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	11/04/2022

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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 Complaint IN00393780. This visit resulted in an Extended Survey- Substandanrd Quality of Care. Complaint IN00393780 - Substantiated. Federal/state deficiencies related to the allegations are cited at F744. Survey date: November 4, 2022 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 8 Medicaid: 32 Other: 23 Total: 63 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 10, 2022	F 0000		
F 0744 SS=H Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			

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

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	Based on observation, interview and record review, the facility failed to provide dementia care and services to support psychosocial well-being for 5 of 25 residents that resided on the secured memory care unit. (Residents B, C, D, E, and F) Findings include: On 11/4/22 at 10:56 A.M., during an initial tour of the secured memory care unit, 6 residents were observed seated at a table working on crafts. 1 resident was seated in a corner of the room with her empty breakfast tray on an overbed table in front of her. 2 residents sat in wheelchairs at another table eating a breakfast of eggs and bacon. 2 residents sat in wheelchairs at a table without meal trays or activity. There was an activity aide trying to help residents with their crafts while trying to keep 1 of the 6 residents from getting up and trying to walk away from the table unattended. An agency nurse passing medications indicated it was their first day at the facility. There were 2 CNA's (Certified Nurse Assistant) assigned to the hall-1 from agency and 1 CNA who usually worked on another unit of the facility. On 11/4/22 at 11:00 A.M., roommates, Resident B and Resident F were observed in their room. Resident B was lying in bed, Resident F sat in a bedside chair and the 2 appeared to be talking. Resident B had a table set up next to her bed with a puzzle on it along with some books and magazines. Resident F had no activity items on her side of the room. The room was quiet without television or music. There was no activity schedule observed on the wall nor on the resident's bedside tables. Resident B indicated she'd had breakfast and was just lying down as there was nothing to do at that time. She indicated	F 0744	**F-744 Dementia Care** **The facility respectfully requests a desk review for this citation.Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Emergency care conferences held for resident B,C, D, E, F. Resident B and F families have chosen for resident to return to non-secured area of facility, per family request. **2. How the facility identified other residents:** All other residents residing in the memory care unit in the facility have the potential to be affected by practice. Audit conducted for all residents residing in memory care unit for elopement risk, depressive symptoms and cognitive decline. Care conferences held with family and residents to discuss benefits and risk of memory care placement and to ensure that family and resident are in agreement with residing in memory care and plan of care.**3.**	11/23/2022

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	she had just been moved to this room and hadn't known why but felt like she was in a prison. She gestured with an outstretched hand towards the window, indicated she had moved from that hallway to here and repeated that she didn't know why. Resident F was very hard of hearing, indicated she couldn't hear what was being said to her and was unable to answer questions. Resident B spoke up for Resident F, indicated she had been moved to this room as well and didn't know why. She indicated both had shared a room on the other hall and were then moved to this room without being told why. -At 12:55 P.M., Resident B was observed in her room, seated in her wheelchair with an uneaten lunch tray in front of her on an overbed table. She wore no pants. Her swollen feet sat uncovered on the floor. She indicated she wasn't hungry. When questioned, she indicated she did not have an activity schedule and didn't know if there were any activities occurring. She liked BINGO but hadn't played recently. If she did go to BINGO, someone had to let her through the locked doors because she couldn't get out by herself to go to the dining room where they played. She showed off her fingernails and said she'd recently got them done but never had that color on them before (the color was black). She indicated she was in a prison and didn't know why she was moved into this room. She indicated one day staff just came in to her old room, started packing her things and told her she was moving. She indicated in this room, she would get frequent unwanted visitors; residents who are in wheelchairs and accidentally wander into her room believing that it is their room. 1. Resident B's record was reviewed on 11/4/22 at 11:57 A.M. Diagnoses included dementia, anxiety, and depression.		**Measures put into place/ System changes:** Social service director and Director of Nursing educated on the admission criteria and procedure for admission into the memory care unit, which includes appropriate care planning and monitoring of residents upon and after admission. Care plans and orders updated as appropriate. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Social service director/designee who will audit BIMSs, elopement risks, care plans, mood and affect of new memory care admissions weekly for compliance with regulation x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **11-23-22**	

