

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155209	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/12/2015
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NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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(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
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K 000  Bldg. 01	<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: 05/12/15</p> <p>Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330</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, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 96 at the time of this visit.</p>	K 000		
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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.

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K 038 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage buildings which were not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 7 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 14 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 05/12/15 at 12:45 p.m., the 100 Hall exit sidewalk had a four foot by six foot section of concrete sidewalk located four feet from</p>	K 038	<ol style="list-style-type: none"> <li>It is the policy of the facility that fire exits are readily accessible at all times.</li> <li>All exits were checked and all other exits comply with our policy.</li> <li>The facility has hired a contractor to replace the concrete walkway outside the exit door. The walkway will meet regulatory guidelines by June 5, 2015. The maintenance director will inspect the sidewalks by exit doors quarterly.</li> <li>The maintenance director will review the results of the inspections in safety meeting quarterly and QA quarterly and as needed. Any negative findings upon inspection will be reviewed with the administrator and a plan of action will be implemented to resolve the</li> </ol>	06/05/2015

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	the exit door pitted with one inch depressions and heaving concrete with two inch elevation changes along the broken sidewalk surface. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/12/15 at 2:15 p.m.  3.1-19(b)		concern.  5. The completion date is 6/5/2015.		