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	08/30/2024

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 IN00439099, IN00440880, and IN00442221. Complaint IN00439099 - Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00440880 - No deficiencies related to the allegations are cited. Complaint IN00442221 - Federal/State deficiencies related to the allegations are cited at F761. Survey date: August 30, 2024 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 11 Medicaid: 63 Other: 19 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 5, 2024.	F 0000		
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on record review and interview, the facility	F 0602	and/or execution of this plan of	09/19/2024

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

Melinda Alcorn | Administrator | 09/16/2024

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.

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	08/30/2024

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
	failed to ensure misappropriation of a resident medication did not occur for 1 of 3 residents reviewed for misappropriation. (Resident D) Findings include: The clinical record for Resident D was reviewed on 08/30/24 at 4:35 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/14/24, indicated the resident was cognitively intact. The diagnosis included, but were not limited to, diabetes mellitus, manic depression, psychotic disorder, and schizophrenia. A facility incident report, dated 08/29/24 at 7:01 A.M., indicated upon shift change, a narcotic medication card and narcotic count sheet were unable to be located. A current physician's order, with a start date of 10/10/23, indicated the staff were to administer Percocet (a pain medication), 7.5-325 mg (milligrams), 1 tablet by mouth every six hours as needed for pain. A current physician's order, with a start date of 09/28/23, indicated the staff were to administer morphine sulfate (a pain medication) oral tablet, 30 mg by mouth, three times a day for chronic pain. During an interview on 08/30/24 at 2:00 P.M., the DON (Director of Nursing) indicated the pharmacy had delivered three cards that contained a total of 84 morphine tablets for Resident D. The medication was incorrect due to an order being put in wrong by the facility staff, so the medication was never used. All three cards were placed in the back of the narcotic box with the resident's other narcotic medications. An additional medication card of Percocet was		correction in general, or this corrective action, 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. date of alleged compliance is 9/19/2024. Facility is respectfully requesting paper compliance for all deficiencies in this POC. F602 Free from Misappropriation/Exploitation It is the policy of this facility to ensure residents are free from abuse, neglect, misappropriation of resident property, and exploitation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee completed a narcotic count audit on all facility carts on 09/03/2024. Resident D was assessed for pain on the 8/30/2024 by DON/Designee no negative	

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	08/30/2024

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
	delivered from the pharmacy. LPN (Licensed Practical Nurse) 4 went to put the Percocet in the medication cart, but she never added the Percocet card into the medication card count. During shift change the next morning LPN 5 realized the card count was the exact same as the day before, but she knew there was a new card of Percocet added the day before. Upon further investigation it was discovered there was a card of morphine missing and the paper documenting it was missing as well. LPN 4 never signed in or out that she had received another narcotic medication card. A Pharmacy Record, dated 08/02/24 at 5:37 A.M., indicated three cards of morphine sulfate 30 mg ER were delivered with the identification numbers 8673***/001, 8673***/002, and 8673***/003 for Resident D. A pharmacy record, dated 08/28/24 at 5:32 P.M., indicated one card of Percocet tablet 7.5-325 were delivered with the identification number 86761***/001 for Resident D. During an interview on 08/30/24 at 3:59 p.m., with the DON and ADON (Assistant Director of Nursing) they indicated that when pharmacy comes in the front door, they would locate a nurse and then both verify medications received and sign off on pharmacy's tablet. Narcotics were in plastic bags that were sealed. Two nurses would verify and sign off that the medications were correct then go to the cart and add them in. On 08/02/24 those three cards of morphine should have been added. It should be on the sheet, but they didn't have the sheet. They could not locate the sheet or the second card of morphine (card 8673***/002). The current facility policy titled, "Controlled		outcome. LPN was suspended on 08/29/2024 pending the outcome of the investigation and then terminated on 09/05/2024. How be identified and what corrective action will be taken? What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/Designee in- nursing staff on Abuse, Neglect, Misappropriation of resident property, and exploitation, Policy and Procedure for receiving controlled substances from pharmacy on or before 09/16/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How be monitored to ensure the deficient practice will recur, i.e. what quality assurance program will be put into place? The DON/Designee will monitor narcotics received from the pharmacy 5 times a times 4	

