STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE C A. BUILDING B. WING				
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD ROSS AVE		
WATER	S OF CLIFTY FALL	LS, THE	MADIS	SON, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0000	REGUENTORT	IN ESC IDENTIFIEND IN ORMETTION	ind		DATE	
Bldg. 00	IN00413207.	the Investigation of Complaint  3207 - Federal/State deficiencies	F 0000			
	related to the alleg F725.	ations are cited at F677 and				
	Survey dates: July Facility number: 0 Provider number:	00116				
	AIM number: 100  Census Bed Type: SNF/NF: 91					
	Total: 91  Census Payor Typ	e.				
	Medicare: 8 Medicaid: 67 Other: 16 Total: 91					
	accordance with 4					
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provid §483.24(a)(2) A carry out activitie necessary service	led for Dependent Residents resident who is unable to es of daily living receives the es to maintain good ng, and personal and oral				
	Based on observat	ion, interview, and record railed to provide timely	F 0677	F677 It is the policy of this facility to provide incontinent ca	08/11/2023	
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Achlov Ro	uulin a		Adminis	tratar	08/20/2023	

Ashley Bowling Administrator 08/29/2023

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays 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			UILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>07/26</b> /	ETED	
NAME OF	PROVIDER OR SUPPLIE	8	•		ADDRESS, CITY, STATE, ZIP COD	•	
					ROSS AVE		
WATER	S OF CLIFTY FALL	S, THE		MADISON, IN 47250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DRRECTION (X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	_	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nd oral care for a dependent			and oral care for all depender	nt	
		residents reviewed for activities			residents.		
	of daily living. (Re	sidents C and B)			4 \0/10 at a superstitute action (a)	11 6 6	
	Findings include:				1.What corrective action(s) will accomplished for those reside		
	rindings include.				found to have been affected by		
	1 The record for P	esident C was reviewed on			deficient practice?	y ine	
		m. A Quarterly MDS (Minimum			Resident C Care Plan update	d to	
		nt, dated 7/15/23, indicated the			reflect oral care, nail care, and		
		rately cognitively impaired. The			check and change program, a		
		ktensive of assistance of two or			added to Kardex.		
	_	nd transfers. The resident was			Resident B Care plan was up	dated	
	always incontinent of bladder and bowel. He had one Stage 2 (Partial-thickness skin loss with				to reflect total dependence wi		
					transfers.		
	exposed dermis, pr	esenting as a shallow open					
	ulcer. The wound b	ed was viable, pink or red,			2. How other residents having	the	
	moist, and may also	o present as an intact or			potential to be affected by the		
		er. Adipose (fat) was not			same deficient practice will be	;	
	_	tissues are not visible.			identified and what corrective		
		slough and eschar are not			action(s) be taken?		
		lcer on admission. The			All residents have the potential		
	_	, but was not limited to,			be affected by the cited practi		
	•	opathy, developmental			therefore, this plan of correction	on	
		tic skills, and signs and			applies to all residents of the		
		g cognitive functions and ident had a tube feed.			facility.		
	awareness. The res	ident nad a tube leed.			An audit was completed on	donto	
