CENTERS FOR	C MEDICARE & MEDIC					1B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMP	LETED
		155209	B. WING			7/2023
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD		
				OSS AVE		
WATERS	OF CLIFTY FALLS	S, THE	MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	.T	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	Ε	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
E 0000						
Bldg						
	An Emergency Prep	paredness Survey was	E 0000			
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.					
Survey Date: 04/17/23		7/23				
	Facility Number: 0	00116				
	Provider Number: 155209 AIM Number: 100266330					
	At this Emergency Preparedness survey, The					
	_	lls was found not in				
	compliance with Er	nergency Preparedness				
	Requirements for N	ledicare and Medicaid				
	Participating Provid	ders and Suppliers, 42 CFR				
	483.73.					
	-	3 certified beds. At the time of				
	the survey, the cens	sus was 92.				
	Quality Review cor	mpleted on 04/24/23				
	*	42 CFR, Subpart 483.73 is NOT				
	MET as evidenced	by:				
E 0041	400 45(a) 400 70	(a) 495 625(a)				
SS=F	482.15(e), 483.73					
		LTC Emergency Power				
Bldg	- , ,	tion for Participation:				
		d standby power systems.				
	•	implement emergency and				
		stems based on the				
		et forth in paragraph (a) of				
	this section and in	•				
		et forth in paragraphs (b)(1)				
	(i) and (ii) of this s	ection.				
	§483.73(e), §485.	625(e)				

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

TITLE (X6) DATE

Ashley Bowling Administrator 05/04/2023

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 04/17/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 CROSS AVE MADISON, IN 47250			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
IAU	(e) Emergency and The [LTC facility as implement emerge systems based or forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location require Care Facilities Counterim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §483 Emergency generation, testing requirements four Facilities Code, Nocode.  482.15(e)(3), §483 Emergency generation, testing requirements four Facilities Code, Nocode.  482.15(e)(3), §483 Emergency generand LTC facilities] source to power end the power systems open emergency, unless *[For hospitals at §483.73(g), and Content of the standards incomplete in the standards in the standards incomplete in the standards in the standa	d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.  33.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with rements found in the Health de (NFPA 99 and Tentative rnts TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing rng is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must regency power system I, and [maintenance] Ind in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs I that maintain an onsite fuel mergency generators must wit will keep emergency perational during the				DAIL
i .	1		Ī	Ī		1

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209		JILDING	NSTRUCTION		SURVEY LETED 7/2023
	OF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, IN 47250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	reference by the Deferrence by the Deferrence by the Deferrence Problem 1   Federal Register in 1   552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rece (NARA). For information this material at NA go to:  http://www.archive.of_federal_regull of any changes in incorporated by redocument in the Feannounce the characteristic (1) National Fire Featterymarch Paracteristic (1) National Fire Featterymarch Paracteristic (1) NFPA 99, Heal 2012 edition, issued (iii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NF 2012.  (iv) TIA 12-4 to NF 2013.  (v) TIA 12-5 to NF 2013.  (vi) TIA 12-5 to NF 2013.  (vi) TIA 12-1 to NF 2014.  (viii) NFPA 101, Liedition, issued Au (viii) TIA 12-1 to NF 2011.  (ix) TIA 12-2 to NF 30, 2012.	Director of the Office of the n accordance with 5 U.S.C. a part 51. You may obtain the sources listed below. The copy at the CMS parts of the copy at the CMS parts of the copy at the CMS parts of the National cords Administration mation on the availability of ARA, call 202-741-6030, or the copy of the copy of the Code at the second of the Code are efference, CMS will publish a coderal Register to the code and the code at t					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING		COMPLETED	
		155209	B. W	ING		04/17	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			ROSS AVE		
WATERS	S OF CLIFTY FALLS	S, THE		MADISON, IN 47250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	22, 2013.						
	(xi) TIA 12-4 to NFPA 101, issued October						
	22, 2013. (xiii) NFPA 110, Standard for Emergency and						
	Standby Power Systems, 2010 edition,						
	including TIAs to chapter 7, issued August 6,						
	2009						
	Based on record review and interview, the facility		E 00	041	E041– It is the intent of the facility		04/20/2023
	failed to implement the emergency power system				to ensure to implement the		
		and maintenance requirements			emergency power system		
	found in the Health Care Facilities Code, NFPA				inspection, testing and		
	110, and Life Safety Code in accordance with 42				maintenance requirements for		
	CFR 483.73(e)(2).				in the Health Care Facilities C	-	
					NFPA 110 and Life Safety Co		
		view and interview, the facility			accordance with 42 CFR 483.	.73(e)	
		of 1 Emergency Power			(2) to meet set standards.		
	1	accordance with NFPA 110,			1. CORRECTIVE ACTION	IS	
	_	gency and Standby Power			TAKEN:		
	1 -	4.9, as required by NFPA 99			a. On 04/20/2023 the		
		ies Code, Section 6.4.1.1.6.1.			Maintenance Supervisor		
		8.4.9 states that all Level 1			conducted the three-year four		
		Systems shall be tested at least			test on the emergency genera		
	-	hree years. Where the			and documented the results in	n tne	
		eater than 4 hours, it shall be			facilities Life Safety Binder to		
	_	ate the test after 4 hours.  6.4.1.1.6.1 states that Type 1 and			meet set standards. The	l.	
		ectrical system power sources			Administrator verified the work	r.	
		it Type 10, Class X, Level 1			4/20/23.		
		s deficient practice could			2. ALL OTHERS WITH POTENTIAL TO BE AFFECT	ED:	
	affect all building of	-					
	arrect air building t	ocupano.			a. All residents and all sta and visitors have the potentia		
	Findings include:				be affected but none were.	1 10	
	I mamas morace.				3. MEASURES TO PREVI	FNT	
	Based on record rev	view on 04/17/23 between 9:00			REOCCURRENCE:		
		with the Maintenance			a. On 4/18/23 the		
	-	the facility provided			Administrator inserviced the		
		testing of the emergency			Maintenance Supervisor/design	anee	
	generator, however				on the requirement that a	55	
	_	three-year 4-hour test. This			three-year four-hour test on the	ne	
		he Maintenance Supervisor at			emergency generator must be		

