STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155183	A. BUILDING 00 B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MARTINSVILLE, THE	2055 HERITAGE DR MARTINSVILLE, IN 46151

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00456968 and IN00456323. Complaint IN00456968 - Federal/State deficiencies related to the allegations are cited at F580, F655, and F689. Complaint IN00456323 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: April 15 and 16, 2025 Facility number: 000096 Provider number: 155183 AIM number: 100290890 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 3 Medicaid: 23 Other: 24 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 23, 2025.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/5/2025. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 5/5/2025.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure the physician was notified of the x-ray results for 1 of 3 residents reviewed for	F 0580	It is the intent of this facility to immediately inform the resident; consult with the resident's	05/05/2025

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

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	accidents. (Resident B) Findings include: On 4/15/25 at 11:24 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, history of healed traumatic fracture, unsteadiness on feet, abnormal gait, osteoarthritis, and osteoporosis. Resident B's progress notes indicated the following: - On 3/23/25 at 3:00 p.m., Resident B had tried to get up out of the bed to the use the bathroom. She leaned on the bedside table and fell to the floor. She had left arm pain. The NP (nurse practitioner) was notified. New orders were received for x-ray of left arm and to notify the clinician of any change in condition. - On 3/23/25 at 10:30 p.m., the physician was notified of the x-ray results. The documentation lacked how the physician was notified. During an interview on 4/16/25 at 10:58 a.m., LPN 2 indicated she worked on 3/23/25 when Resident B fell. She notified the NP of Resident B's complaint of left arm. The NP ordered an x-ray. When the x-ray results came in around 10:30 p.m., she placed the results in the physician binder. She did not call the physician. She only worked weekends and did not know when the physician would see the x-ray results in the binder. On 4/16/25 at 2:05 p.m., the Administrator provided the facility's policy, "Change in Resident's Condition or Status," undated, and		physician; and notify, consistent with his or her authority, the resident representative when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. **1 CORRECTIVE ACTION:** Resident B no longer resides at this facility. **2 IDENTIFICATION OF OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected. Therefore, the plan of correction applies to all residents of the facility. **3 MEASURES TO BE PUT INTO PLACE AND SYSTEMIC CHANGES TO BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT OCCUR.** DON/Designee completed an audit of current resident charts with accidents involving injury and has the potential for requiring physician intervention on 5/5/2025 to ensure all appropriate notifications have been completed. An in-service was completed by DON/Designee for nursing staff on completion of notification of change in resident's condition/status/treatment on 5/5/2025. Any staff that fail to comply with the points of the in-service will be further educated	

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	indicated it was the policy currently being used by the facility. A review of the policy indicated, "...1. The nurse will notify the resident's attending physician when:..An abnormal x-ray result or a worsened x-ray result of a previously know injury or disease process..." This citation relates to Complaint IN00456968. 3.1-5(a)(1)		and/or disciplined as indicated. **4 HOW THE CORRECTIVE ACTION WILL BE MONITORED:** The interdisciplinary team will review all incidents/accidents/and change of condition in daily clinical meeting to ensure all notifications and documentation is in place. This practice will be ongoing. IDT will complete a review of the 24-hour report daily in CQI to identify any incidents/change of condition that require immediate physician notification and will ensure that timely notification was made. Audits to be conducted 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95 % compliance at the end of 6 months the auditing will be stopped. Results of monitoring will be reviewed in QAPI meeting. Any concerns will be addressed. Any needed action plan will be written by QAPI committee. Any written action plan will be monitored by the DON weekly until resolved.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on interview and record review, the facility failed to ensure the baseline care plan was implemented for 1 of 3 residents reviewed for	F 0655	It is the intent of this facility to initiate a baseline care plan within 48 hours, for each resident that	05/05/2025

