

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Northern Lakes Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 516 N Williams St Angola, IN 46703	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

TITLE

(X6) DATE

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was immediately notified when 1 of 3 residents reviewed had a significant change in physical condition (Resident K). This resulted in Resident K's death. The Immediate Jeopardy began on [DATE] at 8:51 p.m. when Resident K complained of radiating pain to his left arm, shoulder, and chest. The facility failed to notify the physician of the change, and Resident K was observed to be deceased the following morning. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on [DATE] at 12:45 PM. Immediate Jeopardy was removed on [DATE] but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy when the facility reeducated all staff on recognizing and communicating change of condition to the physician. Findings include: On [DATE] at 11:04 AM, Resident K's record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD), mild dementia, nicotine dependence, intermittent atrial fibrillation, sick sinus syndrome (a rhythm disorder that occurs when the heart's pacemaker, the Sinoatrial node cannot produce a sufficient heart rate), and left shoulder pain due to degenerative joint disease. The most recent comprehensive Minimum Data Set assessment (MDS) indicated Resident K had clear speech, understood and was able to understand others, had a primary debility related cardiorespiratory conditions including atrial fibrillation, low blood sodium, High blood potassium, and COPD. The resident had mild to moderate cognitive impairment. He had no behaviors or mood indicators. He was independent with his activities of daily living (ADL) but required set up assistance with bathing. During the assessment, he complained of pain in both shoulders but had not received any non-medical interventions. A pain interview indicated Resident K had moderate pain occasionally that did not interfere with activities. The MDS reflected Resident K took medications related to Atrial fibrillation, and a medication to help him sleep at night due to insomnia. Care Plans indicated Resident K was at risk for pain related to multiple old fractures but did not include shoulder pain. The care plan indicated to give medications as ordered, and if the medication was not effective in controlling the pain, or pain worsened, to notify the physician. A care plan regarding intermittent irregular heartbeat indicated to assess for shortness of breath and follow the physician's orders, monitor and assess breath sounds and complaints of shortness of breath, and notify the physician for worsening shortness of breath. The care plan indicated Resident K had insomnia and requested staff not disturb him at night. A Nurse Practitioner (NP) progress note, dated [DATE], indicated Resident K was being seen for follow up after a left shoulder x-ray was completed due to left shoulder pain. The x-ray indicated degenerative joint disease. Referral to Orthopedics vs conservative management was discussed with the resident and he chose to continue current treatment with topical medications and physical therapy. He was planning to be discharged from the facility at the end of the month. His respirations were regular with scattered crackles. Resident K denied chest pain and palpitations. A nurse note, dated [DATE] at 8:51 p.m., indicated the nurse had been called to Resident K's room. Resident K complained of left shoulder pain and it was hard to breathe. His oxygen saturation was 92% (normal >90%) on room air. His blood pressure was normal at 108/68, and pulse was 100. The resident was resting and wanted to see if he felt better. The nurse gave as needed (prn) medications at 8:51 pm but did not chart what medications were given or interventions attempted. The note did not indicate the physician had been notified of Resident K's change in shoulder pain. No pain assessment, pain scale, assessment of respiration rate or character was documented. A nurse note, dated [DATE] at 8:14 a.m., indicated Certified Nurse Aide (CNA) 6 came to get the nurse to check on the resident. Resident K was observed to not be breathing and he had no pulse. CPR was not initiated due to irreversible signs of death. The resident family member and NP were notified of the resident's death. There was no documentation the physician was notified of Resident K's change in condition on [DATE] until after Resident K was found breathless and pulseless on [DATE]. According to the article titled shoulder pain causes and treatment, dated [DATE], retrieved from my.clevelandclinic.org on [DATE] symptoms of cardiac dysrhythmia included palpitations, shortness of breath and chest discomfort. The website indicated to get immediate help when trouble breathing or left shoulder pain occurred. The article indicated when shoulder pain did not improve, was severe, or worsening, the patient could be experiencing a heart attack and to notify the physician immediately. There was no documentation between [DATE] at 8:51 p.m. and [DATE] at 8:14 a.m. regarding assessing the resident for continued or worsening pain, or any notification of the Registered Nurse on duty or</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's complaint of shoulder with radiating chest pain, increased heart rate and shortness of breath (SOB) was re-assessed after initial assessment and treatments given were not monitored for effectiveness for 1 of 3 residents reviewed for quality of care. Resident K was found deceased the following morning. The Immediate Jeopardy began on [DATE] at 8:51 p. m. when Resident K complained of radiating pain to his left arm, shoulder, and chest. The facility failed to assess and monitor his condition, and he was observed to be deceased the following morning. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on [DATE] at 12:45 PM. Immediate Jeopardy was removed on [DATE] but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy when the facility re-educated all staff on recognizing and communicating change of condition. Findings include: On [DATE] at 11:04 AM, Resident K's record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD), mild dementia, nicotine dependence, intermittent atrial fibrillation, sick sinus syndrome (a heart rhythm disorder that occurs when the heart's sinoatrial node cannot produce a sufficient heart rate, and left shoulder pain due to degenerative joint disease. The most recent comprehensive Minimum Data Set assessment (MDS) indicated Resident K had clear speech, understood and was able to understand others, had a primary debility related cardiorespiratory conditions including atrial fibrillation, low blood sodium, High blood potassium, and COPD. The resident had mild to moderate cognitive impairment, . He had no behaviors or mood indicators. He was independent with his activities of daily living (ADL) but required set up assistance with bathing. During the assessment, he complained of pain in both shoulders but had not received any non-medical interventions. A pain interview indicated Resident K had moderate pain occasionally that did not interfere with activities. The MDS reflected Resident K took medications related to Atrial fibrillation, and a medication to help him sleep at night due to insomnia. A care plan, dated [DATE], indicated Resident K used a hypnotic for sleep, and had insomnia. A care plan, dated [DATE], regarding pain indicated Resident K was at risk for pain related to multiple old fractures, but did not include shoulder pain. The care plan indicated to give medications as ordered, and if the medication was not effective in controlling the pain, or pain worsened, to notify the physician. Certified Nurse Aides (CNA) were to notify the nurse if pain increased or worsened. A care plan, dated [DATE], regarding intermittent irregular heartbeat indicated to assess for shortness of breath and follow the physician's orders; monitor; and assess breath sounds and complaints of shortness of breath. CNAs were to notify the nurse if shortness of breath increased. Physician's orders included to give metoprolol tartrate (for atrial fibrillation), 12.5 milligrams (mg), two times per day and to hold the medication for a heartrate less than 60, or a systolic (the top number on blood pressure) blood pressure of less than 60; midodrine (for low blood pressure) 5 mg, three times daily, and to hold the medication if the residents blood pressure was greater than 110, and to recheck the blood pressure after administration or if the blood pressure was outside of normal range; Tylenol (anti-inflammatory) 500mg 2 tablets as needed every 4 hours for pain, and Voltaren gel (pain reliever) topical to the left shoulder as needed; and Trazadone (an antidepressant) 50 mg at bedtime. According to the article metoprolol tartrate, dated [DATE], retrieved on [DATE] from drugs.com, the medication is used to treat heart failure related to atrial fibrillation. Side effects included slow heartbeats, and the patient should notify the physician for shortness of breath or worsening heart symptoms. According to the article Midodrine, dated [DATE], retrieved on [DATE] from drugs.com, the medication is used to treat low blood pressure. Side effects included slow pulse, and the patient should be closely monitored. According to the article titled Tylenol, dated [DATE], retrieved for drugs.com on [DATE], pain should be monitored and when pain was new, continued without relief, or worsened, the physician should be notified immediately. A Nurse Practitioner (NP) progress note, dated [DATE], indicated Resident K was seen for follow up after a left shoulder x-ray was completed due to arthritis. The x-ray indicated degenerative joint disease. Referral to Orthopedics vs conservative management was discussed with the resident and he chose to continue current treatment with topical medications and physical therapy. He was planning to be discharged from the facility at the end of the month. His respirations were regular with scattered crackles. Resident K denied chest pain and palpations. A nurse note, dated [DATE] at 8:51 p.m., indicated the nurse had been called to the resident's room. Resident K complained of left shoulder pain and indicated it was hard to breathe. His oxygen saturation was 92%.</p>		