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	09/04/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on observation, interview, and record review, the facility failed to ensure staff effectively identified skin impairment on the left inner calf from friction and shear was correctly identified as a pressure injury, failed to ensure a physician's order was received prior to the use of a medical device, and failed to ensure a resident with a history of pressure injuries received effective treatment and services to prevent the wound from deteriorating, from developing infection, or to prevent the development of a second wound for 1 of 1 resident reviewed for wound care. (Resident J) This deficient practice resulted in Wound 1 deteriorating to a stage three pressure injury with infection and required sharp debridement. Findings include: In an interview on 9/3/24 at 12:07 P.M., the Resident Council President (RCP) indicated Resident J, who sat at her table in the dining room, had been taken back to her room, without eating lunch, due to her crying out in pain. The RCP was very concerned for the resident because she had been crying about pain in her left lower leg, foot and toes. In an interview on 9/3/24 at 12:15 P.M., the facility Activity Assistant indicated the resident had been having a bad day and liked to be babied at times. The Activity Assistant indicated she had just come from the resident's room and she had been doing fine. An annual MDS (Minimum Data Set) with Care Area Assessments, dated 6/25/24, indicated Resident J had a BIMS (Brief Interview Mental Status) score of 12 (mildly impaired cognition). Her speech was clear, she was able to make her needs known and was able to understand others. She required substantial assistance with bed mobility, transfers, and toileting. She was frequently incontinent of bowel and bladder and had no identified wounds. Staff would continue to anticipate her needs, provide assistance, and keep her physicians informed of any changes. A skin risk assessment dated [DATE] indicated she was at risk for pressure injuries. There were no other assessments or care plans documented related to the identified risk. A current care plan regarding potential for pain, dated 9/3/23, indicated the resident had the potential for pain and would be free from pain with interventions as needed. Interventions included: medications as ordered; notify doctor of uncontrolled pain; and observe for signs and symptoms of pain. (continued on next page)

