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	01/21/2025

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
K 0000 Bldg. 01	An investigation of Complaint Number IN00451274 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number IN00451274 - A Federal/State deficiency related to the allegation was cited at K711. Survey Date: 01/21/25 Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330 At this Complaint survey, The Waters of Clifty Falls was found not 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 alarms in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 92 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Alcorn	Administrator	02/03/2025

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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	not sprinkled. Quality Review completed on 01/22/25			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview the facility failed to ensure the fire safety plan in regard to the use of alarms for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states that any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency.	K 0711	K711 – It is the intent of the facility to ensure the fire safety plan in regard to the use of alarms for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, section 19.7.2.2 to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 1/31/2025 the Administrator inserviced all staff on the proper procedures according to the facilities fire safety plan which includes activating the fire alarm system by pulling the nearest alarm to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. The Administrator/Maintenance Supervisor will ensure all staff are aware of the proper procedures according to the facilities fire safety plan as a part of the facilities Emergency Preparedness Program and document those inspection results	01/31/2025

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	Findings include: Based on interview at the time of record review on 01/21/25 between 10:30 a.m. and 12:30 p.m. with the Administrator and Maintenance Director it was determined the facility had a recent fire/smoke incident. The Maintenance Director said on 01/13/25 at about 3:40 p.m. the battery-powered smoke alarm in resident room 215 was activated and the Housekeeping Supervisor was the first on site. He said she called him because she didn't know why the detector was alarming. He said he got to the room within about 90 seconds and found the exhaust vent fan in the bathroom between rooms 214 and 215 on fire. He said the plastic cover of the exhaust vent fan had fallen on the floor and caught a towel on fire which he said he stomped on and was able to put out. He said a wire on the exhaust vent fan still had a small flame that he was able to put out by fanning it with his hand. He said while this was going on a Code Red had been announced over the intercom system for the 200 hall, so staff had started removing residents from rooms 214 and 215 first, and then the rest of the 200 hall beyond the nearest set of smoke barrier doors. He said staff also brought fire extinguishers to the area. The Maintenance Director said he called the fire department chief and told him he had put out the fire, but still needed someone from the fire department to visit the facility to give them the all clear so residents could be moved back into their rooms. He said the fire department chief came within an hour and gave the facility the all clear. When asked, the Maintenance Director said no fire extinguishers were used and the facility's fire alarm system was not activated at any time during the event, either automatically or manually by staff pulling the fire alarm pull station.		as appropriate. All staff will be inserviced annually or as needed. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with 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. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance 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 as 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 1/31/2025.	

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	Based on review of the facility's fire safety plan for "Procedures for Staff Response to Battery-Powered Smoke Detectors" it is stated "If any evidence of fire or smoke is detected, staff will activate the fire system by pulling the nearest pull station". Based on interview at the time of review, the Maintenance Director acknowledged the written procedure for staff response to the activation of a battery-powered smoke detector, and agreed the fire alarm system should have been activated by pulling the nearest pull station. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) This federal tag relates to complaint number IN00451274.			