STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING 00 B. WING	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00448850 and IN00450457. Complaint IN00448850 - No deficiencies related to the allegations are cited. Complaint IN00450457 - Federal/state deficiencies related to the allegations are cited at F740. Survey date: January 6, 2025 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 1 Medicaid: 33 Other: 30 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 8, 2025	F 0000	Indiana Department of Health Attention: Brenda Buroker Director of the Division of Long-Term Care 2 North Meridian Street Indianapolis, IN 46204 CCN/Provider Number: 155596 AIM Number: 100290510 Facility ID: 000474 Lakeland Rehab and Healthcare Center 500 N. Williams St Angola, IN 46703 Re: Survey Event ID Cycle Start Date: Dear Ms. Buroker, On **Date**, a Complaint (IN00450457) Survey was conducted at the above referenced facility by the Division of Long-Term Care, Indiana Department of Health to determine if the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Enclosed please find the Statement of Deficiencies with our facility's plan of correction for the alleged deficiencies. Please	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey	Floyd	01/16/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction on **Date 1/24/2025.**	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services Based on observation, interview and record review, the facility failed to ensure an effective care plan was developed and implemented regarding sexual behaviors for 2 of 2 cognitively impaired residents reviewed for behavioral health (Resident N and Resident O). Findings include: A complaint, submitted to the Indiana Department of Health on 1/3/24, alleged Resident N was being sexually inappropriate with Resident O. Both residents had impaired cognition and resided on the Memory Care Unit (MCU). Resident N was alleged to be showing signs of aggression towards staff and other residents when Resident O was not near him or he couldn't find her. The complainant alleged both residents were touching, "making out" and Resident N attempted to "go below the belt" of Resident O who was not able to consent. The complainant alleged Resident O's family/Power of Attorney (POA) wasn't notified of the incident. 1. On 1/6/25 at 11:03 A.M., Resident N's record	F 0740	It is the policy of the facility to ensure each resident receives and is provided with necessary behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident N and O: The plan of care for both residents has been reviewed and updated to include effective interventions to ensure an individualized behavior health plan is followed. All residents are at risk to be affected by the deficient practice. The facility IDT team will complete an audit of residents to ensure that any residents in the facility who needs an effective plan of care to address sexual relations	01/24/2025

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	was reviewed. Diagnoses included dementia with severe psychotic disturbance, delusional disorder, and mood disorder. An admission Minimum Data Set (MDS) assessment, dated 12/13/24, indicated a Brief Interview Mental Status (BIMS) score of 9 indicating Resident N had moderately impaired cognition. The MDS didn't indicate if Resident N had the cognitive skills to make daily decisions. He had no signs of delirium. He would often isolate himself socially, but had no behaviors, hallucinations, delusions, or wandering. He had rejected care 1-3 days of the assessment. He was independent with most activities of daily living (ADL) and ambulated independently. He was prescribed antipsychotic and blood pressure medications. A care plan, initiated 12/6/24 and revised 1/6/25, indicated Resident N was at risk for impaired psychosocial well-being, sensory, cognitive, and communication deficits due to dementia, altered mental status, mood disorder, and non-compliance with care (refused showers and medications). Resident N would seek out a specific female resident (Resident O) on the unit and had developed a reciprocated friendship, at times showing affection towards the female resident. Resident N was verbally aggressive towards staff and would raise his fists, shaking them at staff. He wandered in and out of other resident rooms and was often, redirectable. Interventions and dates initiated were: 12/6/24-allow time for resident to comprehend; engage resident in simple, structured activities; approach in a calm manner to avoid frustration and behavior escalation-if resident becomes agitated and shows signs of escalation, reapproach later.		has one in place and that the staff are implementing as indicated by 1/24/25. The facility interdisciplinary team and licensed nurses were in-serviced on or before 1/24/25 on the process for monitoring, assessing, documenting, reporting, and implementing interventions associated with behavioral issues. The 24 hour report will serve as the communication tool and is routinely reviewed by the IDT to determine that resident condition changes such as any newly identified behaviors or worsening behaviors are promptly added to the plan of care with individualized interventions. The nurse managers, ED, and social services director participate in facility rounds and to make observations of the delivery of care and to ensure that interventions are implemented as indicated in the care plan. The SSD or designee will be the responsible party for this Plan of Correction with Executive Director oversight. The SSD or designee will audit the information identified in the 24 hours report related to resident behaviors 2 times weekly for 4 weeks then weekly to ensure the behavior plan of care has individualized interventions documented in the clinical record. Identified areas of concern will be immediately addressed. The results of these audits will be	