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

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 09/04/2024
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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A current care plan regarding at risk for skin breakdown due to edema from heart disease, dated 2/1/24, indicated goals were to provide the resident with preventative measures to avoid skin breakdown and resolution of her edema without complications. Interventions included: float heels while in bed; monitor skin daily during care; mild compression stockings daily-on in the morning and off at night; weekly skin assessment; and observe for any increase in edema. An Incident Report dated 8/8/24 at 9:00 a.m., indicated the resident had a skin tear to her left inner calf with slight bleeding. The skin tear was cleansed and covered with a dry dressing. No other characteristics of the wound had been documented, the physician or family notified. The incident report did not include documentation to determine the root cause of the skin impairment. An Interdisciplinary (IDT) note, dated 8/9/24, indicated the root cause of the left inner calf wound was from the resident rubbing the left leg against an air cast that was applied to the right lower leg. There was no measurement of the area, other characteristics, physician or family notification documented about the skin tear. There was no care plan to address friction and shear related to the air cast. Current physician orders, dated September 2024, did not include an order for the air cast. According to Advances in Skin and Wound Care pg. 222 June 2004 article, friction and shear are mechanical forces contributing to pressure ulcer formation. The tissue injury resulting from these forces may look like a superficial area, yet they often work together to create tissue ischemia (low oxygen) and ulcer development. A nurse progress note, dated 8/11/24 at 4:31 p.m., indicated the resident had a skin tear (stage two pressure ulcer) to her right (sic) (left) lower leg. Her leg was swollen and leaking fluid. The wound was cleaned and her leg wrapped. There was no documentation of how the wound was cleansed, the characteristics of the wound or how the wound had been dressed. A care plan for a skin tear on the right (sic) (left) lower leg, dated 8/12/24, indicated the stage two pressure ulcer on the left lower leg was a skin tear. The goal was to heal without complications. Interventions included: investigate cause of the skin tear; observe for signs/symptoms of infection; take necessary precautions to prevent new areas; and treatments as ordered. There was no assessment or plan of care for pressure risk related to the use of a medical device. A Treatment Administration Record (TAR), dated August 2024, indicated a treatment was ordered on 8/12/24 for a skin tear (ulcer) to the right (sic) (left) lower leg. The skin tear (ulcer) was to be cleansed with soap and water, rinsed, patted dry and dressing applied as needed one time per day. A Daily Skilled Nursing Note, dated 8/13/24 at 11:13 a.m., indicated the stage two pressure ulcer (a partial thickness loss of skin with exposed dermis, presenting as a shallow, open ulcer) identified as a skin tear (ulcer) on her left lower leg continued to drain. There was no documentation of how the wound was cleansed, the specific characteristics of the wound, any drainage associate with the wound or if the wound had been dressed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Nurse Practitioner note, dated 8/14/24 at 10:29 a.m., indicated the resident reported she was having drainage from her left lower leg. The area was dressed with bandages. She had no excessive warmth, redness, or surrounding swelling, but no other characteristics of the wound had been documented. There was no documentation in the progress notes or wound documentation between 8/14 and 8/26-24 to indicate the facility effectively assessed, monitored, or evaluated the skin impairment. The record contained no documentation, in the progress notes, wound reports, or treatment records, between 8/14/2024 and 8/26/2024, to indicate the facility effectively assessed, monitored, or evaluated the skin impairment including 8/15/24, 8/22/24 and 8/29/24. Care plans, dated August and September 2024, did not contain interventions to remove the air cast, or interventions to provide relief to the wounds on the left lower leg. A Change in Condition form, dated 8/26/24 at 11:17 p.m., indicated the resident had 2 newly identified skin tears (ulcers) on her left lower calf. The form indicated the Left lower leg areas caused her significant pain. New orders were obtained to cover the skin tears on the left lower inner leg and left lower outer leg with Mepitel (a wound dressing to allow drainage to pass on to a secondary dressing, reducing pain) followed by Mepilex (a wound dressing to absorb drainage and protect from damage due to the drainage) until healed every night shift, every 7 days. Resident J was administered pain medication-Tramadol 50 mg 1 tablet by mouth every 8 hours as needed-at 8:18 p.m. for a pain level of 9 out of 10 with 10 being the worst pain. The form did not include sufficient documentation to determine the specific characteristics of the wounds, assessments of the wound, possible root cause. According to Molnlycke.us, Mepitel is a dressing designed to minimize pain and trauma at the dressing site. Mepitel does not adhere to a moist wound so it can be easily removed without damaging the skin. Mepitel is designed to remain in place for 14 days, it protects the skin to support faster healing, and seals the wound to prevent the skin from softening and breaking down related to moisture. According to Molnlycke.us, Mepilex is a dressing designed to designed to minimize pain and trauma at the wound site. It seals the wound and absorbs drainage to protect the wound from breakdown. A Change in Condition follow up note, dated 8/27/24 at 9:39 a.m., indicated skin tears (ulcers) to the residents left lower leg were cleansed and redressed. Her left lower leg was swollen, reddened, tender to touch, and had a moderate amount of bloody drainage. There were no measurements or characteristics of the wound documented. The note did not include documentation to indicate the pain/ tenderness in the left lower leg was effectivly assessed. A new onset pain assessment was not completed to address Resident J's pain/tenderness to the left lower leg. The pain assessments, dated from 8/8/24 to 8/31/24 did not include documentation to indicate a pain assessment was completed on 8/27/24. A Medication Administration Record (MAR) dated August 2024 indicated the resident was not provided any pain medication on 8/27/24. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

An untimed physician's order, dated 8/27/24, indicated to cover the skin tears (ulcers) on the left lower inner leg (Wound 1) and left lower outer leg (Wound 2) with Mepitel followed by Mepilex until healed every night shift, for 14 days to be discontinued on 9/3.

A Wound Nurse Practitioner (NP) note, dated 9/3/24 indicated Wound 1 measured 3.5 cm Length (l) X 2 cm Width (w) with moderate bloody drainage. No further assessment of the area had been documented. Wound 2 measured 1 cm (l) X 1 (w) cm in a V shape with moderate bloody drainage, but no further assessment of the area was documented.

An Incident Note, dated 8/28/24 at 8:05 p.m., indicated the residents dressings had been changed per wound orders and she was to be seen by the wound NP the following day (8/29/24). There was no measurement or description of the wound areas or characteristics in the note.

An Incident Note, dated 8/29/24 at 2:19 a.m., indicated the dressings to the residents skin tears (ulcers) were intact and there were no signs/symptoms of infection observed. There was no measurement or description of the wound areas or characteristics in the note.

The Wound NP progress notes and the Physician progress notes, dated between 8/27/24 and 8/31/24, did not include documentation to indicate Wound 1 or Wound 2 was evaluated on 8/29/24.

