STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BU	ILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155209	B. WI	NG		06/04/	/2025	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 950 CROSS AVE MADISON, IN 47250				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
F 0000								
Bldg. 00	Licensure Survey.  Survey dates: May 2025  Facility number: 0 Provider number: AIM number: 1002  Census Bed Type: SNF/NF: 96 Total: 96  Census Payor Type Medicare: 4 Medicaid: 26 Other: 66 Total: 96  These deficiencies accordance with 4: Quality review cor	155209 266330 e: reflect State Findings cited in	F 00	000	Preparation and/or execution this plan of correction in general or this corrective action does not constitute an admission or agreement by this facility of the facts alleged or conclusions of the plan of correction and specific corrective actions prepared and/or executed in compliance with state and fed laws. This plan of correction constitutes our credible allegation of compliance with all regulated requirements. Our date of compliance is 7/3/2025. This provider respectfully requests this 2567 Plan of Correction be considered the Letter of Credital Allegation of Compliance and requests desk review in lieu or post survey review on or after 7/3/2025.	ral, not  e et ection c eral tion ory that e ble		
F 0554 SS=D Bldg. 00		min Meds-Clinically Approp						
	interview, the facil appropriately for 1 self-administering Findings include:	ion, record review, and ity failed to store medications of 1 resident reviewed for medications. (Resident 7)	F 05	54	F554: Resident Self Administration of Meds  It is the policy of this facility to store medications appropriate		07/03/2025	
	-	tion and interview, on 05/29/25 ident 7 was lying in his bed. His			What corrective action will be accomplished for those reside	ents		

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

TITLE

(X6) DATE

Melinda Alcorn Administrator 06/27/2025

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

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YJOB11 Facility ID: 000116 If continuation sheet Page 1 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED
		155209	B. W	ING	<del>.</del>	06/04/	/2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ROSS AVE		
WATERS	S OF CLIFTY FALL	S THE			ON, IN 47250		
WAILIN	- CLII II I ALL	O, 111L		IVIADIO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		was sitting beside the bed and			found to be affected by the		
		icine cups. One cup had one			deficient practice?		
	_	ner had seven pills in it. The					
		he medications had been there			The DON/Designee complete		
	for some time. He believed the medication was his				Medication Self Administration		
		relaxer, and his cholesterol			assessment on 06/05/2025 ar	ıd	
		as unsure what the others were.			resident does not to		
	There were no nursing staff in the room.				self-administer medications.		
	The clinical record for Resident 7 was reviewed on				How other residents of the fac	ility	
	06/02/25 at 9:57 A	.M. A Quarterly Minimum Data			were identified to potentially b	е	
		nent, dated 04/17/25, indicated			affected by the practices are:		
		gnitively intact. The resident's					
	_	, but were not limited to,			The DON/Designee complete	d a	
		etes, hyponatremia, and			Medication Self Administration	1	
	depression.				assessment on residents and	any	
					residents that choose to		
		lacked an assessment for the			self-administer medications w	ere	
		ninister his medications or a			supplied with a lock box to see	cure	
	physician order to s	self-administer medications.			medication, order to		
					self-administer medications a	nd	
	_	w, on 06/03/25 at 2:02 P.M.,			care plans were updated.		
		Nurse (LPN) 2 indicated if a					
		istered medications, then they			What measures will be put in		
	1	ician's order to do so and have			place and what systemic char	ıges	
	an assessment com	pleted.			will be made to ensure the		
	<b>.</b>	06/04/05 110 00 135			deficient practice does not rec	:ur?	
	_	w, on 06/04/25 at 10:09 A.M.,			T. DOMES		
		tor of Nursing (ADON)			The DON/Designee in-service		
		ent did not have an order to			all nursing staff on the policy		
		dications and should not have			Administration of Medications		
		s sitting at his bedside			not medications at bedside or		
	unattended.				before 6/25/25. Additionally, a	•	
	The assument for all the	r naligy titled			staff member that fails to com		
	The current facility policy titled,				with the points of this in-service		
	"Self-Administration of Medications by				will be further educated and/o	ſ	
	Residents", dated March 2023, was provided by the Director of Nursing on 06/03/25 at 3:18 P.M.				disciplined as needed.		
		ed, "Self-administration					
	medications will be	e encouraged if it is desired by	1		1		1

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

PRINTED: 07/02/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	l í	UILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>06/04</b> /	ETED		
	PROVIDER OR SUPPLIER		•	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
IAU	the resident, safe for residents of the facing physician, and appropriate TeamIf the resident safely self-administrates assessment of the strange is conducted obtained to self-adrabove storage and supproved for the resident. The order is resident.	r the resident, and other lity, ordered by the attending oved by the Interdisplinary int demonstrates the ability to the medications, a further afety of bedside medication dA physician order is minister medications if the akill assessment has been sident by the interdisplinary recorded on the MAR aistration Record]"		IAU	How be monitored to ensure to deficient practice will not recuive. What quality assurance program will be put into place.  The DON/Designee will comproom rounds on 20 random residents for medications left bedside weekly x 4 weeks, the 10 random residents weekly x weeks, then 5 random resider monthly x 4 months. Any concerns noted will be immediately addressed and corrected. If the facility is with 95% compliance, will be stopp Results of the monitoring will reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, ar patterns will be identified. Any be written by the QAPI comm. Any written Action Plan will be monitored by the Administrator weekly until resolved.  Date of Compliance: 7/3/2025	he r, ? lete at en 4 hts in bed. be ve vy will ttee. er	DATE		
F 0583 SS=E	483.10(h)(1)-(3)(i) Personal Privacy/	n(ii) Confidentiality of Records							

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet

Page 3 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/04/2025		
	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 LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00	failed to keep reside to resident meal tick 3 of 6 resident confi observations. (Resident confi observations.) (Resident confi observations.) (Resident confiction of the state of the stat	ation, on 05/29/25 at 12:11 e dementia unit were serving mbers Activity Aide 7, et 10, and Licensed Practical e serving the resident meal cards them in the trash can.  The and observation, on 05/29/25 vity Aide 7 indicated they had a meal tickets in the regular have been placed in She removed the following as from the trash can: Residents 2, 45, 57, 91, and 34.  The observation, on 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation, on 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation, on 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.  The observation of 05/29/25 at 12:14 P.M., are resident meal tickets should the shred box.	F 058	3	F583: Personal Privacy/ Confidentiality of Records: It is the policy of this facility to keep resident information privrelated to the meal tickets and computer screens.  What corrective action will be accomplished for those reside found to be affected by the deficient practice?  The DON/Designee assessed resident 26, 73, 23, 36, 77, 42, 57, 91, 34, 66, and split hall a 100 on 06/05/2025 and no negative outcome related to the cited practice.  How other residents of the fact were identified to potentially be affected by the practice:  All residents have the potential be affected by the cited this profice correction applies to all residents.  What measures will be put in place and what systemic charmwill be made to ensure the deficient practice does not recompliant to the policy of Personal Privacy/Confidentiality of Recompt placing meals tickets in the trash can and placing in shreet	ents d ents d 2, 45, nd he cility he al to lan hges cur? ed all l ords, e	07/03/2025