CTATEMEN	IT OF DEFICIENCIES	V1) DDOVIDED (CLIPPI IED /CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(V2) DATE	Y2) DATE SUBVEY	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		DISTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>	COMPL	
		155209	B. W	ING		04/17/	2023
MANGOES	DOMDED OF CLUBS TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	(		950 CR	OSS AVE		
WATERS	OF CLIFTY FALLS	S, THE		MADISON, IN 47250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the time of record r	eview.			conducted and documented in	the	
					facilities Life Safety Binder to		
	_	viewed with the Administrator			meet set standards.		
	and Maintenance S	upervisor during the exit			b. The Maintenance		
	conference.				Supervisor/designee will ensu	re a	
					three-year four-hour generator		
					is conducted and documented		
					the life safety binder to meet s	et	
					standards.		
				c. The Administrator will			
					monitor adherence to the		
					Emergency Preparedness Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:		
					a. At least every three yea	rs	
					the four-hour load test will be		
					completed to ensure complian	ice,	
					the Administrator and		
					Maintenance Supervisor/desig	gnee	
					will review the Emergency	al	
					Preparedness Policy Manual a		
					make changes as necessary t meet set standards. Those	U	
					reviews will be documented as		
					appropriate. The Administrato		
					present the training results at		
					Quality Assurance/ Performan		
					Improvement (QA/PI) meeting		
					Results and system componer		
					will be reviewed by the QA/PI		
					Committee with subsequent p	lans	
					of correction developed and		
					implemented as deemed		
					necessary to ensure complian	ce	
					is maintained.	=	
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
	i		1		1 3		1

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		JILDING		COMP	LETED 7/2023	
	PROVIDER OR SUPPLIER		•	950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
					all regulatory requireme Our date of compliance 4/20/23.		
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0	000			
	Survey Date: 04/17	/23					
	Facility Number: 0 Provider Number: 1002	155209					
	Clifty Falls was fou Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L	Code survey, The Waters of and not in compliance with articipation in 42 CFR Subpart 483.90(a), we and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Type V (000) construction The facility has a find detection in the corricorridor. The facility alarms in all resident	ty was determined to be of ruction and fully sprinkled. The alarm system with smoke ridors and spaces open to the ty has battery operated smoke at sleeping rooms. The facility 8 and had a census of 92 at					
	were sprinkled and services were sprink	dents have customary access all areas providing facility cled. The facility has two orage buildings which were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/17/2023	
	PROVIDER OR SUPPLIER		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
	not sprinkled.  Quality Review constructed, mainta the possibility of a fevacuation of occup could affect mostly the same smoke constructed:  REGULATORY OR not sprinkled.  Quality Review constructed conservation of the Requirem General Requirem List in the REMAR Section 18.1 and that are not addre K-tags, but are dealong with the app NFPA standard circon Form CMS-256 Based on observation of Form CMS-256 Based on observation failed to ensure 1 of enclosure was free states all health care constructed, mainta the possibility of a fevacuation of occup could affect mostly the same smoke constructed:	nents - Other ne		K100— It is the intent of the faci to ensure laundry area dryer ro enclosures are free of lint to me set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 04/21/23 the Maintenance Supervisor/Housekeeping Supervisor/designee cleaned the floor and equipment in the back the dryer enclosure in the launce.	DATE  DATE  DATE  DATE
	p.m. and 2:30 p.m. the Maintenance Su equipment in the ba within the laundry a with dryer lint. Bas observation, the fac agreed there was a slint on the floor and enclosure behind th would increase the	Based on observations on 04/17/23 between 12:00 c.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the floor and quipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint. Based on interview at the time of bservation, the facility Maintenance Supervisor greed there was a substantial amount of dryer and on the floor and equipment within the inclosure behind the dryers, and further said they would increase the cleaning schedule.  This finding was reviewed with the Administrator and Maintenance Supervisor during the exit		area that was covered with dry lint to meet set standards. The Administrator verified the work 04/21/23.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVERECCURRENCE: a. On 04/18/23 the Administrator inserviced the Maintenance	on D:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155209	B. W	ING		04/17	/2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	IR.			ROSS AVE		
WATER	S OF CLIFTY FALL	S THE			ON, IN 47250		
WATER	3 OF CLIFTT FALL	S, ITE		IVIADIS	ON, IN 47230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.				Supervisor/Housekeeping		
					Supervisor/Laundry Staff/desi	gnee	
	3.1-19(b)				on the requirement that the flo	or	
					and equipment in the laundry	area	
					must be clear of dryer lint to m	neet	
					set standards.		
					b. Maintenance Superviso	·r/	
					Housekeeping		
					Supervisor/designee will inspe		
					the laundry area weekly to en		
					the floor and equipment in the		
					laundry area is free of dryer lir		
					a part of the facility's Preventi	ve	
					Maintenance Program and		
					document those inspection re-		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig	-	
					will review with the Administra	tor	
					the inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:	viII	
					a. The inspection results v		
					be presented by the Maintena	rice	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the inspection results at the montl	bly	
					· ·	•	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	Jy	
1			1		the QA/PI Committee with		1

