STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Rehab and Healthcare Center	500 N Williams St Angola, IN 46703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one Qualified Medical Assistant had a current license. Medications were distributed to 69 of 69 residents lived in the facility. Findings include:A record review was completed on [DATE] at 10:08 AM. The facility schedule, dated [DATE]- [DATE], indicated QMA 3 was scheduled to distribute medications and had worked as a QMA on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. QMA 3 had worked in 3 of 3 resident units from April to [DATE].The facility Employee Certification and Licensure binder indicated QMA 3's license expired on [DATE]. The Indiana License Registry website indicated QMA 3 had an expired license as of [DATE].In an interview, on [DATE] at 12:16 PM, the Executive Director indicated staff should not distribute medications with an expired QMA license.In an interview, on [DATE] at 12:37 PM, the Executive Director indicated the facility did not have a written policy about QMAs working with a current license. 410 IAC (Indiana Administrative Code) 3.1-14(i)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food and steam table pan storage practices. Food prepared in the facility kitchen was consumed by 69 of 69 residents who lived in the facility. Findings include:On 5/26/26 at 9:15 AM, a drink cart was observed in the dining room. A pitcher of apple juice was observed to be labeled with an expiration date of 5/23/26. A pitcher of chocolate milk was observed to be without a label.During a tour of the facility kitchen with the Dietary Manager, (DM) beginning on 5/26/26 at 9:18 AM, moisture was observed between 3 of 5 steam table pans viewed. The DM indicated the steam pans had probably just came out of the dishwasher.Cook 2 was observed placing the drink cart into the walk-in cooler. The pitcher of apple juice labeled with an expiration date of 5/23/26 was on the drink cart. The unlabeled pitcher of chocolate milk was on the drink cart. [NAME] 2 indicated the chocolate milk was not labeled because the pitcher had been filled that morning. The DM indicated the pitcher of chocolate milk should have been labeled. The DM indicated the pitcher of apple juice should have been discarded.In an interview, on 5/26/26 at 9:26 AM, the DM indicated the steam table pans were wet but not soiled. The DM indicated they were unaware pans had to be dried before being put away.A current facility policy, dated 2001, indicated all food items should be labeled, dated and monitored to ensure usage prior to the use by date or discarded.410 IAC (Indiana Administrative Code)-3.1-21(i)(1) and (3)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure sanitation of the outside trash storage area for 2 of 2 trash bin outside the facilityFindings include: During a tour of the facility kitchen with the Dietary Manager, (DM) beginning on 5/26/26 at 9:18 AM, 2 outside dumpsters were observed. On the ground under the left dumpster, there was a wet, soiled disposable brief, eggshells too numerous to count and piles of brown, dry debris too numerous to count. On the ground under the right dumpster, there was an empty hand sanitizer container and piles of brown, dry debris too numerous to count.In an interview, on 5/26/26 at 9:26 AM, the DM indicated they were unaware of which department was responsible for the cleanliness of the outside dumpster area. The DM indicated there should not be litter on the ground.A current facility policy, dated 2001, indicated the area surrounding outside dumpsters should be from litter.483.60(i)(4)-3.1-21(i)(5)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure behavioral triggers were identified and assessed for 1 of 2 residents reviewed (Resident 14).Findings include: On 5/26/26 at 10:25 AM, Resident 14 was observed lying in bed. Numerous framed photographs were observed on display in Resident 14's room.In an interview, on 5/26/26 at 10:25 AM, Resident 14 indicated they felt alone due to the loss of their mother and brother. Resident 14 became tearful when showing numerous photos of their mother and brother. Resident 14 indicated their mom passed away in 2020. Resident 14 indicated they found out their brother had passed away on Thanksgiving 2023; the resident had been waiting for the brother to arrive for Thanksgiving dinner. Resident 14 provided a very detailed description of their family. Resident 14 indicated 3 friends who had resided at the facility had passed away in the past year. Resident 14 indicated there were 2 residents at the facility who antagonized them. Resident 14 indicated the 2 residents accused the resident of receiving preferential treatment. Resident 14 indicated the Dietary Manager (DM) had shared the resident's protected health information with other residents. Resident 14 indicated the facility had arranged an outside agency to evaluate them without their permission. Resident 14 indicated the facility staff members are not to be trusted as they are not truthful. Resident 14 indicated a staff member intentionally struck them with another resident's wheelchair.Resident 14's record was reviewed on 5/26/26 at 11:22 AM. Diagnoses included left side weakness due to a stroke, anxiety disorder, insomnia, irritability and anger, major depressive disorder and unspecified affective mood disorder.Resident 14's annual Minimum Data Set, (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive loss).A psychiatric (psych) progress note, dated 11/7/25, indicated Resident 14 had recently sold their home. Resident 14 indicated they were concerned about the holidays and the upcoming anniversary of their brother's death increasing their symptoms.A psychiatric (psych) progress note, dated 12/5/25, indicated the holidays were a bad time of year for Resident 14.A progress note, dated 12/31/25 at 5:29 PM, indicated Resident 14 threatened to sue a lab tech. Resident 14 indicated the hospital prescribed the wrong antibiotic which caused the death of their mother.A psych progress note, dated 1/7/26, indicated Resident 14 did not trust some of the staff. Resident 14 indicated the facility had not addressed their concerns. The psych progress note indicated Resident 14 ruminated on past events. The psych progress note indicated Resident 14 had accused the staff of attempting to poison them. Resident 14 had called the police. Resident 14 had called a lab tech a con and told them to go ---- themselves. Resident 14 indicated they would not take antipsychotic medications because they were not psychotic.A psychotherapy progress note, dated 3/10/26 at 12:59 PM, indicated Resident 14's therapeutic interventions should include relaxation techniques and grief support.A psych progress note, dated 3/30/26, indicated Resident 14 displayed mild paranoia related to state examinations and dietary restrictions.Resident 14's care plan, dated 12/30/25, indicated the resident had experienced trauma due to the loss of their father at a young age, the loss of their mother and the unexpected loss of their brother. The target goal was to be free from re-traumatization through 5/10/26. Identified triggers were when other residents were assisted before them and the presence of a specific resident.Resident 14's care plan, dated 12/30/25, indicated the resident had a history of making false statements, throwing objects and verbal aggression. The target goal was for the resident to be free from psychosocial complications through 5/10/26. The care plan did not include specific triggers.Resident 14's care plan did not indicate holidays, especially Thanksgiving could be a possible behavioral trigger (death anniversary of the resident's brother).Resident 14's care plan did not indicate lab draws could be a possible behavioral trigger (the resident believes the lab is responsible for their mother's death).Resident 14's care plan (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not indicate the resident was at risk for paranoia.Resident 14's care plan did not indicate the resident was at risk for grief.Resident 14's care plan did not indicate relaxation was an intervention.In an interview, on 6/1/26 at 10:35 AM, the Social Service Director (SSD) indicated Resident 14 was paranoid at times. The SSD indicated Resident 14 believed a staff member struck them with another resident's wheelchair.In an interview, on 6/1/26 at 10:46 AM, the SSD indicated they were aware of Resident being verbally abusive to a lab technician. The SSD indicated they were not aware of Resident 14 blaming the hospital lab for their mother's death.A current facility policy, dated 2001, indicated the facility would recognize behavioral changes indicative of psychosocial distress.A current facility policy, dated 1/26/23, indicated the facility must identify resident specific triggers to avoid or lessen re-traumatization.410 IAC (Indiana Administrative Code)-3.1-43(a)(1)