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	09/29/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents were informed of and participated in their treatment plan for 1 of 2 residents reviewed for mood and behavior. (Resident 36)Finding includes:On 9/25/25 at 2:19 p.m., Resident 36's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety disorder, depression, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and dementia.A review of the resident's physician orders indicated from 7/31/25 to 8/12/25 the resident was prescribed Risperdal (antipsychotic medication) 0.5 milligrams (mg) twice daily for bipolar episodes. On 8/13/25, an order indicated the Risperdal was increased to 1 milligram (mg) twice daily.The clinical record lacked an informed consent for the increase of the antipsychotic medication on 8/13/25.During an interview with the Director of Nursing (DON) on 9/26/25 at 11:34 a.m., she indicated there was no documentation that an informed consent was provided prior to the resident receiving the increased dose of Risperdal.On 9/29/25 at 9:45 a.m., the Administrator provided a copy of the facility's Guidelines for psychotropic medication, dated 6/25/23, she indicated this was a current policy used by the facility. The guideline indicated, .Obtain Informed Consent .from the resident and/or resident representative as appropriate, and document education to include: .c) side effects/adverse consequences, d) risks vs Benefits .f) dose changes-if they occur, g) Document this education and form completion in Nurses' Notes .3.1-3(n)(2)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the residents right to be free from physical and verbal abuse by another resident for 1 of 2 residents reviewed for abuse. (Resident 4, Resident 18)Findings include:On 9/24/25 at 10:12 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to depression, anxiety, and post-traumatic stress disorder.An 9/16/25 annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.During an interview on 9/29/25 at 11:16 a.m., CNA 3 indicated Resident 4 was often aggressive with staff and other residents. She was aware of Resident 4 hitting Resident 18 on the head. During an interview on 9/29/25 at 11:20 a.m., LPN 2 indicated Resident 4 had an aggressive affect and she was aware of Resident 4 hitting Resident 18 on the head. During an interview on 9/29/25 at 12:10 p.m., the Administrator (ADM) indicated Resident 4 struck Resident 18 in the face after an altercation. Resident 18 shouted at another resident to stop screaming and Resident 4 went across the hallway and entered into Resident 18's room. The two residents shouted at each other and Resident 18 hit Resident 4 on the head, causing skin tears. She indicated Resident 4 was more cognitively intact than Resident 18.On 9/24/25 at 10:12 a.m., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to bipolar disorder, depression with psychotic features, cognitive communication deficit, adjustment disorder with depressed mood, and anxiety.An 8/15/25 quarterly MDS assessment indicated Resident 18's cognition was severely impaired.During an interview on 9/29/25 at 11:16 a.m., CNA 3 indicated the Resident 18 was not cognitively intact. On 9/23/25 at 12:30 p.m., the ADM provided the facility policy, ABUSE PREVENTION PROGRAM, dated 10/22/22, and indicated it was the policy currently being used. A review of the policy indicated, It is the policy of this facility to prevent resident abuse . mistreatment . This facility will not tolerate resident abuse or treatment by anyone including . other residents .3.1-27(a)(1)3.1-27(b)

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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 record review and interview, the facility failed to ensure the written notification required for a transfer/discharge was provided to the resident and the resident representative for 2 of 4 residents reviewed for hospitalization and discharge. (Resident 8, Resident 66) Findings include: 1. On 9/25/25 at 10:30 a.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and delusional disorder (a mental health condition characterized by persistent, false beliefs (delusions) that are not based on reality). A review of the resident's progress notes indicated the resident was transferred to the emergency room on 7/27/25 and returned to the long-term care facility on 7/30/25. . The clinical record lacked documentation that a written notice was provided to the resident and resident representative. During an interview with the Director of Nursing (DON) on 9/26/25 at 2:19 p.m., she indicated they did not have documentation that the resident and resident representative received a written notice of transfer/discharge. 