	During an observat	ion and interview on 7/26/23 at			8/11/23 for all dependent resident require incontinent care,		
	1	C was lying on his back. He			care oral care. Kardex update		
		d cleaned up due to an			indicated.	u us	
		ot know where his call light			marcate a.		
		odor of stool and the call light			3. What measures will be put	into	
		the left side of the bed. His lips			place and what systemic char		
		peeling, and he constantly			will be made to ensure that th		
		used his teeth to try and			deficient practice does not red		
	remove the dried sl		1		All Nursing Staff was re-educa		
					on ADL's to include incontine		
	During an interview	v on 7/26/23 at 9:46 a.m., the			care and oral care by the		
		of Nursing (ADON) indicated			DON/ADON to meet the need	s for	
	he would get help f	for Resident C. The Certified			all residents in facility, our		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			LETED
		155209	B. W	ING		07/26	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			OSS AVE		
WATERS	OF CLIFTY FALLS	S, THE			ON, IN 47250		
	1				,		I av-
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	Nursing Aides (CNAs) had someone in the shower and would get him cleaned up as soon as			compliance date for this is 8/11/23.			
	possible.				4 11	\:III	
	During an absorpat	ion on 7/26/22 at 0:50 a m			4. How the corrective action(s	) WIII	
	1	ion on 7/26/23 at 9:59 a.m., red Resident C's room. There			be monitored?		
		of loose stool on the residents			ED/Designee will monitor 10		
	_	down his legs. There was dried			residents 5 days a week for 1 months, then 5 residents 3 da	VC 0	
		heet and on the resident's			week for one month, then mo	-	
		tocks. When the fitted sheet			for 4 months for incontinent ca	•	
	_	was a dinner plate sized			nail care and oral care. Any	ai <del>C</del>	
		ool on the mattress. CNA 3			concerns noted in this audit w	ill he	
		oth to clean the mattress.			addressed and corrected	50	
		ark substance under his			immediately.		
		hands. The ADON indicated it			ED/Designee will be responsil	ble	
	_	l under the resident's finger			to provide audit results in Qua		
		JA 3 to clean the resident's			Assurance Meeting. The QAP	-	
	fingernails.				committee will review audit re		
					monthly and may determine the		
	During an observat	ion and interview on 7/26/23 at			monthly auditing can be		
	11:34 a.m., Resider	nt C was lying on his back, there			discontinued when 100%		
	was a dark substance	ce under his finger nails on			compliance has been maintair	ned	
	both hands. He indi	cated he lays on his back most			for 3 consecutive months. The		
	of the time. The res	ident's lips were observed to			Committee will identify any tre	ends	
	be dry and had drie	d skin peeling.			or patterns and make		
					recommendations to revise th	е	
	_	ion and interview on 7/26/23 at			plan of correction as indicated	l.	
		ON was preparing do a dressing					
	_	t C. The ADON had CNA 2					
	_	e the resident since he was					
		licated his mouth was dry. The					
		CNA 2 to use a swab to provide					
		dicated there was only lemon					
	flavored swabs and	the resident did not like those.					
	A C Pi 1	(10/01 1 1 1 1 1 D 11 1 0					
		6/2/21, indicated Resident C					
	_	with activities of daily living					
	1 1	lity. The interventions					
		not limited to, staff assist with					
	toileting as needed,	and set up and assist with					l