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	accidents. (Resident B) Findings include: On 4/15/25 at 11:24 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, history of healed traumatic fracture, unsteadiness on feet, abnormal gait, osteoarthritis, and osteoporosis. The hospital History and Physical note, dated 3/6/25 at 7:27 p.m., indicated Resident B had osteoporosis and compression fracture of the lumbar and thoracic spine. Resident B was on fall precautions. The Baseline Care Plan, dated 3/13/25, lacked documentation of resident having a history of falls or resident's signature. The Fall Risk Review indicated the following: - On 3/13/25 at 10:26 p.m., the review indicated a high risk for falls. - On 3/24/25 at 4:27 a.m., the review indicated high risk for falls. During an interview on 4/15/25 at 11:57 a.m., the Director of Nursing (DON) indicated she presented all Resident B's care plans. At that time, a review of the care plans lacked a high risk for falls care plan. On 4/16/25 at 2:05 p.m., the Administrator provided the facility's policy, Baseline Care Plan Assessment/Comprehensive Care Plans, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...1. Upon admission to the facility, the		includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. **1 CORRECTIVE ACTION:** Resident B no longer resides at this facility. **2 IDENTIFICATION OF OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED:** All residents who reside at this facility have the potential to be affected by the alleged deficient practice. **3 MEASURES TO BE PUT INTO PLACE AND SYSTEMIC CHANGES TO BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT OCCUR:** DON/Designee completed an audit of all Baseline Care Plans on 5/5/2025. Any concerns were addressed, and corrections made if needed. Within 72 hours following a new admission of a resident the baseline care plan will be reviewed/discussed and revised as needed by the Interdisciplinary Team at the CQI meeting. The Baseline Care Plan will continue to be revised until the final completion of the Comprehensive Care Plan. The baseline care plan shall include a history of possible risks as well as the resident's/responsible party	

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	admitting nurse will initiate the Baseline Care Plan Assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions...2. Within 72 hours following the admission of the resident, the Baseline Care Plan Assessment will be reviewed/discussed and revised as needed by the IDT [Interdisciplinary Team] team at the Morning Meeting/CQI (Clinical Quality Indicator) Meeting. The Baseline Care Plan will continue to be revised until the final completion of the Comprehensive Care Plan..." This citation relates to Complaint IN00456968.		signature. An in-service was completed on 5/5/2025 by DON/Designee for nursing staff regarding initiation of and proper completion of Baseline Care Plan. Any staff that fail to comply with the points of the in-service will be further educated and/or disciplined as indicated. **4 HOW THE CORRECTIVE ACTION WILL BE MONITORED:** The Interdisciplinary Team will review all new admissions in the daily clinical meeting to ensure Baseline Care Plans have been initiated. Any corrections will be made by clinical team at that time. This practice will be ongoing. Audits to be conducted 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95 % compliance at the end of 6 months the auditing will be stopped. Results of monitoring will be reviewed in QAPI meeting. Any concerns will be addressed. Any needed action plan will be written by QAPI committee. Any written action plan will be monitored by the DON weekly until resolved.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices A. Based on interview and record review, the	F 0689		05/05/2025

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	facility failed to provide supervision to prevent repeated falls for a resident assessed to be a high risk for falls for 1 of 3 residents reviewed for accidents. This deficient practice resulted in a resident sustaining fractures of the wrist and hand and hospitalization for decreased mobility in lower extremities. (Resident B) B. Based on interview and record review, the facility failed to ensure a resident with an assessed behavior of wandering and a high risk of elopement was provided treatment and services to prevent an elopement which resulted in the resident going through an unlocked door and getting outside without staff knowledge for 1 of 3 residents reviewed for elopement. (Resident C) Findings include: A1. On 4/15/25 at 11:24 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes, osteoporosis (a condition where bones become weak and brittle), osteoarthritis (occurs when flexible tissue at the ends of bones wears down), and history of a healed traumatic fracture. A hospital history and physical, dated 3/6/25 at 7:27 p.m., indicated Resident B had a diagnosis of osteoporosis and compression fracture from a fall in February 2025. Documentation indicated resident had fall precautions. A physician's order for Resident B, dated 3/13/25, indicated up ad lib (able to move and mobilize freely) with assistance. The baseline care plan for Resident B, dated 3/13/25, lacked documentation of resident being at high risk for falls or interventions to prevent falls.		The request for IDR for this citation F689, is to reduce the scope and severity of the citation. It is the intent of this facility to ensure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent hazards. **1 CORRECTIVE ACTION:** Resident B no longer resides at this facility. Resident C's family declined placement on secure unit. A Wander Guard Band was placed on resident and Magnetic Lock on Exit door was repaired by Safe Care on 3/26/2025. DON/Designee updated Resident C's elopement risk assessment on 3/26/2025. **2 IDENTIFICATION OF OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED:** All residents who admit to this facility could have the potential to be affected by the alleged deficient practice. **3 MEASURES TO BE PUT INTO PLACE AND SYSTEMIC CHANGES TO BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT OCCUR:** SSD/Designee completed a review of all residents' elopement assessments and ensured	