2. On 9/29/25 at 10:40 a.m., Resident 66's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction and aphasia. The resident was admitted to the facility on [DATE] and discharged to the hospital on 8/2/25. The clinical record indicated no transfer/discharge notification was provided to the resident or resident's representative in writing. During an interview on 9/29/25 at 2:30 p.m., the Director of Nursing indicated no transfer/discharge notification was provided to the resident or resident's representative in writing. On 9/29/25 at 9:45 a.m., the Administrator provided the facility policy labeled Bed Hold, Transfer and Discharge Policy and Procedure, she indicated this was a current policy used by the facility. A review of the policy indicated .It is the policy of the facility to provide the Resident, Resident's family member and/or the Resident's legal representative, if applicable a written form . prior to transfer to a hospital .certain information regarding the Resident's facility bed status .6. Explain transfer and reason to the resident and/or representative if applicable send the original State Transfer/Discharge/Bed hold notice with the resident and/or representative .Place the facility copy in the health record . 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure an accurate assessment for 2 of 15 residents reviewed for MDS (Minimum Data Set) assessment accuracy. Antidepressants, Level II assessments, and hospice services were coded incorrectly. (Resident 39, Resident 3)Findings include: 1. On 9/25/25 at 1:42 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety disorder, insomnia (persistent problems falling and staying asleep), and depression. The admission Minimum Data Set (MDS) assessment, dated 9/8/25, did not indicate the resident was on an antidepressant medication and indicated the resident had not received a Preadmission Screening and Resident Review (PASRR) Level II. A review of Resident 39's medication orders indicated, the resident was taking Escitalopram (a medication used to treat depression) 20 milligrams (mg) daily. The medication was prescribed on 8/28/25 for a diagnosis of depression, and the resident had continued to take this medication. A review of the resident's documents indicated a notice of PASRR Level II Outcome, dated 9/4/25, Final Determination By: Determination Date: 9/4/25, Level II Outcome: Long Term Approval without Specialized Services. During an interview on 9/26/25 at 12:59 p.m. with the MDS Coordinator, she indicated the resident was on an antidepressant at the time of the admission MDS Assessment, dated 9/8/25. She indicated section N0415C1 Antidepressant, was marked no and it should have been marked yes. The MDS coordinator indicated the facility did not have a MDS policy, she indicated they utilized the Resident Assessment Instrument (RAI) manual to code MDS Assessments. A review of the RAI, Version 3.0 User's Manual, on 9/26/25 at 2:00 p.m., indicated .Item N0415, High-Risk Drug Classes: Use .Review the resident's medical record for documentation that any of these medications were received by the resident .during the 7-day lookback period . During an interview with the MDS coordinator on 9/26/25 at 2:57 p.m., she indicated section A1500 on admission MDS assessment, dated 9/8/25, was marked no and she indicated it should have been marked yes for PASRR Level II. On 9/26/25 at 3:00 p.m., a review of the RAI, Version 3.0 User's Manual, for section A1500 of MDS, indicated Code 1, yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID (Intellectual disability)/DD (Developmental disability) or related condition . 2. On 9/24/25 at 2:20 p.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure and chronic obstructive pulmonary disease. An active physician's order with a start date of 5/22/25 indicated the resident received hospice care. A current care plan, dated of 5/22/25 indicated the resident received hospice care. The quarterly MDS assessment, dated 8/21/25, section J1400 indicated the resident did not have a (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition or chronic disease that may result in a life expectancy of less than six months. Section O0110, K1 indicated the resident did not receive hospice care. During an interview on 9/29/25 at 11:00 a.m., the MDS Coordinator indicated the resident was receiving hospice care, and the assessment was incorrectly coded on the 8/21/25 quarterly MDS assessment. 3.1-31(d)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when a new mental health diagnosis was added for 1 of 3 residents reviewed for PASARR. (Resident 6)Finding includes:On 9/29/25 at 11:33 a.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, depression, and anxiety.The PASARR Level I, dated 2/10/25, indicated no Level II was required due to no severe mental illness. The Level 1 indicated no mental health diagnosis was known or suspected. If new changes occur or new information refuted these findings, a new screen must be submitted.Resident 6 was admitted on [DATE] with diagnoses of depression and anxiety.The clinical record lacked a new Level I screen with the diagnoses of depression and anxiety.During an interview on 9/29/25 at 11:24 a.m., the Minimum Data Set (MDS) nurse indicated a new Level I would be done when a new diagnosis or a new psychotropic medication was prescribed.During an interview on 9/29/25 at 11:43 a.m., the MDS nurse indicated Resident 6 required a new Level I completed due to new diagnoses of anxiety and depression.On 9/29/25 at 1:32 p.m., the facility provided the facility's policy, Guidelines for PASRR Process, dated 5/17/23, and indicated it was the policy currently being used by the facility. The review of the policy indicated .People (residents), who are confirmed to have ID [intellectual disability], DD [developmental disability], MI [mental illness] are evaluated to determine