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMI	e survey pleted 6/2023
	PROVIDER OR SUPPLIE		950 CR	ADDRESS, CITY, STATE, ZIP CO ROSS AVE ON, IN 47250	DD .	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	was at risk for oral/ to requires assistant care. The interventi- limited to, monitor/ needed signs and sy- problems needing a or bleeding; and to A.M./P.M. and as r  A review of the res- through 7/25/23, la resident's oral care  During an observat 2:11 p.m., Resident was observed to ha there was a dark su on both hands. His table to the left of t  During an observat ADON provided or  During an interview Regional Administ should receive as n  2. The record for R 7/25/23 at 10:36 a.i assessment, dated 6 was cognitively int or more staff assist dressing, toileting, resident was occasi He had two unstage skin and tissue loss	ident's record, from 7/9/23 cked documentation of the being provided.  ion and interview on 7/26/23 at C indicated he was thirsty. He we no oral care provided, and bstance under his finger nails call light was lying on the tray				

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i ´		î í		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING			COMPLETED	
		155209	B. W	ING		07/26	/2023	
	PROVIDER OR SUPPLIER			950 CR	ADDRESS, CITY, STATE, ZIP COD OSS AVE DN, 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	
		confirmed. The wound bed						
	1	ough or eschar) pressure						
		. The resident's diagnoses						
		not limited to, hemiplegia						
	_	nfarction affecting left a complete traumatic						
		v level left arm, difficulty						
		ageable pressure ulcer of left						
	hip and right buttoc							
	1	on and interview on 7/26/23 at						
	_	at B was observed lying on his						
		he had asked staff to get him						
	up earlier that morn	ing and he was still waiting.						
	_	on and interview on 7/26/23 at						
	_	reyor observed staff at the						
		otified CNAs 2 and 3 that						
		to get up. The two CNAs wailing for food trays and						
		fter the lunch meal trays were						
	all served.	tier the ranen mear trays were						
		ous interview, from 7/25/23 to						
		dicated there was not enough						
		per care for the residents. Staff						
		esidents basic needs without were call ins, they really						
		days they were not able to do						
		change for the dependent						
	residents.	change for the dependent						
		ous interview, from 7/25/23 to						
		dicated staffing was a struggle						
		of call ins. On the weekends						
	_	the call ins were frequent and it						
	was really hard. The	e residents' care was affected.						
	During an anonymo	ous interview, from 7/25/23 to						
		dicated there was not enough						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	ING		07/26/2023	
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
VA/A TEDO	) OF OUETY FALL (	) THE			OSS AVE		
WATERS	OF CLIFTY FALLS	o, IHE		MADISC	ON, IN 47250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID BROWDER'S BLANGE CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	staff to provide qual	ity care on a good day and					
	when there were cal	l ins, they could just barely					
	meet the resident's b	pasic needs.					
	The current facility	policy, titled "Perineal Care",					
	and not dated, was p	provided by the Administrator					
	-	.m. The policy indicated, "					
	_	e that resident receive					
	-	ter periods of incontinence to					
		dors, and promote comfort"					
	,	,					
	The current facility	policy, titled "Preventive Skin					
		d, was provided by the					
		26/23 at 1:30 p.m. The policy					
		le skin care through careful					
	_	d drying to keep residents					
		well-groomedProcedure: 1)					
		ovided by staffas necessary					
	-	ified as being at high risk for					
		shall be turned and					
	-						
	repositioned frequer	-					
	wrinkle-free, clean,	dry bed linen"					
		G 1 : DI00413207					
	This Federal tag rela	ntes to Complaint IN00413207.					
	2.1.20(.)(2)						
	3.1-38(a)(3)						
F 0725	402.25(a)(4)(2)						
SS=E	483.35(a)(1)(2)	04-#					
	Sufficient Nursing						
Bldg. 00	§483.35(a) Sufficie						
		ave sufficient nursing staff					
		te competencies and skills					
	•	rsing and related services					
		safety and attain or					
	_	est practicable physical,					
		osocial well-being of each					
	resident, as deterr						
		individual plans of care and					
	considering the nu						
	diagnoses of the fa	acility's resident population					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155209	B. W	ING	_	07/26/	/2023
	PROVIDER OR SUPPLIER		•	950 CR	ADDRESS, CITY, STATE, ZIP COD OSS AVE ON, IN 47250	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEARLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	in accordance with required at §483.7	n the facility assessment 70(e).					
	§483.35(a)(1) The services by sufficie following types of basis to provide now in accordance with (i) Except when withis section, licens (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a licens charge nurse on elementary Based on observation review, the facility sufficient nursing stand services related 8 of 27 days of as with residents reviewed by Findings include:  1.a. On 7/26/23 at 1 Assessment Tool", was provided by the Assessment Tool" in residents requiring the staff for transfer was dependent residents requiring a The Staffing Plan in	e facility must provide ent numbers of each of the personnel on a 24-hour ursing care to all residents in resident care plans: aived under paragraph (e) of sed nurses; and personnel, including but not des. eept when waived under his section, the facility must sed nurse to serve as a	F 0'	725	F725 The facility must have sufficien nursing staff with the appropriation competencies and skills sets to provide nursing and related services to assure resident satisfied and attain or maintain the high practicable physical, mental, a psychosocial well-being of ear resident, as determined by resident assessments and individual plans of care and considering the number, acuit and diagnoses of the facility's resident population in accordation with the facility assessment required at §483.70(e).  1. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice?	ate o fety nest and ch  y ance II be ents	08/11/2023
		on 7/26/23 at 11:10 a.m., the			Resident C Care Plan updated reflect oral care, nail care, and		

