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	10/03/2024

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 Complaint IN00444218. Complaint IN00444218 - Federal/State deficiencies related to the allegations are cited at F686 and F580. Survey date: October 3, 2023. Facility number: 000096 Provider number: 155183 AIM number: 100290890 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 2 Medicaid: 31 Other: 19 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 7, 2024.	F 0000		
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 notify physician of a resident's change in condition for 1 of 3 residents reviewed for medication administration. The physician was not notified of resident refusal to take medication or increased behaviors. (Resident C)	F 0580	**F- 580** **It is the policy of this facility to notify the physician of a residents change of condition.** 1 **What corrective action(s)**	10/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Wilson	Administrator	10/17/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Findings include: On 10/3/24 at 10:34 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder, paranoid personality disorder, bipolar, and insomnia. A review of the resident's physician's orders indicated the following: - On 7/29/24 the resident was prescribed divalproex (an anticonvulsant medication indicated for the treatment of the manic episodes associated with bipolar disorder) extended release (ER) 1500 milligrams (mg) at bedtime for bipolar disorder. The medication was discontinued on 8/18/24. - On 8/26/24 the resident was prescribed divalproex sodium ER 1500 mg at bedtime for bipolar disorder. The medication was discontinued on 9/18/24. - On 9/27/24 the resident was prescribed divalproex sodium ER 500 mg three times a day (10:00 a.m., 2:00 p.m., and 8:00 p.m.) for bipolar disorder. A review of the progress notes indicated the following: - On 8/1/24 at 9:35 p.m., the resident refused his medications. A representative for the resident was notified and they informed the staff that he had done this before and did not know what caused it. - On 8/4/24 at 12:26 p.m., the resident demanded ice-cream and was reminded by the staff they did		**will be accomplished for those residents found to have been affected by the deficient practice?** **Resident C MAR was reviewed, physician notified of refusals of medication by the DON/Designee on 10/4/24.** 2 **How other residents having the potential to be affected by the safe deficient practice will be identified and what corrective action(s) will be taken?** **All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. The DON/Designee completed a 30 day look back of current residents EMAR for refusals of medications and the physician was notified as indicated on 10/17/24.** 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **An in-service has been completed by the DON/Designee on 10/10/24 for all nurses on the Guidelines for Notification of Change in residents' condition/status/treatment and refusal of medications.**	

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	not have any. He became agitated, was rude to staff, and caused a disruption. - On 8/4/24 at 1:21 p.m., the resident demanded to go outside to smoke while the CNA's provided care to other residents. The CNA's told him he would need to wait while staff provided care to other residents. The resident became highly agitated, screamed, slammed the table, stomped down the hall, threatened staff, and threatened to call the police to press charges. - On 8/10/24 at 3:30 a.m., the resident was agitated, yelling, talking and laughing to himself at the same time. The staff approached him, but they were unable to understand what he murmured to himself. He was observed to take pictures of the staff at the nurses' station while he laughed hysterically. He remained awake all night. - On 8/12/24 at 12:46 a.m., when the resident was in his bed, he screamed as loud as he could, urinated all over his bed and the floor, and verbally abused two CNA's while they tried to clean him up. He demanded money from the staff and for them to get him food that was not available at the facility. He was cleaned up, encouraged to sit by the nurses' station, and given a drink and a snack. The interventions did not work. He continued to be verbally aggressive with the staff and mumbled obscenities to himself about the staff and services provided. - On 8/13/24 at 5:34 a.m., the resident had been yelling, teasing, and taunting staff all night. He requested cigarettes every hour and stated it was his behavior to be loud. The resident's behavior got worse at 3:00 a.m., with continued yelling, which woke up and upset the other residents. He threatened staff by saying he would cut their		**Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** **The DON/Designee will audit the EMAR of 10 random residents a week for 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months for refusals of medications and notification of physician. If the facility is within 95% compliance at the end of 6 months, then monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.** **5. By what date systemic changes for each deficiency will be completed?** **October 20, 2024**	

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	heads off. He was seen talking to himself, yelling, and slamming his bedroom door. He waited at the nurses' station to eat breakfast and leave the building. - On 8/15/24 at 7:08 p.m., the resident was overhead telling the Qualified Medication Aide (QMA) he would not take his Depakote (divalproex sodium) and he had not taken it for four days. - On 8/15/24 at 7:24 p.m., another resident's family member went up to the nurse and told them the resident walked across the hall into their room with just a sweatshirt on and nothing below (the sweatshirt). The resident shouted to the family he needed a brief and demanded they get him one. When the resident left the room he vehemently shouted curse words indicating he needed a brief. When he was redirected by staff he continued to use curse words and stated the staff needed to do their jobs. - On 8/15/24 at 11:39 p.m., the resident cussed and yelled at the staff for most of the evening. The resident believed a cup at the nurses' station was his and demanded the staff to get it for him. When staff told him it was staff member's personal cup and not his coffee, he continued to yell and curse for 15 minutes. - On 8/16/24 at 11:51 a.m., the Social Services Director (SSD) spoke with the Veterans Administration (VA) social worker who suggested the staff send the resident to VA psychiatry for stabilization. The resident had a history of psychotic behavior and would continue to ramp up. Per the VA social worker, he was manic, psychotic, and needed psychiatric hospitalization.			

