PRINTED: 12/31/2024

EPARIMENT OF HEALTH AND HUI	ARTIMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED				
	155449	B. WING	12/10/2024				

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 516 N WILLIAMS ST

(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
0000				
Bldg. 00				
		F 0000	This Plan of Correction is	
	This visit was for a Recertification and State		submitted under Federal and State	
	Licensure Survey. This visit included the		regulations and status applicable	
	Investigation of Complaint IN00447844.		to long term care providers. This	
	Complaint IN00447844: Deficiency related to the		Plan of Correction does not constitute an admission of liability	
	allegation was F600.		on the part of the facility and such	
			liability is hereby denied. The	
	Survey dates: December 4, 5, 8, 9, and 10, 2024.		submission of this plan does not	
			constitute agreement by the	
	Facility number: 000426		facility that the surveyor's findings	
	Provider number: 155449		or conclusions are accurate, that	
	AIM number: 100275480		the findings constitute a	
	Census Bed Type:		deficiency, or that the scope and	
	SNF/NF: 85		severity regarding any of the deficiencies are cited correctly.	
	Total: 85		Please accept this plan as our	
	10.00		credible allegation of compliance	
	Census Payor Type:		for our recertification & state	
	Medicare: 2		licensure survey.	
	Medicaid: 45		We respectfully request desk	
	Other: 38		review and paper compliance	
	Total: 85		determination on all citations.	
	These deficiencies reflect State Findings cited in			
	accordance with 410 IAC 16.2-3.1.			
	Quality review completed December 11, 2024.			
E 0500	400 404 (44) (6)(1)(1)			
F 0583 SS=D	483.10(h)(1)-(3)(i)(ii)			
Bldg. 00	Personal Privacy/Confidentiality of Records			
Diag. 00		F 0583	The Director of Nursing	01/08/202
	Based on observation, interview, and record	1 0303	re-instructed all nursing	01/00/202
	review the facility failed to ensure privacy of		employees including Nurses,	
	protected health information for 1 of 24 residents		QMAs, and Nurse Aides about	
	reviewed (Resident 44).		Protecting Resident Private Health	

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

Dee Anna Smallman

TITLE

(X6) DATE 12/30/2024

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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Administrator

CENTERS FOI	R MEDICARE & MEDIC						IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. I	BUILDING	00	COMPI	LETED
		155449	В. V	VING		12/10	/2024
					_		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
				516 N	WILLIAMS ST		
NORTHE	ERN LAKES NURS	ING AND REHABILITATION CEN	ITER	ANGO	LA, IN 46703		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		
	`				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Information during medication		
	Findings include:				pass, at nurse's stations, and	-	
	During an observation, on 12/4/24 at 9:34 AM, a				public location. In addition, the	ne	
					administrator conducted		
	worksheet with res	ident information visible was			re-instruction to all departme	nt	
	uncovered on top o	of a medication cart in the			managers on Protecting Res		
	_	nember was in the area.			Private Health Information, a		
		ents were present in the hallway			each manager conducted		
		ected health information			re-instruction on Protecting		
		ssessments, vital signs and			Resident Private Health		
		e visible on the worksheet.			Information to each non-nurs	ina	
	ochavior notes wer	e visiole on the worksheet.			departments.	ıı ıg	
	During on observet	ion, on 12/4/24 at 11:38 AM,			departments.		
	_	Nurse (LPN) 30 walked away			The Director of Numeiron on		
		•			The Director of Nursing or	- 9	
		on cart leaving the computer			Designee are conducting a d	-	
	-	ent information was visible on			audit x 14 days to ensure that		
	the screen.				resident private health inform		
					is being protected across all		
	_	ion, on 12/4/24 at 1:41 PM,			shifts. The findings are being		
		ved standing at the nurses'			reviewed during our weekly (
		taff. The computer screen on			Compliance Meeting. If 1009	%	
	the medication cart	was open to Resident 44's			compliance is achieved and		
	chart with protected	d health information visible on			maintained, the QA Committe	э е	
	the screen. Five ad	lditional staff members walked			will recommend going to the	next	
	past the cart and to	ok no action to conceal the			phase of compliance which is	3 X	
	resident informatio	n.			weekly x one week across all	i	
					shifts, and if 100% compliand		
	During an interview	w, on 12/4/24 at 1:44 PM, LPN			maintained, one final observa		
	30 indicated a butto	on on the computer to hide the			will be completed for all Nurs	es &	
		been pushed before she			QMAs across all shifts.		
		the medication cart. She					
	1	information should not be			To ensure ongoing compliane	ce	
		outer screen when the computer			this audit will be added to our		
	is unattended.	sate serven when the computer			Quarterly QA review through		
	is unauclided.				2025. The role of the QA Pro		
	Resident Alls recor	d was reviewed on 12/9/24 at	1			grani	
					is to review and substantiate	.d 00	
	_	es included unspecified			100% compliance is sustaine		
	_	t hip, subsequent encounter,			this deficiency does not reoc	cur.	
	type 2 diabetes mel	llitus with hyperglycemia, and					

