| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155449 | A. Building<br>B. Wing | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northern Lakes Nursing and Rehabilitation Center | 516 N Williams St<br>Angola, IN 46703 |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>46756<br><br>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).<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Resident 44's current admission Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact).<br><br>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.<br><br>(continued on next page) |

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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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>3-1(p)(5) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>44036<br><br>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).<br><br>Findings include:<br><br>During an interview, on 12/5/24 at 11:18 AM, Resident 15 and Resident 18 indicated Resident 15 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.<br><br>An investigation file was provided by the Director of Nursing (DON) on 12/6/24 at 11:30 AM. The file included the following:<br><br>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.<br><br>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.<br><br>The investigation file included the following interviews:<br><br>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.<br><br>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 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.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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).<br><br>A record review was completed on 12/6/24 at 2:40 PM for Resident 18.<br><br>Resident 18's admission assessment, dated 9/23/24, indicated Resident 18 had a BIMS score of 15/15 (cognitively intact). intact).<br><br>A record review was completed on 12/6/24 at 2:41 PM for Resident 44.<br><br>Resident 44's admission assessment, dated 11/12/24, indicated Resident 44 had a BIMS score of 15/15 (cognitively intact)<br><br>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.<br><br>This finding is related to Complaint IN00447844.<br><br>3.1-27(a)(b) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44036<br><br>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).<br><br>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.<br><br>During an observation on 12/5/24 at 11:34 AM, Resident 15 did not have a splint on her left hand.<br><br>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.<br><br>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.<br><br>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.<br><br>During an interview on 12/5/24 at 1:42 PM, the Director of Nursing (DON) indicated Resident 15 did not have a splint/[NAME] protector order listed. The DON indicated Resident 15 should have a splint order with included instructions/preferences.<br><br>A record review was completed on 12/6/24 at 11:49 AM. Diagnosis included: hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, contracture of left hand, and contracture of left wrist.<br><br>Resident 15's quarterly assessment, dated 10/11/24, indicated Resident 15 had a Brief Interview Mental Status score of 14/15 (cognitively intact).<br><br>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.<br><br>Resident 15's orders were reviewed. There were no orders for a splint or palm protector.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>3.1-37 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794<br><br>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).<br><br>Findings include:<br><br>On 12/5/24 at 11:17 AM, Licensed Practical Nurse (LPN) 20 was observed cleaning a unit glucometer at the medication (med) cart.<br><br>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.<br><br>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.<br><br>On 12/09/24 at11:39 AM, Qualified Medication Aide (QMA) 10 was observed obtaining Resident 59's blood sugar with the unit glucometer.<br><br>Resident 59's record was reviewed on 12/9/24 at 11:43 AM. Resident 59 had a diagnosis of insulin dependent diabetes.<br><br>Resident 59's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated Resident 59's Brief Interview for Mental Status (BIMS) score was 4 (severe cognitive impairment). The MDS indicated Resident 59 received insulin injections 7 days a week.<br><br>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.<br><br>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.<br><br>On 12/9/24 at 12:02 PM, QMA 10 was observed obtaining Resident 26's blood sugar with the unit glucometer.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Resident 26's record was reviewed on 12/9/24 at 12:15 PM. Resident 26 had a diagnosis of insulin dependent diabetes.<br><br>Resident 26's Annual Minimum Data Set, (MDS) dated [DATE], 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.<br><br>A physician order, dated 9/11/24, indicated Resident 26 was to be administered 5 units of insulin with meals every day.<br><br>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.<br><br>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.<br><br>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.<br><br>Reference<br><br>CDC Injection Safety. (2024, August 7). [Centers for Disease Control and Prevention].<br><br>https://www.cdc.gov/injection-safety/hcp/infection-control/index.html<br><br>3.1-18(a)<br><br>3.1-18(b)<br><br>3.1-18 (b)(1) |