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	A quarterly MDS (Minimum Data Set) assessment, dated 9/21/22, indicated a BIMS (Brief Interview Mental Status) score of 9-moderately impaired cognition. She had several mood indicators of moderate depression with trouble falling asleep/sleeping too much; 2-6 days feeling bad about herself; 12-14 days being tired/having little energy and trouble concentrating. Activity care plans, revised on 7/27/22 with target dates of 3/16/23, indicated the resident was capable of independently choosing activity programs to participate in. She enjoyed arts and crafts, music programs, Euchre, BINGO, ceramics and group activities. Interventions included inviting her to activities of interest, providing a monthly calendar of activities and independent activity materials as needed. There was no care plan developed for the resident's person-centered dementia needs and benefits of a secured memory care unit in supporting those needs. An Elopement Evaluation, last completed on 2/25/21, indicated the resident was not an elopement risk. A Care Conference note, dated 10/10/22 at 11:11 a.m., indicated there had been a care plan conference completed with the residents family. The note indicated family were considering moving the resident to memory care and would like to tour the unit. A Room Transfer Notification form, dated 10/10/22 and effective 10/18/22, indicated the resident was being moved to the memory care unit but didn't			

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	indicated the reason for the transfer. Review of progress notes indicated the following: -10/26/22 at 1:28 p.m., resident refused her ace wraps to her legs and remained in bed all day shift. -10/27/22 at 3:12 p.m., the resident was tearful during the afternoon, indicated she felt like a prisoner and all her rights had been taken away. She was told she could leave the unit anytime during the day to work on a puzzle. (The puzzle was located on another wing of the facility where her room had been previously) -11/1/22 at 2:20 p.m., the resident refused her zip up ted hose. She was re-approached and still refused. -11/2/22 at 2:58 p.m., the resident was not dressed and refused to get up all day. Progress notes from 8/18/22 to 10/25/22 did not indicate the resident had any behaviors or refusals of care. There was no assessment to indicate the resident would benefit from specialized dementia care on the secured unit or what services would be provided to her. There was no documentation to indicate physician or family involvement in the decision to transfer the resident to the secured memory care unit. 11/4/22 at 1:33 P.M., the Social Service Director (SSD) was interviewed. During the care conference with Resident B's family members on 10/10/22, they were told about services offered on the memory care unit. Family members were divided on their wishes for the resident to be placed on the unit. The SSD indicated it was			

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	thought the resident would participate more in out of room activities if she resided on the unit. There was no documentation to indicate she hadn't been participating in out of room activities. On 11/4/22, during a confidential interview, Employee 1 indicated they hadn't understood why Resident B and Resident F had been moved to the memory care unit. The staff had been told it was because both residents had a diagnosis of dementia. Both residents had not had any behaviors and were happy with their room. Employee 1 indicated both familys expressed dissatisfaction with their family members being transferred to the unit. Resident B had left behind her puzzle in the sitting room on the unit and Employee 1 indicated the resident verbalized she wanted to go back and finish it. 2. On 11/4/22 at 2:32 P.M., the record for Resident F was reviewed. Diagnoses included dementia, anxiety disorder, and depressive disorder. A quarterly MDS assessment, dated 10/3/22, indicated the resident had a BIMS score of 7-severely impaired cognition. She had minimally impaired hearing. She had mood indicators of moderate depression which were sleeping too much; 2-6 days having little interest or pleasure in doing things; feeling down, depressed, or hopeless; poor appetite; and moving so slowly that others noticed. She had 7-11 days where she had felt tired, had little energy, and trouble concentrating. A care plan, initiated on 8/10/21 and revised 11/4/22, indicated the resident had dementia, a cognitive communication deficit and utilized medication to treat her confusion. The resident would benefit from memory care programming.			