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essential (primary) hypertension.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155449	B. WI	NG		12/10/	2024
				CED DEE	DDDDGG OVEW OTH THE GIR COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NODTHE	DN I AKEC MUDOU	NO AND DELIADILITATION CENT	-D		VILLIAMS ST		
NORTHE	KN LAKES NURSI	NG AND REHABILITATION CENTI	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Set (MDS) indicated Mental Status (BIM intact). During an interview Administrator indic confidential residen visible on top of the station. Resident in screen should be ke computer or hiding was aware staff had The nursing report information should A current policy, ur Administrator on 12 confidential information worksheets should in unattended. The po	at admission Minimum Data d their Basic Interview for IS) score was 15 (cognitively IV, on 12/9/24 at 12:02 PM, the ated staff should ensure t information could not be medication cart or nurses' afformation on the computer pt confidential by closing the the screen. She indicated she aleft a computer screen open. Form with confidential have information hidden. Indicated, provided by the 2/9/24 at 12:33 PM, indicated ation including forms and not be left on medication carts alicy indicated medication cart be left open with resident mattended.					
	Q / ()						
F 0600	483.12(a)(1)						
SS=D	Free from Abuse a	and Neglect					
Bldg. 00	failed to ensure resi abuse for 3 of 5 resi Resident 18, Reside Findings include:	and record review the facility dents were free from verbal idents reviewed (Resident 15, ent 44).	F 06	500	The administrator was notified immediately of the allegations abuse, and the facility Policy & Procedure for Abuse Prohibition was followed as written. The administrator did complete a finvestigation and notified the Indiana Department of Health facility policy and IDOH	of & on ull	01/08/2025
		sident 18 indicated Resident 15			Guidelines. The Charge Nurs	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/10/2024 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 was assisted onto the commode (toilet) by followed facility policy including Certified Nurse Aide (CNA) 2. Resident 18 notifying the administrator of this indicated CNA 2 told Resident 15 to put on her incident and had the employee call light when finished on the commode. Resident leave the facility pending 15 indicated when CNA 2 was getting ready to exit notification and investigation. the room, Resident 15 told CNA 2 she was finished on the commode. Resident 15 indicated The employee was suspended and CNA 2 responded to turn on her call light. at the conclusion of the Resident 18 indicated Resident 15 was frustrated investigation was terminated from so Resident 18 told Licensed Practical Nurse employment with Northern Lakes (LPN) 3 of Resident 15's requested assistance. Nursing & Rehabilitation Center. Resident 18 indicated she then observed CNA 2 The IDOH surveyors completed return to the resident's room and overheard interviews with employees, and yelling. Resident 18 indicated she also observed they were able to state who they CNA 2 exit the resident's room. would report suspected abuse to. An investigation file was provided by the Director All employees were re-instructed of Nursing (DON) on 12/6/24 at 11:30 AM. The file on Abuse Prohibition, Reporting included the following: Abuse, types of abuse. A facility reported incident (FRI), dated 11/23/24, indicated on 11/22/24 CNA 2 and Resident 15 were Social Services will conduct a overheard yelling at each other. The FRI indicated weekly meeting with residents x 2 the Administrator suspended CNA 2 and then weeks specific to Abuse to ensure interviewed 5 residents. no further allegations are made. If CNA 2's file indicated CNA 2 verbally abused a 100% compliance is maintained, a resident by saying "if you're going to act like that twice monthly meeting will be held then someone else can f***** get you." The file with the residents x 2 months. If indicated other residents also heard CNA 2 in the we maintain 100% compliance, hallway using foul language. this will be added to our monthly The investigation file included the following Resident Council Meeting and interviews: reported to the Quality Assurance Resident 15's interview with the Administrator Committee Quarterly. indicated the incident occurred on 11/22/24 around 8 PM. Resident 15 indicated she was To ensure ongoing compliance frustrated with CNA 2. Resident 15 indicated CNA this audit will be added to our 2 was rude and a B*** towards Resident 15. Quarterly QA review throughout Resident 18's interview with the Administrator 2025. The role of the QA Program indicated CNA 2 entered the room and assisted is to review and substantiate her roommate, Resident 15, onto the commode. 100% compliance is sustained so Prior to leaving the room CNA 2 told Resident 15 this deficiency does not reoccur.