the need for specialized services, and appropriate placement options are reviewed .3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary intervention to promote healing of a facility acquired pressure ulcer for 1 of 3 residents reviewed for pressure ulcer. (Resident 53)Finding includes:On 9/23/25 at 12:27 p.m., Resident 53 was observed to be eating lunch in the dining room. She was observed to be wearing a yellow sock on her left foot with her left foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair. On 9/23/25 at 2:29 p.m., Resident 53 was observed to be sitting in the hallway. She was observed to be wearing a yellow sock on her left foot with her left foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair.On 9/24/25 at 9:43 a.m., Resident 53 was observed to be sitting in her wheelchair in the dining room. She was observed to be wearing a yellow sock on her left foot with her foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair.On 9/24/25 at 1:36 p.m., Resident 53 was observed to be sitting in her wheelchair in the dining room. She was observed to be wearing a yellow sock on her left foot with her foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair.On 9/25/25 at 9:40 a.m., Resident 53 was observed to be sitting in her wheelchair in the dining room. She was observed to be wearing a yellow sock on her left foot with her foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair.On 9/25/25 at 2:40 p.m., Resident 53 was observed to be sitting in her wheelchair in the dining room. She was observed to be wearing a yellow sock on her left foot with her foot resting on the floor. No pressure relieving devices were observed to be on her feet or beside her wheelchair.On 9/26/25 at 10:36 a.m., Resident 53's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), unstageable pressure ulcer of the left heel, and vascular dementia.The Braden Scale for Predicting Pressure Score Risk indicated the following:-On 4/30/25 at 8:26 p.m., Resident 53 was a low risk for pressure ulcer.-On 7/30/25 at 10:00 a.m., Resident 53 was a low risk for pressure ulcer.The quarterly Minimum Data Set (MDS) assessment, dated 6/11/25, indicated Resident 53 had severe cognitive impairment and was at risk for pressure ulcers.The care plan, dated 7/29/25, indicated Resident 53 had an unstageable wound to her left heel. The interventions were offloading boots while in bed as tolerated. She kicked off heel boots while in bed at times. The care plan lacked documentation of what interventions were in place to help relieve pressure from left heel while in the wheelchair.The Nurse Practitioner (NP) progress note, dated 9/3/25 at 12:49 p.m., indicated Resident 53 had an unstageable pressure ulcer to left heel. The wound was stable. The size was 2.5 cm (centimeters) x 3 cm x 0.1 cm deep. The current treatment plan was to offload the wound bed.The Weekly Wound Evaluation, dated on 9/3/25 at 1:08 p.m., Resident 53 had a suspected deep tissue injury (damage to the soft tissue under the skin caused by pressure) to left heel. The measurements were length 2.5 centimeters (cm), width 3.0 cm, and depth 0.1 cm. The area was identified on 7/23/25. The wound was pink. The current treatment was to clean wound every day with wound cleanser, apply medical grad honey and apply bordered foam dressing. The current preventative interventions were wheelchair cushion, nutritional supplements, and heel boots.The Weekly Wound Evaluation, dated on 9/10/25 at 10:40 a.m., Resident 53 had a suspected deep tissue injury to left heel. The measurements were length 2.5 cm, width 3.0 cm, and depth 0.1 cm. The area was identified on 7/23/25. The wound was pink. The current treatment was to clean wound every day with Dakin's solution (wound cleanser), apply medical grad honey and cover with Dakin's moisten fluff gauze and bordered foam dressing. The current preventative interventions were wheelchair cushion, nutritional supplements, and heel boots.The NP progress note dated, on 9/10/25 at 1:34 p.m., Resident 53 had an unstageable pressure ulcer to left heel. The wound was stable. The size was 2.5 cm x 3 cm x 0.1 depth. The current treatment plan was to offload the wound bed.The NP progress note dated, on 9/17/25 at 7:49 a.m., Resident 53 had an unstageable pressure ulcer to left heel. The wound was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stable. The size was 2.2 cm x 2.8 cm x 0.1 depth. The current treatment plan was to offload the wound bed.The Weekly Wound Evaluation, dated on 9/17/25 at 10:22 a.m., Resident 53 had a suspected deep tissue injury to left heel. The measurements were length 2.2 cm, width 2.8 cm, and depth 0.1 cm. The area was identified on 7/23/25. The wound was pink. The current treatment was to clean wound every day with betadine (wound cleanser), apply betadine soaked gauze to wound and wrap with kerlix and secure with tape. The current preventative interventions were wheelchair cushion, nutritional supplements, and heel boots.The NP progress note dated, on 9/24/25 at 2:36 p.m., indicated the previous documentation was reviewed. Resident was seen for ongoing assessment and management of the left heel pressure ulcer. Significant slough overlying wound base. Resident tolerated sharp debridement. Depth increased to wound following sharp