

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000000	<p>This visit was for the investigation of Complaints #IN00144111 and IN00144052.</p> <p>Complaint #IN00144111- Substantiated, Federal/State Deficiencies related to the allegations are cited at F225, F226, F250 , and F309</p> <p>Complaint #IN00144052- Substantiated, Federal/State Deficiencies related to the allegations are cited at F225, F226, F250, and F309</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: February 11 - 13, 2014</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>Survey Team: Julie Wagoner, RN TC Deb Kammeyer, RN</p> <p>Census Bed Type: SNF: 12 SNF/NF: 40 Total: 52</p>	F000000	<p>This plan of correction is submitted by Lakeland Rehabilitation and Healthcare Center in order to respond to the alleged allegations cited during our complaint survey which was conducted on February 13, 2014. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective March 5, 2014. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Lakeland Rehabilitation and Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Corrections</p>	
---------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Census Payor Type: Medicare: 11 Medicaid: 33 Other: 08 Total: 52</p> <p>These deficiencies reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on February 20, 2014, by Brenda Meredith, R.N.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	Failure to report resident	03/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>interviews, the facility failed to ensure 2 of 2 allegations of abuse were reported immediately to the Administrator and reported timely to the Indiana State Department of Health.</p> <p>Findings include:</p> <p>1. Review of an incident report form, initiated on 01/29/14 at 2:00 P.M., indicated Certified Nursing Assistant (CNA) #1 observed Resident G hit Resident H on the arm.</p> <p>Interview with the Administrator in Training (AIT), on 02/12/14 at 11:26 A.M., indicated he was notified by the Director of Health Services (DHS) regarding the incident CNA #1 had reported about the altercation involving Resident G and Resident H on the day it had occurred (01/29/14) but later in the day around 4:00 P.M. He indicated he did not report the incident to the Administrator, who was not in the building, nor did he report the allegation to the Department of Health. He indicated he did not look at the investigative documentation. He indicated he thought the DHS had reported the incident and handled the investigation.</p>		<p>toresident. (1). Reportable with resident G and H was submitted to the ISDH on 1/30/14 at 5:01pm. Reportable with residents C and E was reported to ISDH on 2/6/14 at 4:35PM. (2)All residents with incidents for themonth of February were reviewed on2/28/14 by the Executive Director or Administrator in Trainingfor any state reportables notbeing reported. No defincieswere noted at this time.(3)Director of Nursing Services(DHS) and Administer in Training (AIT) werere-inserviced on incidentsconcerning Staterequirements of reportingallegations of abuse, ExecutiveDirector. Executive Director ordesignee will review weeklyincident log to ensure allrequirements are being met.Executive Director or designeewill report findings monthly toQAA.(4) QAA will monitor for anytrends and makerecommendation to the Plan ascorrection as needed. QAA willmonitor monthly for 90 days oruntil 100% compliance isobtained. (5) F225 will becompleted by 3/5/15.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Interview with the Director of Health Services (DHS), on 02/12/14 at 11:45 A.M., indicated she was notified personally by CNA #1, on 01/29/14, of the incident involving Resident G and Resident H. She indicated she immediately notified the Administrator in training and later notified her corporate consultant nurse, the Administrator, and the Department of Health via an email. She was not sure of the exact time of the email notification.</p> <p>Telephone interview with the Administrator, on 02/12/14 at 11:20 A.M., indicated she had been notified of the incident involving Resident G and Resident H by an email sent from the DHS. She indicated she would be able to obtain a copy of the email when she arrived at the facility.</p> <p>Documentation of the email, provided by the Administrator on 02/12/14 at 3:20 P.M., indicated she was notified of the incident on 01/30/14 at 5:01 P.M., over 24 hours after the incident had occurred. The documentation also indicated the incident was not reported to the Department of Health until 01/30/14 at 5:01 P.M.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>2. Review of facility incident documentation, completed on 02/05/14 at 2:20 P.M. indicated Resident C had attempted to give Resident E "something" off of the floor and when Resident E did not take the item, Resident C "tapped" Resident E on the shoulder and arm.</p> <p>Review of a typed narrative note from the DHS, dated 02/05/14, indicated a former staff member had loudly exclaimed [Resident C's name] just slapped the crap out of [Resident E's name]." The note indicated the former employee and another CNA were passing ice water and had observed the altercation between Resident C and Resident E. The narrative further stated the DHS had interviewed Resident E, who the DHS indicated was blind but alert and oriented, and although Resident E indicated Resident C had "tapped her shoulder and arm" it did "sting." The DHS indicated there was no redness observed on Resident E's arm or shoulder.</p> <p>Written statements from the two nursing staff who had witness the altercation between Resident C and Resident E indicated both employee saw Resident C "slap" Resident E</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>twice on the arm and once on the head.