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet

Page 4 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155209	B. W	ING		06/04/	/2025
NAME OF F	AD CLUBED OR CURPLUE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			ROSS AVE		
WATERS	OF CLIFTY FALLS	S, THE		MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					closing the computer/locking		
		sident in a wheelchair propelled			screen during medication		
	by the cart and looked towards the computer and				administration and when not in	า	
	kept going,				use on or before 6/25/25.		
					Additionally, any staff member		
		staff members walked by the			that fails to comply with the po		
	cart, and				of this in-service will be furthe		
					educated and/or disciplined as	3	
	· ·	arse went to the medication cart			indicated.		
	and closed the comp	•					
	_	ous observation, on 05/29/25			How be monitored to ensure t	he	
	from 1:38 P.M. thro	ough 1:44 P.M. the following			deficient practice will not recu	re,	
	was observed:				i.e. what quality assurance		
					program will be put into place	?	
	- At 1:38 P.M., a co	emputer screen was opened on					
	Medication Cart 1 o	on the 100 Hallway that was			The DON/Designee will monit	or	
	sitting between resid	dent Rooms 108 and 109. The			meal service meal services to		
	screen had Resident	t 66's name and medication list			ensure meal tickets are prope	rly	
	visible.				removed from trays and place	d in	
					the shred container 5 days a v	veek	
	- At 1:39 P.M., a re	sident in a wheelchair propelled			x 4 weeks, then 3 days a wee	k x	
	by the cart and look	ted towards the computer and			4 weeks, then weekly x 4		
	kept going,				months.		
	A + 1 · A () D N A - I DN	N 8 who had been standing at			The DON/Decisions will record	or	
		outside of Room 110,			The DON/Designee will monit		
		· · · · · · · · · · · · · · · · · · ·			computer monitors 5 days a w		
		Peet from Medication Cart 1, 109 next to Medication Cart 1			x 4 weeks, then 3 days a wee		
					4 weeks, then weekly x 4 mor	ເເາຣ.	
		of both Medication Carts 1			Any concerns noted will be		
		not close the open computer			immediately addressed and		
	screen on Medication	on Cart 1.			corrected.		
	- At 1:41 P.M., a re	sident in a wheelchair propelled			If the facility is within 95%		
	by the cart,				compliance at the end of 6		
	-,				months, will be stopped. Resu	ılts	
	- At 1:42 P.M., a sta	aff member walked past the cart,			of the monitoring will be review		
		out of room 109 and returned to			at the monthly QAPI meeting.		
	the second medicati				concerns will have been	,	
		•			addressed. However, any pati	erns	
	- At 1:43 P.M a re	sident in a wheelchair propelled			will be identified. Any will be		

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		06/04/2025			
		-	STREE	ET ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIEI	R		CROSS AVE				
WATERS	OF CLIFTY FALLS	S, THE	MAD	MADISON, IN 47250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE			
	by the open compu	PN 8, turned around and went		written by the QAPI committee				
	by the open compu	ter screen agam,		Any written Action Plan will be monitored by the Administrator				
	- At 1:44 P.M., Ou	alified Medication Aide 11 went		weekly until resolved.	"			
	to the Medication Cart 1 and closed the computer			woonly arian roosived.				
	screen.	1						
	During an interview	v, on 06/04/25 at 9:41 A.M.,		Date of Compliance: 7/3/2025	5			
		e computer screens should						
	-	ed or hidden from public view						
	when the nursing st	taff were not at the computers.						
	The assument facility	maliantitled "MEDICAL						
	-	policy titled, "MEDICAL ELINES", dated 01/09/23, was						
		lministrator on 06/04/25 at						
		licy indicated, "The clinical						
	-	s are the property of the						
		Rights related to health						
	information are rec	ognized in accordance with the						
	Privacy Rules of H	ealth Insurance Portability and						
	-	(HIPAA). Clinical records are						
	-	individuals, and stored in an						
		ea that is protectedand						
	should be locked'	•						
	3.1-3(o)							
F 0640	483.20(f)(1)-(4)							
SS=D	Encoding/Transm	ittina Resident						
Bldg. 00	Assessments	9						
	Based on record re-	view and interview, the facility	F 0640	F640: Encoding/Transmitting	07/03/2025			
	failed to ensure a M	Inimum Data Set (MDS)		Resident Assessments				
		nsmitted to the Centers for		It is the policy of this facility to				
		icaid Services (CMS) in a		ensure a Minimum Data Set				
		1 of 20 resident assessments		assessment is transmitted to t				
	reviewed. (Residen	1 63)		Centers of Medicare and Med	icaid			
	Findings include:			services timely.				
	Findings include.			What corrective action will be				
	The clinical record	for Resident 85 was reviewed		accomplished for those reside	ents			

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 6 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155209	B. W	ING	_	06/04/	2025
NAME OF P	DOMDED OF CURRY TER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>			OSS AVE		
WATERS	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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
		1 P.M. A Discharge 2/28/24, indicated the resident			found to be affected by the		
		lity from the hospital on			deficient practice?		
		-			The MDS Nurse/Designee		
	12/04/24. The resident discharged from the facility on 12/28/24. The discharge was unplanned, and				submitted the Discharge		
	the resident went ho	-			assessment for Resident 85 o	n	
	the resident went he	one.			6/4/2025.	''	
	The assessment hist	ory indicated the assessment					
		a batch to be transmitted to			How other residents of the fac	ility	
	CMS.				were identified to potentially b		
					affected by are:		
	-	on 06/04/25 at 2:36 P.M., the					
	-	ordinator indicated it didn't look			The MDS Nurse/Designee		
	_	ssessment was transmitted. It			completed a 90 day look back		
		ent out sooner. The facility did			audit of discharges for submis	sion	
		lated to transmitting MDS			of the Discharge MDS		
		followed the RAI (Resident			assessment on 6/5/2025.		
	Assessment Instrum	nent) manual.			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	3.1-31(a)				What measures will be put in	900	
	3.1-31(a)				place and what systemic chan will be made to ensure that the	-	
					deficient practice does not rec		
					denoient praduce adea not red		
					The Administrator in- the MDS	3	
					Coordinator on transmittal		
					requirements on or before 6/2		
					Additionally, any staff member		
					that fails to comply with the po		
					of this in-service will be further		
					educated and/or disciplined as	5	
					indicated.		
					How the corrective action will	be	
					monitored to ensure the defici		
					practice will not recur, i.e. wha		
					quality assurance program wil		
					put into place:		
					The MDS Coordinator will mor	nitor	
					transmitted assessments 5 da	ys	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 7 of 42

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

PRINTED: 07/02/2025 FORM APPROVED OMB NO. 0938-039

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE COMPL 06/04/	ETED
	PROVIDER OR SUPPLIES			950 CR	ADDRESS, CITY, STATE, ZIP COD OSS AVE DN, IN 47250	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					a week x 4 weeks, then 3 days week x 4 weeks: then weekly months. If the facility is within 95% compliance at the end of months, will be stopped. Resu of the monitoring will be review at the monthly QAPI meeting. concerns will have been addressed. However, any patt will be identified. Any will be written by the QAPI committee Any written Action Plan will be monitored by the Administrato weekly until resolved.	x 4 6 llts ved Any erns c.	
F 0657 SS=D Bldg. 00		and Revision on, record review, and	F 065	7	F657: Care Plan Timing and		07/03/2025
	care plan related to	ity failed to revise a resident's the resident's leg prosthesis s reviewed for care plans.			Revision: It is the policy of this facility to revise a care plan related to the leg prosthesis.		
		oserved in his room on 05/29/25 resident was sitting in his			What corrective action will be accomplished for those reside found to be affected by the deficient practice?	nts	

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

Event ID:

YJOB11

Facility ID: 000116

If continuation sheet

Page 8 of 42

PRINTED: 07/02/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155209	B. WING		06/04/2025	
		l .	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		ROSS AVE		
WATERS	S OF CLIFTY FALLS	S. THE		ON, IN 47250		
	1			1		
(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 APPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ident had a below the knee				
	_	eft leg and was wearing a		The MDS Nurse/Designee upda		
	prosthetic leg.			resident ADL's care plan related		
				his leg prosthesis on 6/05/2025		
		57 A.M., the resident was		1		
		m with a family member. The		How other residents of the facili	ty	
	resident was wearing	ng his prosthetic leg.		were identified to potentially be		
				affected by this practice are:		
		22 P.M., the resident was in his				
		member. The resident was		The MDS Nurse/Designee		
		tic leg. The resident indicated		completed an audit of ADL's ca		
	_	c for 3 or 4 years. He had no		plan and updated as needed or	1	
	_	ursing staff assisted him with		6/5/2025.		
	putting it on every of	day. He did not put it on				
	himself.			What measures will be put in		
				place and what systemic chang	es	
	The clinical record	for Resident 75 was reviewed		will be made to ensure that the		
	on 06/04/25 at 1:25	P.M. A Quarterly Minimum		deficient practice does not recu	r:	
	Data Set (MDS) ass	sessment, dated 05/16/25,				
	indicated the reside	nt was severely cognitively		The Administrator in-serviced th	ne	
	impaired. The diagr	noses included, but were not		DON, ADON and MDS		
	limited to, heart fail	lure, diabetes, non-Alzheimer's		Coordinator on Care Plan Timir	ng	
	dementia, and acqui	ired absence of the left leg.		and Revisions on or before		
	The resident had an	impairment on one side of		6/25/25. Additionally, any staff		
	their lower extremit	ty. There was no indication the		member that fails to comply witl	n	
	resident had a limb	prosthesis. The resident		the points of this in-service will		
	admitted to the faci			further educated and/or disciplin		
				as needed.		
	During an interview	on 06/04/25 at 2:30 P.M., the				
	MDS Coordinator i	ndicated the MDS assessment		How the corrective action will be	е	
	did not indicate the	resident wore a prosthetic leg.		monitored to ensure the deficier		
	He didn't wear a pro	osthesis when he admitted to		practice will not recur, i.e. what		
		ident did have a care plan for		quality assurance program will I	be	
		vities of daily living (ADLs)		put into place:		
		the knee amputation.				
		•		The DON/Designee will review		
	During an interview	v, on 06/04/25 at 2:38 P.M.,		care plans of 20 random reside	nts	
	_	Nurse 5 indicated the resident		care plans weekly x 4 weeks for		
		netic leg since she had taken		revisions and updated with new		
	care of him.	.0		orders, then 10 random residen		
	1		1	1	·- I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/04/2025		
	ROVIDER 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	During an interview Certified Nurse Aid familiar with the rest the resident with car cleaned up and get of on.  The resident's Care 06/03/25 at 3:00 P.I assistance with AD knee amputation lac resident had a prost.  During an interview Assistant Director of aware that the resident's Care Plan prosthetic; there she CNAs.  The current facility Plan Assessment/Cowith a revision date the Regional Direct 3:40 P.M. The polic Comprehensive Car updated every quart may need to review	y, on 06/04/25 at 2:40 P.M., le (CNA) 6 indicated she was sident. Every time she assisted re, she would help him get dressed and put his prosthetic  Plans were reviewed on M. The resident's Care Plan for Ls related to the below the eked any indication the		IAU	weekly x 4 weeks, then 5 rand residents monthly x 4 months. the facility is within 95% compliance at the end of 6 months, will be stopped. Resu of the monitoring will be review at the monthly QAPI meeting. concerns will have been addressed. However, any patt will be identified. Any will be written by the QAPI committee Any written Action Plan will be monitored by the Administrato weekly until resolved.  Date of Compliance: 7/3/2025	If  Its ved Any erns	DATE
F 0684 SS=E Bldg. 00	483.25 Quality of Care						
	physician's orders re	riew, interview, and ility failed to follow elated to cardiac medication I follow manufacturer's	F 00	684	F684: Quality of Care It is the policy of the facility to follow physician orders related to car		07/03/2025

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 10 of 42

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 06/04/2025		
	VIDER OR SUPPLIER F CLIFTY FALLS		STREET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, 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		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
2	esidents reviewed f , 93, 7, 78, and 29)	o insulin pen usage for 5 of 20 For Quality of Care. (Residents			medications and hold paramet and to follow manufacturer guidelines related to insulin pe usage.		
1		cal record was reviewed on					
	06/04/25 at 10:17 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/20/25, indicated				What corrective action will be accomplished for those reside	nte	
	, ,	gnitively intact. The resident's			found to have been affected b		
	-	but were not limited to,			deficient practice:	•	
aı	nemia, hypertensio	on, and chronic kidney disease.			The DON/Designed account		
A	an open-ended phy	sician's order, with a start			The DON/Designee assessed updated the physician for residual control of the physician for the physician for residual control of the physician for the physic		
		dicated the nursing staff were			2 receiving cardiac medication		
		sident's Metoprolol 12.5			without document of blood		
		ly at 9:00 A.M. and 9:00 P.M.			pressure and heart rate, reside		
		ne medication was to be held if			93 for receiving cardiac medic		
	-	ic blood pressure (top			without documentation of bloo		
		rk) was less than 110, the			pressure and heart rate, reside		
	-	sure (bottom number/heart at 60, or the resident's heart rate			received a cardiac medication		
	vas less than 60.	o, or the resident's heart rate			outside of the parameters, resident 78 receiving cardiac		
"	vas iess man oo.				medication outside of paramet	ere	
lπ	he May 1 through	June 3, 2025 Electronic			and resident 29 for not priming		
		stration Record (EMAR)			insulin pen on 6/5/2025.	,	
		nt had received the medication					
tv	wice a day. The rec	ord lacked documentation of			How other residents having th	е	
aı	ny assessment of th	ne resident's blood pressure			potential to be affected by the		
aı	nd heart rate for the	e 9:00 P.M. dose of the			same deficient practice will be		
n	nedication.				identified and what corrective		
					action will be taken:		
	-	policy titled "PHYSICIAN			The DON/Deed	J	
<b>I</b>		VING PHYSICIAN ORDERS			The DON/Designee completed		
		a review date of 02/12/24, was ministrator on 06/04/25 at			audit of residents with parame and medication administered	iers	
1 ^	•	icy indicated, "It is the policy					
	_	low the orders of the			outside of the parameters and notified the MD as needed and		
	hysician"	tow the orders of the			residents receiving insulin via	101	
1 ~	•	d for Resident 93 was reviewed			insulin pen and potential of no	t	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 11 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155209	B. W	ING		06/04/	2025
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\4/4.TED	OF OUETY FALL	. THE			ROSS AVE		
WATERS	OF CLIFTY FALLS	D, IME		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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	on 06/02/25 at 10:4	7 A.M. An Admission MDS			receiving full does and physici	an	
	assessment, dated 0	5/01/25, indicated the resident			notified on 6/5/2025.		
	was severely cognit	rively impaired. The resident's					
	diagnoses included,	but were not limited to,			What measures will be put in		
	hypertension and orthostatic hypotension.				place and what systemic chan	iges	
					will be made to ensure that the	-	
	An open-ended phy	sician's order, with a start			deficient practice does not rec		
	date of 04/25/25, indicated the staff were to				,		
		ent's Midodrine 5 mg, twice a			The DON/Designee in-service	d all	
		n. The staff were to hold the			nursing staff on or before 6/25		
		sident's systolic blood			on administering medications		
		r than 120 or the diastolic was			outside of hold parameters an	d	
	greater than 80.				priming insulin pens. Additiona		
					any staff members that fail to	,	
	The May and June 2	2025 EMAR and Vitals Report			comply with the points of this		
	-	lent had the blood pressure			in-service will be further educa	ated	
		dministration of the medication			and/or disciplined as indicated		
		00 P.M. through 06/03/25 at 9:00					
	A.M.	S			How the corrective action will	be	
					monitored to ensure deficient		
	3a. The clinical reco	ord for Resident 7 was reviewed			practice will not recur, i.e. wha	ıt	
		A.M. A Quarterly MDS			quality assurance program wil		
		4/17/25, indicated the resident			put into place:		
		act. The resident's diagnoses			ļ ·		
		not limited to, hypertension,			The DON/Designee will monitor	or	
		mia, and depression.			the EMAR for medications with		
		-			parameters and following		
	An open-ended phy	sician's order, with a start			physician orders 5 times a we	ek x	
		dicated the staff were to			4 weeks, then 3 times a week		
		ent's Coreg 25 mg, twice a day			weeks, then once a week x 4		
	for hypertension. Th	he staff were to hold the			months.		
	medication if the re-	sident's systolic blood					
	pressure was less th	an 110 or the diastolic blood			The DON/Designee will compl	lete	
	pressure was less th	an 60.			observations for priming insuli		
					pens with 10 random nurses 4		
	The April and May	2025 EMAR indicated the			weeks, then 5 random nurses		
	resident had received the medication when their		weekly x 4 weeks, then 3 random				
	diastolic blood pres	sure was less than 60 on the			nurses monthly x 4 months.		
	following dates and				, , , , , , , , , , , , , , , , , , , ,		
					If the facility is within 95%		