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	The Admission MDS (Minimum Data Set) assessment, dated 3/18/25, indicated the resident had moderately impaired cognition, had history of falls on admission and had falls since admission. A Progress Note, dated 3/13/25 at 10:15 p.m., indicated the resident slid off her bed while attempting to stand. The fall was witnessed and an assessment was completed with no injuries or reports of pain. The physician and family were notified. A Fall Risk Assessment, dated 3/13/25 at 10:26 p.m., indicated Resident B was assessed as high fall risk due to ambulation, elimination, gait and balance. A Progress Note, dated 3/14/25 at 2:42 p.m., indicated an IDT (interdisciplinary team) Fall follow up, indicated the resident slid off the bed while attempting to get up. The resident was assessed and not observed to be injured. The care plan was reviewed and updated and a new intervention for a scoop mattress was added. A Progress Note, dated 3/23/25 at 3:00 p.m., indicated the resident had an unwitnessed fall and complained of left arm pain. The on-call physician was contacted and new orders were received as follows: x-ray of left extremity (hand, wrist and elbow), fall precautions, assess pain, monitor neurological checks and notify a clinician of any change in condition. The x-ray report for Resident B, dated 3/23/25 at 8:04 p.m., indicated the following the left hand demonstrated an oblique fracture (break that occurs at an angle across the bone's length) of the midshaft of the fourth metacarpal (a break in the		interventions to prevent elopement were in place on 3/26/25. All exit doors were checked for proper functioning on 3/26/2025 and will be checked each day on all shifts by Maintenance Director/Designee. This will be ongoing. DON/Designee completed a review of all current resident fall assessments and fall documentation in the last 30 days on 5/5/2025. Any residents that triggered as a high fall risk had their fall prevention interventions reviewed, and care plans updated on 5/5/2025. DON/Designee completed an in-service for staff on 5/5/2025 which included fall assessment completion upon admission, elopement assessment completion upon admission, implementation of elopement interventions, review of fall prevention program, and required documentation as it relates to accidents/incidents, supervision and assistance devices to prevent hazards. Any staff that fail to comply with the points of the in-service will be further educated and/or disciplined as indicated. **4 HOW THE CORRECTIVE ACTION WILL BE MONITORED:** All new admissions will be reviewed daily in CQI to ensure elopement assessments, fall assessments, and appropriate	

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	middle of the bone in the hand that connects to the ring finger). There was an acute fracture of the torus variety (causes one side of the bone to bend, but does not actually break through the entire bone) in the distal left radius (the lower end of the radius bone in the forearm, located nearest the wrist). No other fractures are noted. A Progress Note, dated 3/23/25 at 10:30 p.m., indicated the physician was notified of x-ray results. The clinical record lacked documentation of any new orders or interventions after x-ray results were received. A Progress Note, dated 3/24/25 at 3:30 a.m., indicated the resident was assisted to the restroom by CNA 1. The resident was incontinent and slipped on the wet floor. CNA 1 lowered the resident to floor and called for assistance. LPN 4 went to the resident's room to assist CNA 1. The resident was unable to stand from a seated position and they placed a sheet under her and transferred her back to bed. The resident had no complaints of pain and neurological checks were with in normal limits. A Fall Risk Assessment, dated 3/24/25 at 4:27 a.m., indicated Resident B was assessed as a high fall risk due to history of falls, ambulation, elimination, gate and balance. On 3/24/25 at 3:40 a.m., a Change in Condition Summary was sent to the provider due to the fall. The summary indicated the resident had weakness in bilateral lower extremities, was unable to stand, and recommend a physical therapy evaluation. The primary care feedback indicated that there were no new interventions, testing, or		interventions and supporting documentation is in place. IDT will review all 24-hour reports, incident reports, and change in condition daily in CQI. Care plans will be updated as indicated at that time. Audits to conducted 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months the auditing will be stopped. Results of monitoring will be reviewed in QAPI meeting. Any concerns will be addressed. Any needed action plan will be written by QAPI committee. Any written action plan will be monitored by the DON weekly until resolved.	