</p> <p>Telephone interview with the Administrator, on 02/12/14 at 11:20 A.M., indicated she had been notified of the incident involving Resident C and Resident E by an email sent from the DHS. She indicated she would be able to obtain a copy of the email when she arrived at the facility.</p> <p>Interview with the Administrator in Training, Employee #3, on 02/12/14 at 11:26 A.M. indicated he was notified of the incident "just minutes" after it had occurred. He indicated he had not read the witness statements or the investigative documentation, but thought the two staff who witnessed the altercation had only witness the last "hit." He indicated he did not notify the Administrator not had he send the report to the Department of Health.</p> <p>Interview with the DHS, on 02/12/14 at 11:45 A.M. indicated she was notified of the altercation involving Resident C and Resident E on 02/05/14 between 2:15 - 2:30 P.M. She indicated the AIT was made aware of the incident at the same time. She indicated she did not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>notify the Administrator but she did notify her corporate nurse consultant. She indicated she though the corporate consultant had sent an email to the Administrator, who was not in the building at the time. The DHS indicated she notified the Department of Health on 02/06/14 at 4:31 P.M.</p> <p>Review of an email, provided by the Administrator, on 02/12/14 at 3:20 P.M., when she arrived at the facility, indicated she had been notified via an email of the incident involving Resident C and Resident E on 02/06/14 at 4:35 P.M., over 24 hours after the altercation had occurred.</p> <p>This federal tag relates to Complaint #IN00144111 and #IN00144052.</p> <p>3.1-28(c) 3.1-28(e)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to follow their abuse policy and procedure regarding notifying the Administrator and the Department of Health for 2 of 2 allegations of abuse.</p> <p>Finding includes:</p> <p>Based on record review and interviews, the facility failed to ensure 2 of 2 allegations of abuse were reported immediately to the Administrator and reported timely to the Indiana State Department of Health.</p> <p>Findings include:</p> <p>1. Review of an incident report form, initiated on 01/29/14 at 2:00 P.M., indicated Certified Nursing Assistant (CNA) #1 observed Resident G hit Resident H on the arm.</p> <p>Interview with the Administrator in Training (AIT), on 02/12/14 at 11:26</p>	F000226	F226 same as F225	03/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>A.M., indicated he was notified by the Director of Health Services (DHS) regarding the incident CNA #1 had reported about the altercation involving Resident G and Resident H on the day it had occurred (01/29/14) but later in the day around 4:00 P.M. He indicated he did not report the incident to the Administrator, who was not in the building, nor did he report the allegation to the department of health. He indicated he did not look at the investigative documentation. He indicated he thought the DHS had reported the incident and handled the investigation.</p> <p>Interview with the Director of Health Services (DHS), on 02/12/14 at 11:45 A.M. indicated she was notified personally by CNA #1 on 01/29/14 of the incident involving Resident G and Resident H. She indicated she immediately notified the Administrator in training and later notified her corporate consultant nurse, the Administrator, and the Department of Health via an email. She was not sure of the exact time of the email notification.</p> <p>Telephone interview with the Administrator, on 02/12/14 at 11:20 A.M., indicated she had been</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>notified of the incident involving Resident G and Resident H by an email sent from the DHS. She indicated she would be able to obtain a copy of the email when she arrived at the facility.</p> <p>Documentation of the email, provided by the Administrator on 02/12/14 at 3:20 P.M., indicated she was notified of the incident on 01/30/14 at 5:01 P.M., over 24 hours after the incident had occurred. The documentation also indicated the incident was not reported to the Department of Health until 01/30/14 at 5:01 P.M.</p> <p>2. Review of facility incident documentation, completed on 02/05/14 at 2:20 P.M. indicated Resident C had attempted to give Resident E "something" off of the floor and when Resident E did not take the item, Resident C "tapped" Resident E on the shoulder and arm.</p> <p>Review of a typed narrative note from the DHS, dated 02/05/14, indicated a former staff member had loudly exclaimed "[Resident C's name] just slapped the crap out of [Resident E's name]." The note indicated the former employee and another CNA were passing ice water</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>and had observed the altercation between Resident C and Resident E. The narrative further stated the DHS had interviewed Resident E, who the DHS indicated was blind but alert and oriented, and although Resident E indicated Resident C had "tapped her shoulder and arm" it did "sting." The DHS indicated there was no redness observed on Resident E's arm or shoulder.</p> <p>Written statements from the two nursing staff who had witness the altercation between Resident C and Resident E indicated both employee saw Resident C "slap" Resident E twice on the arm and once on the head.</p> <p>Telephone interview with the Administrator, on 02/12/14 at 11:20 A.M., indicated she had been notified of the incident involving Resident C and Resident E by an email sent from the DHS. She indicated she would be able to obtain a copy of the email when she arrived at the facility.