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 12 of 42

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155209	B. W	ING		06/04/	2025
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIER	₹			OSS AVE		
WATERS	S OF CLIFTY FALLS	S, THE		MADIS	ON, 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		00 A.M., the resident's blood			compliance at the end of 6		
	pressure was 200/5				months, will be stopped. If the		
		00 P.M., the resident's blood			facility is within 95% complian		
	pressure was 111/5				at the end of 6 months, will be		
		00 A.M., the resident's blood			stopped. Results of the monitor	-	
	pressure was 159/5				will be reviewed at the monthl	-	
	- On 05/24/25 at 9:00 A.M., the resident's blood				QAPI meeting. Any concerns		
	pressure was 113/59.				have been addressed. Howev		
	21. A				any patterns will be identified.	Any	
	3b. An open-ended physician's order, with a start				will be written by the QAPI		
	date of 05/20/25, indicated the staff were to				committee. Any written Action		
	administer the resident's Lisinopril 10 mg, once a				Plan will be monitored by the		
	day for hypertension. The staff were to hold the medication if the resident's systolic blood				Administrator weekly until		
					resolved.		
	_	nan 110 or the resident's heart					
	rate was less than 6	0.					
	The May 2025 EM	AR indicated the resident had					
	1	ation when their heart rate was					
	less than 60 on the	following dates:					
	0.05/24/25 4	.1 4.1 4 4 50					
		esident's heart rate was 58.					
		esident's heart rate was 58.			Data of Commission 270/0005		
	- On 05/31/25 the r	esident's heart rate was 59.			Date of Compliance: 7/3/2025	)	
	4. The clinical reco	rd for Resident 78 was reviewed					
		3 A.M. A Quarterly MDS					
		03/12/25, indicated the resident					
		tively impaired. The resident's					
		, but were not limited to,					
	_	ostatic hypotension,					
		e ulcer to the left buttock, and					
	adult failure to thriv						
		s's order, with a start date of					
	08/21/24, indicated the staff were to administer the resident's Midodrine 10 mg, every 8 hours for						
		taff were to hold the					
	medication when the	ne resident's systolic blood					
	pressure was greate	er than 100.					

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 13 of 42

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155209		 ILDING	00	COMPL 06/04/	ETED	
NAME OF F	PROVIDER OR SUPPLIER	1		DDRESS, CITY, STATE, ZIP COD		
WATERS	OF CLIFTY FALLS	S, THE	MADISC	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)	TE	(X5) COMPLETION DATE
	resident had receive	d June EMAR, indicated the ad the medication when their ure was greater than 100 on and times:				
	- On 04/02/25 at 10 pressure was 109/60 - On 04/03/25 at 2:0 pressure was 101/65 blood pressure was - On 04/04/25 at 2:0 pressure was 116/79 - On 04/05/25 at 2:0 pressure was 111/69 - On 04/06/25 at 10 pressure was 116/75 - On 04/10/25 at 2:0 pressure was 113/72 - On 04/11/25 at 6:0 pressure was 110/58 - On 04/12/25 at 2:0 pressure was 10/64 - On 04/13/25 at 10 pressure was 106/60 - On 04/14/25 at 6:0 pressure was 102/50 resident's blood pre - On 04/15/25 at 2:0 pressure was 10/54 blood pressure was - On 04/16/25 at 10 pressure was 10/54 blood pressure was 10/54 con 04/16/25 at 10 pressure was 10/56 con 04/16/25 at 10 pressure was 10/56 con 04/16/25 at 10 pressure was 10/56 con 04/16/25 at 2:0 pressure was 10/56 con 04/18/25 at 2:0 pressure was 10/56 con 04/18/25 at 2:0 pressure was 11/76 con 04/18/25 at 2:0 pressure was 11/7	2:00 P.M., the resident's blood 2), 30 P.M., the resident's blood 5 and at 10:00 P.M., when the 112/67, 30 P.M., the resident's blood 9. 30 P.M., the resident's blood 1. 30 P.M., the resident's blood 1. 30 P.M., the resident's blood 2. 30 A.M., the resident's blood 3. 30 P.M., the resident's blood 4. 30 P.M., the resident's blood 4. 30 P.M., the resident's blood 5. 30 P.M., the resident's blood 6. 30 P.M., the resident's blood 7. 81 A.M., the resident's blood 82 A.M., the resident's blood 83 A.M., the resident's blood 84 A.M., the resident's blood 85 A.M., the resident's blood 86 A.M., the resident's blood 87 A.M., the resident's blood 88 A.M., the resident's blood 89 P.M., the resident's blood 90 P.M., the resident's blood				
	- On 04/19/25 at 10 pressure was 108/72 - On 04/22/25 at 2:0 pressure was 102/50	:00 P.M., the resident's blood 2. 00 P.M., the resident's blood				

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

Event ID:

YJOB11

Facility ID: 000116

If continuation sheet

Page 14 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/04/2025	
	PROVIDER OR SUPPLIER		950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX	(EACH DEFICIEN	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 APPROPR	
TAG	pressure was 116/64	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	- On 04/25/25 at 6:0	00 A.M., the resident's blood			
	pressure was 114/62 - On 04/27/25 at 2:0	2. 00 P.M., the resident's blood			
	pressure was 106/58				
		00 P.M., the resident's blood			
	pressure was 102/62	2. 00 A.M., the resident's blood			
		2 and 2:00 P.M., the resident's			
	blood pressure was				
	_	:00 P.M., the resident's blood			
	pressure was 102/58	3.			
	- On 05/12/25 at 2:00 P.M., the resident's blood				
	pressure was 107/64.				
		00 A.M., the resident's blood			
	1 -	3 and 10:00 P.M., the resident's			
	blood pressure was				
	pressure was 102/55	00 P.M., the resident's blood			
	1 ^	00 P.M., the resident's blood			
		3 and 10:00 P.M., the resident's			
	blood pressure was				
	_	00 A.M., the resident's blood			
	pressure was 103/53	3.			
	- On 05/23/25 at 2:0	00 P.M., the resident's blood			
	-	and 10:00 P.M., the resident's			
	blood pressure was				
		00 P.M., the resident's blood			
	pressure was 106/60				
	- On 05/26/25 at 2:0 pressure was 118/62	00 P.M., the resident's blood			
	1 ^	:00 P.M., the resident's blood			
	pressure was 112/66				
	1 ^	00 A.M., the resident's blood			
	pressure was 106/64				
		y, on 06/03/25 at 2:02 P.M.,			
		Nurse (LPN) 2 indicated when a			
		n had hold parameters, she tal sign before giving the			