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	12/31/24-provide a safe and respectful environment; reassessments to be completed as needed to re-evaluate capacity to consent: and encourage resident to participate in activities. 1/6/24-encourage resident to reminisce about being a train conductor and time spent working for the railroad. Progress notes indicated: -12/12/24 at 10:00 a.m., a psychiatric Nurse Practitioner (NP) progress note indicated an initial psychiatric assessment was completed. Resident N had been admitted for continued care and secure memory care support. Prior to admission, he had been taken to the ER by police due to wandering in traffic and making inappropriate statements, where he received psychiatric assistance. He remained in the ER and was boarded for an extended period of time due to placement issues. Per the resident, he sold his home in Missouri in 2021 and had been homeless since that time. Hospital medical records indicated he'd had several ER visits in various states over the past several years. Currently he was delusional and agitated and indicated he had to get to Missouri today to get to the bank for money owed him. During the visit, Resident N expressed disgust at not being able to leave and go to the bank. He knew who he was, that he was in Angola, and the facility was a place for homeless people. He had poor insight/judgement, short and long term memory that varied. He had severe dementia with psychotic disturbance, delusional disorder and mood disorder. He was to continue his antipsychotic medication to treat his delusions. -12/29/24 at 4:06 p.m., Resident N had been following a female resident (Resident O) most of the shift and tried to lead her into his room.		reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicate.	

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	Resident N, was observed by an activity aide, kissing Resident O's neck and shoulders and both had kissed on the lips while in the puzzle room. Both residents were re-directed multiple times to common areas. The nurse covering the hall, on-call manager, and Director of Nursing (DON) were all notified and instruction given to continue to re-direct the residents. -12/30/24 at 4:22 p.m., Resident N and Resident O were sitting in the dining room, "being affectionate" with each other. Resident N refused his antipsychotic medication and became upset and agitated. He stated "I'm with my woman, you can get out of here". -At 9:59 p.m., Resident N was overheard telling Resident O "do you think those girls are gonna make a big stink if I sneak you to my room?" Resident N was notified, per management, it was okay for the 2 residents to be friendly and affectionate but they needed to stay in the common area. Resident N was agitated but agreed to stay in the dining room and watch a movie. Resident N later attempted to guide Resident O down to his room while saying inappropriate things to her. Staff redirected Resident O to her own room to lie down while Resident N walked around to other residents' rooms, stood in their doorways and looked for Resident O. -12/31/24 at 12:05 p.m., Resident N was seen by the medical Nurse Practitioner (NP) for complaints of needing "a blood thinner for clots in his fingers". Resident N told the NP he used to take a supplement he had gotten in Butler Mississippi and needed to get them. The NP assured him staff would monitor him for signs of vascular disease but was unable to order him the supplements because she nor the resident knew what supplement he had previously taken. The NP			