</p> <p>Interview with the Administrator in Training, Employee #3, on 02/12/14 at 11:26 A.M. indicated he was notified of the incident "just minutes" after it had occurred. He indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>he had not read the witness statements or the investigative documentation, but thought the two staff who witnessed the altercation had only witness the last "hit." He indicated he did not notify the Administrator not had he send the report to the Department of Health.</p> <p>Interview with the DHS, on 02/12/14 at 11:45 A.M. indicated she was notified of the altercation involving Resident C and Resident E on 02/05/14 between 2:15 - 2:30 P.M. She indicated the AIT was made aware of the incident at the same time. She indicated she did not notify the Administrator but she did notify her corporate nurse consultant. She indicated she though the corporate consultant had sent an email to the Administrator, who was not in the building at the time. The DHS indicated she notified the Department of Health on 02/06/14 at 4:31 P.M.</p> <p>Review of an email, provided by the Administrator, on 02/12/14 at 3:20 P.M., when she arrived at the facility, indicated she had been notified via an email of the incident involving Resident C and Resident E on 02/06/14 at 4:35 P.M., over 24 hours after the altercation had occurred.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000250 SS=E	<p>Review of the Abuse and Neglect policy and procedure, dated as revised on 09/16/11, and received from the Administrator in Training (AIT) on 02/12/14, included the following: "d. Identification...iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee....vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies...g. Reporting ...ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies...."</p> <p>This federal tag relates to Complaint #IN00144111 and #IN00144052.</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Based on observation, record review and interviews, the facility failed to ensure the behaviors were consistently documented and the behavior interventions were implemented to ensure 4 of 4 residents reviewed for behaviors were adequately managed . (Residents C, D, F, and G)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 02/11/14 between 9:30 A.M. - 10:30 A..M., LPN #4, indicated Resident D was confused and would get upset and threaten others with her fork in the assisted South dining room. LPN #4 indicated she did not feel this was "a behavior" for Resident D. During the tour, Resident D was observed seated in the dining room, dressed in her bathrobe. She had her head down, was seated by herself at a table, and was talking out loud with a rambling, disjointed conversation. She was overheard, repeating "I'm the flying nun, I'm related to Al Capone, and I'm afraid." During the course of her verbal rambling she would become "agitated" and was also noted to gesture with her hands. She did not respond or make eye contact when she was</p>	F000250	F2501. Resident G, C, F in the 2567 can not be corrected due to no list of Resident Identifier due to complaint survey.2. Residents with behaviors in the last 30 days were re-assessed to ensure behaviors have interventions .3. Nursing staff was re-inserviced on 2/27/14 documentation related to behaviors. Clinical care meeting will be held and all residents with behaviors from Care tracker and will be printed off- will be re-assessed to ensure the intervention are effective. Any resident that interventions are not effective will be referred to Mental health services. Director of Healthcare (DHS) will montior 5 times per week for 90 days to ensure documentation is being completed. DHS or designee will report finding to QAA monthly for 90 days. 4. QAA will monitor for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.5. Completion of tag: 3/5/14	03/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>greeted with her name, her rambling paused for a few seconds and then continued.</p> <p>On 02/11/14 at 11:10 A.M., Resident D was observed ambulating with her walker on the 200 hall. She was still dressed in her bathrobe, which was visibly wet. The resident's hair was disheveled and she smelled strongly of urine. The resident was still verbally rambling as she ambulated up and down the hallway. She attempted to enter another resident's room, and was verbally and physically redirected from the room. The resident's verbal rambling continued and she did not seem to acknowledge or comprehend staff attempts at redirection. RN #5 and LPN #6, who were passing medications on the 200 hall, each attempted to convince Resident G to go to her room to "get dressed and cleaned up." The resident was noted to be very resistant to their attempts. LPN #6 was able to get Resident G to ambulate into her room, and for a brief 3 second window, the resident stopped her rambling and exclaimed, "Wow, I smell don't I." LPN #6 agreed and told the resident he would help her get dressed, however, any attempts to assist the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>resident in removing her soiled clothing resulted in physical resistance as the resident became irritated and swatted his hand away from her body. She continued the verbal rambling and staff were not able to get her to accept care. She proceeded to ambulate back out into the hallway in her soiled bathrobe.</p> <p>On 02/11/14 at 11:25 A.M., RN #5 was overheard informing the acting Assistant Director of Nursing (ADON) of the resident's care needs, odor of "pee," and resident's resistance to care attempts and "jittery" behaviors.</p> <p>On 02/11/14 at 11:30 A.M., a friend came to visit Resident G and the resident was able to focus on her friend, stop the verbal rambling, and with a lot of encouragement from her friend, Resident G did finally accept care and get dressed for the day. She then was observed seated at a dining table in the South dining room eating lunch with her visitor. During the lunch, Resident G's conversation drifted from topic to topic, but she was not distressed and was eating her meal.