

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/26/2023	
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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00420122, IN00419987, IN00419802, IN00419645, IN00419357, and IN00418755. Complaint IN00420122 - No deficiencies related to the allegations are cited. Complaint IN00419987 - No deficiencies related to the allegations are cited. Complaint IN00419802 - No deficiencies related to the allegations are cited. Complaint IN00419645 - No deficiencies related to the allegations are cited. Complaint IN00419357 - No deficiencies related to the allegations are cited. Complaint IN00418755 - No deficiencies related to the allegations are cited. Survey dates: October 24, 25, and 26, 2023 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 6 Medicaid: 56 Other: 26 Total: 88			F 000			

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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F 000	Continued From page 1 The Waters of Clifty Falls was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00420122, IN00419987, IN00419802, IN00419645, IN00419357, and IN00418755. Quality review completed on October 30, 2023.	F 000			