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	progress note hadn't indicated Resident N had refused medications or was having agitation related to wanting to be with Resident O or regarding their special friendship. -1/2/25 at 10:00 a.m., a psychiatric NP progress note indicated Resident N was seen for an increase in agitation, delusions, intrusiveness into staff areas, other resident rooms and getting agitated with redirection. He was noted to be fond of a female resident and sought her out at times and staff were redirecting them to the common areas. During the visit, Resident N was awake, alert, and oriented to self. He was observed wandering the halls and looking out doorways. He indicated he was anxious about money and needed to get to Missouri before his son took his money; he continued to be delusional. Staff were instructed to provide gentle redirection from entering the female resident's room, be guided to common areas and continued on his antipsychotic medications. -At 3:38 p.m., Resident N attempted to follow staff into the shower room while staff were assisting Resident O to shower. He was upset with redirection and staff were told to secure the bathroom door while bathing Resident O. -1/3/25 at 4:12 p.m., Resident N went into Resident O's bed and leaned over her while she was sleeping. He was assisted out of the room and re-directed to the main dining room. He became agitated, verbally aggressive, and balled his hands into fists while standing over staff. He stated "why can't I do what I want with her?!" The resident was instructed he and Resident O could visit together in the main dining room but not in her room while she was sleeping. He cursed at staff and demanded a key to get out of the building. He went to his room, packed his bags			

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	and started banging on the exit door to another hallway. Attempts made to redirect his behavior were ineffective. The DON, Administrator and nurse covering the hall were notified and instructions given to write a progress note, inform construction crew working in the building to be cautious when entering and exiting the hall and continue with 15 minute checks. -At 5:42 p.m., the activity aide approached the resident about eating his evening meal. He raised his fists and yelled at staff while shaking his fist near her face. He was provided space and allowed to sit and calm down where he sat. He refused his meal. -1/6/25 at 8:42 a.m., the resident refused his morning medications, was combative and cursed at staff. -At 10:15 a.m., the Social Services Director (SSD) indicated a call had been placed to the Resident N's POA and notified of the resident's reciprocating friendship with a female resident (Resident O). The POA had no concerns. -At 11:45 a.m., the nurse attempted to obtain lab work. Initially the resident had been pleasant and cooperative however, when an attempt was make to stick with the needle, he became very agitated and raised his voice, threatening to smack the nurse in the face and then made attempt to do so. The nurse left the room and the 2nd shift nurse was to try and obtain the blood work. During an observation on 1/6/25 at 12:15 P.M., Resident N was observed seated on side of his bed with a lunch tray in front of him. He agreed to a visit. He indicated he was not doing well and was having issues with his stomach but was unable to get his medication for it. He indicated he had to digitally remove stool due to inability to have a bowel movement. He agreed to a visit later			

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	in the day. -At 3:40 P.M., Resident N was observed lying down in bed. He indicated he wanted to get out of the facility and go live with a buddy who was in Albion but he was stuck here. He wanted to take a chair and hit the window so he could get out. He indicated he'd had a female friend here but hadn't known her name. He went to her room and was holding her hand when "that bitch" came in and told him he had to leave the room so now he was just going to stay in his room. He hadn't remembered what holiday was just celebrated but knew it was cold out because of the snow outside his window. When asked the year, he indicated 2024 but then looked at his calendar on the wall and stated "oops-it's 2025 there on the calendar". Resident N had not been observed out of his room during the survey and remained in the room with his door closed. A Resident Capacity to Consent to Sexual Relations Assessment form, dated 12/30/24 at an unknown time, indicated Resident N knew who he wanted sexual contact with; was not delusional of who the other person was; was able to state what level of sexual intimacy he was comfortable with; made him happy to have sexual intimacy; was consistent with his formerly held beliefs and values; he had the capacity to say no to uninvited sexual contact; was not being bribed for sexual intimacy; understood the relationship may be time limited and could describe how he would feel when the relationship ended. It was determined by the Administrator, DON, and SSD, Resident N had the capacity to consent to a sexual relationship with Resident O. Resident N's care plan did not indicate he had the capacity to consent to sexual relations with Resident O, what those sexual relations were (etc,			