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	OF CORRECTION	IDENTIFICATION NUMBER 155449	A. BU	A. BUILDING 00 B. WING			COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIER	NG AND REHABILITATION CENT	ER	516 N W	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	she would return. Roverheard Resident finished on the come CNA 2 left Resident the room. Resident Resident 15 yell she was shut. Resident 13 of Resident 15's room and close indicated she overhyelling at each other their room and close indicated she overhyelling at each other then observed CNA LPN 3 "just because as quickly as she was the floor, and I am rowell Resident 44's intervindicated she overhindicated she overhindicated she overhindicated she overhindicated staff shoresidents. CNA 4 in frustrated with staff nurse was notified. A record review was AM. Diagnosis includisorder and hemiph nontraumatic intrace left dominant side. Resident 15's quarte 10/11/24, indicated Interview Mental Staff (cognitively intact).	esident 18 indicated she 15 tell CNA 2 twice she was mode. Resident 18 indicated t 15 on the commode and left 18 indicated she overheard e was finished, and the door 18 indicated she notified LPN equested assistance. Resident en observed CNA 2 return to ed the door. Resident 18 eard CNA 2 and Resident 15 r. Resident 18 indicated she 2 leave the room and told e I didn't get back to her room anted me to, she threw stuff on not cleaning it up." iew with the Administrator eard Resident 15 yelling on ning for assistance. Resident 44 eard CNA 2 indicate f**** fool" in the hallway. 7, on 12/6/24 at 11:15 AM, CNA buld never yell at any dicated when a resident was and needs weren't met, the s completed on 12/6/24 at 11:49 uded: major depressive legia/hemiparesis following erebral hemorrhage affecting erly assessment, dated Resident 15 had a Brief tatus (BIMS) score of 14/15						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155449	B. WI	NG		12/10/	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			VILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENTI	ER		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	·ΤΕ	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	PM for Resident 18						
		ssion assessment, dated					
	·	Resident 18 had a BIMS score					
of 15/15 (cognitively intact). intact).							
		as 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 (cognitivel	ly 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							
		ouse: use of oral or gestured					
		ally includes disparaging and					
		residents or within hearing					
		of the resident's ability to					
	comprehend."	of the resident's domity to					
	comprehend.						
	This finding is relat	ed to Complaint IN00447844.					
	3.1-27(a)(b)						
F 0688	483.25(c)(1)-(3)						
SS=D		Decrease in ROM/Mobility					
Bldg. 00							
			F 06	588	The Director of Nursing & The	rapy	01/08/2025
	Based on observation	on, interview and record			Director reviewed all current		
	review the facility f	ailed to ensure orders were			orders, care plans, and therap	у	
	entered and followe	ed for 1 of 3 residents reviewed			communication forms to ensur		
	(Resident 15).				that we have appropriate nurs	ing	
					orders.		
	During an interview	on 12/5/24 at 11:34 AM,					
	Resident 15 indicate	ed she had a history of a stroke			Nursing department was		
	with left side affects	ed. Resident 15 indicated she			reinstructed on the use of dev	ices	
		n therapy and recommended to			such as palm protectors, splin	ts	
	_	left hand. Resident 15			and other preventative/restora	itive	
	indicated the staff n	o longer placed the splint on			type devices.		
	her hand.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155449		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/10/2024		
	PROVIDER OR SUPPLIER	NG AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP COD 516 N WILLIAMS ST TER ANGOLA, IN 46703				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
