

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Waters of Lagrange Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 787 N Detroit St Lagrange, IN 46761	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37147</p> <p>Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse for 1 of 3 residents reviewed (Resident Q).</p> <p>Findings include:</p> <p>A report, submitted to the Indiana Department of Health (IDOH), dated 3/26/24, indicated on 3/19/24 at 6:30 a.m., a CNA (Certified Nurse Aid) had used their cell phone to create a video of Resident Q without her permission. The video was shared with several staff members.</p> <p>On 4/2/24 at 2:16 P.M., Resident Q's record was reviewed. Diagnoses included dementia with behavioral disturbance, delusional disorder, and generalized anxiety disorder.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 12/19/23, indicated Resident Q had severely impaired cognition and verbal behaviors of yelling out.</p> <p>A care plan, revised on 1/15/24, indicated Resident Q displayed mood issues such as yelling out at staff and calling them derogatory names, delusions, hitting, kicking, and barricading herself. An intervention, dated 3/27/24, was for care to be provided in pairs (2 staff members).</p> <p>In an interview on 4/2/24 at 9:55 A.M., the Director of Nursing (DON) indicated, on 3/19/24 at an unknown time, CNA (Certified Nurse Aide) 5 sent her a video recording of CNA 7 providing care for Resident Q. CNA 5 alleged CNA 7 mistreated the resident while providing care. The DON indicated she passed the video on to the Administrator and CNA 5 was instructed to delete the video from her phone. CNA 7 was suspended pending investigation. The video was viewed by the Administrator, DON, and other nurse managers. The actions of CNA 7 were determined to be appropriate, without any signs of mistreatment, and CNA 7 was allowed to come back to work the following day. The DON indicated, there had been no further action regarding CNA 5's use of her cell phone to record a resident without permission, until 3/25/24 when CNA 5 was suspended and then terminated on 3/26/24.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/2/24 at 10:58 A.M., CNA 7 indicated on 3/19/24, she was sent home after being told there had been an allegation made against her for mistreatment of Resident Q. She indicated, the morning of 3/19/24, she had been providing care to the resident while she lay in bed. The resident hadn't felt well and was resistant to being changed and yelling at her. She indicated she kept trying to encourage the resident as she quickly tried to change her soiled brief. CNA 5 came into the room and asked if she could finish the resident's care as the resident was upset and perhaps a different caregiver would calm her down. CNA 7 left the room and continued caring for other residents until she was sent home. She indicated she was told after she returned the following day, CNA 5 had opened the door to the room while she was providing peri-care to the resident and began recording her and Resident Q. She had no idea she or the resident were being recorded.</p> <p>In an interview on 4/2/24 at 1:07 P.M., CNA 5 indicated she had worked 3rd shift and the morning of 3/19/24, she was doing rounds before her shift ended when she heard a resident yelling. She indicated she knew it was Resident Q because she always yelled out when care was given. She went to the room to help and walked into what she alleged was mistreatment. She indicated CNA 7 wasn't verbally mistreating the resident but believed her actions indicated mistreatment. She hadn't provided what actions the CNA 7 had taken to indicate mistreatment. She began recording the care provided by CNA 7 and how the resident had responded. After recording, she went into the room, took over for CNA 7 and finished care of the resident. After caring for the resident, she showed the recording to the 1st shift nurse who reported to the DON. When questioned, CNA 5 indicated staff were not allowed to record residents on any devices including cell phones. She provided no further information.</p> <p>A current policy, titled Abuse Prevention Program, was provided by the Regional Director of Operations on 4/2/24 at 12:15 P.M. which stated: It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings .6. Mental Abuse: Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate residents .Neglect/Mistreatment: means the failure to provide, or willful withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish or mental illness of a resident</p> <p>This tag relates to Complaint IN00431290.</p> <p>3.1-27(a)(b)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37147</p> <p>Based on interview and record review, the facility failed to ensure a timely report of suspected abuse for 1 of 3 residents reviewed. (Resident Q).</p> <p>Findings include:</p> <p>A report, submitted to the Indiana Department of Health (IDOH), dated 3/26/24, indicated on 3/19/24 at 6:30 a.m., CNA 7 (Certified Nurse Aid) had used their cell phone to videotape Resident Q without her permission. The video was shared with several staff members.</p> <p>Refer to F600.