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	hand holding, kissing on the mouth, fondling, "hand below the belt", or intercourse), and what sexual actions were to be reported or required intervention by staff. The care plan didn't indicate 15 minute safety checks were being conducted, why they were being completed or when they should be stopped or continued since both residents had been assessed as having capacity to consent. 2. On 1/6/25 at 10:45 A.M., Resident O's record was reviewed. Diagnoses included dementia, major depressive disorder, anxiety, and disorientation. A quarterly MDS assessment, dated 10/23/24, indicated Resident O had severely impaired cognition with a BIMS score of 2. She resided on the memory care unit. She had no behaviors, no rejection of care, no mood issues, and no wandering. The MDS didn't indicate if she had the cognitive skills for daily decision making. She required assistance with all ADL's, ambulated with a walker and supervision to touch assist while walking. She was prescribed medication to treat depression. A care plan, initiated 8/27/23 and revised on 12/31/24, indicated Resident O was at risk for impaired psychosocial well-being, sensory, cognitive, and communication deficits due to anxiety, depression, insomnia, and dementia. She had behaviors of verbal and physical aggression and refusals of care. She sought out a specific male (Resident N) on the memory care unit and had developed a reciprocated friendship, at times, showing affection towards the male resident. Interventions, initiated on 12/31/24, were: provide a safe and respectful environment; reassessments to be completed as needed to re-evaluate capacity			

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	to consent: encourage resident to participate in activities; and encourage to socialize in common areas. Progress notes indicated: -12/29/24 at 4:04 p.m., the resident had been following a male resident all shift and had been redirected several times, out of the male residents room (Resident N). She and Resident N were observed in the common area/dining room touching and kissing each other. Resident O became combative and aggressive when redirected. The nurse covering the hall, on-call unit manager, and DON were notified. -12/31/24 at 3:31 p.m., the SSD spoke with Resident O's family members regarding the resident developing a reciprocating friendship with a male resident (Resident N) on the unit. Family expressed understanding and were notified they would be updated with any changes. -1/2/25 at 10:15 a.m., a psychiatric NP progress note indicated the resident was seen for assessment. Since the last visit, the resident had periods of being combative with care, agitated with redirection, refusal of medications and recently followed a male resident around the unit. During the visit, the resident was awake and alert, indicated she felt safe, affect was flat, quiet, normal thoughts but forgetful and fixated at times. She was pleasantly confused. Staff were encouraged to redirect the resident to common areas to visit with male friend and provide gentle redirection from room with male friend. Staff were to continue with nonpharmacologic interventions for periods of agitation and continue to monitor safety, moods, sleep and behaviors.			

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	On 1/6/25 at 12:05 P.M., Resident O's family member/POA was interviewed. The POA indicated, on 12/31/24, they were notified of Resident O having a male friend she would hold hands with and give/receive a "peck" on the cheek. Resident O hadn't had a special male friend since being at the facility so the POA came in to visit the resident. When he had arrived, Resident O was seated, at a table in the dining room, next to an older gentleman (Resident N). Neither resident was talking nor were they holding hands. Resident N sat facing forward in his chair and never spoke with the POA during his visit. He believed it was odd for Resident O to have a male friend to hold hands with and kiss but was assured staff would monitor and report any changes. When questioned, he indicated he had not been informed of any other sexual behaviors between the residents other than hand holding and kiss on the cheek. On 1/6/25 at 3:20 P.M., Resident O was observed seated at the dining room table in the common area where a Christmas tree sat near the window in her line of sight. She replied to questions in a very soft, gentle voice. During the visit, she was asked what holiday was just celebrated and she replied she hadn't known despite the Christmas tree being in her sight. A television was on and playing a black and white video of I love Lucy. When asked, she gently replied she didn't know what the show was or who the characters were. She was observed to maintain eye contact and appeared in no distress. She did not know the day of the week, nor could she identify she had any friends. A Resident Capacity to Consent to Sexual Relations Assessment form, dated 12/30/24 at unknown time, indicated Resident O knew who she wanted sexual contact with; was not			