	During an observation Resident 15 did not During an observation palmor hand splint bed. An upside-dow wear splint daily/nit reapply after care. To recommendations patter the Therapist. During an interview Certified Nurse Aid 15 wore a hand splint AM - 10 AM. CNA splint was located in During an interview Registered Nurse (I wore a hand splint patterns and patterns an	ion on 12/5/24 at 11:34 AM, have a splint on her left hand. ion on 12/5/24 at 1:30 PM, a was in a bag by Resident 15's on paper indicated Resident to ghtly, remove for AM/PM and The paper indicated rovided by Occupational ion on 12/5/24 at 1:12 PM, le (CNA) 6 indicated Resident nt for 4 hours a day, between 6 to 6 indicated Resident 15's in a bag by her bed. ion 12/5/24 at 1:32 PM, RN) 5 indicated Resident 15 per the instructions on the wall dicated the signage indicated redially/nightly, remove for y after care. RN 5 indicated the gned by occupational therapy. ident 15 did not have an order for the splint, but that staff ons in the report. RN 5 ald be an order for Resident ructions in her chart. ion 12/5/24 at 1:42 PM, the follow) indicated Resident 15 to 15 to 15 should have a cluded			The Director of Nursing & The Director will conduct 3 times weekly x 2 weeks observation ensure orders are followed. T 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 an review each week at the week QA Compliance Meeting. If we maintain 100% compliance due each review the Director of Nu will add to our ongoing QA review. The role of the ongoin QA Calendar is to review and substantiate 100% compliance sustained so this deficiency do not reoccur.	s to he whe ation ad d ly e rring ursing	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155449	(X2) MULTIPL A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 12/10/2024
	PROVIDER OR SUPPLIER ERN LAKES NURSING AND REHABILITATION CENT	516	EET ADDRESS, CITY, STATE, ZIP COI 3 N WILLIAMS ST IGOLA, IN 46703	D
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APP	ULD BE COMPLETION
	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			
	3.1-3/			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155449	B. WI	NG		12/10/	/2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			WILLIAMS ST		
NORTHE	RN LAKES NURSI	NG AND REHABILITATION CENT	ER		LA, 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	·ΤΕ	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0880							
SS=D	Infection Prevention	on & Control					
Bldg. 00							
			F 08	380	The Director of Nursing & Stat	if	01/08/2025
		on, interview and record			Development Coordinator		
	review, the facility failed to ensure a blood sugar				reinstructed all Nurses & QMA		
		was properly disinfected			on our Policy & Procedure for		
		ent use for 2 of 2 residents			sanitizing glucometers between		
	reviewed (Resident	59 and Resident 26).			use immediately when this wa		
					brought to our attention. Each		
	Findings include:				medication cart was immediat	ely	
	0 10/5/01 111				stocked with Sani-Wipes		
		7 AM, Licensed Practical Nurse			(approved bleach sanitizer) fo	r	
		rved cleaning a unit glucometer			use.		
	at the medication (n	ned) cart.			l		
		10/5/01 . 11 00 . 11 7 7 7 7 7 00			We now utilize two glucomete	rs	
		12/5/24 at 11:20 AM, LPN 20			for each medication cart this		
	_	lucometer was used to obtain			allows the Nurses and QMAs		
	-	the diabetic residents on the			sanitize the glucometer and le	t It	
		ted they cleaned the			sit for the recommended 4		
	-	n each resident use with an			minutes and utilize the other		
	_	0 indicated cleaning the cohol after each use was			glucometer that has been		
	_	conor after each use was			sanitized and ready to use.		
	standard practice.				The Diverton of Numerican on		
	On 12/5/24 of 11.24	6 AM, items in a unit med cart			The Director of Nursing or	,	
		LPN 20. The med cart did not			Designee are conducting daily audit x 14 days to ensure that		
	contain disposable				1		
	contain disposable i	oleach wipes.			Nurses & QMAs are utilizing the Sani Wipes (approved bleach		
	On 12/09/24 at11:3	9 AM, Qualified Medication			sanitizer) and following the fac		
		s observed obtaining Resident			policy on sanitizing glucomete	-	
		th the unit glucometer.			between each resident use. T		
	5) 5 61664 Bugar Wi	ar the unit gracometer.			findings are being reviewed du		
	Resident 59's record	d was reviewed on 12/9/24 at			our weekly QA Compliance	y	
		t 59 had a diagnosis of insulin			Meeting. If 100% compliance	is	
	dependent diabetes.				achieved and maintained, the		
	-F				Committee will recommend go		
	Resident 59's Ouart	erly Minimum Data Set, (MDS)			to the next phase of compliance	-	
	-	eated Resident 59's Brief			which is 3 X weekly x one week		
		al Status (BIMS) score was 4			across all shifts, and if 100%		
	I	, ,	1		1		i e