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09/05/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155209 B. WING 07/26/2023 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Administrator indicated there was one nurse, one check and change program, also Oualified Medication Aide (OMA), and two CNAs added to Kardex. on the three Living Well Hallways. There was a Resident B Care plan was updated total of 45 residents on the three hallways. to reflect total dependence with all transfers. The Daily "As Worked" Nursing Schedules were provided by the Administrator on 7/26/23 at 11:12 1. How other residents having the a.m., and indicated the following nursing staff potential to be affected by the worked the following dates: same deficient practice will be identified and what corrective - 7/26/23, Wednesday, 4 nurses, 1 QMA, and 9.5 action(s) be taken? CNAs. All residents have the potential to - 7/22/23, Saturday, 6 nurses, 1 QMA, and 6.5 be affected by the cited practice, CNAs, therefore, this plan of correction - 7/13/23 Thursday, 7 nurses, and 9 CNAs, applies to all residents of the - 7/7/23, Friday, 7 nurses, and 10 CNAs, facility. - 7/6/23, Thursday, 7 nurses, and 10 CNAs, - 7/4/23, Tuesday, 7 nurses, 1 QMA, and 9.5 1.What measures will be put CNAs. into place and what systemic - 7/1/23, Saturday, 7 nurses, and 9 CNAs, and changes will be made to ensure - 6/30/23, Friday, 6 nurses, 1 QMA, and 9 CNAs. that the deficient practice does not During an interview on 7/26/23 at 11:15 a.m., the The ED was re-educated relative Administrator indicated when the facility to Sufficient Staffing by the RDO, assessment tool was updated on 3/1/23 the including but not limited to average number of residents was 87 and the provision of sufficient staffing current number of residents in the building was based on resident acuity to meet 91. the needs and preferences of residents on 8/9/23. During an observation and interview on 7/26/23 at 9:45 a.m., Resident C was lying on his back. He 1. How the corrective action(s) indicated he needed cleaned up due to an will be monitored? accident and did not know where his call light ED/Designee will monitor staffing was. There was an odor of stool and the call light levels 5 days a week for 1 month, was in the floor on the left side of the bed. His lips then 1 day a week for one month, were dry with skin peeling, and he constantly then monthly for 4 months. Any licked his lips and used his teeth to try and concerns noted in this audit will be remove the dried skin. addressed and corrected

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During an interview on 7/26/23 at 9:46 a.m., the

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immediately.

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ED/Designee will be responsible

