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	02/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37147 Based on interview and record review the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents reviewed (Resident J). The deficient practice was corrected on 1/22/25 prior to the start of the survey and was therefore past non-compliance. Findings include: A facility reported incident to the Indiana Department of Health, dated 1/21/25, indicated an allegation of verbal abuse had occurred and was being investigated by the facility. The allegation involved verbal abuse from a Certified Nurse Aid (CNA) to a resident. On 2/3/25 at 12:53 P.M., Resident J's record was reviewed. Diagnoses included Alzheimer's disease with late onset. A significant change Minimum Data Set assessment, dated 1/8/25, indicated the resident had severely impaired cognition and required maximal to dependent care for her activities of daily living. She had no behaviors or rejection of care. A care plan, dated 1/8/25, indicated Resident J had cognitive impairments related to dementia and short term memory loss. Her goals were to have her needs met and anticipated. Interventions included: if upset/or distressed check for any unmet needs; give resident two choices when presenting decisions; and observe and report changes in cognitive status. On 2/3/25 at 12:30 P.M., the Administrator was interviewed. He indicated on 1/21/25, he was notified that CNA 8 had been overheard by staff, being rude to Resident J and calling her a bitch in front of her. CNA 8 was asked to write and sign a statement and immediately suspended pending investigation. Resident J was assessed, found with no injury, and was monitored for psychosocial distress. The Administrator interviewed witnesses and contacted the police. A thorough investigation was completed, the facility reeducated all staff and began quality reviews to prevent further verbal abuse. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Abuse Prevention Program, provided by the Director of Nursing on 2/3/25 at 3:46 P.M., indicated: It is the policy of this facility to prohibit and prevent resident .Verbal abuse: any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability The past non-compliance deficiency began on 1/21/24 and deficient practice corrected on 1/22/25 after the facility suspended CNA 8's employment, reported the incident to IDOH as required, re-inserviced all staff on abuse prevention, and began quality monitoring to prevent recurrance. Resident J was assessed for injury with none found and psychosocial monitoring put into place. This Citation relates to Complaint IN00451712. 3.1-27(a)(b)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 37147 Based on interview and record review, the facility failed to ensure residents were free from misappropriation of property for 4 of 4 residents reviewed (Resident K, Resident L, Resident M, and Resident N). The deficient practice was corrected on 1/22/25 prior to the start of the survey and was therefore past non-compliance. Findings include: A facility-reported incident was submitted to the Indiana Department of Health on 1/10/25, which indicated potential misappropriation of resident property had occurred and the facility was investigating the allegation. On 2/3/25 at 3:10 P.M., the Director of Nursing (DON) was interviewed. She indicated she had been conducting routine compliance audits of controlled medication records when she noticed a pattern of administration. Licensed Practical Nurse 5 (LPN) administered opioid pain medications to residents with as needed orders for pain medication consistently and without assessment of pain prior to administration. The DON indicated LPN 5's documentation of administration was not completed according to facility policy and the administration records hadn't matched the controlled medication records but should have. During the compliance audits, the DON was notified, 1 opioid medication for Resident N hadn't been accounted for and the controlled medication record was off by 1 pill. 1. On 2/3/25 at 2:15 P.M., Resident K's record was reviewed. Diagnoses included status post pelvis fracture (9/24) and dementia. A physician order, dated 9/30/24, was for Oxycodone 5 milligrams (mg)-give 2 tablets every 4 hours as needed for moderate to severe pain. A Controlled Drug Record, initiated 10/18/24, indicated Oxycodone had been administered as ordered, 1 time on 10/23/24 by LPN 2. LPN 5 administered Oxycodone as ordered on 10/23/24, 11/3, 11/16, 11/20, 12/4, 12/7, 12/9, 12/15, 12/18, 12/23/24, 1/6/25, and 1/8/25. No other nurses administered Oxycodone to the resident. The Medication Administration Records (MAR), dated October 2024, November 2024 and December 2024 had no documentation to indicate Oxycodone had been administered to Resident K on dates the medication was signed out on the controlled drug record by LPN 5. 