STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155209		04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00197141 and IN00197895. Complaint IN00197141 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250. Complaint IN00197895 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: April 18 and 19, 2016 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census bed type: SNF/NF: 84 Total: 84 Census payor type: Medicare: 12 Medicaid: 65 Other: 7 Total: 84 Sample: 5 These deficiencies reflect State findings	F 0000	Preparation and or execution of the plan of correction in general, or this correction in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth i the statement of deficiencies, the plan of correction and specific corrective actions are prepared ande or executed in compliance with state and federal laws.The facility respectfully request a desk review.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155209		04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cited in accordance with 410 IAC 16.2-3.1.			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide a psychiatric evaluation to determine competency as recommended by a physician for one cognitively intact resident placed on elopement restrictions (Resident D). Findings include: Resident D's clinical record was reviewed on 4/18/2016 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension, peripheral vascular disease, anxiety, and depression. The resident had no diagnosis of dementia, Alzheimer's, or psychosis. Resident D's quarterly Minimum Data Set (MDS) assessment, dated 2/17/2016, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15;	F 0250	It is the policy of the facility to see that any psychiatric evaluations recommended or ordered by a physician for any resident to determine the resident's competency is completed timely. Resident D has now had a psychiatric evaluation as recommended by her physicain. Her WanderGuard has been removed. She has agreed to notify the staff before she leaves the facility and to sign the designated log book as she comes and goes so that the facility will know her whereabouts, she understands that is for her safety and to ensure she does not miss meals or meds. her care plan has been updated.Any resident who has had a recommendation or an order for a psychiatric evaluation to determine competency and has yet to have the psychiatric evaluation completed could be affected by this finding. A 60 day	05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155209		04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicating Resident D was cognitively intact. The assessment indicated the resident had no disorganized thinking, hallucinations, delusions, rejection of care, wandering, or behaviors. The resident was independent with transfers, ambulation, and toileting. MDS assessment indicated Resident D required minimal assist with dressing and eating. Nurses Note for Resident D, dated 12/22/2015 at 3:15 p.m., indicated, "Received call from [Physician A]. Stated resident made her own appointment with MD [Physician A], left facility with [community bus service] without notifying staff, resident reported to [Physician A] that she is putting her medications under her tongue and spitting them out after nurse leaves room, also told MD she attempted to order her own medications from [local pharmacy], resident reported that she is planning to disappear to California, after speaking with [Physician A and facility MD] both MD's feel resident would be safer to reside on Hope Springs Unit [locked dementia unit] at this time r/t [related to] dementia with psychosis." Physician's Orders, signed by facility MD and dated 12/22/2015, indicated, "Resident to reside on Hope Springs Unit r/t Dx: Dementia with psychosis."		look back audit was completed facility wide to determine if there were any outstanding recommendations or ordered psychiatric evaluations not yet completed. None were found.Any findings would have been addressed and scheduled immediately. going forward the DON/designee will review all new orders daily at the CQI meetings. Any orders\recommendations for psychiatric evaluations will be discussed with the Social Services Designee who will see that the evaluation is scheduled and completed as soon as possible. All appropriate notifications and care planning will be completed as well. Further, all necessary documentation will be completed related to the psychiatric evaluation. Additionally, the SSD will see that the results of any psychiatric evaluations are reviewed by the attending physician and the resident's responsible party as well as the IDT Team. Any appropriate actions and care planning will take place related to the findings of the evaluations. This process will be ongoing.At an inservice held 5\11\16 for nurses and Social Services the following was reviewed.1. Psychiatric evaluations: Why? Who can order? Who can complete?2.SSD responsibilities: Scheduling/Notifications/Transportation/Care Planning/Documentation3. Follow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's Orders, signed by facility MD and dated 12/23/2016, indicated, "1. D/C [discharge] Resident to reside on Hope Springs unit. 2. Resident to have Wanderguard [electronic departure alert system worn around the ankle] on at all times...." An Elopement Risk Review for Resident D, dated 1/15/2016, indicated a total score of 8; indicating the resident was an elopement risk. A care plan for Resident D, initiated 1/19/2016, indicated, "Focus: Resident at risk for elopement AEB [as evidenced by]: making statements of wanting to move away or leave building without staff having knowledge of her whereabouts...Interventions: Activities as per calendar. Picture/info in elopement binder. Wander risk assessment quarterly and as needed. Wanderguard placed & checked per order for placement & function every shift." Physician's Progress Notes, dated 3/9/2016, indicated, "...