

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/24/14</p> <p>Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Clifty Falls was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke</p>	K010000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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. The facility respectfully requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

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
	<p>detectors in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 97 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except the 100 East Hall sprinkler riser room and two detached wooden storage buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/04/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

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
K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 103 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice could affect 23 residents who use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/24/14 at 11:20 a.m. with the physical plant director, the kitchen set of double doors leading into the main dining room had a two inch gap along the top of both doors where the doors met in the closed position. Furthermore, the kitchen set of double doors leading into the main</p>	K010018	<p>It is the facility policy that all corridor doors latch and resist the passage of smoke with no impediment to closing the doors. The double doors into the main dining room are being replaced to ensure the doors latch and resist the passage of smoke with no impediment to closing the doors. As part of the Preventative Maintenance Program, the Maintenance Director or designee will inspect all corridor doors for appropriate latching and ensure the doors are resistant to the passage of smoke. This will be documented monthly in the Preventative Maintenance Program. The Maintenance Director will review the results of the inspections and plan of action at the next Quality Assurance Meeting on March 18th, 2014. Any negative findings will be</p>	03/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
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	
K010025 SS=E	<p>dining room lacked latching hardware. This was verified by the physical plant director at the time of observation and acknowledged by the administrator at the exit conference on 02/24/14 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 103 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 23 residents who use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p>	K010025	<p>reviewed by the interdisciplinary team and a plan of action will be implemented to resolve the concern. The Maintenance Director or Designee will review any concerns in the Preventative Maintenance Program at each monthly Quality Assurance Meeting.</p> <p>It is the policy of this facility that the ceiling smoke barriers and room wall barriers maintain a one half hour fire resistance rating. The kitchen north wall has been covered so that that there is now no gap. The kitchen boiler room drywall was repaired and fire stopped the water pipe gaps. As part of the Preventative Maintenance Program, the Maintenance Director or designee will monitor smoke barriers to ensure the appropriately prevent the passage of smoke. The Maintenance Director will review</p>	03/25/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
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	
	<p>Based on observations with the physical plant director on 02/24/14 during a tour of the kitchen from 11:30 a.m. to 12:15 p.m., the kitchen north wall next to the exit door had a two foot by four foot painted plywood cover over the lower portion of the wall covering plumbing pipes with a one inch gap around the painted plywood wall covering. Furthermore, the kitchen boiler room, which was located on the other side of the north wall, had a two foot by four foot area of drywall missing where the plumbing was located and the ceiling above the north wall had a water pipe penetration with a two inch gap which was not firestopped. This was verified by the physical plant director at the time of observations and acknowledged by the administrator at the exit conference on 02/24/14 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>results of the inspections and plan of action at the next Quality Assurance Meeting on March 18th, 2014 Any negative findings will be reviewed by the interdisciplinary team and a plan of action will be implemented to resolve the concern. The Maintenance Director or Designee will review any concerns in the Preventative Maintenance Program at each monthly Quality Assurance Meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 103 rooms were sprinkled. This deficient practice could affect 26 residents who reside on the 100 East Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/24/14 at 1:00 p.m. with the physical plant director, the 100 East Hall sprinkler riser room was not sprinkled. This was verified by the physical plant director at the time of observation and acknowledged by the administrator at the exit conference on 02/24/14 at 1:30 p.m.</p> <p>3.1-19(b)</p>	K010056	<p>It is the policy of this facility that the rooms are sprinkled per regulation and code. The sprinkler riser room is now sprinkled as of March 17th, 2014. Installation was completed by our contracted sprinkler company. The facility will continue to monitor all sprinkler to ensure in working order. The facility has contracted with a Fire and Sprinkler Inspection Company to ensure the sprinkling system is in working order and is inspected each quarter. The Maintenance Director will review results of the inspections and plan of action at the next Quality Assurance Meeting on March 18th, 2014. Any negative findings will be reviewed by the interdisciplinary team and a plan of action will be implemented to resolve the concern. The Maintenance Director or Designee will review</p>	03/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
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			
K010211 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 76 of 76 resident room alcohol based hand rub dispensers were not located over an ignition source. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/24/14 during the tour of the facility from 9:20 a.m. to 1:30 p.m. with the physical plant director, all seventy six resident rooms in the facility had a 1200 milliliter container of alcohol based hand sanitizer</p>	K010211	<p>any concerns in the Preventative Maintenance Program at each monthly Quality Assurance Meeting</p> <p>It is the policy of this facility that alcohol based hand rub dispensers are not located over an ignition source. The Maintenance Director or designee has moved all alcohol hand rub dispensers away from the room lights and outlets so that they are not located over an ignition source. All dispensers have at least 6 inch clearance from any ignition source. The Maintenance Director will review the location of all alcohol hand rub dispensers as part of his preventative maintenance program. The Maintenance Director will review results of the inspections and plan of action at the next Quality</p>	03/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
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			
	mounted on the wall above the room light electric switches. This was verified by the physical plant director at the time of observations and acknowledged by the administrator at the exit conference on 02/24/14 at 1:30 p.m. 3.1-19(b)		Assurance Meeting on March 18th, 2014. Any negative findings will be reviewed by the interdisciplinary team and a plan of action will be implemented to resolve the concern. The Maintenance Director or Designee will review any concerns in the Preventative Maintenance Program at each monthly Quality Assurance Meeting.				