STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING **01** B. WING _____	R **08/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	**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
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/16/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/11/22 Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330 At this PSR survey to the Emergency Preparedness survey, The Waters of Clifty Falls was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 138 certified beds. At the time of the survey, the census was 88. Quality Review completed on 08/11/22	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/16/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/11/22 Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330 At this PSR survey, The Waters of Clifty Falls	{K 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING **01** B. WING _____	R **08/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	**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
{K 000}	Continued From page 1 was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 and spaces open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 88 at the time of this visit. 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. Quality Review completed on 08/11/22	{K 000}		