STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155449	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lakes Nursing and Rehabilitation Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure dignity was provided with timely meal service for residents seated together for 2 of 8 residents reviewed (Resident 30 and Resident 70).Findings include:During an observation on 12/01/2025 11:41 AM, Activity Aide (AA) 2 served a sandwich, pasta salad, yogurt and peach cobbler to Resident 61 at a table in the dining room. Resident 30 was seated next to Resident 61 and did not have any food or drinks in front of her. On 12/01/25 at 11:43 AM, Resident 30 grabbed the bowl of cobbler from Resident 61 and held it in her hands touching the cobbler and the bowl. On 12/1/2025 11:44 AM, AA2 removed the cobbler and handed it back to Resident 61. Resident 30 continued to lean toward and reach for Resident 61's food several times over the next few minutes. Resident 30's lunch tray was served on 12/01/25 at 12:05 PM, 24 minutes after the tablemate. In an observation, on 12/01/2025 11:52 AM, Resident 9 was served his lunch. On 12/01/2025 11:58 AM Resident 70, seated next to Resident 9 leaned toward and reached for Resident 9's food. Resident 70's lunch tray was served on 12/01/2025 12:05 PM, 13 minutes after the tablemate. In an observation, on 12/01/2025 12:05 PM, a few minutes after Resident 70's tray was served, Resident 9 grabbed Resident 70's silverware. No staff were in the immediate vicinity of the residents.1) Resident 30's record was reviewed on 12/2/25 at 10:42 AM. Diagnoses included neurocognitive disorder with Lewy bodies and major depressive disorder, recurrent.A review of Resident 30's current quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 3 (severely impaired). The MDS indicated Resident 30 needed supervision and touching assistance with dining.A review of Resident 30's current care plan titled cognitive loss/dementia indicated Resident 30 had a problem of severe cognitive impairment, with a goal date of 12/31/25. Interventions included setting up meals and assisting Resident 30 if she became tired.2) Resident 70's record was reviewed on 12/3/25 at 11:57 AM. Diagnoses included cerebral infarction and dementia, moderate with agitation.A review of Resident 70's current significant change Minimum Data Set assessment (MDS), dated [DATE], indicated his Basic Interview for Mental Status (BIMS) score was 3 (severely impaired). The MDS indicated Resident 70 needed partial or moderate assistance with eating tasks.A review of Resident 70's current care plan titled I require assistance.indicated Resident 70 had a problem of functional decline, with a goal date of 1/31/26. Interventions included providing close supervision and assistance during all meals.During an interview, on 12/03/2025 10:01 AM, the Director of Nursing indicated staff should serve a table at a time in the dining room, ensuring residents would not sit for long periods of time without food when others at their table had food. She indicated a 24-minute wait to be served after a table mate was served was an excessive wait. She indicated this was an undignified practice and should not have occurred.A current policy titled Nursing Responsibilities for Meal Service, undated, provided by the DON on 12/3/25 at 12:40 PM, indicated nursing staff were expected to be available during mealtimes to assist with meal service. The policy (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated meal trays should be distributed in a timely manner and residents should be assisted in eating as needed.3.1-3(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure continuous and consistent communication with the dialysis center for 1 of 1 resident reviewed (Resident 6).Findings include:Resident 6's record was reviewed on 12/4/25 at 11:09 AM. Diagnoses included end stage renal disease and diabetes.Resident 6's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 (no impairment). The MDS indicated Resident 6 was dependent on dialysis.A physician order, dated 2/1/25, indicated Resident 6's vital signs were to be assessed prior to dialysis and upon return from dialysis.A review of Resident 6's dialysis treatment notes indicated the following:- notes dated 5/7/25 through 8/15/25 were uploaded on 8/18/25-notes dated 9/22/25 through 11/7/25 were uploaded on 11/11/25-notes dated 8/18/25 through 8/29/25 were uploaded on 12/4/25There was no consistent communication documented in the nurses notes, or in a binder to indicate consistent communication with the dialysis center was completed and available to ensure staff could access resident status before, during and after dialysis. In an interview, on 12/4/25 at 10:18 AM, the Director of Nursing (DON) indicated the facility did not communicate with the dialysis center daily on dialysis days. The DON indicated the resident was assessed before and after dialysis. The DON indicated the pre and post assessments were recorded in the resident's medical record. The DON indicated the facility did not utilize a communication binder. The DON indicated the facility communicated with the dialysis center as needed by phone. The DON indicated they were not aware of any requirement to maintain regular ongoing communication with the dialysis center.In an interview, on 12/4/25 at 1:20 PM, Registered Nurse (RN) 10 indicated pre and post dialysis assessments were recorded in the resident progress notes. RN 10 indicated the facility scanned dialysis center treatment notes