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	The goals, revised on 7/21/22 with a target date of 1/1/2023 were that the resident would have improvement in her cognitive function; would maintain her current cognitive function; would be able to communicate her basic needs; and would develop skills to cope with her cognitive decline and maintain safety. Interventions were to administer medications as ordered; ask yes/no questions in order to determine the resident's needs; communicate with resident/family/caregivers regarding resident's capabilities and needs; cue, reorient and supervise as needed; discuss concerns about confusion and disease process; keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. An updated intervention on 11/4/22 included: resides on memory care unit. A care plan, initiated 7/21/22, indicated the resident had trouble hearing so she didn't attend many activities offered. The goal was for her to let the activity department know what activities she was interested in. The intervention was to remind her she could leave activities at any time and was not required to stay for the entire activity. An Elopement Evaluation, last completed on 7/26/21, indicated the resident was not an elopement risk. A Room Transfer Notification form, dated 10/10/22 and effective 10/18/22, indicated the resident was being moved to the memory care unit but did not indicate the reason for the transfer. Review of progress notes indicated the following: 8/22/22 at 12:35 p.m., the SSD spoke with the			

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	resident's family member regarding her room move to the secured memory care unit scheduled for that day. The family member expressed no concerns. 8/24/22 at 1:19 p.m., the resident voiced no concerns about her room move but was unable to be convinced to come out of her room for activities or meals. 8/27/22 at 11:30 a.m., the nurse checked in with the resident regarding an incident with her roommate. She expressed being sorry for the roommate's problems and was a little upset but hadn't appeared anxious. 8/28/22 at 7:53 a.m., the resident was tearful in the evening and anxious. She was very upset and bothered by incidents surrounding her roommate. She was complaining of nausea and refusing breakfast. 8/29/22 at 8:05 a.m., the resident denied nausea and took her medications but was more disoriented and struggled to find things in her room that were right by her. She was wearing the same clothes from the day before and indicated she hadn't realized that she'd slept in them. 8/29/22 at 11:48 a.m., the NP (Nurse Practitioner) visited the resident and indicated she was seen due to behavior changes and confusion. She'd had a recent change of rooms and on 8/27/22, had witnessed significant disruptive behaviors from her roommate. Staff were now reporting odd behaviors, decreased appetite, and increased confusion over the last day. The resident indicated she felt awful and was tired. 9/15/22 at 10:00 a.m., the psychiatric NP visited the			

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	resident to follow up on a recent room move, dementia, depression, and anxiety. The resident had been moved to the memory care unit and then moved back to her original room per family and resident request. During the visit, the resident indicated she was glad to be back in her room although was still looking for some of her belongings that had been missed during the move. 10/3/22 at 12:00 p.m., the NP conducted a routine visit for the resident's blood pressure. There were no issues identified or changes to her plan of care. 10/10/22 at 3:24 p.m., the NP visited the resident for pharmacy recommendations. The resident had some recent behavior concerns thought to be related to a room change but had returned to baseline when she moved back to her original room. She was very hard of hearing and appeared slightly anxious. 10/19/22 at 1:50 p.m., the SSD met with the resident to follow up on her room move back onto the secured memory care unit. The resident was observed walking with a family member in the front lounge area. She nor the family member voiced any concerns. There was no documentation completed to indicate why the resident had been moved back to the secured memory care unit on 10/18/22. She had a previous unsuccessful move to the unit back in August 2022 when she had experienced physical distress. This resulted in moving back to her original room. 3. On 11/4/22 at 11:05 A.M., Resident C, identified as interviewable, was observed lying in bed in her room. A half eaten breakfast try sat on her			