</p> <p>On 02/12/13 at 8:55 A.M., Resident G was observed seated in a chair in</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>her room. The resident was dressed but had an angry look on her face. When questioned regarding her state, Resident G indicated she was upset about her bed, she physically threw two small magazines from her lap onto the floor, and then grabbed her head and exclaimed "there are loud bells ringing inside my head."</p> <p>Interview with CNA 7, who was working on the 200 hall for the day, indicated Resident G was very agitated but was "more lucid." CNA #7 indicated Resident G often spent large portions of the day talking to "no one." CNA #7 indicated during these times, Resident G was very hard to redirect and would not allow care to be provided for her. She indicated she would report the issues to the nurse and could document the behaviors in the KIOSK electronic charting system. CNA #7 indicated she was not aware of any specific behavior management interventions to assist staff when Resident G was having her "episodes."</p> <p>On 02/12/14 at 1:30 P.M., Resident G was observed seated in her room. She responded pleasantly to conversation, was telling multiple stories from her past, at times was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>able to answer direct questions and give her opinions on specific topics. She was making good eye contact and was laughing during the conversation.</p> <p>On 02/13/14 at 9:00 A.M., Resident G was observed seated in the dining room holding a spoon. She was dressed in the same pants and shirt as she wore yesterday, her head was down and she was verbally rambling. She again was mentioning "Flying nuns."</p> <p>On 02/13/14 at 10:00 A.M., Resident G was observed still seated at the dining room table, holding a spoon, and verbally rambling. After three attempt to address the resident with her name, she did stop the rambling, made eye contact, and spoke briefly with visitor. After a few minutes of conversation, she then dropped her head and went back to her verbal rambling.</p> <p>Interview with LPN #8, indicated she was now going to start "charting" and documenting the resident's behaviors. She indicated she had not been documenting all of Resident G's behaviors. She indicated she was to chart behaviors on the paper chart on a Mental</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Health/Behavior change form. She indicated the resident had been evaluated by the psychiatric nurse practitioner since she had been admitted to the facility. LPN #8 did not know if the nurse practitioner was aware of the resident's verbal ramblings, resistance to care needs, and agitation. LPN #8 indicated she was not aware of any specific interventions to address Resident G's behaviors.</p> <p>The clinical record for Resident G was reviewed on 02/11/14 at 11:00 A.M. Resident G was admitted to the facility on 12/10/13, with diagnosis, including but not limited to, osteoarthritis, lactose intolerance, carpal tunnel, confusion, altered mental state, and failure to thrive.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 12/23/13 for Resident G, indicated she was moderately cognitively impaired, had continuous behaviors of delirium displayed as inattention and disorganized thinking, had mood issues of feeling down or depressed, or hopeless, and trouble falling or staying asleep or sleeping too much, there were no behavior issues documented on the assessment except wandering.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The Individual Plan Report, not located on the paper chart but typed in the electronic Kiosk system, for Resident G, included the following plan: "Cognition 01/14 - I have a diagnosis of confusion and altered mental status. I will talk almost as if rambling, about a variety of subjects, but once directed, am able to answer questions. Sometimes it's difficult to tell if I am answering the question appropriate though. If you have any concerns about this, please speak with my newpewh [sic ] [nephew's name], as he knows me best. Moving into this facility has been a big lifestyle change for me and although i am adjusting, it has been a little hard on me. I hae [sic] specific activities and a routine that i like to do and it keeps me calm and at peace. Please allow me to go about my day in the way that I like, as long as I am safe to do so. My goal is to be content, well-adjusted, and to have the best quality of life possible while at this facility. If you notice any changes in my cognition, please inform my doctor. Please review this care plan by 04/14....Mood and behaviors 01/14 - At this time, the majority of my behaviors are the result of my confusion. Throughout the day and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the night, I can become very flustered, I will pack and unpack my belongings multiple times, rearrange things in my room, and at times will flush large amounts of paper towels down the toilet. I have also left the water running in the sink for quite some time. During times that I am doing these things, please approach me and attempt to calm me down. There are several different things that I enjoy doing, such as sorting papers, looking through magazines, and folding laundry. These items are available at the nurses station. Please offer these to me, or maybe even a snack, when you see that i am restless. My goal while here it to able to be (sic) calm and at peace. I want to feel like I have a purpose and a set schedule for the days, as i have "boundless energy." I want the best quality of life possible. Please monitor my behaviors, as well as my moods, and report any changes to my doctor. At this time, I am seeing the psychologist from [name of psychiatric group], per the verbal consent of my nephew. So far, this has been good for me. Please review this care plan by 04/14 to make any necessary updates or changes and to ensure that my needs are being met...