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 15 of 42

NAME OF PROVIDER OR SUPPLIER  WATERS OF CLIFTY FALLS, THE  SOCROSS AVE  MADISON, IN 47250  SUMMARY STATEMENT OF DEFICIENCE  REGILATORY OR INCUDINTUYENG INFORMATION  TAG  PREFIX  TAG  PROGRESS ALSO COMMENTED PROCEEDED BY FULL  TAG  PROGRESS ALSO COMMENTED PROCEEDED BY FULL  TAG  PREFIX  TAG  PROGRESS ALSO COMMENTED PROCEEDED BY FULL  TAG  PREFIX  TAG  PROGRESS ALSO COMMENTED PROCEEDED BY FULL  TAG  PREFIX  TAG  PROGRESS ALSO COMMENTED  PREFIX  TAG  PROGRESS ALSO COMMENTED  PREFIX  TAG  COMPLETION  DATI  DIPORT AND ASSOCIATION  COMPLETION  TAG  C		AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155209		A. BUILDING  B. WING	00	COMPLETED 06/04/2025
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG  REGULATORY OR ISE, IDENTIFYING INFORMATION  REGULATORY OR ISE, IDENTIFYING INFORMATION  Medication. If the vital was outside the parameters, then she would not administer the medication was nowell document in the EMAR that the medication was nowell document in the EMAR that the medication was nowell administered.  5. During an observation and record review, on 06/02/25 at 9/03 A.M., LPN 2 gathered Resident 29s Lantus pen from the medication cart. The resident was to receive 34 units of Lantus. The LPN removed the cap, cleansed the top with an alcohol pad, placed the needle on the pen, and turned the pen to 34 units. She went into the resident's room and administering the Lantus.  During an interview, on 06/04/25 at 11:53 A.M., LPN 3 indicated before administering insulin in a pen she would prime the pen with two units of insulin.  The current "Lantus" insert, was provided by the Regional Director of Operations on 06/04/25 at 3:46 P.M. The insert indicated, "Do a safety testAlways do a safety test before each injection to: Check your pen and the needle to make sure they are working properlyMake sure that you can get the correct LANTUS doseSelect 2 units by turning the dose selector until the dose pointer is at the 2 mark. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly"  3.1-37(a)  F. 0686 SS=D Bldg. 00  DATE  PREFIX TAG  PROFINATION TAG  PROFINATION TAG  PROFINATION TAG  PROFINATION TAG  TAG  PROFINATION TAG  TAG  PROFINATION TAG  The armorest proficion to the appropriation to the profice and the profit of the profit of the profit of the profit of the parameters, the profit of the pro				950 CR	OSS AVE	
parameters, then she would not administer the medication. She would document in the EMAR that the medication was not administered.  5. During an observation and record review, on 06/02/25 at 9.03 A.M., LPN 2 gathered Resident 29's Lantus pen from the medication cart. The resident was to receive 34 units of Lantus. The LPN removed the cap, cleansed the top with an alcohol pad, placed the needle on the pen, and turned the pen to 34 units. She went into the resident's room and administered the insulin. The LPN did not prime the insulin pen prior to dialing up the required units or administering the Lantus.  During an interview, on 06/04/25 at 11:53 A.M., LPN 5 indicated before administering insulin in a pen she would prime the pen with two units of insulin.  The current "Lantus" insert, was provided by the Regional Director of Operations on 06/04/25 at 3:46 P.M. The insert indicated, "Do a safety testAlways do a safety test before each injection to: Check your pen and the needle to make sure they are working properlyMake sure that you can get the correct LANTUS doseSelect 2 units by turning the dose selector until the dose pointer is at the 2 mark. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly"  3.1-37(a)  F 0.686 SS=D Bleg, 00  Ulcer	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
SS=D Treatment/Svcs to Prevent/Heal Pressure Bldg. 00 Ulcer		medication. If the vital was parameters, then she would medication. She would doc that the medication was not 5. During an observation ar 06/02/25 at 9:03 A.M., LPN 29's Lantus pen from the m resident was to receive 34 to LPN removed the cap, clea alcohol pad, placed the nee turned the pen to 34 units. Stresident's room and administ LPN did not prime the insutup the required units or admitted the pen to 34 units. Stresident's room and administ LPN did not prime the insutup the required units or admitted before admitted the pen she would prime the pen insulin.  The current "Lantus" insert Regional Director of Opera 3:46 P.M. The insert indicatestAlways do a safety test injection to: Check your pen make sure they are working that you can get the correct doseSelect 2 units by turn until the dose pointer is at the injection button all the way comes out of the needle tips correctly"	outside the not administer the ument in the EMAR administered.  Independent of the state of the			
	SS=D	Treatment/Svcs to Preve Ulcer		F 0686	F686: Treatment/Services to	07/03/2025

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

Event ID:

YJOB11

Facility ID: 000116

If continuation sheet

Page 16 of 42

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  06/04/2025	
	ROVIDER 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 APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	orders related to wo	failed to follow physician's und treatments for pressure idents reviewed for pressure		Prevent/Heal Pressure Ulcer It is the policy of this facility to follow orders of the physician related to wound treatments for pressure ulcers.	
	P.M., with the Wou the Assistant Direct resident had a wour hip bone area) that I measured 0.5 centir cm, and the resident (bottom of the spind cm X 0.4 cm.  The clinical record on 06/03/25 at 10:0 Data Set (MDS) assindicated the reside impaired. The resid were not limited to,	nd Nurse Practitioner (NP) and or of Nursing (ADON). The ad to the left ischium (lower mad no signs of infection and meters (cm) by (X) 0.3 cm X 0.2 thad a wound to the sacrum be) that measured 0.8 cm X 0.8  for Resident 78 was reviewed 3 A.M. A Quarterly Minimum measured 0.3/12/25, and was severely cognitively ent's diagnoses included, but cerebral palsy, orthostatic assion, pressure ulcer to the left adultre to thrive.		What corrective action will be accomplished for those reside found to have been affected be deficient practice:  The DON/Designee notified the Wound NP to clarify resident wound treatments orders on and notified MD of delay in changing treatment orders on DATE.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	ents by the ne 78's DATE
	indicated the reside tissue loss with exp pressure ulcer to the measured 1 cm X 0 order was to be cha with Dakins solutio	assment Report, dated 10/28/24, and had a Stage 4 (full-thickness osed muscle, tendon, or bone) teleft ischium. The wound 6 cm X 0.3 cm. The treatment niged to cleanse the wound n, apply collagen to the wound border gauze, daily.		The DON/Designee complete look back of the Wound NP n for correct treatment orders in PCC on 6/5/2025 concerns w immediately addressed.	otes I
	The physician's ord initiated untill 11/08  A Wound NP Asses	er, dated 10/28/24, was not 8/24.		What measures will be put in place and what systemic char will be made to ensure that the deficient practice does not reconstruction.	e
	indicated the reside	nt had a Stage 4 pressure ulcer		All licensed nursing was	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 17 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	NG		06/04/	/2025
				_			
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					OSS AVE		
WATERS	S OF CLIFTY FALLS	S, THE		MADIS	ON, 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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	to the left ischium.	The wound measured 0.6 cm X			in-serviced by the DON/Design	nee	
	0.5 cm X 0.2 cm. T	he treatment order was to be			on or before 6/25/27 on the po		
	changed to cleanse	the wound with Dakins			physician orders, signing the 1	-	
	solution, apply coll	agen with silver, and cover			completing treatments as orde		
	with border gauze,	daily.			and timely transcription of orde		
					and in-serviced the ADON on		
	The physician's ord	er, dated 12/16/24, was not			timely transcription of treatme	nt	
	initiated untill 12/2				orders by the wound NP on		
					6/5/2025. Additionally, any sta	ff	
	A Wound NP Assessment Report, dated 01/08/25,				member that fails to comply w		
	indicated the resident had a Stage 4 pressure ulcer				the points of this in-service wil		
	to the left ischium. The wound measured 1.4 cm X				further educated and/or discip		
	1 cm X 0.5 cm. The treatment order was to be				as indicated.		
	changed to cleanse the wound with Dakins						
	solution, apply Dak	ins moistened fluffed gauze to					
	the wound, and cov	er with border gauze, twice a					
	day.				How corrective action will be		
					monitored to ensure deficient		
	The physician's, da	ated 01/08/25, was not initiated			practice will not recur, i.e. wha	ıt	
	untill 01/12/25.				quality assurance program will	l be	
					put into place:		
	A Wound NP Asse	ssment Report, dated 01/20/25,					
	indicated the reside	nt had a Stage 4 pressure ulcer			The DON/Designee will audit t	the	
	to the left ischium.	The wound measured 1.4 cm X			wound NP notes weekly for tin	nely	
	1 cm X 0.8 cm. The	e treatment order was to be			transcription of treatment orde	rs x	
	changed to cleanse	the wound with Dakins			6 months.		
	solution, apply coll	agen particles, and cover with					
	border gauze, daily				The DON/Designee will audit t	the	
					TAR for nurse electronic signa	iture	
	The physician's ord	er, dated 01/20/25, was			five times a week x 4 weeks, t	hen	
	transcribed for a tw	rice a day treatment instead of			3 times a week x 4 weeks, the	n	
	daily.				once a week x 4 months. If the	e	
					facility is within 95% compliand	ce	
		sment Report, dated 02/26/25,			at the end of 6 months, will be		
		nt had a Stage 4 pressure ulcer			stopped. Results of the monito	oring	
		The wound measured 1.8 cm X			will be reviewed at the monthly	y	
		e treatment order was to be			QAPI meeting. Any concerns v		
	-	with Dakins solution, apply			have been addressed. However	er,	
		and apply negative pressure			any patterns will be identified.	Any	
	wound therapy, three	ee times a week.			will be written by the QAPI		

