24 at 1:50 PM, indicated the glucometers were to be cleaned with disposable bleach wipes after each use. The policy indicated the glucometers were to remain wet for 1 minute. Reference "CDC Injection Safety." (2024, August 7). [Centers for Disease Control and Prevention]. https://www.cdc.gov/injection-safety/hcp/infection-control/index.html 3.1-18(a)			

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	3.1-18(b) 3.1-18 (b)(1)			