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>A nursing note, dated 01/25/14 at 9:00 P.M., indicated the resident had sat in the dining room all evening and would not allow staff to toilet her. Resident also would not allow staff to assist her with the evening meal. There was no further documentation regarding what interventions were attempted in regards to the resident's resistance with care.</p> <p>A nursing note, dated 02/01/14 at 4:00 P.M., indicated the resident threw her fork because her knife had been removed. There was no further explanation as to why her knife was removed or what interventions were attempted to address the behavior.</p> <p>A nursing note, dated 02/02/14 at 5:00 A.M., indicated the resident had refused to lay in her bed or be toileted. The note indicated she "shook her fist" when asked to go to toilet. Resident also noted to be "mumbling" to herself most of the shift. This behavior was also documented in the electronic Kiosk system and the note indicated the resident "failed to comprehend that caregivers were trying to help her...." An electronic note, dated 02/02/14 at 4:03 A.M., indicated "1 to 1" was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>attempted to address the resident's behaviors but was unsuccessful.</p> <p>An electronic behavior documentation entry, dated 02/02/14 at 9:34 A.M., indicated the resident threw her food and liquid when she was asked if she needed any help cutting up her food.</p> <p>A nursing note, dated 02/02/14 at 12:54 P.M., indicated the resident became agitated when redirected from storing dirty silverware in her walker basket.</p> <p>A nursing note, dated 02/02/14 at 6:00 P.M., indicated when staff were clearing the dining room, the resident grabbed a glass of milk and "spilled" the milk across the table splashing another resident.</p> <p>A nursing note, dated 02/03/14 at 8:00 P.M., indicated the resident kept setting off her bed alarm and became agitated with staff when attempts to assist her were made.</p> <p>On 02/05/14 at 9:44 P.M., an electronic entry indicated the resident refused to be toileted even though she was soaked with urine and bm (bowel movement). The note indicated the resident became</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>"very upset" when staff approached her. Redirection was not effective as an intervention.</p> <p>On 02/05/14 at 9:56 P.M., an electronic entry indicated at 4:00 P.M., Resident G had thrown a cup of apple juice in the face of another resident who had attempted to talk with her. The note indicated redirection was not effective as an intervention.</p> <p>On 02/10/14 at 9:27 A.M., an electronic entry indicated at 3:15 A.M., Resident G had resists/rejects care and redirection of ineffective. There was no narrative attached to the documentation.</p> <p>A nursing note, dated 02/11/14 at 6:00 A.M., indicated the resident had sat in the dining room all night and when encourage to go to the bathroom, would shake her fists and stated "I don't have to go to bathroom." The resident was reapproached two hours later but had the same response. The resident was also documented as "mumbling" to self.</p> <p>On 02/11/14 at 11:18 A.M., an electronic entry indicated Resident G had refused personal care, when</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>staff attempted she became agitated, and angry, and she was "constantly rambling to self about her pass (sic)."</p> <p>Interview with CNA #11, on 02/11/13 at 11:15 A.M., indicated there had been an inservice regarding behaviors a few weeks ago but she was now being instructed not to document behaviors. She did not know why she was given these instructions.</p> <p>Interview with CNA #9, on 02/12/14 at 3:15 P.M., indicated approximately two weeks ago, she had observed Resident G throw her drinks and silverware at another resident. She indicated she did not chart the behavior in the Kiosk system because she had been instructed that what Resident G did was not a behavior but was just due to her dementia.</p> <p>Interview with CNA #2, on 02/12/13 at 2:30 P.M. indicated she did not know where to find interventions for behaviors. She indicated she had been instructed not to chart behaviors because they were "just due to the resident's dementia."</p> <p>Review of a Social Service note,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>dated 02/11/14, indicated the social service director, Employee #11, had been made aware of Resident G's behaviors of "resistant to staff care" and "calling out loudly when staff arrives to assist her." The note further indicated a visitor had a "calming" effect on the resident and the SSD was going to attempt to contact the visitor to see if she could visit more often as an intervention. There was no documentation the SSD was aware of the resident's other behaviors, the scope of the resident's behavior, or the duration and frequency. There was also no indication the physician or psychiatric service was going to be notified of the behavior issues or any other attempt was going to be made to effectively manage the resident's worsening behavior issues.</p> <p>2. During the initial tour of the facility, conducted on 02/11/14 between 9:45 A.M. - 10:30 A.M., LPN #4 indicated Resident C was confused, suspicious at times, had "outburst" with other residents, and was easily agitated at times.</p> <p>Resident C was observed, on 02/11/14 at 12:20 P.M., seated in the South dining room at a table with two other residents feeding herself.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>The clinical record for Resident C was reviewed on 02/12/14 at 9:10 A.M. Resident C was admitted to the facility on 10/30/07 with diagnosis, including but not limited to dementia, depressive disorder, difficulty walking, hypertension, hyperlipidemia, hypothyroidism, atrial fibrillation, and status post cerebral vascular accident.