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 18 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155209	B. W	ING		06/04	/2025
NAME OF P	PROVIDER OR SUPPLIEI	R	-		ADDRESS, CITY, STATE, ZIP COD	-	
					OSS AVE		
WATERS	OF CLIFTY FALLS	S, THE		MADIS	ON, IN 47250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	The and are +	gorillo d to algorigo the comment			committee. Any written Action		
		scribed to cleanse the wound			Plan will be monitored by the		
		er, apply collagen particles, and			Administrator weekly until		
	_	gauze every 12 hours from			resolved.		
	02/27/25 through 0	13/14/23.					
	A Wound NP asses	ssment Report, dated					
		ted the resident had a Stage 4					
	pressure ulcer to the left ischium. The wound						
	l -	1 cm X 0.8 cm. The treatment					
	order was to be changed to cleanse with Dakins						
	solution, apply collagen particles, and apply						
	negative pressure wound therapy, on Wednesday						
	and Saturdays.				Date of Compliance: 7/3/2025	5	
					,		
		ound was not changed until					
	03/15/25.						
	The December 202	4 through May 2025 Electronic					
		stration Record (ETAR) lacked					
		Resident 78's left ischium being					
	completed on the fo	_					
	- 12/07/24,						
	- 12/12/24,						
	- 12/19/24,						
	- 01/03/25,						
	- 01/20/25 at evening	_					
	- 01/30/25 at evening	ng,					
	- 02/09/25,						
	- 05/08/25,						
	- 05/16/25,						
	- 05/19/25, and						
	- 05/23/25.						
	During an interview	w, on 06/04/25 at 10:04 A.M.,					
		ed they would follow the orders					
		The Wound NP came to the					
	building weekly. W	Vithin 24 hours of her visit, she					
		ne ADON) new orders or					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/04/2025	
	PROVIDER OR SUPPLIER		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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		He would transcribe and orders within 24 hours of			
F 0688	ADON indicated the have been followed. They were either traimplemented timely ETAR it meant the The current facility ORDERS/FOLLOW GUIDELINE", with provided by the Ad 10:50 A.M. The pollowed and the provided to the pollowed and	w, on 06/04/25 at 2:57 P.M., the e resident's treatments should per the Wound NP's orders. anscribed wrong or not w. If there was a blank in the treatment was not completed.  Policy titled "PHYSICIAN WING PHYSICIAN ORDERS of a review date of 02/12/24, was ministrator on 06/04/25 at licy indicated, "It is the policy low the orders of the			
SS=D Bldg. 00	Based on observation review, the facility were in applied as of	Decrease in ROM/Mobility on, interview, and record failed to ensure splint devices ordered for 1 of 1 resident of motion. (Resident 84)	F 0688	F688: Increase/Decrease in ROM/Mobility It is the policy of the facility to ensure splints devices are applias ordered.	07/03/2025
	at 11:00 A.M. The rehead of his bed was not wearing hand or During an interview the resident's family never wore his hand	served in his room on 05/29/25 resident was in bed and the selevated. The resident was relbow splints.  y, on 05/30/25 at 10:51 A.M., y member indicated the resident d or elbow splints. The splints et, and they were supposed to		What corrective action will be accomplished for those resider found to have been affected by deficient practice:  Therapy assessed resident 84 bilateral hand and arm splints of 6/5/2025, order received to	the for

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet

Page 20 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. WI	NG		06/04/	2025
				CTP FFT	ADDRESS SET STATE OF		
NAME OF P	PROVIDER OR SUPPLIEF	t .			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		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	be on his arms.				continue with current splints.		
	The resident was ob	oserved in his room on			How other residents having the	е	
	06/02/25 at 9:16 A.	M. The resident was in bed.			potential to be affected by the		
	There were no hand	l or elbow splints in place.			same deficient practice will be		
					identified and what corrective		
	The resident was observed in his room on				action will be taken:		
	06/02/25 at 10:48 A.M. The resident's arms were						
	folded over his chest. There were no splint				Therapy completed an audit a	nd	
	devices in place.				assessment on residents with		
					splints and braces on 6/6/2025	5	
	The resident was observed in his room on				concerns were immediately		
	06/03/25 at 9:14 A.M. The resident was in bed.				addressed.		
	There were no splin	t devices in place.					
					What measures will be put in		
	The resident was ob	oserved in his room on	place and what systemic changes				
	06/03/25 at 2:00 P.I	M. The resident was in bed.	will be made to ensure that the				
	There were no splin	it devices in place.			deficient practice does not rec	ur:	
		oserved in his room on			The DON/Designee in-service		
		M. The resident was in bed.			nursing staff on or before 6/25	/25	
	There were no splin	it devices in place.			orders for splints/ROM and		
					donning and doffing splints an		
		cal record was reviewed on			braces as ordered. Additionally	у,	
		M. A Quarterly Minimum Data			any staff member that fails to		
		ed 02/27/25, indicated the			comply with the points of this		
		ately cognitively impaired. The			in-service will be further educa		
	1	s included, but were not			and/or disciplined as indicated		
		c brain injury, quadriplegia, and			l		
		Mobility in the resident's upper			How the corrective action will I		
		es was impaired on both sides,			monitored to ensure the deficie		
		s dependent on staff for all			practice will not recur, i.e. wha		
	activities of daily li	ving.			quality assurance program will	pe	
	Th	na nharatatanta andar 1 1 1 1 1			put into place:		
		nt physician's orders included,			The DON/Deet "" "		
	but were not limited	to the following:			The DON/Designee will monito		
	] ,	1 21 4 1 6			residents with splints and brace		
		der, with a start date of			five times a week x 4 weeks, the		
	· ·	sident to wear bilateral hand			3 times a week x 4 weeks, the	n	
	splints. The splints	were to be applied in the	1		once a week x 4 months for		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	ING		06/04/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\\/\TED(		S THE			ON, IN 47250		
WATERS	S OF CLIFTY FALLS	5, THE		MADIS	ON, 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
	morning for 3 hours	s and then removed, and			braces and splints being donn	ed	
					and doffed per physician orde	rs. If	
	- An open-ended or	der, with a start date of			the facility is within 95%		
	02/25/25, for the re	sident to wear bilateral elbow			compliance at the end of 6		
	splints. The elbow	splints were to be applied after			months, will be stopped. Resu	lts	
	_	re removed and were to be			of the monitoring will be review		
	worn for 3 hours.				at the monthly QAPI meeting.	Any	
					concerns will have been		
	Nursing staff documented in the resident's				addressed. However, any patt	erns	
	Electronic Treatment Administration Record				will be identified. Any will be		
	(ETAR) for May and June 2025 that the resident's				written by the QAPI committee		
	hand splints and elbow splints had been applied				Any written Action Plan will be		
	every day.				monitored by the Administrato	r	
					weekly until resolved.		
	_	v, on 06/04/25 at 10:58 A.M.,					
		Nurse 4 indicated the CNAs					
		applied the splints, but the					
		TAR indicating the arm and					
	_	applied. She signed off that the					
		d that morning. It had been a			Date of Compliance: 7/3/2025		
	_	had observed the resident					
	wearing hand or elb	oow splints.					
	D	06/04/25 4 0 25 4 34					
	_	v, on 06/04/25 at 9:35 A.M.,					
		de (CNA) 3 indicated she was					
		sident. He did not wear splints ns or elbows. He wore them					
		to the facility. It had been a					
		e worn them. The splints were in the resident's room.					
	observed on a table	in the resident's room.					
	The CNA Tack Cha	arting for May and June 2025					
		ncluded, but was not limited to,					
	the following tasks:						
	and following tasks.						
	- NURSING REUA	AB: Assistance with Splint. The					
		pating in a splint program to					
	_	tracture to bilateral hands and					
	_	should be applied after Passive					
		PROM). Bilateral hand splints					
	Tange of Monoli (I	1011). Difateral fiante spinits					