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023				
	PROVIDER OR SUPPLIEF		950 CF	STREET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, IN 47250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/21/2023.	as			
K 0271 SS=E Bldg. 01	7.7, provides a level the provisions of 7 changes in elevate free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to maintain the discharge areas. The affect at least 10 results visitors.  Findings include:  Based on observation p.m. and 2:30 p.m. the Maintenance Susidewalk from the I had two, one to two		K 0271	K271– It is the intent of the facto ensure to maintain the walk surface for exit discharge area meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. On or by 5/17/23 the Maintenance Supervisor/Cond Contractor will replace the two sections of the outside exit sidewalk from the Living Well 200 back hall with concrete to meet set standards.  2. ALL OTHERS WITH	sing as to  S crete O Unit			
	public way could be	concrete sidewalk to the e a tripping hazard while exiting e event of an emergency.		a. All residents and all star and visitors have the potential	ff			

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Based on interview at the time of observation, the

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be affected but none were.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/17/2023	
	PROVIDER OR SUPPLIER		950 C	CADDRESS, CITY, STATE, ZIP COD ROSS AVE SON, IN 47250	
	S OF CLIFTY FALLS  SUMMARY S (EACH DEFICIEN REGULATORY OR Maintenance Superone to two inch leve to the public way from this finding was reserved.)	S, THE  STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  visor agreed there were two, el changes along the sidewalk	950 C	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  3. MEASURES TO PREV REOCCURRENCE: a. Maintenance Supervisor/designee will inspall exit discharge and paths to public way to ensure they are readily accessible and free of obstructions or impediments part of the facility's Monthly Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they waddressed and resolved immediately. The Maintenan Supervisor/designee will reviewith the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	ect o e f all as a gram on y vill be ce
				4. MONITORING CORRECTIVE ACTION: a. The inspection results be presented by the Maintens Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performan Improvement (QA/PI) meetin Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented	ethly nce g. n by

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155209	B. W	ING		04/17	/2023
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED C	OF CLIETY FALLS	S THE			OSS AVE		
WATERS	OF CLIFTY FALLS	o, THE		MADISC	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is		
					5/17/23.		
K 0321	NFPA 101						
SS=E	Hazardous Areas						
Bldg. 01	Hazardous Areas						
		are protected by a fire					
		our fire resistance rating					
	`	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
	•	e areas shall be separated					
		by smoke resisting					
	-	rs in accordance with 8.4.					
	Doors shall be sel	<del>-</del>					
	-	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Aroo	Automatic Chriskles					
	Area Separation	Automatic Sprinkler N/A					
	•	-Fired Heater Rooms					
		er than 100 square feet)					
	, -	nance, and Paint Shops					
		ooms (exceeding 64					
		Joins (exceeding 04					
	gallons)	n Doomo					
	e. Trash Collection						
	(exceeding 64 gal	•					
l l	i i. Combustible Sta	orage Rooms/Spaces	1				I

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Event ID:

7IVU21

Facility ID: 000116

If continuation sheet

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AND PLAN OF CORRECTION    IDENTIFICATION NUMBER   155209       IDENTIFICATION NUMBER   155200       IDENTIFICATION NUMBER	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (OVER 50 square feet)  g. Laboratories (if classified as Severe Hazard - see K322)  Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as storage room door, was provided with a self closing device. This deficient practice could affect mostly staff in the service hall, plus any residents while in the same smoke compartment.  Findings include:  Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the Housekeeping Office was also being used as a storage room.  This room was over 50 square feet in size and was full of combustible items such as cardoard boxes, paper towel rolls, and chemical and cleaning  STREET ADDRESS, CITY, STATE, ZIP COD 950 CROSS AVE MADISON, IN 47250  (X5)  CMPLETION TAG  (X5)  CMPLETION TAG  (X5)  (X5)  CMPLETION SCAPLER BYLAN OF CORRECTION PRACTION SIDELLAGE CONNECTION APPROPRIATE  (X5)  COMPLETION DATE  (X5)  CMPLETION SCAPLER BYLAN OF CORRECTION CASH SHOWS SHEETED STAN SHOULD BE CONNECTION APPROPRIATE  (X5)  COMPLETION DATE  (X5)  CMPLETION SCAPLE BYLAN OF CORRECTION CASH SHOWS SHEETED STAN SHOULD BE COMPLETION DATE  (X5)  COMPLETION DATE  (X5)  CMPLETION SCAPLE BYLAN OF CORRECTION CASH SHOWS SHEETED STAN SHOULD BE CONNECTION DATE  (X5)  COMPLETION DATE  (X5)  CMPLETION STANDS HOLD BE CONNECTION DATE  (X5)  COMPLETION DATE  (X5)  CMPLETION SHOULD BE CACH CORRECTION STANDS HOLD BE CONNECTION DATE  (X5)  COMPLETION DATE  (X5)  CMPLETION SHOULD BE CACH CORRECTION STANDS HOLD BE CONNECTION DATE  (X5)  COMPLETION STANDS HOLD BE CACH CORRECTION CASH SHOULD BE CACH CORRECTION CASH SHOULD BE CONNECTION DATE  (X6)  CMPLETION STANDS HOLD BE CACH CORRECTION CASH SHOULD BE CACH CORRECTI	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01		
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full of combustible items such as cardboard boxes, paper towel rolls, and chemical and cleaning  4/20/23.  2. ALL OTHERS WITH		Office was also being	ng used as a storage room.		-			
paper towel rolls, and chemical and cleaning  2. ALL OTHERS WITH		This room was over	50 square feet in size and was			Administrator verified the work on		
						4/20/23.		
supplies. The corridor door to this room was not								
						POTENTIAL TO BE AFFECTE	ED:	
provided with a self closing device to ensure the a. All residents and all staff		_	_					
door would close automatically. Based on and visitors have the potential to			-			·		
interview at the time of observation, the be affected but none were. On							n	
Maintenance Supervisor confirmed the 04/20/23 the Maintenance		_						
Housekeeping Office/Storage room was not  Supervisor/designee inspected all							d all	
provided with a self closing device. hazardous area doors for		provided with a self	closing device.					
self-closing devices and found no		TEL: (" 1"	1 14 4 4 1 1 1 1			_	l no	
This finding was reviewed with the Administrator other negative findings.		_					-NIT	1
and Maintenance Supervisor during the exit conference.  3. MEASURES TO PREVENT REOCCURRENCE:			apervisor during the exit				:N I	
12000000000000000000000000000000000000		conference.						
a. On 04/18/23 the 3.1-19(b) Administrator inserviced the		3.1-19(b)						
Maintenance		3.1-19(0)						
Supervisor/designee/all staff on							n .	
the requirement that all hazardous								
area doors must be protected with						1		
a self-closing device to meet set						1		
standards.						_		
b. Maintenance								

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Event ID:

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Facility ID: 000116

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PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155209	A. BUILDING B. WING	01	COM	E SURVEY PLETED 7/2023
	ROVIDER OR SUPPLIEF		950 CF	ADDRESS, CITY, STATE, ZIP ROSS AVE ON, IN 47250	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				Supervisor/designee of all hazardous area do throughout the facility ensure there is a self-device as a part of the Preventive Maintenant and document those is results as appropriate issues are discovered addressed and resolv immediately. The Ma Supervisor/designee with the Administrator inspection results.  c. The Administrator inspection results.  c. The Administrator inspection results.  documentative Maintenant schedule and validated Preventative Maintenant documentation is in place. The inspection be presented by the Maintenant of the presented by the Maintenant of	monthly to colosing a facility's ace Program inspection a. If any d, they will be red intenance will review the ance at the ance date.  ON:  results will Maintenance to the red and the sent the he monthly arformance meeting. It is system to eviewed by with correction mented as a ensure med.  On the results will meeting.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7IVU21