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AND PLAN OF CORRECTION  DENTIFICATION NUMBER  A BUILDING  NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIETY FALLS, THE  SIRRET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, IN 47250  ID  PREFIX  (PACH DEPICIPACY MIST HE PRECEDED BY PLI I.  TAO  Assistant Director of Nursing (ADON) indicated he would get help in Resident. C It not certified Nursing Aids (CNAs) had someone in the shower and would get him cleaned up as soon as possible.  1.b. During an observation on 7/26/23 at 9:59 a.m., CNAs 2 and 3 entered Resident C's room. There was a large amount of loose stool on the resident's skin from his waist down his legs. There was dried stool on the fitted sheet was removed there was a dinner plate sized amount of loose stool on the mattress.  Resident C had a dark substance under his fingernalis on both hands. The indicated he lays on his back, there was a dark substance under his fingernalis on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back, there was a dark substance under his finger nails on both hands. He indicated he lays on his back, there was a dark substance under his finger nails on both hands. He indicated his moth was day. The ADON instructed CNA 2 to use a swab to provide ord care. CNA 2 indicated there was only lemon flavored awabs and the resident did not his those.  A review of the resident's councer their grovided.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE  (X9) ID  SUMMARY STATEMENT OF DEFICIENCIE (INCHI DEFICINCY MICT BE PRICEDED BY PELL  TAG  Assistant Director of Nursing (ADON) indicated he would get him fee Resident C. The Certified Nursing Aides (CNAs) had someone in the shower and would get him cleaned up as soon as possible.  1.b. During an observation on 7/26/23 at 9.59 a.m., CNAs 2 and 3 entered Resident C's room. There was a large amount of loose stool on the residents skin from his waist down his legs. There was dried stool on the fitted sheet and on the resident's legs, waist, and buttocks. When the fitted sheet was remived there was a dimer plate sized amount of floose stool on the metatress. Resident C had a dark substance under his fingermalis.  During an observation and interview on 7/26/23 at 11:34 a.m., Resident C was lying on his back, there was a dark substance under his finger nails on both hands. The indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both lands the resident fine has a back most of the time. The resident's finger nails on both hands. He indicated he lays on his back most of the time. The resident's finger nails on both hands. He indicated his mouth was dry. The ADON mistrueted CAVA 2 to use a swal bur provide oral care. CNA 2 indicated there was only femon flavored wabs and the resident did not like those.  A review of the resident since he was wet. Resident C indicated his woulh was dry	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETED			LETED
MATERS OF CLIFTY FALLS, THE  WATERS OF CLIFTY FALLS, THE  SIMMARY STATEMENT OF DEPKIENCIE.  (PACH DEPKIENCY MIST UP PRICEDED BY RELL.  TAG  Assistant Director of Nursing (ADON) indicated he would get help for Resident C. The Certified Nursing Aides (CRAS) had someone in the shower and would get him cleaned up as soon as possible.  1.b. During an observation on 7/26/23 at 9.59 a.m., CNAs 2 and 3 entered Resident C's room. There was a large amount of loose stool on the residents legs, waist, and buttocks. When the fitted sheet was removed there was a dinner plate sized amount of loose stool on the mattress. Resident C had a dark substance under his finger mails, and asked CNA 3 to clean the resident's finger mails, and asked CNA 3 to clean th			155209	B. W	B. WING 07/26/2023			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WXUG11 Facility ID: 000116

If continuation sheet Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 5/2023	
	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 APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TAG	During an observativas observed to have there was a dark sulton both hands. His of table to the left of the dark of the left o	on and interview on 7/26/23 at C indicated he was thirsty. He we no oral care provided, and ostance under his finger nails call light was lying on the tray	TAG	DEFICIENCY		DATE
	7/26/23, Staff 11 indue to the number of with good weather to	ous interview from 7/25/23 to dicated staffing was a struggle of call ins. On the weekends the call ins were frequent and it the residents' care was affected.				

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

Event ID:

WXUG11 Facility ID: 000116

If continuation sheet Page 10 of 11

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

PRINTED: 09/05/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>			COMPLETED	
		155209	B. WIN	B. WING		07/26/2023		
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			OSS AVE			
WATERS OF CLIFTY FALLS, THE				OSS AVE ON, IN 47250				
WATERO	OF CENTITIALES			WIADIO(	3N, IN 47230			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ous interview from 7/25/23 to						
	7/26/23, Staff 12 in	dicated there was not enough						
	staff to provide qua	lity care on a good day and						
	when there were cal	ll ins, they could just barely						
	meet the resident's l	basic needs.						
	The current, undate	d, facility policy, titled						
	"Perineal Care", wa							
		26/23 at 1:30 p.m. The policy						
		ose: to ensure that resident						
	-	giene after periods of						
	-	vent infection, odors, and						
	_							
	promote comfort							
	The current facility	policy, titled "Standard						
		onitoring", and dated 11/25/11,						
	_	e Administrator on 7/26/23 at						
		ry indicated, "guideline						
		· -						
		tive intervention promoting						
		and psychosocial well-being						
		ff assignments are based on the						
		far as their acuitymeeting						
those needs to include physical, emotional,								
	psychosocial, social	l, and spiritual, will be						
	accomplished by pr	ovision of as much "hands						
	on" care as necessar							
	This Federal tag rel	ates to Complaint IN00413207.						
	3.1-17(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WXUG11 Facility ID: 000116 If continuation sheet Page 11 of 11