A Daily Skilled Nursing Note, dated 8/31/24 at 5:47 a.m., indicated the resident complained of pain in her left foot. There was no documentation completed of the wound site, the measurements of the wounds, swelling in the leg or condition of dressings. There was no pain assessment completed nor pain medication administered. The note did not include documentation to indicate Wound 1 or Wound 2 was evaluated on 8/31/24.

There was no documentation of wound evaluations, treatments, monitoring, or pressure relief between 8/31 and 9/3/24.

During an observation from the hallway outside Resident J's room, on 9/3/2024 at 2:20 P.M., Resident J was heard crying out in pain. She was observed lying in her bed with her legs flat on the mattress, covered with a sheet and blanket. She was anxious, grimacing, moaning, and calling out. She was crying and indicated her left leg hurt terribly. Licensed Practical Nurse (LPN) 3 was observed to enter the room and indicated the resident had her left leg wound debrided (physical removal of necrotic tissue with use of scalpel and forceps) before lunch. LPN 3 indicated Resident J had been administered Tylenol after the procedure but needed something stronger for the pain. LPN 3 was observed to administer Tramadol (pain medication used for moderate to severe pain) 50 mg (milligrams) 1 tablet by mouth for the leg pain. After she took the medication, she began to yell for her leg to be elevated. LPN 3 placed pillows below her legs to elevate them. After the medication administration, Resident J was observed to yell for the left leg to be elevated and LPN 3 was observed to place pillows under the resident's legs.

