STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155118	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lagrange Skilled Nursing Facility, The	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 37147 Based on observation, interview and record review, the facility failed to develop and implement an effective behavior management plan for a resident with a history of alcohol abuse. This resulted in public resident to staff altercations (Resident G) and 5 residents fearing for their safety (Resident P, Resident Q, Resident S, Resident T, and Resident U). Findings include: On 7/16/24 at 11:06 A.M., during an initial tour of the southwest hallway, a middle aged appearing male resident (Resident G) was observed seated in a wheelchair at the nurses station, speaking with a staff member. His speech was slightly slurred and rapid. Seated behind the resident, approximately 5 feet away, sat a female resident in a wheelchair with her feet resting on foot pedals. She was observed to have a grimace on her face, furrowed eyebrows, and nervous expression as she stared at the back of Resident G's wheelchair. She shifted her weight several times as if trying to move her wheelchair herself. Residents seated in the adjacent lounge area, indicated there had been issues with Resident G and they were frightened of him. On 7/17/24 at 10:16 A.M., Resident G's record was reviewed. Diagnoses included alcohol dependence with withdrawal, generalized anxiety disorder, major depressive disorder, mild cognitive impairment and muscle weakness. An Admission MDS (Minimum Data Set) assessment, dated 6/11/24, indicated he had a BIMS (Brief Interview Mental Status) score of 14-no cognitive impairment but had inattention and disorganized thinking daily. He had mood indicators of feeling down, depressed, and hopeless but had no behaviors, hallucinations, delusions, rejection of care or wandering. Care plans and dates initiated included: --6/10/24: The resident had a history of alcohol abuse with a goal of reducing or eliminating the consumption of alcohol. Interventions were to inform his visitors not to bring in alcohol; notify physician as needed; and praise resident for demonstrating consistent acceptable behavior. -6/10/24: The resident wandered due to cognitive impairments and feeling lost. Interventions included: provide assistance in locating his room; provide directional cues such as pictures or name on his door; and wander guard to prevent elopement. (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7/11/24: Level II recommendations-the resident had mental illness due to major depressive disorder with a goal of his psychosocial needs being met. Interventions included: case management to explore community living; training in community living skills; training in self healthcare management; behaviorally based treatment plan, dementia workup; and individual therapy from mental health services. A hospital note, dated 6/7/24, indicated the resident had been hospitalized for disorientation, electrolyte imbalances, and alcohol withdrawal following lifelong alcoholism. He was a chronic cigarette smoker and used a marijuana vape pen. He had physical debility of uncertain reason and was wheelchair bound. He was recommended to have inpatient physical therapy at an extended care facility. While hospitalized , he had been prescribed Librium (sedative to treat alcohol withdrawal symptoms) which was discontinued following hospital discharge. Progress notes, Behavior charting, and Psychiatric Nurse Practitioner notes indicated the following: -6/13/24 at 7:00 a.m., the resident made homophobic slurs toward staff and harassed them for matches. He was observed trying to elope and wandered off to other units looking for exits. Staff tried to redirect him, offered snacks and activities but the resident refused. All interventions were ineffective. -6/14/24 at 8:50 a.m., the resident was observed at the central doors watching persons entering through the door. He indicated he wanted to get through the doors and get to his people. He was re-directed towards the south hall which was effective. -6/16/24 at 2:54 a.m., the resident was brought to the south nurses station several times by staff as he was looking for ways to leave the building to go smoke. He had cigarettes and a lighter in his pocket. He was asked to surrender them for safe keeping in the medication cart which he had done but was angry about. He was redirected to watch TV in the southwest lounge and eventually went to bed. -6/20/24 at 12:46 a.m., Resident G was looking on the floor and picking up things not there. He had the entire back off of his wheelchair, wanted to go home, and refused to go to bed. A psychiatric NP progress note, dated 6/20/24 indicated the resident was seen for medication management. The resident had a long-standing history of alcohol abuse. He'd experienced withdrawal symptoms and given Librium at the hospital but was no longer prescribed. Since being admitted to the facility, his anxiety levels fluctuated and he exhibited intermittent irritability, anger and at times, had become verbally and physically aggressive with staff. Assessment and Plan were: -Alcohol dependence:continue on thiamine supplement (B vitamin), monitor for signs of withdrawal and manage symptoms. Encourage the resident to engage in alcohol cessation programs and provide resources for support. -Major depressive disorder: resident with history of depression and had been off his antidepressants for an unspecified period; Initiate Lexapro (antidepressant) 5 mg by mouth daily for depression. -Generalized anxiety disorder: Continue to monitor anxiety symptoms closely and if symptoms persist, will consider antianxiety medication. Encourage him to engage in stress management techniques and provide resources for support. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress notes continued: -6/23/24 at 6:50 p.m., the resident repeatedly asked to leave the facility. He was looking for his children, was grabbing, yelling out to and asking every person seen to help find his kids. He yelled at staff for lying and trying to keep him from them. He went into other resident's rooms and moved their furniture in attempts to find them. His behaviors started in the morning and increased in frequency throughout the day. Staff had tried to redirect, reassure him, and attempted to call his family to have them reassure him but there had been no answer. Other residents were upset he was going into their rooms, yelling and grabbing at them and their visitors. All interventions were ineffective. -6/24/24 at 2:05 p.m., the resident asked for help. He was tearful and said he had to get to the bank for money because his wife took his and he owed someone money and was in trouble. Staff tried to reassure him, redirected the conversation, and offered him a snack; all interventions were ineffective. A psychiatric NP progress note, dated 7/3/24 indicated the resident was seen for follow up and medication management. He was initiated on Lexapro during the last visit due to history of depression. Despite the treatment, he continued to have increased anxiety, exit-seeking behavior, and intermittent cognitive impairment. His anxiety was difficult to redirect, prompting the initiation of Librium 10 mg by mouth 3 x/day. Following initiation of Librium, the resident had shown overall improvement and was less anxious and calm. Staff report he was less impulsive and was able to participate in mealtimes and activities. His sleep had improved and he was sleeping through the night. Assessment and Plan were: -Alcohol dependence: The resident had a history of alcohol abuse. There were no acute concerns or negative symptoms reported during the visit which suggested his alcohol abuse was uncomplicated. He would be monitored for alcohol consumption and potential impact on overall health. He was encouraged to continue to abstain from alcohol and to participate in support groups or counseling if needed. -Major depressive disorder: His depression was being managed with Lexapro 5 mg per day. He reported feeling better overall and would continue the current regimen. -Generalized anxiety disorder: His anxiety had been a concern with symptoms of increased anxiety, exit seeking, and difficulty with redirection. Librium 10 mg 3 x/day was initiated on 6/24/24 which resulted in significant improvement in his anxiety symptoms. Would continue with current regimen of Librium 10 mg 3 x/day. -Mild cognitive impairment: He had been experiencing intermittent cognitive impairment however since initiation of Librium, he reported feeling like his brain was slowing down which suggested an improvement in his cognitive function. Progess notes contiued: -7/10/24 at 5:30 p.m., the CNA (Certified Nurse Aid) reported to the SSD (Social Service Director), that the resident had rolled up to them and stated If you go anywhere near that golf team of children again, I am going to shoot you in the face. You have no business coaching them again. The resident was redirected but was ineffective. He continued to wheel himself down the hallway. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 5:55 p.m., the resident became very upset after his mother left. He went between sobbing and yelling/swearing at staff for trying to take his things and fun times away. He believed his family was harming his rehomed pets. He believed his roommate was talking poorly about his father and tried to hit the roommate. These behaviors occurred from 3:30 p.m. - 6:00 p.m. Staff tried to reassure and distract him with conversation which was not effective. He went to bed and started to relax until his roommate entered the room. Staff intervened when he tried to hit his roommate and the roommate began screaming which escalated his behaviors. The behavior caused behaviors in his roommate. Staff were afraid he would be violent with them. The resident cries or screams almost every time staff talk to him. All interventions were ineffective. -7/11/24 at 3:40 p.m., the resident was observed, by the Admissions Director, standing at the central nurses station shaking. She attempted to help him sit down when he pointed a finger in her face and yelled accusations of her killing everyone. She backed up and gave him space and tried to calm him. Another staff member walked by and he started screaming at them for killing everyone too. The SSD came up and tried to calm the resident