[Facility] is legally responsible for pt. [patient] who seems very intelligent and [facility] feels pt. is a flight risk out of [facility]. Eventual disposition of pt. should probably be made by a judge in a court of		UP: SSD sharing results with attending physician/Resident Responsible Party/IDT Team.4. Monitoring Care Plan Interventions(rolled out as a result of the psychiatric evaluation.5.Questions/AnswersA t the monthly QA meetings the results of the monitoring of orders and/or recomendations for psychiatric evaluations for competency will be reviewed. Any concerns will be addressed. If needed, an action plan will be written by the committee to address any patterns. Any action Plan will be monitored by the Administrator weekly until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	law. In the meantime, the nursing home is responsible for her safety and welfare. She needs a psychiatric exam by a psychiatrist...Regarding the Wonder Guard: The pt. feels it is very undignified and humiliating and says I do not believe there is justification to have it on my leg." The Ombudsman was interviewed on 4/18/2016 at 12:56 p.m. She indicated she had multiple communications with Resident D since 12/22/2016, and was working with the resident and the facility to find alternate living arrangements for the resident. The Ombudsman indicated she did not believe the resident was an elopement risk and did not require the Wanderguard. Resident D was interviewed on 4/18/2016 at 2:55 p.m. She indicated she made an appointment to see her primary care physician in December, 2015 because she was preparing to move back to California, and the physician made "false accusations" about her threatening to leave the facility. The resident indicated that when she returned to the facility, she was "surrounded by staff" and told she had to either move to Hope Springs (locked dementia unit) or wear an "ankle bracelet." The resident indicated facility staff told her that if she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	did not agree to wear the Wanderguard, she would be moved to the locked unit where she would not be able to smoke. The resident indicated she was not putting medications under her tongue and had no plans to leave the facility without a discharge plan. The resident was tearful and indicated, "I can't go anywhere, I can't do anything [with Wanderguard/elopement restrictions]...I'm 86 [years old]. I don't have a car, no friends, no family. Where am I going to go? This...[indicating Wanderguard around her left ankle] causes me anxiety...grief...anger. Get it off. I am not going to run away." The resident was observed during multiple random observations throughout the survey ambulating independently without assistive devices. The resident ambulated outside during designated smoking breaks and back to her room. A written statement from the Business Office Manager (BOM), dated 4/18/2016 and provided by the ED on 4/18/2016 at 1:10 p.m., indicated, "As the Guardian Angel [facility staff member who routinely checks on residents in the facility and acts as an advocate within the facility] for [Resident D], I check on her concerns each week. [Resident D] is [sic] believes that her physician...made			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	false claims that she has dementia and that she is a flight risk. As a result, [Resident D] says that following her last visit to [Dr. A] on December 22, 2015, upon her returnto [sic] the [facility] she 'was surrounded' by nursing staff and forced to wear an ankle bracelet... [Resident D] and I have discussed her leaving [facility] to live in an inexpensive rooming house or apartment unit she can travel out west....." Certified Nurse Assistant (CNA) #3 was interviewed on 4/18/2016 at 3:20 p.m. She indicated she had "no idea" why Resident D was required to wear the Wanderguard. She indicated, "She feels like she's in prison. She said she can't even go sit outside on the porch and enjoy the sun unless it's with the activity people, and they don't do that [take residents outside] very often." CNA #2 was interviewed on 4/18/2016 at 3:48 p.m. CNA #2 indicated she was on duty 12/22/2015 when the resident left the facility without their knowledge to see her primary care physician [Physician A]. CNA #2 indicated, "The doc [physician] said Hope Springs [locked dementia unit] or the Wanderguard...She [the resident] gets very upset about it." The BOM was interviewed 4/19/2016 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:10 a.m. The BOM indicated he did not believe Resident D would leave the facility without having a discharge plan. He indicated the resident wanted to find somewhere affordable to live close to her belongings (in a storage unit) where she could get public transportation. He indicated, "She wants to have a plan." The Activities Director was interviewed on 4/19/2016 at 11:39 a.m. She indicated Resident D liked to socialize and participated in activities. She indicated the resident enjoyed outings to a local department store and propelled around the store in a scooter and did not exhibit elopement behaviors. She indicated, "No, I don't think she's a flight risk...I think the Wanderguard should come off." On 4/19/2016 at 11:50 a.m., the Executive Director (ED) indicated Resident D had not been referred to a psychiatrist as recommended by the physician on 3/9/2016. The ED indicated a psychiatric evaluation may determine whether or not Resident D was competent to make her own decisions and subsequently, discontinue the elopement restrictions. The Social Services Director (SSD) was interviewed on 4/19/2016 at 12:00 p.m. She indicated she was not aware of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician's recommendation regarding a judge determining the disposition/competency of the resident and that she was not responsible for the referral to a psychiatrist. A current copy of the Policy and Procedure for Personal Safety Devices for Residents at Risk of Elopement was provided by the ED on 4/18/2016 at 4:25 p.m. The policy indicated, "...all residents are provided adequate supervision to meet each resident's nursing and personal care needs...All resident's [sic] assessed to be at risk of elopement will be provided with a Personal Safety Device. Procedure: ...4. The Personal Safety Device will be applied to the resident according to resident needs...8. When residents are no longer deemed to be at risk of elopement, the resident's physician shall be notified. New orders shall be obtained to discontinue the Personal Safety Device...." A current copy of the Director of Social Services Job Description was provided by the ED on 4/19/2015 at 11:47 a.m. The Position Summary indicated, "...Responsible for managing policies and procedures for determining and assessing residents' long range and short range goals for social, psychological, emotional			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155209		04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and financial needs....Maintains significant social service progress notes on he resident's medical chart on a timely basis...." A current copy of the Social History/Psychosocial Assessment Policy and Procedure was provided by the ED on 4/19/2016 at 11:47 a.m. The document indicated, "Guideline: Social service staff will assess the resident's sense of well being and evaluate coping skills and support systems...." 3.1-34(a) This Federal tag relates to Complaint IN00197141.			