STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING 00 B. WING	10/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Complaints IN00391559 and IN00392382. Complaint IN00391559 - Substantiated. Federal/State deficiency related to the allegation is cited at F689. Complaint IN00392382 - Substantiated. Federal/State deficiency related to the allegation is cited at F921. Survey date: October 17, 2022. Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 12 Medicaid: 48 Other: 25 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 26, 2022.	F 0000	Deficiency ID: F _ 0000 Completion Date: October 18, 2022 Plan of Correction Text: 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. Facility's date of alleged compliance is: October 18 , 2022. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure preventative interventions (transporting residents in a facility vehicle and following the appropriate user instructions for the facility's latching/seat belt device system) were in place for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: During an observation and interview on 10/17/22 at 12:49 p.m., Transport Staff 5 indicated when you transport a resident in the van you always secure the resident's wheelchair and the resident. The staff member was transferring a resident back to the facility at the time of the observation. The resident was secured prior to his removal. The appropriate way to secure a resident in a wheelchair was to secure the wheels with a four point strap and always place a lap belt on the resident. During an interview on 10/17/22 at 1:02 p.m., the Administrator indicated there was an incident that they reported to the State involving a resident who was not appropriately secured and fell to the floor during transportation. The resident (Resident B) whom had fallen, was in an electric chair. The driver secured the wheels of the chair and failed to secure the resident with a lap belt. The driver was suspended upon the facility's notification from the resident and later terminated.	F 0689	Past noncompliance: No POC required.	11/02/2022

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	During an interview and observation on 10/17/22 at 1:27 p.m., Resident B indicated he was being transferred for an appointment with his surgeon in the facility van. The driver secured his electric wheelchair but forgot to secure his lap belt. There was another resident on the bus going to the same location. The other resident was secured in a regular seat. The driver was driving too fast and smoking on the bus while driving. She had to slam on the brakes while they were inroute to the location they were going. He slid out of his wheelchair and onto the floor. The driver could not lift him off the floor and she drove to the destination with him still on the floor. Once they arrived to the destination, two random surgeons helped get him off of the floor. He did not tell his surgeon about the incident. On the return drive to the facility, the driver was still driving too fast and had to slam on the brakes again. This time he was secured and did not fall out of the chair. The driver did not report the incident to the facility at the time of the event. The resident informed the staff at the facility once he returned. The resident was observed to have a boot on his ankle and he indicated in the fall he had sprained his ankle. During an interview on 10/17/22 at 1:35 p.m., the Transport Manager indicated she was off work during the incident. She normally calls the drivers and does not leave the facility until the transport van was close to the facility. She was not notified until Sunday (two days after the event). The Administrator called her to let her know the driver needed to be susupended and possibly let go. The driver was trained how to appropriately secure the residents, no smoking while driving, and to only use the cell phone for GPS. The facility has formal training in April of every year. This employee was hired after April and did not have the formal training. She herself had			

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	completed the drivers training directly and she knew how to secure the residents with a returned demonstration. The driver did not report the incident to any staff member. All drivers are to stop and call 911 if an incident happens on the van. The clinical record was reviewed for Resident B on 10/17/22 at 2:30 p.m. The resident's diagnosis included, but was not limited to: quadipalegia (paralysis of all four limbs). The Admission MDS (Minimum Data Set) assessment, dated 1/20/22, indicated the resident was alert and oriented and was total dependent on staff for transfers. An Accident and Incident Report, dated 10/3/22 at 9:19 a.m., indicated on 10/2/22 a resident fell out of wheelchair during transport. The Employee Disciplinary Action Report, dated 10/7/22, indicated the date of incident was "10/2/22 [9/30/22]". The incident was described as a violation of a safety rule. The Transportation: Automobile/Van Safety Program training was provided by the Administrator on 10/17/22, The training was signed by Transport Staff 1 on 6/6/22. The training included, but was not limited to: the driver and passengers were required to wear seat belts and shoulder harnesses. No one oter than the facility trained driver should secure a resident in the vehicle. This Federal tag related to Complaint IN00391559 3.1-45(a)(2)			
F 0921 SS=D	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure residents' hallway and rooms were free from water on the floor after a hard rain for 1 of 2 exit doors observed related to the environment. (200 Hall court yard door) Findings include: During an interview on 10/17/22 at 1:05 p.m., Resident C indicated for years after a hard rain water would run directly into her room from the outside door. She tried to keep items on the floor to catch the rain. She was concerned about slipping on the wet floor. An observation on 10/17/22 at 1:13 p.m., indicated there was waters marks along the outside walkway leading into the corner of the 200 Hall exterior door. The corner of the door had an approximately an one inch gap in the bottom corner. During an interview on 10/17/22 at 1:15 p.m., Maintenance Staff 1 indicated the facility had a few issues with water during torrential down pours. A couple of the problem areas were the dining room and the 200 Hall court yard door. The dining room was fixed this past summer. The problem with the 200 Hall was not address with the initial quote. The problem had been going on for at least five years. Prior to the last five years he was unsure of how long the problem had exited. The perimeter drains were fixed two years ago and it seemed to help a little. The past year the the drains were not efficient. The gap under the doors had not been addressed.	F 0921	**F-921** It is the policy of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed to ensure proper weatherstripping was present on all exit/entry doors and no signs of water leaking were present. Sealant was installed where the cement ground meets the vertical brick wall on both sides of the courtyard entry/exit. A new horizontal drain with sump pump was installed in the area of the drainage issue on the 200 hall courtyard entryway which will pump water into the main drain of the courtyard. Maintenance Supervisor/Designee will monitor 200 hall to ensure no water is seeping inside of the facility on the 200 hall. Monitoring will occur using an Environmental Audit Tool 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly until 4 consecutive weeks of no negative findings then weekly	10/18/2022

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	During an interview on 10/17/22 at 1:30 p.m., QMA 5 indicated for years when the rain poured down hard water would come into the facility from under the 200 Hall court yard door. The water would run down the hallway and slightly into a few of the residents rooms. The staff had to use a mop and a shop vacuum to clean up the water. Review of the repair quote for the facility dining room was provided by Maintenance Staff 1 on 10/17/22 at 2:00 p.m. The quote was dated for 6/11/22 and indicated the dining room water issues were repaired. The quote lacked to address the 200 Hall concern. This Federal tag relates to Complaint IN00392382 3.1-19(a)(4)		ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months then monitoring can be stopped. At an in-service held by the Administrator on___10/17/2022____for the maintenance staff the following was reviewed: 1. Environmental Manual 2. Notifications of Work Orders needing addressed Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the Maintenance Supervisor/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	