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155449	B. W	VING		12/10/	/2024
				CTREET	DDDFGG CITY GTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
NODTHE	DNII AIZEO NIIIDOI	NO AND DELIABILITATION CEN	TED		VILLIAMS ST		
NORTHE	KN LAKES NURSI	NG AND REHABILITATION CEN	IEK	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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(severe cognitive in	npairment). The MDS indicated			compliance maintained, one fi	nal	
	Resident 59 receive	ed insulin injections 7 days a			observation will be completed	for	
	week.				all Nurses & QMAs across all		
					shifts.		
	A physician order,	dated 10/7/24, indicated					
	Resident 59 was to	be administered insulin			To ensure ongoing compliance	е	
	injections according	g to a sliding scale (doseage			this audit will be added to our		
	calculated from blo	od sugar results) 4 times a day.			Quarterly QA review througho	ut	
					2025. The role of the QA Prog	ıram	
		7 AM, QMA 10 was observed			is to review and substantiate		
	wiping the glucome	eter with an alcohol pad. QMA			100% compliance is sustained	d so	
	10 placed the gluco	meter on top of the med cart.			this deficiency does not reocc	ur.	
		2 PM, QMA 10 was observed					
	_	26's blood sugar with the unit					
	glucometer.						
		5 PM, QMA 10 was observed					
		cometer with an alcohol pad.					
	_	er was wiped with alcohol,					
		glucometer on the top of the					
	med cart.						
	,	10/0/04 + 10 07 PM (0) 51 10					
		12/9/24 at 12:07 PM, QMA 10					
		idents on the unit used the					
	_	OMA 10 indicated they					
	_	meter between each resident					
	use with an alcohol						
		of the med cart to dry for 2					
		cated they had been trained to ers with an alcohol pad					
	between each use.	ers with an alcohol pad					
	between each use.						
	On 12/9/24 at 12:12	2 PM, items in a unit med cart					
		QMA 10. The med cart did					
	not contain disposal						
	not contain disposa	ole oleach wipes.					
	Resident 26's record	d was reviewed on 12/9/24 at					
	_	t 26 had a diagnosis of insulin					
	dependent diabetes.						
	acpendent diabetes.		1				I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155449	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIER	NG AND REHABILITATION CEN	TER	516 N W	DDRESS, CITY, STATE, ZIP COD VILLIAMS ST A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
	dated 11/7/24, indic Interview for Menta (no cognitive impai Resident 26 receive week. A physician order, of Resident 26 was to insulin with meals of A physician order, of Resident 26 was to	al Minimum Data Set, (MDS) cated Resident 26's Brief al Status (BIMS) score was 15 rment). The MDS indicated d insulin injections 7 days a dated 9/11/24, indicated be administered 5 units of every day. dated 10/22/24, indicated be administered insulin g to a sliding scale 4 times a					
	of Nursing (DON) is should be cleaned we sanitizer after each indicated alcohol part a disinfectant for she 2024). The DON in	12/9/24 at 3:26 PM, the Director ndicated shared glucometers with an approved bleach resident use. The DON ads were not recommended as ared glucometer use (CDC, dicated each med cart should container of disposable bleach					
	DON on 12/9/24 at glucometers were to bleach wipes after e	acility policy, provided by the 1:50 PM, indicated the be cleaned with disposable each use. The policy indicated re to remain wet for 1 minute.					
	[Centers for Disease	ety." (2024, August 7). e Control and Prevention]. v/injection-safety/hcp/infectio					
	3.1-18(a)						

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

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/10/2024	
NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP COD 516 N WILLIAMS ST TER ANGOLA, IN 46703				
(X4) ID	SUMMARY S	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-18(b) 3.1-18 (b)(1)						

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