STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155343	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lagrange	0770 North 075 East 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to ensure a resident's body was not exposed and visible to passersby for 2 of 8 residents reviewed (Resident 2, and Resident 8).Findings include:Findings include:1) In an observation, on 4/21/2026 at 8:53 AM, Licensed Practical Nurse (LPN) 2 lifted Resident 2's shirt exposing her abdomen and administered an injectable medication. Resident 2 was seated in a wheelchair in her room in full view from the hallway. The door to Resident 2's room was wide open. 2 unidentified residents were observed passing by the door glancing in the room during the time of preparation and administration. In an interview, on 4/21/2026 8:54 AM, LPN 2 indicated Resident 2's door should have been shut while Resident 2's abdomen was exposed for an injected medication.Resident 2's record was reviewed on 04/21/2026 at 11:35 AM. Diagnoses included Type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder and social phobia.A current significant change Minimum Data Set (MDS) assessment, dated 3/17/2026, indicated Resident 2 had a Brief Interview for Mental Status (BIMS) score of 12 (mild cognitive impairment).Physician orders, dated 1/30/2026, indicated Resident 2 should have Mounjaro 7.5 mg/0.5 ml injected weekly for type 2 diabetes mellitus with diabetic neuropathy.In an interview, on 04/21/2026 2:06 PM, The Assistant Director of Nursing (ADON) indicated a privacy curtain should be pulled or a door should be closed when an injectable medication was administered abdominally to provide privacy.A current policy, titled General Dose Preparation and Administration, dated 11/15/2024, provided by the Administrator on 4/21/2026 at 1:20 PM, indicated privacy rights should be observed during medication administration including using privacy curtains to avoid exposure.2) In an observation, on 4/20/2026 at 9:57 AM, Resident 8 was observed from the hallway, lying in bed. Resident 8 had no clothing on, with his upper body naked and exposed. Resident 8's room door was open, and the privacy curtain was not pulled to block the view from the hallway.In an observation, on 04/20/2026 at 1:43 PM, Resident 8 was observed from the hallway, lying in bed wearing a blue tee shirt and no pants with his lower body loosely covered with a sheet.In an observation, on 04/21/2026 at 9:01 AM, Resident 8 was observed from the hallway, unclothed, with a sheet covering from the waist down.Resident 8's record was reviewed on 4/20/26 at 11:03 PM. Diagnoses included athetoid cerebral palsy, torticollis, spastic quadriplegic cerebral palsy, unidentified intellectual abilities and aphasia.A current quarterly Minimum Data Set (MDS) assessment, dated 2/24/2026, indicated Resident 8 was rarely or never understood with severely impaired decision-making skills. A current care plan, titled ADL (Activity of Daily Living) self-care performance deficit, indicated Resident 8 had a problem of dependance on staff for ADL performance with a goal date of 6/10/2026. The care plan indicated Resident 8 was totally dependent for dressing tasks.In an interview, on 4/21/2026 2:03 PM, the Assistant Director of Nursing (ADON) indicated she did not know why Resident 8 was not wearing any clothing in bed.In an interview, on 4/22/2026 11:51 AM, the ADON indicated staff told her Resident 8 never wore clothing because family had not provided any.In an interview, on 4/22/2026 12:26 PM, the Administrator indicated Resident 8 had not worn a gown since admission, but she could not locate any notes indicating why. She indicated her staff could not recall any specific instructions on what Resident 8 should wear. A current policy, titled Resident Rights, dated 9/26/2025, provided (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the Administrator, on 4/22/2026 at 2:51 PM, indicated care should be provided in a manner to promote resident dignity.410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a Self-Administration of Medication assessment was completed for medication left at the bedside for 1 of 7 residents reviewed. (Resident 5) Findings include: During an observation, on 4/22/2026 at 11:04, LPN 2 placed a cup with one 500 mg acetaminophen tablet and a cup of water in front of Resident 5. LPN 2 left the room and did not maintain visual observation when Resident 5 consumed the acetaminophen tablet.A record review for Resident 5 began on 4/23/2026 at 1:19 PM. Diagnoses included gout, pain in both legs, depression, post-traumatic stress disorder, and dysphagia (difficulty swallowing).A review of Resident 5's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact).A review of physician orders, dated 2/1/26 at 11:13 PM, indicated one 500 mg acetaminophen tablet was scheduled to be administered three times a day for pain. The order did not indicate Resident 5 was able to self-administer the medication.A review of clinical assessments, dated 1/1/25-4/24/26, indicated a Resident Medication Self-Administration Assessment had not been completed for Resident 5.In an interview, on 4/22/2026 at 11:40 AM, the Director of Nursing indicated staff were to watch the administration of medication for each resident. Residents may administer their own medication when a Self-Administration Assessment had been completed and was determined to be appropriate for an individual resident, or when an order was in place for a resident to self-administer a specific medication.A current policy, dated 12/1/07, provided by the Director of Nursing, indicated staff administering medication were to observe the resident's consumption of the medication.410 IAC (Indiana Administrative Code 3.1-11(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure bed hold policy notification was provided to resident emergency contacts for 2 of 3 residents reviewed (Resident 5 and Resident 57).Findings include: Resident 5's record was reviewed on 4/23/26 at 9:45 AM. Diagnoses included chronic kidney disease, diabetes and seizure disorder.Resident 5's quarterly Minimum Data Set, (MDS) dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 15 (no cognitive deficit).A progress note, dated 1/23/26 at 6:30 PM, indicated a physician had ordered Resident 5 to be transferred to the hospital for evaluation. The progress note indicated Resident 5 was not responding.An Indiana Bed Hold Notification, signed and dated by Resident 5 on 1/23/26, indicated the resident did not request their bed to be held during their absence.In an interview, on 4/23/26 at 10:11 AM, the Administrator indicated Resident 5 was the responsible party for themselves. The Administrator indicated Resident 5's sister was their durable power of attorney. The Administrator indicated Resident 5's sister was their emergency contact.In an interview, on 4/23/26 at 11:30 AM, the Administrator indicated Resident 5's sister should have been contacted if the resident was not responding.2. Resident 57's record was reviewed on 4/23/26 at 10:10 AM. Diagnoses included atrial fibrillation, (irregular heartbeat) lumbar fracture, lumbar spine wound dehiscence, (split open) and malnutrition.Resident 57's discharge Minimum Data Set (MDS), dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 5 (severe cognitive impairment).Resident 57's care plan, dated 3/2/26, indicated the resident had severe cognitive impairment.A progress note, dated 3/3/26 at 1:52 PM, indicated Resident 57 had been transferred to the hospital. The progress note indicated the bed hold policy was sent with the Emergency Medical Technician. The progress note indicated Resident 57's emergency contact had been made aware of the hospital transfer. The progress note did not indicate Resident 57's emergency contact had been made aware of the facility's bed hold policy.A Transfer Form, dated 3/3/26, indicated Resident 57's emergency contact had been made aware of the resident's transfer to the hospital. The transfer form did not indicate the emergency contact had been made aware of the bed hold policy.An Indiana Bed Hold Notification, signed and dated by Resident 57 on 3/33/26, indicated the resident did not request their bed to be held during their absence.In an interview, on 4/23/26 at 11:30 AM, the Administrator indicated Resident 57 was cognitively impaired. The Administrator indicated Resident 57's emergency contact should have been notified of the bed hold policy.No facility policy was available for review at the time of exit from the facility.