but he began to shout at her to give him her gun because the Admissions Director had killed all the babies. He was assisted to sit down but then began to swing his arms at staff and continued to yell at each staff member as they approached and tried to calm him. He jumped from topic to topic and continued talking about guns, people trying to kill each other, shackles and being in jail. All non-pharmacological interventions were ineffective. The psychiatric NP was contacted and orders given for 1 time dose of Haldol (antipsychotic) 5 milligrams (mg) intramuscularly (IM) for agitation and start Risperdal (antipsychotic) 0.5 mg by mouth twice daily. -At 3:55 p.m., the resident was extremely agitated, stood up from his wheelchair and tried to open the furnace room door while yelling they are coming to kill me. He pointed at female staff and said he was going to hit them. His mother was contacted by phone and indicated she would come right away to the facility. All interventions were ineffective. -4:05 p.m., the resident continued with agitation. He was assisted into the lounge area and away from other residents who witnessed the outburst. He begged staff to shoot him in the head and was inconsolable. His family arrived to the facility and he continued to cry excessively. He was administered the injection of Haldol which eventually helped to calm him. -7/14/24 at 3:15 p.m., the resident was observed walking down the hallway without his walker or wheelchair with a very unsteady gait. Staff attempted to help him sit in his wheelchair. He refused and threatened to hit staff while kicking staff and the wheelchair. He began yelling You all are going to blow this place up and kill me and kill them all! After 40 minutes, staff were able to calm him down. He had been physically and verbally aggressive towards staff and visually agitated. Other residents became anxious while the resident was yelling and agitated. All interventions were ineffective -7/15/24 at 1:02 p.m., a Change in Condition form indicated the resident had increased confusion, delusions, hallucinations, physical and verbal aggression and was a danger to himself and others. The resident was unable to differentiate between what was real and what was in his mind. The primary care provider responded back to monitor the resident. All interventiosn were ineffective -At 2:51 p.m., a Change in Condition form indicated the resident had other behavioral symptoms which were not identified. There was no response from the primary care provider. All interventions were ineffective. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 4:52 p.m., the resident was yelling down the hallway, they're killing them, they're killing them as 5 visitors exited another resident's room. He attempted to go into another resident's room. He was redirected to come to the nurses station where he continued to yell out and tried to hit staff. He was able to grab a staff members arm and punched another staff member in the head as his behaviors escalated and more staff called to the area for assistance. All residents in the immediate area were moved. He eventually calmed after being assisted to walk and talk with staff. -7/16/24 at 2:05 p.m., the psychiatric NP gave orders to send the resident to the psychiatric hospital for increased behaviors. He was to be picked up the following day and transported to the hospital. -At 10:00 p.m., the resident was seated in the recliner chair in the TV lounge after refusing to go to bed. Staff heard a noise and observed the resident crawling on his hands and knees on the floor. He was asked if he needed assistance and he replied with name calling and threw his wheelchair at the staff member. He then kept repeating kill me, kill me, kill me. All interventions were ineffective. -At 11:30 p.m., the physician was notified of the resident's behaviors and new order given for Haldol 5 mg IM 1 time for agitation. -7/17/24 at 12:15 a.m., the SSD indicated she had been notified of the resident's behaviors and interventions tried. The resident had gotten back into the recliner chair and lights turned down low which calmed the resident and he wasn't administered the Haldol injection. -At 10:52 a.m., the resident was transported to the psychiatric hospital. Confidential interviews were conducted during the course of the survey. Resident P, Resident Q, Resident S, Resident T, and Resident U each indicated they were afraid of Resident G. They had witnessed his verbal behaviors toward other residents and staff and physical behaviors with staff. The resident had wandered into their rooms and became angry when asked to leave. He had yelled at them and their visitors and in some rooms, had moved other resident's personal items and furniture. They indicated everything the staff tried was ineffective. Confidential employee interviews indicated there had not been enough staff to manage Resident G's behavior, no education provided on caring for a resident with substance use disorder (SUD), unanswered calls for help when the resident was acting out, slow staff response during physical altercations, and concerns regarding other residents who witnessed the behaviors, their distress and need for protection, intrusion