into the medical record monthly.A current facility policy, dated 11/26/24, provided by the DON on 12/4/25 at 1:55 PM, indicated the facility would send all appropriate medical information with the resident to the dialysis center.3.1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure infection control practices were observed for 7 of 24 residents reviewed (Resident 61, Resident 30, Resident 9, Resident 70, Resident 40, Resident 1, and Resident 86).Findings include:1) During an observation, on 12/01/2025 11:41 AM, Activity Aide (AA)2 served a sandwich, pasta salad, yogurt and peach cobbler to Resident 61 at a table in the dining room. Resident 30 was seated next to Resident 61 and did not have any food or drinks in front of her. On 12/01/25 at 11:43 AM, Resident 30 grabbed a bowl of cobbler from Resident 61, held it in her hands touching the cobbler and the bowl. On 12/1/2025 11:44 AM, AA2 removed the cobbler from Resident 30 and handed it back to Resident 61. Resident 70's lunch tray was served on 12/01/2025 12:05 PM. A few minutes after Resident 70's tray was served, Resident 9, seated next to Resident 70, grabbed Resident 70's silverware, touching handles and mouthpieces of the silverware. After Resident 9 laid the silverware back on the table, Resident 70 picked the silverware up and used it to eat.In an interview, on 12/01/2025 at 11:45 AM, AA2 indicated she should not have handed the cobbler back to Resident 61 after Resident 30 had touched it. She indicated she should have removed the cobbler and obtained a new serving from the kitchen.2. Resident 61's record was reviewed on 12/03/2025 11:25 AM. Diagnoses included Alzheimer's disease, depression, and muscle weakness. Resident 61's current quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated her Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). The MDS indicated Resident 61 needed supervision and touching assistance with dining.Resident 61's current care plan titled I require assistance. indicated Resident 61 had a problem of dementia, with a goal date of 2/10/26. Interventions included supervising Resident 61 while eating.3) Resident 9's record was reviewed on 12/03/2025 12:23 PM. Diagnoses included Pick's disease and dementia, severe with mood disturbance.Resident 9's current quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated his Basic Interview for Mental Status (BIMS) was not conducted because he was rarely able to make himself understood. The MDS indicated Resident 9 was dependent for eating activities.Resident 9's current care plan titled I require assistance.indicated Resident 9 had a problem of functional decline, with a goal date of 2/7/26. Interventions included assisting Resident 9 with meals.4) Resident 70's record was reviewed on 12/3/25 at 11:57 AM. Diagnoses included cerebral infarction and dementia, moderate with agitation.Resident 70's current significant change Minimum Data Set assessment (MDS), dated [DATE], indicated his Basic Interview for Mental Status (BIMS) score was 3 (severely impaired). The MDS indicated Resident 70 needed partial or moderate assistance with eating tasks.A review of Resident 70's current care plan titled I require assistance.indicated Resident 70 had a problem of functional decline, with a goal date of 1/31/26. Interventions included providing close supervision and assistance during all meals.During an interview, on 12/03/2025 10:01 AM, the Director of Nursing indicated staff should serve resident trays and sit next to them providing any needed assistance. She indicated staff should supervise residents and ensure they do not touch one another's food or utensils. Any contaminated items should be immediately removed and replaced.A current policy titled Nursing Responsibilities for Meal Service, undated, provided by the DON on 12/3/25 at 12:40 PM, indicated nursing staff were expected to be available during mealtimes to assist with meal service. 5) During an observation on 12/2/25 at 11:48 AM, Certified Nurse Aide (CNA) 5, touched a pillow, personal items, a cup, and manually positioned Resident 40. CNA 5 touched her hair with her right hand and then obtained an iced tea pitcher, touching it with her right hand. CNA 5 touched a cup at the lip with her left index finger, poured, and gave the cup to Resident 40. CNA 5 then went into Resident 1's room, picked up a napkin from the floor with her right hand. She touched her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hair with her right hand, picked up Resident 1's meal tray with both hands, and touched her left eye with her left hand. She went to the kitchen and stood inside the kitchen doorway. She returned to the unit, opened the door to the tray cart, pulled a tray out, and gave it to Resident 30. While serving Resident 30's tray, she touched her silverware, removed lids from bowls and cut Resident 30's food. No hand hygiene occurred during the continuous observation. In an interview, on 12/2/25 at 12:08 PM, CNA 5 indicated she should have used hand sanitizer when contacting anything or touching a resident. She indicated she should have washed her hands if she contacted something soiled. 