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 22 of 42

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	ľ	UILDING	nstruction 00	(X3) DATE COMPI 06/04	LETED	
	PROVIDER OR SUPPLIER		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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	were to be applied to were removed, bilato applied for 3 hours. Peripherally Inserted the elbow splint was extremity.  The Task record for documentation indiction hand and elbow splith that she had applied to be applied.  During a follow-up A.M., CNA 3 review when she entered a about splint usage of referring to the PRC with the resident. So splint device. She different section that specific task as well splints in a long time he was resistant to resisted or refused as such. If they conclet the nurse know.  The current facility ORDERS/FOLLOW GUIDELINE", with provided by the Ad 10:50 A.M. The po	for 3 hours daily and after they teral elbow splints were to be If the resident had a ad Central Catheter in one arm, is not to be applied to that and Yellow the applied to that and Yellow the applied to that and Yellow the ints daily. CNA 3 documented the splints that morning.  Interview, on 06/04/25 at 9:51 wed her charting and indicated time and initialed the section earlier that morning, she was DM exercises she performed the did not apply a brace or at was designated for that the tweeting the brace. If a resident wearing the brace. If a resident eare, it should be documented tinued to refuse, they would policy titled "PHYSICIAN WING PHYSICIAN ORDERS of a review date of 02/12/24, was ministrator on 06/04/25 at liey indicated, "It is the policy low the orders of the						
F 0732 SS=C Bldg. 00	483.35(i)(1)-(4) Posted Nurse Sta	ffing Information						

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

Event ID:

YJOB11

Facility ID: 000116

If continuation sheet

Page 23 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	NG		06/04/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF OUETY FALL	) THE			ROSS AVE		
WATERS	OF CLIFTY FALLS	o, THE		MADIS	ON, IN 47250		
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation	on and interview, the facility	F 07	732	F732: Posted Nursing Staffing		07/03/2025
	failed to post nurse	staffing accurately for 2 of 6			Information		
	staff posting observations.				It is the intent of this facility to		
	Findings include:				post staffing accurately. Wha		
					corrective action will be		
					accomplished for those reside	nts	
	During an observati	on, on 05/29/25 at 10:44 A.M.,			found to have been affected b		
		ng was sitting on the desk at			deficient practice: No residen	•	
	_	y the front door visible for			were identified. How other		
	· · · · · · · · · · · · · · · · · · ·	staff posting was dated			residents having the potential	to	
	04/22/25.	-			be affected by the same defici		
					practice will be identified and		
	During an observation, on 05/29/25 at 3:00 P.M.,				corrective action will be taken:	All	
	the nurse staff posti	ng was sitting on the desk at			residents that reside in the fac	ility	
	the nurse's station b	y the front door visible for			have the potential to be affect	ed	
	visitors to see. The	staff posting was dated			by the alleged deficient therefo		
	04/22/25.				this plan of correction applies		
					all residents that reside in the		
	During an interview	y, on 06/04/25 at 10:16 A.M.,			facility. What measures will be	put	
	the Assistant Direct	or of Nursing indicated the			in place and what systemic		
	nurse staff posting s	should be changed daily.			changes will be made to ensu	re	
					that the deficient practice does	s not	
	No facility policy w	as provided for nurse staff			recur. The Administrator		
	posting.				in-serviced the DON, ADON a	nd	
					scheduler on 6/25/25 on the		
					requirements for Posted Nursi	ng	
					Staffing Information daily.		
					Additionally, any staff member		
					that fails to comply with the po		
					of this in-service will be further	r	
					educated and/or disciplined as	3	
					indicated. How the corrective		
					action will be monitored to ens	sure	
					the deficient practice will not		
					recur, i.e. what quality assurar	nce	
					program will be put into		
					place: The Administrator will a	audit	
					the Posted Nursing Staffing		
					Information 5 days a week x 4		
					weeks, then 3 days a week x	1	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 24 of 42

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/04/2025
	PROVIDER OR SUPPLIER		950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	1
(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
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4) Drug Regimen Re On Based on record rev failed to ensure pha addressed timely fo drug regimen review Findings include: The clinical record on 06/04/25 at 1:25 Data Set assessmen resident was severe resident's diagnoses limited to, heart fail dementia, anxiety, a	(5) View, Report Irregular, Act View and interview, the facility rmacy recommendations were r 1 of 5 residents reviewed for W. (Resident 75)  for Resident 75 was reviewed P.M. A Quarterly Minimum t, dated 05/16/25, indicated the lly cognitively impaired. The included, but were not fure, diabetes, non-Alzheimer's	F 0756	weeks, then weekly x 4 month the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. If the facility is within 95% compliance at the end of months, will be stopped. Result of the monitoring will be review at the monthly QAPI meeting. Concerns will have been addressed. However, any path will be identified. Any will be written by the QAPI committed Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025  F756: Drug Regiment Review It is the policy of the facility to ensure pharmacy recommendations are.  What corrective action will be accomplished for those reside found to have been affected by deficient practice:  Resident 75's Citalopram recommendation was completed on 3/12/2025.  How other residents having the potential to be affected by the	6 alts wed Any derns e

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

twice a day. The dose exceeded the maximum

Event ID:

YJOB11

Facility ID: 000116

6 If continuation sheet

same deficient practice will be

Page 25 of 42

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATI		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155209	B. WI	NG		06/04/	2025
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R					
\\\ATED(		C THE			ROSS AVE		
WATERS	S OF CLIFTY FALLS	5, THE		MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	recommended dose	of 40 mg per day. The resident			identified and what corrective		
	was receiving doub	le the recommended dose and			action will be taken:		
	the pharmacist reco	ommended reducing the order					
	to 40 mg per day. T	The Nurse Practitioner agreed			The DON/Designee complete	da	
	with the recommen	dation on 02/26/25.			90 day look back at pharmacy		
					recommendations, any conce		
	The resident's Elect	tronic Medication			will immediately on 6/5/2025.		
	Administration Rec	cord (EMAR) for February and			,		
	March 2025 indicat	ted the resident continued to			What measures will be put in		
	receive 40 mg of ci	talopram twice a day from			place and what systemic char	nges	
	I	3/11/25. On 03/12/25 the			will be made to ensure that the	•	
	pharmacy recomme	endation from 02/15/25 for the			deficient practice does not rec	our:	
		resident's citalopram from			'		
	twice a day to daily	-			The Administrator in-serviced	the	
					DON and ADON on or before		
	During an interview	v on 06/04/25 at 11:50 A.M., the			6/25/25 on completing Pharm	acy	
	Clinical Corporate	Support Nurse indicated			Recommendations timely.		
	pharmacy recomme	endations should be addressed			Additionally, any staff membe	r	
	timely. The medica	tion order should have been			that fails to comply with the th		
	changed sooner tha	n it was.			in-service will be further educa		
					and/or disciplined as indicated	d.	
	The current, undate	ed facility policy, titled "Policy					
	and ProcedurePha	armacy Recommendation" was			How the corrective action will	be	
	provided by the Ad	lministrator on 06/04/25 at			monitored to ensure the defici	ent	
	10:50 A.M. The po	licy indicated, "A response as			practice will not recur, i.e. wha	at	
	to the action to be t	aken regarding the Pharmacy			quality assurance program wil	ll be	
	Consultant's recom	mendation will be documented			put into place:		
	within 7 days of the	e receipt of the					
	recommendation'	1			The DON/Designee will monit	.or	
					pharmacy recommendations a	are	
	3.1-25(3)(i)				completed timely monthly x 6		
					months. If the facility is within		
					95% compliance at the end of	the	
					6 months, then monitoring will		
					stopped. If the facility is within		
					95% compliance at the end of	<sup>:</sup> 6	
					months, will be stopped. Resu		
					of the monitoring will be review		
					at the monthly QAPI meeting.		
					concerns will have been	-	