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment for Resident C, completed on 12/21/13, indicated the resident was severely cognitively impaired, displayed continuous inattention and disorganized thinking, had a poor appetite, and had displayed verbal behavior symptoms 1 - 3 times in the assessment period.</p> <p>The current individual plan report [care plan] included the following plan and documentation: a. Update 02/11/14 - On 02/05/14 it was documented that I was physically abusive to another resident, when in fact, I was just touching her arm in an attempt to get her attention. Going forward, if I am seen interacting with this resident, please remind me that she is not able to see me and may no [sic] be able to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

	<p>understand what I am saying to her or what I need. Please help me in any way you can or redirect me towards another activity, such as helping laundry by folding towels....</p> <p>b. ...11/19/13 - on 11/18/13 I had the reported behavior of refusing to get out of bed in the morning. The reason for this is because I prefer to sleep in in the mornings. I worked 3rd shift for many years and I naturally sleep better during the day. Please allow me to sleep in as late as I would like each morning, unless I say otherwise...</p> <p>c. 11/25/13- It was reported to staff on this date that I was physically abusive to another resident in the South dining room. Going forward, please redirect me when I am around this other resident so that I do not become agitated, perhaps talk to me about my life in Chicago. I have a dx (diagnosis) of dementia and a hx (history) behaviors and I can become very agitated quite quickly, although I do not have a history of behavior of this specific kind. Please keep me on 15 minute checks when this type of behavior occurs and discharge me from those checks after an approved amount of time. Pleases continue to monitor</p>			
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>my behaviors, as well as my cognition, and report any changes to my doctor as needed. Please make attempts to keep me occupied, as I especially enjoy chatting with others and doing some activities. These things may prevent me from becoming agitated and having behaviors towards others. Please update this care plan by 05/14 to make any necessary updates or changes and to ensure that my needs are being met.</p> <p>d. Update 12/17/13 - on this date it was reported that I had a physical altercation with a male resident here in the facility. Our wheelchairs had bumped and we both became agitated and began "swatting" at each other. To avoid this incident in the future, please ensure that during the day, my time is occupied and I do not find myself bored or unsure of what to do in the facility. I appear to become agitated more easily when I am not occupied or if I am around others who are already agitated themselves. I am very particular and sensitive to my surroundings. I like things to be neat and tidy and I don't like a lot of noise or commotion. I also become agitated if people are in my way or sitting idle in the hallway. Please</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>encourage me to attend activities that my be of interest to me and/or conversate with me about topics of interest to me. I love to just sit and talk with people and I also love to watch movies. Please continue to monitor me for further mood or behavior issues and update my doctor as needed.</p> <p>An altercation/Concern Circumstance Assessment and Interventions, completed on 12/17/13 at 2:06 P.M., indicated the resident was involved in a "physical" incident with another resident in the hall or common area on the South hall. The form indicated the resident had been in close proximity with the other resident who can be aggressive.</p> <p>A physician office progress note, dated 01/13/14, indicated the following: "Has had a few scuffles with a new resident, who is a man and is rather confrontational, and she's not one to put up with that or back down. So have had a few altercations....Staff trying to keep them away from each other...."</p> <p>A nursing note entry, dated 01/25/14 at 7:00 P.M., indicated the resident was "cleaning" and became agitated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>with other residents, wandered into another resident's room and yelled at the other resident.</p> <p>An electronic Kiosk entry, completed on 01/25/14 at 8:22 P.M., indicated the resident was "in a mood and refused 5 times when offered a shower."</p> <p>A nursing note entry, dated 02/05/14 at 2:30 P.M., indicated Resident C had become agitated with another resident when the other resident would not take something off of the floor Resident C was trying to hand her. Review of an investigation of the incident, dated 02/06/14, indicated two witnesses, who were CNA's had reported Resident C had "slapped" another resident in the arm twice and the head once.</p> <p>An electronic entry, dated 02/05/13 at 9:58 P.M., indicated Resident C had been involved in an incident with another resident and had "hit" another resident 3 times.</p> <p>The Quarterly Social Service note, dated 02/11/14, indicated the following: "Resident continues to do well in facility. She spends most of her day doing self directed activity's and enjoys organizing and "tidying</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>up" things. Resident has good continued support from her family and is very social in facility. Resident has had several recent behaviors...staff continue to monitor or observe resident for mood or behavioral issues."