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	recommendations applicable. On 3/24/25 at 8:33 a.m., a Change in Condition Summary was sent to the provider due to altered mental status and new neurological signs. The provider recommended the resident be sent to the emergency room. On 3/24/25 at 10:09 a.m., a late entry nursing note indicated, at 7:30 a.m., LPN 5 entered resident's room and noticed the resident was confused, had slurred speech and could not open her right eye all the way. Neurological checks were completed and the resident could not feel or move her legs. The resident complained of abdominal and low back pain. Emergency Medical Services were called and resident was transferred to the emergency room. The clinical record lacked documentation of an IDT note after Resident B's falls on 3/23/35 and 3/24/25. During an interview on 4/15/25 at 11:57 a.m., the DON indicated that resident was admitted to the facility due to a urinary tract infection and history of spinal injury from a previous fall. The DON indicated that Resident B was walking with a CNA on 3/24/25 when her legs became weak and the resident was lowered to the floor. The DON indicated that the resident was unable to stand, so the staff placed a sheet under Resident B to take her back to bed. The DON indicated they did not send the resident to the hospital due to she was lowered to the floor, her neurological checks were normal and she did not complain of pain. The DON indicated that the resident was now paralyzed. During an interview on 4/15/25 at 2:33 p.m., CNA 1			

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	indicated she had assisted Resident B to the restroom on 3/24/25. CNA 1 indicated that Resident B had tingling and numbness occasionally in her legs. CNA 1 indicated she asked the resident if she was experiencing any tingling or numbness and the resident denied having any. CNA 1 indicated that Resident B ambulated with a walker. CNA 1 indicated while walking Resident B to the restroom, the resident complained of left leg pain and tingling, CNA 1 indicated she had resident sit on the seat of her walker and pushed her to the restroom. CNA 1 indicated the resident was able to stand and pivot to the commode but started to urinate while standing. CNA 1 indicated the resident's right foot was sliding and she lowered the resident to the floor. CNA 1 indicated she called for assistance and LPN 4 came to assist her, she indicated that they were unable to get a mechanical lift into the restroom, so they placed a sheet under Resident B and carried her back to bed. During an interview on 4/16/25 at 9:52 a.m., LPN 5 indicated she had received report on 3/24/25 at approximately 6:30 a.m. LPN 5 indicated it was reported that Resident B had a fall during the night. LPN 5 indicated that when LPN 5 went to Resident B's room to check her blood sugar LPN 5 noticed the resident was confused and not acting like herself. LPN 5 indicated the resident complained of low back pain and stomach pain. LPN 5 indicated the resident was unable to move her legs and could not feel the nurse touching them. LPN 5 indicated she called 911 and the ambulance arrived at approximately 8:00 a.m. During an interview on 4/16/25 at 10:58 a.m., LPN 2 indicated she had worked on 3/23/25 when Resident B had slid off her bed. LPN 2 indicated that Resident B complained of wrist and hand pain			