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	- On 8/16/24 at 1:29 p.m., the resident was picked up by an ambulance and transported to VA emergency department for manic/psychotic episodes. - On 8/26/24 at 2:35 p.m., the resident arrived back to the facility from the VA hospital. - On 9/30/24 at 10:16 a.m., the resident refused Depakote, stated he would not take it, and preferred the psychiatric provider would prescribe something different. - On 10/2/24 at 10:09 a.m., the resident refused Depakote and continued to verbalize he would not take it. - On 10/2/24 at 3:06 p.m., the resident refused Depakote and stated he would not take it. - On 10/3/24 at 11:26 a.m., the resident continued to refuse Depakote. A review of the resident's EMAR (Electronic Medication Administration Record) indicated during the month of August, 2024, the resident received his divalporex medication 5 times from 8/1/24 to 8/15/24. He was sent to the VA hospital on 8/16/24. The September, 2024, EMAR indicated he received his divalporex medication 14 times from 9/1/24 to 9/26/24. On 9/27/24 his order was updated to divalporex 500 mg, 3 times a day. From 9/27/24 to 9/30/24 he received 6 out of 12 doses of medication. The resident's October, 2024, EMAR indicated he received 3 out of 8 doses of the divalporex medication.			

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	On 10/3/24 at 3:45 p.m., during an interview with the Director of Nursing (DON) she indicated she was not sure of the facility's policy in regard to residents refusal of medication. However, she believed it staff should call the physician after three refusals. On 10/3/24 at 4:54 p.m., the DON provided the facility policy, "Change in Resident's Condition or Status," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 1. The nurse will notify the resident's attending physician when: ... The resident repeatedly refuses treatment or meds (2 times consecutively or 3 times in a 7 day period) ..." This citation relates to Complaint IN00444218. 3.1-5(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to ensure care was provided consistent with professional standards of practice for 1 of 3 residents reviewed for pressure ulcers. Treatment orders were not implemented. (Resident B) Findings include: On 10/3/24 at 11:10 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's Disease and depression. A Wound Assessment Report, dated 9/11/24, indicated a stage 3 pressure wound on the	F 0686	**F- 686** **It is the intent of this facility to ensure care is consistently provided with professional standards of practice.** 1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Resident B orders were reviewed, all pending orders confirmed and activated.** **I would suggest here: The**	10/20/2024

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	resident's coccyx was discovered on 9/11/24 during the resident's stay at the facility. The treatment recommendations were to daily cleanse the wound with normal saline, apply collagen particles, and cover with bordered gauze. A Wound Assessment Report, dated 9/18/24, indicated the treatment recommendations were to cleanse the wound with normal saline, apply collagen particles, and cover with a transparent film dressing 3 times a week and as needed. A Wound Assessment Report, dated 9/25/24, indicated the treatment recommendations were to cleanse the wound with normal saline, apply collagen particles, and cover with a transparent film dressing 3 times a week and as needed. The Medication Administration Record and Treatment Administration Record (MAR/TAR) indicted no order for treatment was entered for the 9/11/24 and 9/18/24 Wound Assessment Report treatment recommendations. A physician's order, dated 9/26/24, was entered for the 9/25/24 Wound Assessment Report treatment recommendations and indicated the wound was to be cleansed with normal saline, collagen particles applied, and covered with a transparent film 3 times a week and as needed. The MAR/TAR indicated no treatment was administered during the period of time from the 9/11/24 discovery of the wound until treatment was documented on 10/1/24. During an interview on 10/3/24 at 3:40 p.m., the Director of Nursing indicated treatment orders for the pressure wound may not have been entered properly by staff.		**DON/Designee assessed on 10/1/24, no negative outcome related to the cited practice. Treatment orders were entered on EMR on 10/1/2024.** 2 **How other residents having the potential to be affected by the safe deficient practice will be identified and what corrective action(s) will be taken?** **The DON/Designee completed an audit on 10/17/24 of residents with alteration is skin integrity and verified treatment order were entered in the EMAR/ETAR.** 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **An in-service has been completed by the DON/Designee on 10/10/24 with the wound nurse and nurse staff on properly entering new orders and confirming those new orders. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put**	

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	During an interview on 10/3/24 at 3:50 p.m., the Administrator indicated the treatment orders for the pressure wound had been entered into the clinical record, however the entry had been electronically placed in a cue and not activated. This citation relates to Complaint IN00444218. 3.1-40(a)(2)		**into place?** **The DON/Designee will audit residents with pressure ulcers to verify treatment orders have been confirmed and on EMAR/ETAR for nurses to complete 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% complaint at the end of 6 months, then monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.** **5. By what date systemic changes for each deficiency will be completed?** **October 20, 2024**	