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	overbed table. She had a scowl on her face. She indicated the food was okay and she got a menu each day to choose from. She preferred to stay in her room where she ate all her meals. She indicated she didn't participate in activities per her choice. Resident C's record was reviewed on 11/4/22 at 12:01 P.M. Diagnoses included dementia and cognitive communication deficit. Upon admission, she was assigned to the secured memory care unit. An admission MDS assessment, dated 6/28/22, indicated a BIMS score of 8-moderately impaired cognition. She had mood indicators of mild depression which were being tired and having little energy 7-11 days of the assessment. A quarterly MDS assessment, dated 9/22/22, indicated a BIMS score of 6-severely impaired cognition. She had an increase in mood indicators which suggested moderate depression. 12-14 days of the assessment, she had little interest in doing things; felt down, depressed, and hopeless; had trouble falling asleep; and felt tired/little energy. An Elopement Evaluation, last completed on 9/22/22, indicated the resident was not an elopement risk. A care plan, initiated 6/22/22 and revised 11/4/22, indicated the resident had impaired function/dementia and would benefit from memory care programming. The goal was for her to communicate her basic needs. Interventions included: administer medications, ask yes/no questions; cue, reorient and supervise as needed; keep the resident routine consistent and provide consistent caregivers; and present 1 thought,			

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	idea, question, command at a time. A care plan, initiated 10/6/22, indicated the resident was at risk for displays of manipulative behavior that was disruptive, insensitive, and/or disrespectful to staff and peers related to dementia. The goal was for her to identify her own feelings of loss of control and poor self esteem. The intervention was to assure the resident staff would be willing to address "legitimate" concerns. There was no care plan developed for the resident's person-centered dementia care needs and benefits of a secured memory care unit in supporting those needs. There were no further assessments or changes to the care plan following the resident's decline in cognition and increase in depressive mood symptoms. 4. On 11/4/22 at 11:07 A.M., Resident D, identified as interviewable, was observed sitting up in her bedside chair. She indicated she had come into the facility with her husband but he died shortly after they moved in. She indicated she was still very sad about it and missed him terribly as she teared up. She indicated she didn't do any activities but occasionally would play BINGO to "keep my brain active". She ate all her meals in her room. On 11/4/22 at 12:05 P.M., Resident D's record was reviewed. Diagnoses included diabetes, anxiety, and dementia. An admission MDS assessment, dated 3/25/22, indicated a BIMS score of 12-moderately impaired cognition. A quarterly MDS assessment, dated 6/17/22, indicated a BIMS score of 4-severely impaired			

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	cognition. She had mood indicators of mild depression which were 7-11 days of little interest/pleasure in doing things; feeling down, depressed, hopeless; and feeling bad about herself. A quarterly MDS assessment, dated 9/4/22, indicated a BIMS score of 5-severely impaired cognition. She had mood indicators of moderate depression which were 7-11 days of little interest/pleasure in doing things; feeling down, depressed, hopeless; and feeling bad about herself; and 12-14 days with little energy and feeling tired. An Elopement Evaluation, last completed on 9/18/22, indicated the resident was not an elopement risk. Care plans included the following: -Initiated on 4/4/22 and revised on 9/20/22-The resident had very little to no activity involvement due to her spouse just passing and having no desire to participate. The goal was that she would participate in activities of her choice at her discretion. Interventions were to explain the importance of social interaction and leisure activity time; encourage her to participate; encourage family to come and do activities with her. -Initiated on 6/17/22 and revised 11/4/22-The resident had impaired cognitive function/dementia related to BIMS score less than 13. She would benefit from memory care programming. The goal was for the resident to be able to communicate basic needs. Interventions included: administer medications, ask yes/no questions; cue, reorient and supervise as needed; keep the resident			

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routine consistent and provide consistent caregivers; present 1 thought, idea, question, command at a time; and reminisce with the resident using photos or family/friends.

There was no care plan developed for the resident's person-centered dementia care needs and benefits of a secured memory care unit in supporting those needs. There were no further assessments or changes to the care plan following the resident's decline in cognition and increase in depressive mood symptoms.

5. On 11/4/22 at 1:24 P.M., Resident E's record was reviewed. Diagnoses included dementia and major depressive disorder.

An admission MDS assessment, dated 6/9/22, indicated a BIMS score of 8-moderately impaired cognition. She had no mood indicators of depression.