A care plan for skin impairment, dated 9/3/24, indicated Resident J had a wound to her left posterior calf and skin tear (ulcer) to her left lower leg. Goals were for the wound to show signs of improvement, be free from infection, and her skin tear to heal. Interventions included: encourage the resident to elevate her legs; provide wound care as ordered; evaluate and change treatment as needed; monitor for signs/symptoms of pain, administer medications, and re-assess as needed; measure wounds at regular intervals; and monitor signs of healing or wound declining.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 9/4/24 at 9:44 A.M., Resident J was observed in her room, seated in her wheelchair, with both leg pedals slightly elevated, but low to the floor. Her left leg was wrapped from mid foot to top of her calf with an ace wrap bandage. The toes of her left foot were uncovered. The toes were red in color. She was feeling better on this day but indicated the day prior (9/3/24), had been a rough day. The Wound Nurse Practitioner (NP) had been in to visit to treat the wound on her left calf. The wound was painful during the treatment and worsened as the day wore on. She indicated she had been given stronger pain medication. The medication had provided relief from the pain. A Wound NP progress note, dated 9/3/24, indicated the resident was being seen to evaluate skin tears (ulcers) to her left lower extremity. She was observed to have a 1 cm x 1 cm x 0.1 cm V shaped laceration-type skin tear (ulcer) to the left anterior calf (Wound 2) with a non-viable flap and a 3.5 cm x 3.5 cm x 0.4 cm full thickness ulceration to the left medial part of her posterior lower left calf (Wound 1) which appeared consistent with a venous ulcer. There was slough observed to wound (Wound 1) which required sharp debridement to clearly assess the wound. The resident had no documented history of venous stasis disease but had chronic edema to her lower legs due to extensive history of CHF. The resident indicated she had pain at rest in her left lower leg. The tissue around the wound to the left anterior calf (Wound 2) was intact but fragile and there was a scant amount of serosanguineous (blood and clear fluid) drainage. The resident indicated no pain at rest with this wound. The wound to her left posterior lower calf (Wound 1) was 80% covered with slough (dead skin cells) (Stage 3 pressure area presents as a full-thickness loss of skin. Slough may be visible, but does not obscire the depoth of tissue loss) . Tissue around the wound was fragile and there was a heavy amount of serous (clear/cloudy) drainage. The resident complained of severe pain during removal of the bandages and indicated she had severe pain at rest with this wound. Both wounds were numbed and debrided which the resident tolerated without pain. New treatment orders were given to cleanse both wounds, apply calcium alginate (a dressing to promote fliud and enzyme stasis with a wound) to base of wounds, secure with a dressing and rolled gauze, every other day and as needed, followed by compression with Ace wrap to the left lower extremity. Recommendation was made to obtain venous reflux imaging to confirm the diagnosis of venous stasis ulcer to the left medial posterior calf. Intermittent leg elevation, at or above the heart level, was to be completed as tolerated. There was no documentation related the the air cast on the right lower leg. The results of the venous imaging were not available related to the test not having been completed at the time of the survey. Care plans did not reflect they had been updated to include the addition of the Calcium alginate. A Daily Skilled Nursing Note, dated 9/3/24 at 7:40 p.m., indicated the resident's wound showed signs and symptoms of infection and new orders were received to start Keflex (antibiotic) 500 mg by mouth, 3 times per day for 10 days. The note did not include sufficient documentation to determine the signs/symptoms exhibited. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 9/3/24 at 2:36 P.M., LPN 3 was interviewed. She indicated she'd asked the wound NP to check on Resident J's skin tears (ulcers) while she was in the facility on 9/3/24, seeing other residents. She indicated the resident's wounds looked bad and she was complaining of pain to the area. She indicated the resident had skin tears (ulcers) since the beginning of August but didn't have treatments or follow up documentation completed. Resident J was to wear compression stockings daily but hadn't been wearing them due to her wounds leaking fluids. LPN 3 did not indicate how long the wounds had been leaking, what was the facility's response was, or any interventions implemented. On 8/31 and 9/1/24, LPN 3 had wrapped the residents 's legs with ace wraps because her legs were too swollen for the compression stockings. When asked, she was unsure how the resident got the skin tears (ulcers) but thought the resident may have hit her calves on the wheelchair pedals or sides of the chair. In an interview on 9/4/24 at 10:19 AM, the Regional Nurse Consultant indicated she was unable to find any further documentation of the skin tear (ulcer) on the left lower leg, identified on 8/8/24 nor was there further documentation of the skin tear (ulcer) on the right lower leg which had been identified on 8/12/24. There were no observations for signs/symptoms of infection, no investigation for cause of the skin tears (ulcers), no documentation of interventions put into place to prevent further skin tears (ulcers) and no documentation of the wound being healed. The Regional Nurse Consultant indicated she was unable to find any further documentation of the skin tear (ulcer) on the right lower leg, and there was no documentation of the skin tear (ulcer) on the right lower leg being healed. On 9/4/24 at 11:10 A.M., the Wound NP was interviewed. She indicated she visited the facility on Tuesdays for wound rounds. She would see residents with different types of wounds, upon notification from staff. She indicated, there was no designated nurse to complete wound rounds with and would speak with the nurse caring for the resident on the day of her visits. On 9/3/24, she was notified by LPN 3, of the skin tears (ulcers) Resident J had. She had last seen the resident on 8/6/24 for follow up to a pressure wound she'd acquired while hospitalized in July 2024. The pressure wound was healed and required no further treatment. She indicated she hadn't been made aware of the resident's skin tears/wounds to her right or left lower extremities prior to 9/3/24. She indicated the resident complained of much pain when her left calf was lifted up and old dressings removed because of the swelling to her calf. She had proceeded with the debridement of both wounds following numbing the area and resident's comfort determined. The resident had tolerated the procedure without complaints of pain but had pain when the calf was re-dressed. The nurse gave the resident Tylenol after the procedure was completed. When questioned, she indicated residents with painful wounds should be pre-medicated with pain medication prior to her visits and treatments. She had not been told the resident had severe pain following the debridement procedure. When questioned regarding a visit to have been done on 8/29/24, she indicated her partner completed wound rounds on that day and their progress notes had not indicated Resident J was to be visited so she was not. On 9/4/24 at 10:19 A.M., the Regional Nurse Consultant indicated there was no facility policy specific to skin tears but provided a current copy of their policy monitoring skin and weights (S.W.A.T.) program. The policy indicated: Skin alterations such as the following will appear on the weekly skin assessments and will be followed by the clinical management staff for progress. These conditions/alterations will be care planned and managed and treated as per physician order. any concerns with progress and/or healing will be reported to the physician for guidance, recommendations, and/or orders .These areas are non-Pressure Ulcers or Pressure injuries and are therefore not routinely reviewed/discussed at the S-W-A-T meetings. a. skin tears . f. lacerations .m. other (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 9/4/2024 at 12:09 P.M., Resident J was observed in the dining room, seated in her wheelchair with her legs slightly elevated but low to the floor. She wore a frown on her face and her eyes were partially closed. When questioned, she indicated she was fine but was observed to be intermittently grimacing. This Citation refers to Complaint IN00440946. 3.1-40