in their personal space and change in other residents preferences and movements in the facility (i.e. , having to close their door to keep the resident out and having to be moved away from common areas when his behaviors occurred). They indicated they had no direction to provide interventions for the behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 1:56 P.M., the SSD was interviewed. She indicated prior to admission and while hospitalized , the resident had no behaviors. During his admission MDS assessment time frame, he had no behaviors and a care plan was not developed for behavior management nor had one been developed and implemented since his behaviors started. She was aware he had a history of alcohol abuse but had not received training for residents with substance abuse disorders nor had staff. When questioned about the facility behavior management program, documentation of behaviors and how interventions were communicated to staff, she indicated behaviors and interventions were documented in the nurse progress notes and in the resident's MAR. CNA's had no access to the residents MAR and she wasn't sure how behavior interventions were communicated to them. A care plan was not developed and interventions put into place when Resident G began to exhibit behaviors which affected other residents and staff safety. He was not offered services to assist him with alcoholism or stress management as recommended by the psychiatric NP. There was no follow up for behaviors not able to be altered by staff including actions taken when the resident was a threat to other residents safety. A current facility policy, titled Guidelines for Behavior Management Meetings and Psychotropic Medications was provided on 7/17/24 at 2:35 P.M. by the Regional Nurse Consultant who indicated this was the policy followed for behavior management which stated: Standards: The facility will investigate behaviors in an effort to determine the root cause of the behavior. In so doing, it may become evident that a non-pharmacological intervention would be effective in managing or even eliminating the behavior without the use of psychoactive medications .Psychiatrist/Mental Health Provider may assist the facility in establishing appropriate guidelines for use, dosage and monitoring of psychoactive medications .be available for consultation and helps develop behavior management plans as needed .Nursing .Monitors for presence of target behaviors on a daily basis and documenting same .Assist in developing behavior care plans .Social Services .assists in compiling quantitative data (number of behaviors/side effects of med's) .Guidelines for Psychotropic Medication: Policy . Residents will not receive psychotropic medications unless other types of interventions have been attempted to meet the resident's targeted behavioral goals and have failed. These include Behavioral Programming by a trained Behavioral Therapist, environmental changes and/or other non-pharmacological interventions This tag relates to Complaint IN00436738. 3.1-37

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F 0744 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 dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on observation, interview and record review, the facility failed to ensure dementia care and services was provided to 1 of 3 residents reviewed for dementia care (Resident E). Findings include: A complaint reported to the Indiana Department of Health, alleged residents who resided on the memory care unit at the facility were unsafe due to lack of nursing staff, medications not being provided timely, and lack of activities. On 7/17/24 at 11:27 A.M., Resident E's record was reviewed. Diagnoses included dementia with behavioral disturbance, delusional disorder, insomnia, major depressive disorder, and diabetes. He had been hospitalized for 2 weeks in May 2024 for increased delusions and physical behaviors. Hospital notes indicated the plan of care was to minimize polypharmacy and provide a structured, secured environment. The resident returned to the facility on [DATE] with orders for 2 antidepressant medications and an antipsychotic medication which hadn't been prescribed prior to his hospitalization . A quarterly MDS (Minimum Data Set) assessment, dated 4/9/24, indicated Resident E had severely impaired cognition. He had little interest or pleasure doing things 2-6 days but had no behaviors, rejection of care or wandering. He required partial assistance with eating, dressing and ambulation. The resident was always incontinent of bladder and required maximal assistance with toileting. He'd had no falls since his previous assessment, dated 1/24/24. Care plans included: -Dated 10/6/23: The resident resided on the memory care unit due to dementia and would benefit from programming on the unit. The goal was he would participate in programming on the unit. Interventions included: Secured unit and provide specialized programming. there was no indication what the specialized programming consisted of. -Revised 3/26/24: The resident was interested in activities such as movies, bingo and trivia. The goal was for him to attend at least 3 activities per week. Interventions included: Invite, encourage, and assist resident to activities of his interest. -Revised 5/23/24: The resident had mood issues exhibited by screaming, yelling, swearing and delusions of believing others were out to get him. The goal was he would have no side effects from his medications. Interventions were: Administer psychotropic medications as ordered and monitor side effects; notify physician as needed; monitor use of psychotropic medication quarterly; Listen to his concerns, provide support and encouragement; Social Services Director (SSD) to visit as needed. On 7/16/24 between 9:00 Am and 10:55 A.M., Resident E was observed at the dining room table being assisted to eat by his spouse. She indicated the purple-yellow bruise around his right eye had been due to a fall. There was music playing, but no activities or programming was observed on the unit. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 between 9:45 A.M. and 10:00 AM, Residents who resided on the unit were observed seated in recliner chairs in the lounge area; most appeared asleep with eyes closed. 1 female resident was wandering around the lounge. Resident E was observed in his room, lying in bed with his eyes closed. There were no activities or programmng on the unit. -At 1:45 P.M., he was observed lying in bed in his room, sleeping. His spouse was present and she indicated he slept a lot now. She was asked about activities on the unit and she indicated the activities and programming were very sporadic and not routine. Progress notes and Psychiatric NP ((Nurse Practitioner) notes were: -6/18/24 at 9:01 a.m., the IDT (Interdisciplinary Team) met to discuss the residents recent behaviors. Staff would complete a dipstick to rule out UTI (urinary tract infection) and have the psychiatric NP visit their next time in the facility. -6/20/24 at 4:30 p.m., the resident was tearful, confused and asking why his wife hadn't visited yet. Staff offered reassure which was effective for a short period of time. -At 5:31 p.m., he was sitting in the nurse station when he asked staff if he could go out and get his gun. Staff tried to distract him which was initially effective however the resident told staff they needed to call the police because he had killed someone. His wife later visited which calmed him and he had no further behaviors. There was no activites or programming offered for Resident E. -6/30/24 at 8:45 a.m., the resident swatted a staff member on the side of their face with the back of his hand. He'd been restless, agitated and tried to walk without his walker. Staff reported he had been awake all night. Staff spent 1:1 time with him, read a book and was give and accepted hot chocolate. Interventions were ineffective however, his wife called and after speaking with her, he was calm. -At 12:32 p.m., the SSD called and spoke with the psychiatric NP regarding increase in residents behaviors. New order was given to restart Trazodone (used for sleep) as he'd previously been on the medication and had slept better with a decrease in his behaviors during the day. -At 8:44 p.m., the resident was restless, agitated and had attempted to stand and walk around his room with an unsteady gait. He had refused his evening medications, knocked a cup of water over the staff member and his wife and hit out. Wife and staff tried to talk to him, offered snacks and activities. He eventually agreed to take his medication, was assisted into bed, calmed down and fell asleep with his wife at his bedside. There was no activites or programming offered for Resident E. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation of sensory stimulation and activities in July 2024, indicated between 7/1/24 through 7/16/24, sensory stimulation of hearing music occurred 6 days and activities 6 days with 2 refusals. There no other activities or programming scheduled for Resident E. Resident E's care plan indicated a decline in his functional abilities and increase in behaviors without new interventions put into place to prevent further decline in his condition. The care plan indicated he should be encouraged to exercise during the day and naps discouraged but no other non-pharmacological interventions were put in place. A current facility policy, provided by the Regional Nurse Consultant on 7/17/24 at 11:47 A.M. and titled A Dedicated Dementia Care Unit Philosophy, stated: We believe that the quality of life for our residents is enriched when their days are filled with meaningful and enjoyable structured activity. We believe that this activity serves as a powerful coping mechanism in times of fear and stress .We believe that behaviors displayed during this [dementia] journey are caused by a progressive degeneration of the brain .We choose to modify the environment, change our expectation and focus on intervention/redirection to ensure our residents have opportunities to be content and socially successful .Pre-Admission Assessment: Memory Springs is a secured neighborhood and a program specifically designed to provide a safe and home-like environment that promotes independence and socialization .Guidelines for Initial Admission .Individual will benefit from a specialized dementia program This tag relates to Complaint IN00438589. 3.1-37