A quarterly MDS assessment, dated 9/9/22, indicated a BIMS score of 7-severely impaired cognition. She had mood indicators of mild depression such as feeling down, depressed, hopeless; trouble falling asleep; and 2-6 days of having little energy/tired.

Care plans indicated the following:

-Initiated 6/3/22 and revised 9/14/22, the resident had a history of depression and making negative statements regarding wanting to die or going to sleep and not waking up. The goal was to remain free of distress. Interventions included: administer medications and monitor/document/report any risk for harm to self and depressive symptoms.

-Initiated 6/3/22 and revised 11/4/22, the resident

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

(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
	had impaired cognitive function/dementia related to BIMS score less than 13. She would benefit from memory care programming. The goal was to maintain her current level of cognitive function. Interventions included: administer medications, ask yes/no questions; cue, reorient and supervise as needed; keep the resident routine consistent and provide consistent caregivers; present 1 thought, idea, question, command at a time; and reminisce with the resident using photos or family/friends. -Initiated 6/22/22, the resident wanted to focus on therapy and would spend the majority of her time resting in her room. The goal was to empower her to make independent leisure choices daily and attend group activities of assessed interest 3 times per week. The intervention was: She enjoyed watching TV and could turn on her television by herself. There was no care plan developed for the resident's person-centered dementia care needs and benefits of a secured memory care unit in supporting those needs. The current care plan indicated she was at the facility for long term care rehabilitation. On 11/4/22 at 12:49 P.M., the Memory Care Unit Director was interviewed. She indicated she was new to the facility and was in the process of developing the dementia program. She indicated it was the goal to have residents on the unit do activities in group settings. She didn't have a wall calendar currently with events but had an 8 x 10 paper propped up on the nurses desk with a list of activities for the day. She indicated there were no specific dementia care interventions for residents on the unit at the time.			

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	On 11/4/22 at 1:09 P.M., the Administrator and Regional Nurse Consultant were interviewed. Both indicated the process for determining if a resident would benefit from dementia care was done through the Social Services department. The SSD would have conversations with the resident and family and explain the benefits of being on the unit which could include activity programming, more consistent routine care, and dementia specialty care. To qualify for the dementia care unit, residents must have a diagnosis of dementia and a physician order that they may reside on the secured memory care unit. On 11/4/22 at 1:33 P.M., the Social Service Director (SSD) was interviewed. She indicated if a resident qualified for the dementia care unit, she would speak with the resident and family during care plan conferences about the benefits of being on the unit. She indicated the facility didn't currently have a good definition for what dementia care looked like in the care plan but were working on this. Residents on the secured memory care unit should have person-centered, dementia-specific care plans when residing on the unit. On 11/4/22 at 2:30 P.M., physician orders for all residents residing on the secured memory care unit were reviewed. The following residents had no physician orders to indicate need for secured memory care prior to being placed on the unit: Resident C, Resident D, and Resident E. A current facility policy, titled "Castle Healthcare Admission Process-Dementia Units" was provided by the Administrator on 11/4/22 at 11:54 A.M. and indicated the following: "Castle Healthcare has developed specialized areas of our campuses to serve those living with dementia and the associated challenges...Admission Criteria:			

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	Prior to admission, the potential resident shall have a physician's diagnoses of some type of irreversible dementia or dementia related illness as well as a physician order stating potential resident needs a secured environment to be documented in their record. Upon admission resident is to receive BIMS assessment...If the BIMS assessment is 13 or less, resident will be deemed appropriate for memory care unit...Once the resident has a diagnosis of dementia, the IDT team will determine the type is one that can be served with the current resources available to the memory care unit...The IDT team shall assess whether the potential resident's current cognitive, medical, physical, and emotional state can be appropriately served...that the resident can benefit from the cognitively/socially oriented services provided on the memory care unit. The potential resident shall demonstrate that they can benefit, even passively from the specialized memory care activity programming...It shall be the final decision of the IDT team to determine a resident "appropriate" for the memory care unit." This Federal tag relates to Complaint IN00393780. 3.1-37			