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37147 Based on observation, interview and record review, the facility failed to provide effective pain management for 1 of 1 residents experiencing pain (Resident L). Findings include: On 9/3/24 at 2:01 P.M., Resident L's record was reviewed. Diagnoses included unstageable pressure ulcer to the right heel, diabetes, intellectual disabilities, and neuropathy. The resident had been hospitalized for a hip fracture due to a fall. A quarterly Minimum Data Set (MDS) assessment, dated 8/17/24, indicated her cognition could not be assessed due to intellectual disabilities. She had verbal behaviors and behaviors not affecting others 1-3 days of the assessment and when asked, indicated she had pain but was unable to give further details. She required maximal assistance with all Activities of Daily Living (ADL's). Care plans with effective dates, indicated: -8/13/24: Resident had potential for pain related to neuropathy and recent hip fracture. The goal was her pain to be controlled at an acceptable level. Interventions included: assess pain using the 0-10 scale; administer pain medication and monitor effectiveness; offer non-pharmacological interventions for pain relief such as dim lights, repositioning, back rub, heat or cold; document and report complaints and non-verbal signs of pain; and reposition as needed for comfort. -9/4/24: Resident was admitted with a pressure injury to her right heel. The goal was to heal. Interventions were: administer treatments as ordered; nurse to measure/assess weekly and notify family and physician as needed; provide heel protectors in bed; and refer to nutritional plan of care. On 9/3/24 at 10:30 A.M., Resident L was observed seated in a wheelchair across from the nurses desk. She was speaking animatedly with other residents around her. She repeated herself often, was restless and fidgeting in her chair. Both feet were resting on the carpeted floor with a sock on her left foot and ace wrap around her right ankle/foot. She verbalized twice, she was having pain in her right foot and indicated she had a sore on the foot. -At 2:15 P.M., the resident remained seated in her wheelchair with her feet down in front of the nurses desk. A bedside table sat in front of her and she was playing with a peg board with colored pegs. She indicated her foot hurt twice during the observation. On 9/4/24 at 9:42 A.M., the resident was observed seated in her wheelchair with her feet on the floor, across from the the nurse desk. She had the table in front of her and was playing with her peg board. She was heard telling staff present, several times, her foot hurt. One staff member, told her the doctor and staff were aware and the pain was due to swelling in her foot. A physician order, dated 8/10/24, was for Gabapentin (used to treat nerve pain) 100 mg (milligrams)-give 1 capsule by mouth 2 times per day and give 2 capsules at bedtime for neuropathic pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 7/25/24, was for Tylenol 325 mg-give 2 tablets by mouth every 4 hours as needed for pain. A Medication Administration Record (MAR), dated September 2024, indicated the resident had been administered Tylenol 325 mg-2 tablets by mouth on 9/1/24 at 11:33 a.m. for pain and again, on 9/2/24 at 4:00 p.m. Both doses were noted to have been ineffective in relieving the residents pain. Tylenol was not administered on 9/3/24 or 9/4/24 when the resident complained of pain in her right foot. A nurse progress note, dated 9/2/24 at 5:20 p.m., indicated the resident had swelling to her right foot and complained of pain. The nurse assessed the wound and indicated there was pitting edema in her right foot. Tylenol was given as ordered without pain relief. The unit manager was notified and staff would continue to monitor. A Wound Nurse Practitioner (NP) progress note, dated 9/3/24 at an unknown time, indicated the resident had been seen for continued care to the unstageable pressure ulcer on her right heel. Resident L refused to have the pressure ulcer debrided due to pain. She had pitting edema to the right foot and it was tender to touch. The wound was healing and there was no redness/warmth, foul odor or abnormal drainage from the wound. On 9/4/24 at 2:30 P.M., the Administrator and Regional Nurse Consultant were interviewed. They indicated it was expected, residents verbalizing pain would be assessed, pharmacological and non-pharmacological interventions put into place. A current policy, titled Guidelines for Pain Management was provided by the Regional Nurse Consultant, on 9/4/24 at 2:45 P.M., which stated the following: Methods to achieve goals of pain management: 1. Promptly and accurately recognizing and assessing pain. 2. Encouraging residents to self-report to staff when they experience pain. 3. Being cognizant of the non-verbal signs/symptoms of pain in residents not able to verbally express their pain .7. Preventing and minimizing anticipated pain when possible. 8. Using non-pharmacological means for pain relief when appropriate This Citation relates to Complaint IN00440946. 3.1-37(a)