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	delusional of who the other person was; was able to state what level of sexual intimacy she was comfortable with; was happy with sexual intimacy; was consistent with her formerly held beliefs and values; she had the capacity to say no to uninvited sexual contact; was not being bribed for sexual intimacy; but had not understood the relationship may be time limited nor describe how she would feel when the relationship ended. It was determined by the Administrator, DON, and SSD, Resident O had the capacity to consent to a sexual relationship with Resident N. Resident O's care plan did not indicate she had the capacity to consent to sexual relations with Resident N, what those sexual relations she was comfortable with (etc, hand holding, kissing on the mouth, fondling, "hand below the belt", or intercourse), or what sexual actions were to be reported or required intervention by staff. The care plan didn't indicate 15 minute safety checks were being conducted, why they were being completed or when they should be stopped or continued since both residents had been assessed as having capacity to consent. On 1/6/25 at 11:58 A.M., Licensed Practical Nurse (LPN) 5 indicated on 1/1/25 during day shift, she had been alerted by an activity aide of Resident N's attempt to put his hand down Resident O's pants. Both had been seated in the dining room at a table in front of the nurses desk. She indicated she notified the Administrator and DON and immediately started 15 minute safety checks of both residents. She did not document the incident in the progress notes but indicated, 15 minute safety checks had been and continue to be done since 1/1/25. She was instructed the residents could hold hands and kiss but had to remain in the common areas with supervision.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 1/6/25 at 12:01 P.M., 15 minute safety check sheets were reviewed. The checks indicated 15 minute safety checks had been completed since 1/1/25 at 2:15 p.m. for Resident N and Residnet O. Confidential interviews conducted during the survey, indicated the following: -Staff hadn't felt Resident O was able to consent to a sexual relationship. -Staff had witnessed Resident N had put his hand on Resident O's pants while both resident's were seated in the dining room at a table located in front of the nurses desk. -Resident N had combative and agitated behaviors not easily re-directed, when he wanted to be with Resident O. -Resident O would refuse medications at times and could get agitated, irritated and combative if she didn't want to do something or be re-directed. On 1/6/25 at 2:15 P.M., the Administrator, DON, SSD, and Regional Nurse Consultant were interviewed and indicated both residents had been assessed and determined to have capacity to consent to sexual relations with each other. They indicated the 15 minute safety checks continued to ensure Resident N and Resident O were safe and only holding hands or kissing each other on the cheek. There was no further information provided verbally or in writing to indicate need for 15 minute safety checks, need for redirection of residents to a common area or limitations on sexual relation behaviors such as only being allowed to hold hands or kissing on the cheek as both residents were assessed to have capacity to consent.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING 00 B. WING	01/06/2025

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	On 1/6/25 at 3:30 P.M., the DON provided a current copy of the facilities policy, effective 6/13/24, and titled "Resident Capacity to Consent to Sexual Relations" which stated: "It is the policy of the facility to evaluate any resident that is suspected to be engaged in sexual relationship with another individual that may not have the capacity to consent to sexual activity. Once a suspicion has been formed, an assessment of the resident's capacity to consent will be completed...Sexual conduct between residents must be consensual...Procedure: The recommended steps when sexual relations are suspected or witnessed between residents living with dementia: step 1: intervene and separate pending assessment and evaluation. step 2. investigate and assess capacity to consent of each resident. 3. physician and responsible party notification if deemed applicable. 4. care plan and education. 5. ongoing monitoring and evaluation of assessment and care plan...If the resident has been determined to have the capacity to consent to sexual relations, the residents will be assisted with privacy and the facility will provide discrete indicator for residents to utilize on door such as "Do Not Disturb" sign etc. Resident care plans will be updated to reflect determination. Documentation of the assessment and any additional discussions and/or education provided to the resident will be documented in the EMR...." The Citation relates to Complaint IN00450457. 3.1-37			