Facility ID: 000116

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			î î		(X3) DATE SURVEY  COMPLETED  04/17/2023	
		130209		ADDRESS, CITY, STATE, ZIP COD	04/17/2023	
	PROVIDER OR SUPPLIED  OF CLIFTY FALL		950 C	ROSS AVE SON, IN 47250		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
				all regulatory requirements. Our date of compliance is 04/20/23.		
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cook appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartm patients comply with 30 or fewer productions under Cooking facilities with 30 or fewer productions under Cooking facilities NFPA 96 per 9.2. enclosed as hazabe open to the cooking facilities NFPA 96 per 9.2. enclosed as hazabe open to the cooking facilities NFPA 96 per 9.2. enclosed as hazabe open to the cooking facilities NFPA 96 per 9.2. enclosed as hazabe open to the cooking facilities of the cooking facilities NFPA 96 per 9.2. enclosed as hazabe open to the cooking facilities of the cooking facilities	ent is protected in NFPA 96, Standard for of and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited lance with 18.3.2.5.2, s open to the corridor in ents with 30 or fewer with the conditions under 2.5.3, or s in smoke compartments patients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be ardous areas, but shall not pridor. h 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 view and interview, the facility of 1 kitchen range hood	K 0324	K324— It is the intent of the facto ensure kitchen range hood	cility 05/17/2023	
	working order. Th	em was maintained in proper is deficient practice could affect f, plus any residents while in room.		extinguishing system is maintained in proper working to meet set standards.  1. CORRECTIVE ACTIONS TAKEN: a. On or by 5/17/23 the Facili licensed fire alarm contractor	ties	
		view on 04/17/23 between 9:00 a. with the Maintenance		complete the repairs to the fire alarm panel to meet set		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/17/2023 155209 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 950 CROSS AVE WATERS OF CLIFTY FALLS, THE MADISON, IN 47250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Supervisor present, the 04/10/23 range hood standards. The Administrator will suppression report from the facility's vendor verify the work on or by stated "Fire Panel shows "Laundry" when system 5/17/23. is activated.", furthermore, the 10/14/22 range 2. ALL OTHERS WITH hood suppression report from the facility's vendor POTENTIAL TO BE AFFECTED: stated "Alarm Signal On Fire Panel Shows "200 a. All residents and all staff and Hall Laundry"." Based on interview at the time of visitors have the potential to be record review, the Maintenance Supervisor said affected but none were. the facility was aware of the issue with the range 3. MEASURES TO PREVENT hood/fire alarm panel and were waiting on parts REOCCURRENCE: that have been ordered to fix the problem. a. On 04/18/23 the Administrator inserviced the This finding was reviewed with the Administrator Maintenance Supervisor/designee and Maintenance Supervisor during the exit on the requirement that the fire conference. alarm panel must be in operating condition and free of any trouble 3.1-19(b) alarms to meet set standards. b. Maintenance Supervisor/designee will ensure the fire alarm panel is in operating condition and free of any trouble alarms as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in

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place.

ACTION:

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4. MONITORING CORRECTIVE

a. The inspection results will be

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	OF CORRECTION	IDENTIFICATION NUMBER  155209	A. BUILDING B. WING	01	COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE SON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 5/17/23.	hly ce J. by
K 0345 SS=E Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to ensure 1 of continuously in projudeficient practice con	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K345– It is the intent of the fato ensure fire alarm systems a continuously in proper operatic condition to meet set standard 1 CORRECTIVE ACTION	ng ds.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/17/2023	
	PROVIDER OR SUPPLIER		950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DATE
	a.m. and 12:00 p.m. Supervisor present, system inspection a facility's vendor stawhen activated show Kitchen is not near interview at the tim Maintenance Superaware of the issue was panel and were wait ordered to fix the put This finding was re-	view on 04/17/23 between 9:00  with the Maintenance the 04/10/23 annual fire alarm and testing report from the ted "Kitchen Fire System ws "200 Hall/Laundry Zone, the listed zone"." Based on e of record review, the visor said the facility was with the range hood/fire alarm ting on parts that have been roblem.  viewed with the Administrator upervisor during the exit		TAKEN:  a. On or by 5/17/23 a certifire alarm contractor/designee repaired the fire alarm panel to meet set standards. The Administrator will verify the regon or by 5/17/23.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were.  3. MEASURES TO PREVE REOCCURRENCE: a. On 04/18/23 the Administrator inserviced the Maintenance Supervisor/design on the requirement that fire alarsystems must be maintained in proper operating condition to reset standards. b. Maintenance Supervisor/designee will ensure fire alarm systems are maintain in proper operating condition apart of the facility's Preventive Maintenance Program and document those inspection resure as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	pair  ED:  ff  to  ENT  gnee arm n meet  re ined as a e sults are sseed ne gnee
				accumentation is in place.	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER		950	ET ADDRESS, CITY, STATE, ZIP COE CROSS AVE IISON, IN 47250	)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE COMPLETION COMPLETION  DATE
K 0353 SS=E		Maintenance and Testing		4. MONITORING CORRECTIVE ACTION: a. The inspection resiste presented by the Main Supervisor/designee to the Administrator monthly and Administrator will present inspection results at the Quality Assurance/Perform Improvement (QA/PI) means the QA/PI Committee with subsequent plans of correction developed and implement deemed necessary to encompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requiremed. Our date of compliance 5/17/23.	ntenance he ad the to the monthly rmance seting. setem wed by h section nted as sure d. se with sents.
Bldg. 01	Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available.			
	b) Who provided	<u> </u>			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155209	B. W	NG		04/17/	/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
\\\\\\		S THE			ROSS AVE		
WATERS	OF CLIFTY FALLS	o, THE		MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL					COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Provide in REMAR	 RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,	-					
		on and interview, the facility	K 0	353	K353 – It is the intent of the		05/17/2023
		nkler heads in 1 of 7 smoke	I K U	333	facility to ensure sprinkler hea	de	03/1//2023
	_	red with corrosion were			in smoke compartments cover		
	_	, 2011 edition, at 5.2.1.1.1			with corrosion are replaced to	- <del>-</del>	
	_	show signs of leakage; shall			meet set standards.		
	_	, foreign materials, paint, and					
		nd shall be installed in the			1.CORRECTIVE ACTIONS		
		e.g., up-right, pendent, or			TAKEN:		
	sidewall). Furthern	nore, at 5.2.1.1.2 any sprinkler			1.On or by 5/17/23 a		
	that shows signs of	any of the following shall be			Certified Sprinkler Contractor		
	replaced: (1) Leaka	age (2) Corrosion (3) Physical			replaced three sprinkler heads	s in	
	Damage (4) Loss of	fluid in the glass bulb heat			the Supply Room that were		
	responsive element	(5) Loading (6) Painting			covered with corrosion to mee	t set	
	unless painted by th	e sprinkler manufacturer.			standards. The Administrator	will	
	_	ice could affect mostly staff			verify the work on 5/17/23.		
	-	hile in the same smoke			2.ALL OTHERS WITH		
	compartment.				POTENTIAL TO BE AFFECTE		
					1.All residents and all sta		
	Findings include:				and visitors have the potential	to	
	Dagad1	oma om 04/17/22 k-t 12 00	1		be affected but none were.	-	
		ons on 04/17/23 between 12:00			3.MEASURES TO PREVEN	ı	
		during a tour of the facility with pervisor, there were three			REOCCURRENCE:		
		ne Supply Room covered with			1.On 04/18/23 the		
	•	n interview at the time of			Administrator inserviced the	noo	
		interview at the time of sintenance Supervisor agreed			Maintenance Supervisor/design on the requirement that the	ji i <del>ee</del>	
		neads in the Supply Room was			sprinkler system must be prop	arly	
	_	ion and should be replaced.			maintained, and sprinkler head	-	
	25 verea with collos	non and should be replaced.			must remain free of corrosion		
	This finding was re	viewed with the Administrator			meet set standards.		
		apervisor during the exit			2.Maintenance		
	conference.	5	1		Supervisor/designee will ensu	re	
					the sprinkler systems are	-	
	3.1-19(b)				maintained and sprinkler head	ls	
	. ,				remain free or corrosion as a		
	1		1		i '		I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE A. BUILDING B. WING	e construction  5	(X3) DATE SURVEY COMPLETED 04/17/2023
NAME OF F	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP COD CROSS AVE	
WATERS	OF CLIFTY FALLS	S, THE		DISON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				of the facility's monthly Prev Maintenance Program and document those inspection ras appropriate. If any issue discovered, they will be addit and resolved immediately. Maintenance Supervisor/des will review with the Administ the inspection results.  3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4.MONITORING CORRECT ACTION:  1. The inspection results be presented by the Mainter Supervisor/designee to the Administrator will present the inspection results at the mor Quality Assurance/Performating Improvement (QA/PI) meeting Inspection results and syste components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensurcompliance is maintained. This plan of correction constitutes our credible allegation of compliance wall regulatory requirements Our date of compliance is 5/17/23.	results as are ressed The signee rator  TIVE s will nance ne e nthly nce ng. m d by on l as e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       04/17/2023			
	PROVIDER OR SUPPLIER		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extir Portable Fire Extir Portable fire exting installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 12 of were installed in a vinjury. This deficie residents, as well as Findings include:  Based on observation p.m. and 2:30 p.m. the Maintenance Su extinguishers located the egress corridors corridor wall cut-out extinguishers were such that the time Maintenance Super extinguishers were stalling.  This finding was residued.	nguishers nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of 26 portable fire extinguishers way to prevent damage and nt practice could affect all	K 0355	K355— It is the intent of the facto ensure portable fire extinguishers are installed in a way to prevent damage and into meet set standards.  1.CORRECTIVE ACTIONS TAKEN:  a. On 04/25/23 the facilitie Maintenance Supervisor/designstalled wall mounts for the typortable extinguishers located throughout the facility in the egress corridors that were freestanding on a corridor wall out shelf to meet set standard. The Administrator verified the on 04/25/23.  1.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all stand visitors have the potential be affected but none were.  2.MEASURES TO PREVENT REOCCURRENCE:  1.On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designs that portable fire extinguishers must be installed in a way to prevent damage and injury to	cility 04/25/2023 a sijury s gnee velve I cut s. work ED:  Iff to T

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2.Maintenance

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/17/2023
	ROVIDER OR SUPPLIE		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5)  COMPLETION  DATE
				Supervisor/designee will ensigner portable fire extinguishers are installed in a way to prevent damage and injury monthly a part of the facility's Prevention Maintenance Program and document those inspection of as appropriate. If any issue discovered, they will be addit and resolved immediately. Maintenance Supervisor/designer will review with the Administration the inspection results.  3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  3. MONITORING CORREC ACTION:  1. The inspection results be presented by the Maintensupervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the more Quality Assurance/Performa Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wall regulatory requirements.	re de