2. On 2/3/25 at 2:30 P.M., Resident L's record was reviewed. Diagnoses included heel wound. A physician order, dated 12/6/24, was for Hydrocodone-Acetaminophen 5-325 mg tablets-take 1 tablet every 6 hours as needed for moderate pain. A Controlled Drug Record, initiated 12/16/24, indicated LPN 5 administered Hydrocodone as ordered on 12/28/24 at 8:00 a.m., 1/6/25 at 8:00 a.m. and 1:30 p.m., and on 1/8/25 at 7:30 a.m. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Records, dated December 2024 and January 2025, had no documentation to indicate Hydrocodone had been administered to the resident on dates the medication was signed out on the controlled drug record by LPN 5. Resident L was interviewed by staff and police during the investigation. The resident indicated he hadn't asked for pain medication on 1/6/25 and hadn't remembered getting any. He indicated he only requested pain medication in the evenings/night time due to pain in his heel during those times. 3. On 2/3/25 at 3:00 P.M., Resident M's record was reviewed. Diagnoses included arthritis and chronic pain. A physician order, dated 3/1/23, was for Hydrocodone 10-325 mg-give 1 tablet by mouth every 4 hours as needed for moderate pain. A Controlled Drug Record, initiated 12/31/24, indicated Hydrocodone had been administered by LPN 5, on 1/8/25 at 3:30 p.m. A MAR, dated January 2025, had not indicated on 1/8/25 Hydrocodone had been administered by LPN 5. The MAR indicated no doses of Hydrocodone had been administered on 1/8/25. When questioned by staff, Resident M indicated she had not been give Hydrocodone on 1/8/25. Her last dose had been given on 1/7/25 around 9:00 p.m. by Nurse 3. The MAR and Controlled Drug Record indicated Hydrocodone had been signed out and administered on 1/7/25 at 9:07 p.m. 4. On 2/3/25 at 3:48 P.M., Resident N's record was reviewed. Diagnoses included pressure wound to back and buttocks. A physician order, dated 11/16/24, was for Norco 5-325 mg tablets-give 1 tablet every 8 hours as needed for severe pain. A Controlled Drug Record, initiated 11/22/24, indicated LPN 5 signed out Norco 1 tablet at 8:00 a.m. and 1:00 p.m. on 1/6/25 and on 1/8/25 at 10:30 a.m. The record indicated on 1/6/25 at 1:00 p.m., a Norco tablet was dropped and then wasted. LPN 5 signed their name but there was no second nurse signature as required for disposing of a controlled substance. An email sent to the DON, dated 1/9/25, indicated LPN 7 worked on 1/6/25 and had counted the controlled medications with off-going nurse, LPN 5. LPN 7 indicated the record had been off for Resident N's Norco. There were supposed to be 25 tablets but there were only 24 tablets in the card holding the medication. LPN 7 questioned LPN 5 about the discrepancy. She indicated she wasn't sure if she'd accidentally pulled it and given to someone else in place of theirs but all other narcotics were accounted for. LPN 5 indicated to LPN 7 she would just write that it had been dropped and ask the unit manager or DON to sign for it later. Both the unit manager and DON were seated at the desk by the medication cart where the 2 nurses were counting but LPN 5 hadn't asked either to sign for her at that time. LPN 7 reported the discrepancy to the DON and unit manager after LPN 5 left the building. A MAR, dated January 2025, had not indicated Norco had been administered by LPN 5 on 1/6/25 at 8:00 a.m. or at 1:00 p.m. The MAR hadn't indicated Norco had been administered by LPN 5 on 1/8/25 at 10:30 a.m. as signed out on the controlled drug record. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/25 at 3:59 P.M., the Administrator was interviewed. He indicated the DON had notified him of the discrepancy with the controlled medication count and the pattern of administration by LPN 5. The police were contacted and report completed. LPN 5 was immediately suspended. The facility pharmacy conducted a facility wide reconciliation of all controlled medications on all units/residents with no further discrepancies found. A current facility policy, titled Abuse Prevention Program, provided by the DON on 2/3/25 at 3:46 P.M., indicated: It is the policy of this facility to prohibit and prevent .misappropriation of resident property .is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongs or money without the resident's consent The past non-compliance deficiency began on 1/10/24 and deficient practice corrected on 1/22/25 after the facility suspended LPN 5, then reported the incident to IDOH as required. Resident K, Resident L, Resident M, and Resident N were assessed for pain with no adverse effects, all nursing staff were inserviced on misappropriation of property, reporting, and drug diversion and quality monitoring initiated to prevent recurrance. This Citation relates to Complaint IN00451002. 3.1-28(a)