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	03/30/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and evaluate smoking safety for 2 of 3 residents reviewed for accidents (Resident F and Resident H). The facility also failed to ensure the environment was free of accident hazards by not correcting bunched up and uneven carpet in a resident hallway creating a tripping hazard for residents. Findings include:1.a. A report, dated 3/25/26, indicated Resident F had a fall while smoking in the facility parking lot. The fall resulted in nose fractures and hematoma to the right knee. On 3/27/26 at 1:12 P.M., Resident F's record was reviewed. Diagnoses included Alzheimer's disease and nicotine dependence. A quarterly Minimum Data Set (MDS) assessment, dated 12/31/25, indicated Resident F had moderately impaired cognition. Quarterly Smoking Evaluations, dated 9/30/25 and 12/29/25, indicated the resident was not using smoking, nicotine, or tobacco products. Current care plans indicated she was at risk for falls, had impaired cognition due to dementia, at risk for abnormal bleeding due to use of anticoagulant medication, and was at risk for injury related to impaired vision. Interventions included: staff were to anticipate and meet her needs; assess the environment; make modifications as necessary to make the environment conducive to safety & on-going interaction; and keep area free from hazards. A care plan, dated 1/9/26 and revised on 3/29/26, indicated Resident F had a history of nicotine dependence but did not smoke while residing at the facility. She would occasionally smoke when going out with her family. The goal was for her to not smoke at the facility daily. Interventions included to ensure if resident brought in a lighter or cigarettes back from an outing, she would return them to the nurse; and she would be reminded periodically of the smoking policies. The revised care plan, dated 3/29/26, hadn't indicated Resident F was an everyday smoker, was safe to ambulate off the property to smoke, had staff interventions to ensure her safety off site, or observations to be made for continued physically and cognitively safe smoking. A change in condition form, dated 3/14/26 at 10:32 a.m., indicated Resident F had a fall with injuries. The resident indicated she had stood up, felt dizzy, lost her balance, and fell forwards. She was sent to the ER for evaluation and treatment and returned to the facility on 3/14/26 at 1:30 p.m. At the hospital she was diagnosed with facial fractures, traumatic hematoma to her right knee and bruises to her face, scalp, and neck. On 3/27/26 at 1:15 P.M., Resident F was interviewed. She indicated she had gone outside the entrance to the facility to smoke and had been sitting on her rolling walker. She went to stand up, and the pocket of her coat caught on the handle of her walker and she fell forwards, face down. She usually went to smoke across the parking lot to a nearby church, but it had been so windy that day, she had smoked outside the entrance of the building instead. She indicated it was a good thing she was near the entrance and another resident out smoking with her because she didn't know what she would've done without the other resident going in the facility to find someone to help her. She indicated she had smoked for many years and knew the facility was non-smoking. She had no issue with going across the parking lot to smoke off the property. A pack of cigarettes was observed sitting on the end table beside the resident. 1.b. On 3/30/26 at 2:05 P.M., Resident H's record was reviewed. Diagnoses included paralysis of lower extremities. An admission MDS assessment, dated 3/13/26, indicated Resident H (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was cognitively intact and did not use tobacco. An admission smoking evaluation, dated 3/6/26, indicated Resident H was not using smoking, nicotine, or tobacco products. A significant change smoking evaluation, dated 3/13/26 and signed off on 3/30/26, indicated Resident H was using tobacco products including cigarettes and vape pen. A care plan, dated 3/14/26, indicated Resident H had the potential for safety hazard and injury related to smoking. He was a smoker and the facility had a non-smoking policy. The goals were for the resident to not cause injury to himself or others due to smoking and to not smoke on facility grounds. Interventions included to provide the resident with a copy of the facility smoking policy and store smoking materials per facility policy. Resident H was observed several times during the survey, propelling himself in his wheelchair, up and down the halls and to the front of the facility entrance. During observations, he always had an odor of cigarette smoke about him. Leave of Absence sign in/out forms for Resident H were provided by a nurse on 3/30/26 at 2:25 P.M. The forms indicated beginning 3/10/26, the resident signed himself out multiple times per day, for approximately 20 minutes each time, to go smoke. On 3/30/26 at 2:25 P.M., Certified Nurse Aid (CNA) 5 was interviewed. When asked, she indicated on her hallway, there were 3 residents who smoked. Residents weren't allowed to smoke on the property because it was a non-smoking facility. Residents who smoked, would go across the facility parking lot, over to the next-door church parking lot to smoke. CNA 5 indicated the 3 residents were to sign themselves in/out on the LOA book and get their smoking materials from the nurse. She indicated the residents were to give back their smoking materials upon return and they weren't allowed to be kept in their rooms. When asked, she indicated sometimes residents hadn't returned their smoking materials and staff were to report it to the nurse. On 3/30/26 at 2:45 P.M., the Social Services Director (SSD) and Director of Nursing (DON) were interviewed. The SSD indicated Resident F had not had a smoking evaluation completed following her fall until 3/29/26. The smoking evaluation indicated the resident was safe to light up her own cigarette, hold it independently, and dispose of the ashes and cigarette safely. The SSD indicated Smoking Contract Agreements were completed with Resident F and Resident H on 3/27/26. The SSD and DON were asked how residents were assessed for safety when leaving to go off the property to smoke with no response. A current smoking policy was provided by the DON on 3/30/26 at 2:50 P.M., which indicated the following: Smoking was not permitted in every facility. If smoking was permitted, residents were to smoke only in designated outdoor smoking areas. If smoking was permitted at a facility, staff were to be assigned a time to be responsible for monitoring the smoking area. Staff were to ignite cigarettes for residents and to be present to monitor all residents for safety. Any change in resident competency for smoking was to be reported to the nurse. Smoking was not permitted during mealtimes. The policy hadn't indicated resident safety for going off the property would be assessed or where resident's who signed themselves out to smoke off property were permitted to smoke such as a local business parking lot near the facility. 2. On 3/27/26 at 10:40 A.M., during observation on the northwest rehabilitation hallway, carpeting in the middle of the hallway was bunched up, causing ripples in the carpet and a hazard for tripping. The bunched-up carpet was observed extending from room [ROOM NUMBER] to room [ROOM NUMBER]. 5 rooms were occupied with short-term stay residents. Staff and visitors were observed walking in the hallway with no residents observed. Confidential interviews conducted during the survey, indicated the following:1. The carpet in the hallway had been bunched up for some time and administration staff were aware of the problem.2. A resident had fallen in the hallway, where the bunched-up carpeting was, last year causing severe injuries.3. Mechanical lifts were difficult to get down the hallway because of bunched-up, uneven carpet.4. The bunch-up carpeting caused several people to trip with near falls.5. There was a plan to replace the carpet but the front entrance needed done first. On 3/27/26 at 3:15 P.M., the Administrator was interviewed. He indicated there were plans to replace the carpet but they couldn't do all the proposed changes at one time. He was not aware of any falls occurring in the area where the bunched-up carpet was located but would look into having the carpet stretched until it could be replaced. This Citation relates to Intake 2965357. 410 IAC 16.2-3.1-45(a)