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	01	COMPLETED	
		155209	B. WIN	NG		04/17/20	)23
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ROSS AVE		
WATERS	S OF CLIFTY FALLS	S, THE		MADIS	ON, IN 47250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					Our date of compliance is 04/25/23.		
14.0500							
K 0522	NFPA 101						
SS=E	HVAC - Any Heat	_					
Bldg. 01	HVAC - Any Heat	_					
	1 -	e, other than a central					
	•	esigned and installed so					
		rials cannot be ignited by					
		safety feature to stop fuel					
	1	uipment if there is					
excessive temperature or ignition failure. If fuel fired, the device also:							
	* is chimney or ve						
	1	nbustion from outside.					
		ombustion system separate					
	from occupied are	•					
	19.5.2.2	а аппоэрнего.					
		on and interview, the facility	K 05	:22	K522 – It is the intent of the	1	04/25/2023
		ike combustion air from the	IK 03	122	facility to ensure intake	'	)4/23/2023
		ed in 2 of 6 rooms/areas			combustion air from the outsid	le is	
	_	d equipment. This deficient			provided in rooms/areas conta		
	_	e an atmosphere rich with			fuel fired equipment to meet so	-	
	carbon monoxide w	hich could cause physical			standards.		
	problems for mostly	y staff in the service corridor			1.CORRECTIVE ACTIONS		
	and adjacent rooms				TAKEN:		
					1.On 04/21/23 the		
	Findings include:				Maintenance Supervisor remo	ved	
					the obstruction from the air ve	nt in	
		ons on 04/17/23 between 12:00			the laundry room to meet set		
		during a tour of the facility with			standards. The Administrator		
		pervisor, the following was			verified the work on 04/21/23.		
	noted:				b. On 04/25/23the		
	a. The dryer room within the laundry room had				Maintenance Supervisor/desig		
	I	ers that had no fresh air vent on air from the outside			installed a fresh air vent in the		
					supply room to meet set		
	-	closed room. There was an			standards. The Administrator		
		screen vent, however, the			verified the work on 04/25/23.		
		locked up at sometime,			1.ALL OTHERS WITH	=D.	
	I minimore, mere v	was a ceiling duct, but it also	1		POTENTIAL TO BE AFFECTE	<u>ا</u> . لا	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023
	PROVIDER OR SUPPLIEI		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE SON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
TAG	had been capped at b. The Supply Roc There was no fresh air from the outside Based on interview observation, the Ma confirmed there was these rooms.	sometime. om had a fuel fired water heater. air vent for intake combustion e provided for this room.	TAG	1.All residents and all s and visitors have the potenti be affected but none were.  2.MEASURES TO PREVE REOCCURRENCE:  1.On 04/18/23 the Administrator inserviced laur staff, Maintenance Supervisor/designee on the requirement that the fresh ai intake must be provided and remain free obstructions to reset standards.  2.Maintenance Supervisor/designee will ensith the fresh air intake is provided remains free of obstructions part of the facility's monthly Preventive Maintenance Professults as appropriate. If an issues are discovered, they addressed and resolved immediately. The Maintenance Supervisor/designee will rever with the Administrator the inspection results.  3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  3.MONITORING CORREC ACTION:  1.The inspection results be presented by the Maintenance documentation results and the Maintenance will prevented the Administrator monthly and the Administrator will present the Administrator will p	taff al to  NT  Indry  reset  sure ed and as a  gram ion ny will be nce iew  TIVE  s will nance ne

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COM	e survey pleted 7/2023
	ROVIDER OR SUPPLIER		950 CF	ADDRESS, CITY, STATE, ZI ROSS AVE SON, IN 47250	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. der load conditions include		inspection results at Quality Assurance/P Improvement (QA/PI Inspection results ar components will be in the QA/PI Committee subsequent plans of developed and impledeemed necessary to compliance is maintated. This plan of correct constitutes our creallegation of compliall regulatory required. Our date of compliance of compliance of compliance is maintated.	Performance I) meeting. Ind system reviewed by e with correction emented as to ensure ained. tion dible iance with rements.	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO		COMPL	COMPLETED	
		155209	B. WING 04			04/17/	/2023
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
MATERO OF OUETVEALLO THE					ROSS AVE		
WATERS	S OF CLIFTY FALLS	D, I П E		MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	IFPA 111. Main and feeder					
	circuit breakers ar	e inspected annually, and a					
	program for period	dically exercising the					
	components is est	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	and readily availal	ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate from	n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)						
					facility to ensure to maintain		
	Based on record review and interview, the facility		K 0	918			04/20/2023
	failed to maintain 1 of 1 Emergency Power						
	Standby System in accordance with NFPA 110,				emergency power standby sys		
	_	ency and Standby Power			in accordance with NFPA 110	· ·	
	-	4.9, as required by NFPA 99			Standard for Emergency and		
		es Code, Section 6.4.1.1.6.1.			Standby Power Systems, Sec	ired by NFPA 99	
		8.4.9 states that all Level 1			8.4.9, as required by NFPA 99		
		Systems shall be tested at least hree years. Where the			healthcare facilities code, section		
	-				6.4.1.1.6.1 to meet set standa		
		eater than 4 hours, it shall be			1. CORRECTIVE ACTION	ı <b>S</b>	
	-	ate the test after 4 hours.			TAKEN:		
		.4.1.1.6.1 states that Type 1 and			a. On 04/20/23 the		
		ectrical system power sources			Maintenance Supervisor		
		t Type 10, Class X, Level 1			conducted the three-year four		
		s deficient practice could			test on the emergency genera		
	affect all building occupants.				and documented the results in	ı tne	
					facilities Life Safety Binder to		
	Findings include:				meet set standards. The	ı.	
	Based on record review on 04/17/23 between 9:00				Administrator verified the worl	(	
					04/20/23.		
	_	with the Maintenance			2. ALL OTHERS WITH	ED.	
		the facility provided testing of the emergency			POTENTIAL TO BE AFFECTI		
	generator, however,				a. All residents and all sta		
	_	-			and visitors have the potential	ιο	
documentation of a three-year 4-hour test. This				be affected but none were.			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/17/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			STREET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, IN 47250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE  COMPLETION DATE			
	the time of record r  This finding was re	he Maintenance Supervisor at eview.  Eviewed with the Administrator upervisor during the exit		3. MEASURES TO F REOCCURRENCE:  a. The Administrator inserviced the Maintena Supervisor/designee on requirement that a three four-hour test on the em	r ince the e-year nergency			
	3.1-19(b)			generator must be cond documented in the facili Safety Binder to meet so standards.  b. The Maintenance Supervisor/designee will three-year four-hour test emergency generator the conducted every three year documented in the life so binder as a part of the fact Preventive Maintenance and document those instresults as appropriate. issues are discovered, the addressed and resolved immediately. The Maintenance is supervisor/designee will with the Administrator the inspection results.  c. The Administrator the inspection results and validate the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place 4. MONITORING CORRECTIVE ACTION:  a. The inspection results and the inspection results are the inspection results.  4. MONITORING CORRECTIVE ACTION:  5. The inspection results and the inspection results are the inspection results and the inspection results are th	ducted and ties Life et  Il ensure a tof the est is years and cafety accility's e Program spection If any hey will be denance ell review he ece he ce ce ce ce ce ce ce ce ce the not			