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	08/30/2024

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
	substances", dated May 2019, was provided by the Administrator on 08/30/24 at 4:45 P.M. The policy indicated, " ...While a controlled substance is in use the nursing staff with maintain the following medication records: "...Controlled Substance Count Sheet..." The current facility policy titled, "Delivery Manifest", dated May 2019, was provided by the Administrator on 08/30/24 at 4:45 P.M. The policy indicated, " ...The contents of the facility's delivery will be reviewed by facility staff. This review will be documented on a delivery manifest form ...The contents will be taken to their intended storage area ..." This Citation relates to Complaint IN00439099. 3.1-28(a)		weeks; then 3 times a week x 4 weeks, then 1 time a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on record review and interview, the facility failed to store medications in a secure manner related to medications left on top of the medication cart unattended for 1 of 3 medication carts reviewed. (Living Well Long Hall Cart) Findings include: The clinical record for Resident D was reviewed on 08/30/24 at 10:15 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/14/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, osteomyelitis, bipolar disorder, psychotic disorder, psychoactive substance abuse, and schizophrenia.	F 0761	F761 It is the policy of this facility to provide separately locked, permanently affixed compartments for storage of controlled drugs. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident D was assessed by the DON/Designee on 08/30/2024 with no negative outcome related to the cited practice. How be identified and what	09/19/2024

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	08/30/2024

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
	The Progress Notes for Resident D were provided by the Administrator on 08/30/24 at 3:28 P.M., and included, but not limited to, the following: - A Nursing Progress Note, dated 08/21/24 at 12:02 A.M., indicated Resident D was following a QMA (Qualified Medication Aide) during medication pass, even after being asked multiple times to keep going down the hallway. The QMA turned to take a resident's blood pressure when Resident D took a cup of pills off of the medication cart. A CNA (Certified Nurse Aide) saw the resident in front of the cart, reaching up for medication cup. When asked, the resident denied taking the medications. Resident D was searched, and nothing was found on his person. After returning to the medication cart, a medication cup with 2 pills (Metformin and Lamictal) was found on the cart. The only pills that were missing were a Clonazepam (an antianxiety medication) 0.5 mg (milligrams) and a Tamsulosin (Flomax). The resident was put on checks every four hours for vital signs and observation. - A Nursing Progress Note, dated 8/20/24 at 9:24 P.M., indicated the MD was notified of the resident grabbing medications that were not his and taking only the Clonazepam and the Terazosin (an antihypertensive) from the cup per the nursing staff. New orders were received to monitor the resident for any adverse side effects for 24 hours, and to obtain vital signs every four hours. The resident and family were updated. During an interview on 08/30/24 at 1:56 P.M., the DON (Director of Nursing) indicated Resident J's medications were left in a cup on top of the medication cart. A QMA was on the cart administering residents' medications. The QMA turned around, and Resident D took the cup of		corrective action will be taken? What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/Designee in-serviced nurses and qualified medication assistances on Proper Medication Storage on or before 09/16/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DON/Designee will monitor Medication Administration for 10 residents weekly x 4 weeks; then 5 residents weekly x 4 weeks; then 3 residents weekly x 4 months. If the facility is in 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will addressed immediately. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action	

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	08/30/2024

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
	medications. It happened on 08/20/24 at around 9:00 P.M. Resident D apparently took two medications out of the cup because they found the others in his room. The Clonazepam and Tamsulosin were missing. The MD was notified. Resident D was monitored. The same incident was documented by LPN (Licensed Practical Nurse) 2. The facility completed a risk management assessment, watched the resident, called the doctor, and called their Corporate Associate. The Corporate Associate indicated the facility did not need to report the incident to the Indiana Department of Health because Resident D had no adverse reactions from taking Resident J's medications. Staff educated Resident D and monitored him for adverse side effects. No other interventions were put into place for Resident D. During an interview on 08/30/24 at 3:17 P.M., QMA 3 indicated she had set up Resident J's pills in a cup on top of the medication cart in the hallway. She turned around and went into Resident J's room to take his vital signs. She knew she should have not left the medication unsecured on top of the medication cart. While she was turned around, Resident D took the cup of pills off the cart and headed towards his room. One of the CNAs went down and asked Resident D if he had taken the medications. Then, later two of the pills magically appeared on top the medication cart lying loosely. She did not see Resident D bring the medications back. Resident D asked, about an hour later, if she was mad at him. She reported the incident to her nurse, LPN 2. The current undated Medication Storage in the Facility policy was provided by the Administrator on 08/30/24 at 3:26 P.M. The policy indicated, "...The medication supply is accessible only to licensed nursing personnel, pharmacy personnel,		Plans will be monitored by the Administrator weekly until resolved.	

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	08/30/2024

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
	or staff members lawfully authorized to administer medications..." The current Drug Administration - General Guidelines policy, dated May 2019, was provided by the Administrator on 08/30/24 at 3:28 P.M. The policy indicated, "...Medications are administered as prescribed, in accordance with good nursing principles and practices...No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by...When medication administration is dependent upon vital sign measures, this monitoring should be performed before the administration of the prescribed medication..." This citation relates to Complaint IN00442221. 3.1-25(m)			