STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155183	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Martinsville, The	2055 Heritage Dr Martinsville, IN 46151

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34848 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) 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 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. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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 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 . - 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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. 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)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36912 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 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. 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)