</p> <p>Interview, on 02/11/14 at 11:15 A.M., with CNA #10 indicated she had noted Resident C screaming and yelling at another resident but she had not documented the behaviors.</p> <p>Interview with LPN #8, on 2/12/14 at 9:30A.M., indicated on 02/05/14, she had been informed by two CNA's that Resident C had hit another resident. LPN #8 indicated she had not witnessed the altercation, nor had she "heard" the hit. She indicated she documented an incident form and documented Resident C had "tapped" another resident. She indicated she was directed to document "tap."</p> <p>Interview with LPN #12, on 02/11/14 at 3:05 P.M., indicated Resident C frequently became agitated at other resident and at time hit other resident.</p> <p>Interview with CNA #2, on 02/12/13</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>at 2:30 P.M., indicated she did not know where to find interventions for behaviors. She indicated she had been instructed not to chart behaviors because they were "just due to the resident's dementia."</p> <p>Interview with CNA #11, on 02/11/13 at 11:15 A.M., indicated there had been an inservice regarding behaviors a few weeks ago but she was now being instructed not to document behaviors. She did not know why she was given these instructions.</p> <p>3. During the initial tour of the facility, conducted on 02/11/14 between 9:45 A.M. - 10:30 A.M., LPN #4 indicated Resident F was confused, would hit with care and also had behaviors of verbal altercations with other residents.</p> <p>Resident F was observed, on 02/12/14 at 1:45 P.M., in the hallway in his wheelchair. He was noted to be propelling his wheelchair down the hallway. He was slightly agitated when approached but calmed with continued conversation.</p> <p>The clinical record for Resident F was reviewed on 02/11/14 at 11:20 A.M. Resident #F was admitted to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the facility on 10/01/13 with diagnosis, including but not limited to coronary artery disease, vascular dementia with delusions, dementia with agitation and aggression, Alzheimer's dementia, and organic psychosis.</p> <p>His current Individual Plan Report (care plan) included a plan to address the following behaviors: "Agitation, verbal abuse, physical abuse. The interventions were: explain what you are going to do for the resident before you begin to do it, pause to let resident absorb what you have said, approach slowly while explaining each step of care, offer coffee or snack, conversate about sports or military, have wife join resident when possible....When you notice I am getting agitated, please tell me where my wife is or take me to her, if possible. I like to have snacks or talk about sports or my past in the Army, or have a cup of coffee...Sometimes, it may be best to leave me alone for a while so I can calm down and then return later...."</p> <p>The plan indicated it had been updated, on 12/11/13 and 12/17/13, after the resident had physical altercations with other residents.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Nursing note indicated, on 01/08/14, the physician was notified of the resident's behaviors. It was unclear what behaviors the resident was experiencing.</p> <p>The electronic behavior documentation, from 01/15/14 - 02/11/14, indicated on 01/16/14 at 7:30 A.M., the resident became physically abusive and redirection was not an effective intervention; and, on 02/09/14 at 12:30 A.M., the resident was observed wandering in his wheelchair and attempted twice to go into another resident's room. Redirection was an effective intervention.</p> <p>On 01/16/14, a Mental Health Wellness Circumstance, Assessment, and Intervention form indicated the resident became verbally and physically abusive to nursing staff with care.</p> <p>Nursing notes, on 01/24/14 at 6:00 P.M., indicated the resident became upset and agitated when nursing staff tried to get him to sit in his wheelchair.</p> <p>Nursing note, on 01/24/14 at 7:00 P.M., indicated the resident was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>wandering in other resident's room and when redirected the resident became agitated and was yelling.</p> <p>Nursing note, on 02/03/14 at 8:00 P.M., the resident was documented as having hit a CNA with bedtime care.</p> <p>Interview with LPN #12, on 02/11/14 at 3:05 P.M., indicated Resident F frequently became agitated at other resident and had other behavior issues at least twice a week on average. LPN #12 indicated they were able to know "how to approach" the resident to "de-escalate" the resident's behaviors.</p> <p>Interview with CNA #2, on 02/12/13 at 2:30 P.M. indicated she did not know where to find interventions for behaviors. She indicated she had been instructed not to chart behaviors because they were "just due to the resident's dementia."</p> <p>Interview with CNA #11, on 02/11/13 at 11:15 A.M., indicated there had been an inservice regarding behaviors a few weeks ago but she was now being instructed not to document behaviors. She did not know why she was given these</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>instructions.</p> <p>It was unclear if Resident F was exhibiting behaviors at least twice a week and/or why the behavior documentation was so nonresistant.</p> <p>4. On 2-12-14 at 2:00 P.M., a review of the clinical record for Resident G was conducted. The record indicated the resident was admitted to the facility on 10-25-10. The resident's diagnoses included, but were not limited to: hypertension, senile dementia, celiac disease, depression, psychosis with behaviors and osteoporosis.</p> <p>A review of a physician's order, dated 1-20-14, indicated Risperdal, an antipsychotic medication to treat behaviors, was decreased from 0.5 mg (milligrams) BID (twice a day) to 0.25 mg. in AM and 0.5mg at 3 PM.