</p> <p>In an interview on 4/2/24 at 12:28 P.M., the Director of Nursing (DON) indicated, on 3/19/24, CNA 5 (Certified Nurse Aid) reported mistreatment of Resident Q by CNA 7 and provided a cell phone recording of the alleged event. CNA 7 was suspended pending investigation and allowed to return to work the following day after the allegation of mistreatment was unsubstantiated. The unauthorized recording of Resident Q, obtained while the resident was being provided pericare, was not reported to IDOH until someone reported to corporate. CNA 5 still had the recording on her phone. CNA 5 had not been suspended pending investigation after sharing the video with staff members. The allegation of mistreatment regarding Resident Q by CNA 7 was not reported to IDOH as required. The DON indicated the event and CNA 5 should have been reported to IDOH within 24 hours per regulations.</p> <p>On 4/2/24, confidential interviews were conducted with staff. The interviews indicated CNA 5 recorded Resident Q receiving pericare without knowledge of the resident or CNA being recorded and the recording remained on her cell phone. CNA 5 was not suspended for filming the care and had continued to provide resident care for approximately one week after the event. Staff anonymously notified corporate staff on 3/25/26. CNA 5 was suspended and terminated.</p> <p>A current policy, titled Abuse Prevention Program, was provided by the Regional Director of Operations on 4/2/24 at 12:15 P.M. which stated: Abuse reporting: This facility will not tolerate resident abuse or mistreatment by anyone, including staff members .6. Mental Abuse: Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate residents .Any alleged violations involving mistreatment, abuse, neglect .MUST be reported to the Administrator and Director of Nursing .After notification of alleged abuse or neglect, the Administrator or person in charge of the facility shall immediately commence an investigation of the incident reported .the Administrator or person in charge of the facility will notify .immediately .State Licensing and Certification Agency (IDOH)</p> <p>This tag relates to Complaint IN00431290.</p> <p>3.1-28(c)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>37147</p> <p>Based on interview and record review the facility failed to ensure protection from abuse for residents while an investigation of abuse was conducted for 1 or 3 residents reviewed (Resident Q).</p> <p>Findings include:</p> <p>A report, submitted to the Indiana Department of Health (IDOH), dated 3/26/24, indicated on 3/19/24 at 6:30 a.m., a CNA (Certified Nurse Aid) had used their cell phone to record Resident Q without her permission. The recording was shared with several staff members. The incident was not reported on 3/19/24 when it occurred. The involved CNA was not suspended until 6 days later. After 3/19/24, the CNA provided care to residents on 3/21/24, 3/23, and 3/24/24 from 6:30 p.m. until 7 a.m.</p> <p>Refer to F600.</p> <p>During an interview on 4/2/24 at 12:28 P.M., the Director of Nursing (DON) indicated, on 3/19/24, CNA 5 (Certified Nurse Aid) reported mistreatment of Resident Q and provided a cell phone recording of the alleged event. The unauthorized recording of Resident Q, obtained while the resident was being provided pericare, was not reported nor was CNA 5 suspended for making the recording. The DON indicated after CNA 5 reported the allegation of mistreatment and the recording viewed, CNA 5 was told to delete the video. The DON indicated she asked CNA 5 why she hadn't intervened if she believed the resident was being mistreated. CNA 5 indicated if she could do it over, she would have intervened to keep the resident safe.</p> <p>Staff meetings were scheduled and began on 3/19/24. Staff were re-educated regarding the abuse policy, use of cell phones and unauthorized recording of residents.</p> <p>In an interview on 4/2/24 at 1:07 P.M., CNA 5 indicated she had worked 3rd shift and the morning of 3/19/24. She was doing rounds before her shift ended when she heard a resident yelling. She indicated she knew it was Resident Q because she always yelled out when care was given. She went to the room to help and walked into what she alleged was mistreatment. She indicated CNA 7 wasn't verbally mistreating the resident but believed her actions indicated mistreatment. She hadn't provided what actions CNA 7 had taken to indicate mistreatment. She began recording the care provided by CNA 7 and how the resident had responded. After recording, she went into the room, took over for CNA 7 and finished care of the resident but had not attempted to intervene during the recording. After caring for the resident, she showed the recording to the 1st shift nurse who reported to the DON. When questioned, CNA 5 indicated staff were not allowed to record residents on any devices including cell phones.</p> <p>Confidential interviews were conducted with staff on 4/2/24. The staff indicated CNA 5 recorded the resident receiving pericare without knowledge of the resident or staff member being recorded and alleged the recording remained on her cell phone. She was not suspended for recording the care and had continued to provide resident care for approximately one week after the event. Staff anonymously notified corporate staff on 3/25/26, CNA 5 was suspended and terminated.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current policy, titled Abuse Prevention Program, was provided by the Regional Director of Operations on 4/2/24 at 12:15 P.M. which stated: If you suspect abuse: Separate the alleged perpetrator and assure all residents safety .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway .Staff members who are suspected of abuse or misconduct shall immediately be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation</p> <p>This tag relates to Complaint IN00431290.</p> <p>3.1-28(d)</p>		