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	after the fall. LPN 2 indicated she called the provider on call and received an order for an x-ray. She indicated at approximately 10:30 p.m., LPN 2 notified the family, the DON and Executive Director (ED) of the results. LPN 2 indicated she placed the x-ray results in the provider binder at the nurses station. LPN 2 indicated she did not call the provider on call with the results. LPN 2 indicated she was unsure when the medical providers looked at the binder because she only worked Saturdays and Sundays. During an interview on 4/16/25 at 2:05 p.m., the ED indicated there was no IDT note or root cause analysis completed after falls on 3/23/25 or 3/24/25, for Resident B. On 4/15/25 at 12:53 p.m., the DON provided the facility's policy "Guidelines for Incidents/Accidents/Falls," dated 6/30/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately...a written report will be entered into Risk Management...information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible...6. The incident/accident report will be completed as soon as information is obtained...11. All falls will have a site investigation by appropriate staff in an effort to define the root cause of the fall...15. Based on results of the incident/accident/fall, the resident's care plan will be addressed...with appropriate interventions in place..."B1. Resident C's clinical record was reviewed on 4/15/25 at 12:38 p.m. The diagnosis included, but was not limited to, Lewy Bodies dementia.			

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	The Elopement Risk Review form, dated 2/19/25, for Resident C indicated the resident was assessed as being a high risk for elopement. A care plan, initiated on 10/2/23, for Resident C indicated, " ...Focus: Resident is at risk for wandering ... Goal: Resident will have no injuries related to wandering daily ... Interventions: Document any wandering activity and interventions attempted ... Notify and update MD/NP [medical doctor/nurse practitioner] and family of any changes in wandering activity ... Provide resident with food, drink, offer toileting, walk with resident and offer other activities ..." A review of a State Reportable on Resident C indicated, on 3/26/25 at 11:01 a.m., staff observed the resident in a wheelchair immediately outside of the exit door. Staff immediately accompanied the resident inside the facility without incident. Resident was wearing appropriate clothing and footwear. The follow up on 4/4/25 indicated, the exit door mag lock failed and the resident was able to exit. A review of nursing progress notes on Resident C indicated, on 3/26/25 at 11:34 a.m., the resident was unable to be evaluated by the skin and wound team due to resident being out of the room and was unable to be located. The progress notes lacked documentation of an incident where Resident C was found outside of the exit door on 3/26/25. During an interview on 4/15/25 at 2:30 p.m., the DON indicated she was on vacation when Resident C eloped but she believed it to be in the daytime. He was in a wheelchair and rolled down the unit that was closed and not used for residents. The lock was not working and he was			

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	155183	A. BUILDING 00 B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MARTINSVILLE, THE	2055 HERITAGE DR MARTINSVILLE, IN 46151

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	able to get out. She was unsure how long he had been outside but believed the weather to be nice that day. The facility did do an incident report but did not make a note in the nursing progress notes. During an interview on 4/16/25 at 9:30 a.m., Physical Therapist 1 indicated she found Resident C outside the door in the back on the hallway with no residents sometime before noon on 3/26/25. The wound care team had been looking for him and couldn't find him. She went looking and decided to try the back door on the closed unit. He was sitting outside unharmed. She was unsure how long he had been outside. During a tour on 4/16/25 at 10:26 a.m., the closed unit was observed to have two closed doors with a sign indicating the unit was closed. A door at the end of the hallway was observed to lead out to a porch with a ramp directly behind the backside of the smoking shack used by residents. No residents or staff were observed to be in the area at the time. During an interview on 4/16/25 at 11:02 a.m., the Administrator indicated she was unable to locate nursing progress notes related to Resident C's elopement on 3/26/25. During an interview on 4/16/25 at 11:25 a.m., LPN 1 indicated she had checked Resident C's blood sugar at approximately 9:00 a.m. on 3/26/25, and would have checked it again around 11:00 or 11:30 a.m., that same morning. She did not remember seeing him between those times. During an interview on 4/16/25 at 11:34 a.m., LPN 3 indicated she had been telling the facility for quite some time the back door lock was not working and she had seen Resident C attempting to get			

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	through the doors to the closed unit many times. He had indicated to her, "I'm an escapee you know." On 4/16/25 at 11:11 a.m., the Administrator provided the policy, "Policy and Procedure for Personal Safety Devices for Resident at Risk of Elopement, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs ... 6. All ... exit doors alarms will be tested every shift to verify that each device and door alarm are functioning properly ..." This citation relates to Complaints IN00456323 and IN00456968. 3.1-45(a)(2)			