debridement today. Able to identify bone underlying slough with use of cotton tipped applicator. Wound staging updated to stage 4 pressure ulcer from unstageable. The wound was not listed as worsening as this was an expected progression with removal of slough and better evaluation of wound base. Wound care recommendation for hydrogel for ongoing autolytic debridement. The Weekly Wound Evaluation, dated on 9/24/25 at 3:03 p.m., Resident 53 had a suspected deep tissue injury to left heel. The measurements were length 2.0 cm, width 2.8 cm, and depth 0.1 cm. The area was identified on 7/23/25. The wound was pink. The current treatment was to clean wound every day with wound cleanser, apply hydrogel (wound dressing) to wound and pack with lightly with moistened normal saline gauze, and wrap with kerlix and secure with tape. The current preventative interventions were wheelchair cushion, nutritional supplements, and heel boots.The Physician Order indicated to cleanse the left heel with wound cleanser and pat dry, apply hydrogel to wound, packed lightly with moistened normal saline gauze, wrap with rolled gauze, and secure with tape. (Start date 9/24/25)The clinical record lacked documentation of how to ensure Resident 53 had pressure relieving to her pressure ulcer on her left heel while up in her wheelchair.During an interview on 9/26/25 at 10:13 a.m., CNA 1 indicated Resident 53 had a pressure ulcer to her left heel. She indicated while in bed Resident 53 had a wedge to keep heels off the mattress. While in the chair, Resident 53 was to keep her feet off the floor. If Resident 53's feet were on the floor, they would use wheelchair pedals and float her heels while she was in the wheelchair. During an interview on 9/26/25 at 10:19 a.m., Qualified Medication Aide (QMA) 1 indicated while Resident 53 was in bed, her heels were floated. She was unsure if Resident 53 was to float heels while in wheelchair.During an observation on 9/26/25 at 11:43 a.m., the Director of Nursing (DON) removed the dressing off Resident 53's left foot. A quarter-sized pressure ulcer was observed on the bottom of her left heel.On 9/29/25 at 1:32 p.m., the Administrator provided the facility policy, Guidelines for Prevention/Treatment of Pressure Injuries, dated 10/9/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated .Encourage the use of.fabrics/appropriate bed surfaces - mattresses/positioning devices.3.1-40(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a resident received the appropriate care to prevent urinary tract infections for 1 of 2 residents reviewed for urinary tract infections. (Resident 9)Findings include: On 9/26/25 at 11:31 a.m., Resident 9 was observed in the activity room with his urinary catheter bag inside of a concealed bag, which was touching the ground, below his reclining wheelchair.On 9/26/25 at 2:40 p.m., Resident 9 was observed in the activity room with his urinary catheter bag inside of a concealed bag, which was touching the ground, below his reclining wheelchair.On 9/24/25 at 10:39 a.m., Resident 9's clinical record was reviewed. The diagnoses included, but were not limited to Alzheimer's disease, type 2 diabetes mellitus, benign prostatic hyperplasia with lower urinary tract symptoms, dementia, obstructive and reflexive uropathy (a condition where urine flow is blocked in the urinary tract, leading to a buildup of urine and potential damage to the kidneys). A care plan, initiated 3/17/23, indicated the resident had a supra pubic catheter placed on 6/20/25 and had a diagnosis of BPH with obstructive uropathy. An intervention included, Monitor position of drainage bag .A 9/11/25 UTI (Urinary Tract Infection) note indicated the resident was diagnosed with a UTI, prescribed an antibiotic until 10/11/25, and had cloudy, foul-smelling urine.During an interview on 9/26/25 at 2:00 p.m., the clinical nurse consultant indicated there was not an infection control issue with the concealment bag being on the ground. However, she indicated it did not look pretty, and she was going to reposition the bag so it was not on the ground.On 9/29/25 at 1:32 p.m., the Administrator provided the facility policy, GUIDELINES FOR INDWELLING FOLEY CATHETER CARE, dated 10/16/24, and indicated it was the policy currently being used. A review of the policy did not indicate guidelines for urinary catheter bag placement in regard to touching the ground. 3.1-41(a)(2)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily census report had the actual hours worked by staff for 7 of 7 days of daily posted nurse staffing reviewed. Finding includes:On 9/23/25 at 11:30 a.m., the daily census report, dated 9/23/25, indicated no actual hours worked.On 9/29/25 at 12:23 p.m., the Administrator (ADM) presented the daily census report, dated 9/23/25 through 9/29/25. The daily census report lacked documentation of actual hours worked.During an interview on 9/29/25 at 12:58 p.m., the ADM indicated the daily census report posted lacked documentation of the actual hours worked.On 9/29/25 at 1:32 p.m., the ADM provided the facility's policy, Staffing Posting Requirement, undated, 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, in cooperation with Medicare/Medicaid Services (CMS), to comply with the requirement of daily posting staff in the facility .