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l '		IDENTIFICATION NUMBER  155209	A. BUILDING B. WING	01	COMPLETED 04/17/2023
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE		950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withir space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enc noncombustible co minimum 1/2 hr. fi Less than or equa In a single smoke	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.		inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/20/23.	by n as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/17/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			STREET ADDRESS, CITY, STATE, ZIP COD  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  FREFIX  GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	of less than or equived to be stored cylinders must be as specified in 11. A precautionary si on each door or groom, where the sa minimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders. cylinders with interpretable threshold pressure established. Empty avoid confusion. Care protected from 11.3.1, 11.3.2, 11.99)  Based on observation failed to ensure cylinders with interpretable to ensure cylinders. The supplier is a second confusion. Care Facilities Codes states storage for not compared to or meters (300 cubic from 11.3.3.1 shall be in 11.6.2.3(11) states for properly chained or stand or cart. This cover 20 residents, startings include:	gn readable from 5 feet is ate of a cylinder storage ign includes the wording as FION: OXIDIZING GAS(ES) NO SMOKING." It is so cylinders are used in y are received from the ylinders are segregated When facility employs gral pressure gauge, a econsidered empty is ty cylinders are marked to cylinders stored in the open in weather. 3.3, 11.3.4, 11.6.5 (NFPA)  In and interview, the facility inders of nonflammable gases exproperly secured from falling inpartments. NFPA 99, Health exproperly secured from falling inpartments. NFPA 99, Health exproperly secured from 11.3.3 inflammable gases with a total diess than greater than 8.5 cubic every shall comply with 11.3.3.1 in a 99, Section 11.3.3.2 states ling cylinders specified in accordance with 11.6.2. Section freestanding cylinders shall be supported in a proper cylinder deficient practice could affect	K 0923	K923 – It is the intent of the facility to ensure cylinders of nonflammable gases such as helium are properly secured falling in smoke compartment meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. On 04/19/23 the Maintenance Supervisor/desiremoved the helium tank that in the floor of the Activity Offic and moved it to the Oxygen Fand mounted it to meet set standards. The Administrator verified the work on 04/19/23.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta	rom s to  IS  gnee was ce coom		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		<u>01</u>	COMPLETED	
155209		B. WING			04/17/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			TE	(X5) COMPLETION DATE
	PROVIDER OR SUPPLIER  S OF CLIFTY FALLS, THE  SUMMARY STATEMENT OF DEFICIENCIE				and visitors have the potential be affected but none were. Or 04/19/23 Maintenance Supervisor/designee checked areas of the facility for impropestored helium cylinders and for no other negative findings.  3. MEASURES TO PREVENTE REOCCURRENCE: a. On 04/18/23 the Administrator inserviced Maintenance Supervisor/Activ Director/Activities Staff on the requirement that helium cylind must be properly secured from falling in smoke compartments meet set standards. b. The Maintenance Supervisor/Activities Director/designee will ensure a helium cylinders are secured falling in smoke compartments monthly as a part of the faciliti Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they will addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION:	all erly und  ENT  ities ers n s to  all from s es ram n	

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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 04/17/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			a. The inspection results we be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/23.	nity ce	

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