</p> <p>A nursing note, dated 1-29-14 at 9 P.M., indicated, "...Medicated with Tylenol 650 mg. [milligrams] at 3pm et [and] 8pm for back et leg pain. N.O. [new order] to obtain UA [urinalysis] with C&amp;S [culture &amp; sensitivity] if indicated (May straight cath if necessary) Son [name] notified of incident et behavior...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>A review of the Kiosk electronic documentation indicated, on 1-29-14, Resident G had "...none of these behaviors apply...." documented on her behavior detail report.</p> <p>Review of an Incident Report Form, dated 1-29-14, indicated a resident to resident incident involving Resident G occurred on 1-29-14, and was report to Indiana State Health Department the next day. This documentation was not part of Resident G's clinical chart.</p> <p>During an interview, on 2-12-14 at 2:50 P.M., CNA #2 indicated Resident G had many episodes of hitting, kicking and at times screaming. When CNA#2 was asked why the Kiosk Behavior Detail report from January 15 through the present indicated there was no behaviors documented for Resident G, CNA #2 explained that she was directed not to document those incidents as behaviors, as the resident's actions were part of her dementia.</p> <p>On 2-13-14 at 9:00 A.M., a review of the careplan for Mood &amp; Behavior for Resident G indicated, on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>11-8-13, resident was "...verbally abusive to her roommate...." The careplan indicated the residents where no longer roommates, and staff were to continue to monitor her moods and behaviors. The interventions for the plan for agitation included, but limited to: offer resident a cup of coffee or a snack, call her son, and inform her physician of changes in behavior.</p> <p>During an interview, on 2-13-14 at 10:04 A.M., the Social Service Director indicated she reviewed the "Behavior Detail" report from the Kiosk daily. She further indicated that she had not been informed of Resident G's behaviors of hitting, kicking, and at times screaming. She indicated staff were encourage to notify her of the residents behaviors and she had never told staff not to document behaviors due to behaviors being a part of the resident's dementia. She further indicated that she would have a difficult time doing her job if behaviors were not being documented accurately or consistently.</p> <p>Review of the facility policy and procedure, titled, "Guidelines for Behavior Observation, " provided on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>02/13/14 at 9:30 A.M. by the Consultant Nurse, RN #12 indicated the following: "1. Each resident currently on a Mental Health Wellness/Behavior Management Program shall have a Behavior Monitoring Record either in paper form or via the Care Tracker system. 2. It is the practice of [corporate name] to chart by exception. If no behaviors occur during the staff member's shift it is not necessary to document...." There were specific instructions for documenting what behavior the resident was displaying, the potential trigger or etiology for the behavior, the approaches or interventions attempted in response to the behavior.</p> <p>Interview, on 02/13/14 at 9:30 A.M., with the SSD, employee #11, indicated the facility did not utilize the instructions for a "paper" form but instead utilized an electronic charting system on the Kiosk for behavior documentation. She did indicate nurse's could also document behaviors in the nursing progress notes.</p> <p>This federal tag relates to Complaint #IN00144111 and #IN00144052.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000490 SS=D	<p><b>3.1-34(a)</b></p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the facility was administered effectively to ensure abuse protocol was followed.</p> <p>Finding includes:</p> <p>During the Annual Recertification and State Licensure survey, completed on 01/15/14, a deficiency was cited related to the facility's failure to follow their Abuse Policy and Procedure to ensure allegation of abuse were reported timely to the Department of Health.</p> <p>During the course of a Complaint Survey, conducted on 02/11/14 - 02/13/14, two allegation of resident</p>	F000490	F4901. Residents identify with state reportable were reported per the 2567.2. All residents were potentially effective. No adverse effects were noted.3. Executive Director was appointed to the campus who will be here full time. Executive Director will monitor abuse allegation and ensure they are reported timely to the state. Director of Healthcare will monitor Care tracker for any documentation related to physical or verbal abuse and will notify the Executive Director immediately upon being reported to Director of Healthcare. Executive Director will report any allegations and complete the investigation. Executive Director will report findings to QAA monthly for 90 days.4. QAA will monitor for any trends and make recommendations to the plan of	03/05/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/13/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>to resident abuse were reviewed. Both allegations were not reported immediately to the Administrator and both allegations were not reported within 24 hours to the Department of Health.</p> <p>Interview with the Administrator, on 02/13/14 at 10:30 A.M. indicated she was only in the facility on average of 2 working days a week but was available by telephone. She confirmed she was notified of both allegations of abuse via an email sent over 24 hours after the allegations had occurred. She indicated the AIT (Administrator in Training) was in the facility and there was an interim Director of Nursing in the building.</p> <p>She indicated the issues at the facility were due to the staff's resistance to accept the corporations "culture" change and standards.</p> <p>3.1-13(g)</p>		<p>correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.5. Completion of tag: 3/5/14</p>		