6) Resident 40's record was reviewed on 12/3/25 at 1:41 PM. Diagnoses included heart failure and dementia.A current significant change MDS assessment, dated 11/11/25 indicated Resident 40 had a BIMS score of 14 (cognitively intact). The MDS indicated Resident 40 needed set-up assistance with meals.A current care plan titled I require assistance.indicated Resident 40 had a problem of declining condition, nearing end of life, with a goal date of 2/9/26. Interventions included setting up meals.7) Resident 1's record was reviewed on 12/03/2025 2:13 PM. Diagnoses included cerebrovascular accident with right sided hemiplegia.A current significant change in status MDS assessment, dated 10/14/25, indicated Resident 1 had a BIMS score of 13 (cognitively intact).A current care plan titled I require assistance.indicated Resident 1 had a problem of functional decline, with a goal date of 12/30/25. Interventions included setting up meals.8) Resident 30's record was reviewed on 12/2/25 at 10:42 AM. Diagnoses included neurocognitive disorder with Lewy bodies and major depressive disorder, recurrent.Resident 30's current quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 3 (severely impaired). The MDS indicated Resident 30 needed supervision and touching assistance with dining.Resident 30's current care plan, titled cognitive loss/dementia, indicated Resident 30 had a problem of severe cognitive impairment, with a goal date of 12/31/25. Interventions included setting up meals and assisting Resident 30 if she became tired.In an interview, on 12/2/25 at 2:02 PM, the DON indicated employees should wash their hands after every third tray and use hand sanitizer between each contact. She indicated staff should perform hand hygiene after any contact with their hair or face.A current policy titled Nursing Responsibilities for Meal Service, undated, provided by the DON on 12/3/25 at 12:40 PM, indicated hand sanitizing should occur at least every third tray passed and after every resident contact. A current policy titled Handwashing, dated 1/2025, provided by the Administrator on 12/2/25 at 1:35 PM, indicated hand hygiene should be performed after each direct resident contact, during meal service, and after touching one's face or hair.9) During an observation on 12/02/2025 11:36 AM, Housekeeper 6 was pulling linens off Resident 86's bed. Housekeeper 6 was not wearing gloves and held dirty linens against her body as she stuffed the linens into a plastic bag. In an interview, on 12/02/2025 11:37 AM, Housekeeper 6 indicated she was deep cleaning the room. She indicated she should have been wearing gloves when touching dirty linen and should ensure the contaminated linens did not touch her body. She indicated she got busy and forgot. 10) Resident 86's record was reviewed on 12/03/2025 2:35 PM. Diagnoses included chronic inflammatory demyelinating polyneuritis and acute pyelonephritis.A current significant change in status MDS assessment, dated 10/10/25, indicated Resident 86 had a BIMS score of 15(cognitively intact).A current policy titled Procedure for Handling Linens, dated 1/2025, provided by the DON on 12/3/2025 at 12:40 PM indicated soiled linen should be handled in such a way to prevent the spread of infection.A current policy titled Infection Control: Housekeeping, dated 1/2025, proved by the DON on 12/3/2025 at 12:40 PM indicated gloves should be worn when handling soiled linens and gowns or aprons may be indicated when contact with soiled items may be anticipated. 3.1-18(a)3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe and homelike environment for 7 of 7 residents reviewed residing in rooms 17, 19, 20, and 21. Findings include:During a continuous observation on 12/1/25 between 10:50 AM through 11:35 AM, the following was observed:In room [ROOM NUMBER], a large section of marked and scuffed wall, approximately 3 feet by 4 feet, had 2 curls of peeling white substance behind the head of the resident's bed approximately 4 inches long. The wall damage in room [ROOM NUMBER] was visible from the hallway. In room [ROOM NUMBER], a 2 inch by 6 inch section of bathroom floor was missing. In room [ROOM NUMBER], black scuff marks were found on the bathroom door approximately 3 feet high and the full width of the door. Peeling paint with a section of exposed, soft drywall measured approximately 3.5 inch by 3.5 inch was found between the windowsill and room temperature control unit. One of three wooden trim pieces was missing on the left side of the temperature control unit. The wall damage in room [ROOM NUMBER] was visible from the hallway. In room [ROOM NUMBER], peeling paint was found next to the heater unit at the floor trim level. Flooring was missing, approximately 1 foot by 1 foot. The wall damage in rooms [ROOM NUMBERS] was visible from the hallway. In an interview, on 12/1/25 at 11:15 AM, Resident 1, identified as able to answer questions appropriately, indicated the wall damage in room [ROOM NUMBER] had occurred when their roommate had lived there. The former roommate needed mechanical assistance, and the wall had been hit by equipment. The former roommate had been gone from the room for 6 months. In an interview, on 12/3/25 at 1:00 PM, the Director of Maintenance indicated work orders included wheelchair and equipment maintenance, plumbing concerns, and lighting concerns. Any staff could submit a work order. No work orders for room [ROOM NUMBER] had been submitted. Once a month, maintenance was expected to inspect each room. The Director of Maintenance indicated he had forgotten resident's verbal requests for work. A current policy, reviewed in 2025, provided by the Assistant Administrator, indicated work orders were required to be completed to establish priority of maintenance services. Work order forms were to be maintained at nurse's stations. Every employee had a responsibility to fill out work orders.3.1-19(e)