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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209		ILDING	instruction 00	(X3) DATE ( COMPL 06/04/	ETED
	ROVIDER 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 LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE
					addressed. However, any patter 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	483.45(g)(h)(1)(2)				Date of Compliance: 7/3/2025		
SS=D Bldg. 00	failed to store medication carts (S <sub>I</sub>	on and interview, the facility cations appropriately for 2 of 3 olit Cart and Living Well Cart) medication rooms (Dementia	F 07	61	F761: Label/Storage Drugs ar Biologicals It is the policy of thi facility to store medications appropriately.		07/03/2025
	06/04/25 at 10:26 A Nurse (LPN) 12. Th unopened and undat belonged to Resider was unsure when th from the refrigerato	tion Cart was observed onM., with Licensed Practical the medication cart contained an attended Fiasp insulin pen that at 22. The LPN indicated she are insulin pen was removed at as she had not been the one should have stayed in the was needed.			What corrective action will be accomplished for those resider found to have been affected by deficient practice:  The DON/Designee disposed or residents insulin for resident disposed of resident 12's Combivent and resident 301's Ellipta inhaler on 6/5/ medication	/ the	
	•	Medication Cart was observed 6 A.M., with LPN 4. The cart			were re-ordered. The DON/Designee disposed of the	e	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 27 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155209	B. W	ING		06/04/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	S.			ROSS AVE	
WATERS	OF CLIFTY FALLS	S, THE			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 DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG		DATE
	contained the follow	ving:			tuberculin solution,	
	A.,				acetaminophen suppositories	
	Resident 12 with no	vent inhaler that belonged to			the Dementia medication cart	on
		inhaler that belonged to			6/5/2025.	
	Resident 301 with n				How other residents having th	_
	resident 501 With 1	to open dute.			potential to be affected by the	
	The current "Fiaso"	insulin pen package insert			same deficient practice will be	
	_	e Regional Clinical Consultant			identified and what corrective	
		8 A.M. The insert indicated,			action will be taken:	
	"Not-in-use (unopened)single-patient-use					
	Fiasp FlexTouch pe	nRoom temperature28			The DON/Designee completed	t l
days"				audits on medication carts for		
					dated medications and labeled	t
		ivent package insert was			with name concerns were	
	1 -	sistant Director of Nursing			immediately addressed on	
	` ′	25 at 3:59 P.M. The insert			6/5/2025.	
		be discarded at the latest 3				
	months after first us	se"			What measures will be put in	
					place and what systemic chan	-
	_	" package insert was provided			will be made to ensure that the	
	1 -	5/04/25 at 3:59 P.M. The insert			deficient practice does not rec	ur:
	foil tray"	d6 weeks after opening the			The DON/Designee in-service	d all
	ion nay				nursing staff on proper medica	
	3. The Dementia Ur	nit's medication room was			storage, dating medications w	
		25 at 10:37 A.M., with Qualified			opened and labeled with resid	
		(MA) 14. The following items			name on or before 6/25/25.	
		ion room refrigerator:			Additionally, any staff member	
		•			that fails to comply with the po	
	- A bottle of tubercu	ılin serum that was half full			of this in-service will be further	
	and had an open dat	te of 04/18/25, and			educated and/or disciplined as	s
	- Six acetaminopher	n suppositories, 650 milligrams.			indicated.	
		vere not in any bag or labeled				
	with a resident's nar	ne.			How the corrective action will	be
					monitored to ensure the defici-	
		bservation QMA 14 indicated			practice will not recur, i.e. wha	
		ould have had a resident's			quality assurance program wil	l be
	name on them.				put into place:	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		E CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155209	B. WI	NG		06/04/	/2025
	ROVIDER OR SUPPLIER			950 CR	ADDRESS, CITY, STATE, ZIP COD OSS AVE ON, IN 47250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T	ID	PROUPERS N. IV OF CORRESTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	on 06/04/25 at 10:46 A.M.,			The DON/Designee will monitor	or	
		alers should be dated when			Medication carts and medicati		
		nd the tuberculin serum was			room storage, dates on opene		
	only good for 30 da	ys after it was opened.			and labeled with name five tim		
	The Tark				week x 4 weeks; then 3 times		
		um package insert was gional Clinical Consultant on			week x 4 weeks, then weekly x	X 4	
		.M. The directions for storage			months. If the facility is within 95% compliance at the end of	6	
		use more than 30 days			months, will be stopped. Resu		
	should be discarded	-			of the monitoring will be review		
					at the monthly QAPI meeting.		
	_	policy titled, "Medication			concerns will have been		
	_	y" dated, February 2017, was			addressed. However, any patt	erns	
	-	nical Support Consultant on			will be identified. Any will be		
		.M. The policy indicated,			written by the QAPI committee		
		biologicals are stored safely,			Any written Action Plan will be		
	securely, and proper	rly"			monitored by the Administrato	r	
	3.1-25(o)				weekly until resolved.		
	3.1-23(0)						
					Date of Compliance: 7/3/2025		
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Service	es					
Diag. 00	failed to ensure that results were receive physician in a timel completed after a fa	and record review, the facility critical laboratory (lab) test d and reported to the y manner; and a lab test was ll related to seizure medication reviewed for lab services.	F 07	770	F770: Laboratory Services: It the policy of this facility to ens critical laboratory test results a received and reported to the physician in a timely manner.	ure	07/03/2025
	Findings include:				What corrective action will be		

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 29 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155209	B. WI	NG		06/04/	/2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	8			OSS AVE		
\\\\\\TEDC	OF CLIETY EALLS	S THE					
WAIERS	OF CLIFTY FALLS	ع, ۱۱۱۱ <u>۵</u>		INIADISC	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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1. Resident 11's clir	nical record was reviewed on			accomplished for those reside	nts	
	06/02/25 at 1:02 P.I	M. A Quarterly Minimum Data			found to have been affected by	y the	
	Set (MDS) assessm	ent, dated 04/05/25, indicated			deficient practice:		
	the resident was mo	derately cognitively impaired.					
	The resident's diagr	noses included, but were not			The DON/Designee notified th	e	
	limited to, heart fail	lure, hypertension, renal			physician of resident 11's BMF	>	
	insufficiency, and d	liabetes.			results on 6/3/2025. The		
					DON/Designee notified the		
	A Progress Note, da	ated 05/28/25 at 6:29 P.M.,			physician of the missed level f	or	
	indicated the Nurse	Practitioner (NP) reviewed the			on 6/5/2025, no new orders.		
	resident's recent Ba	sic Metabolic Panel (BMP) lab					
	results. The residen	t's potassium level was critical			How other residents having the	е	
	at 2.4 (the normal ra	ange for potassium was 3.5 to			potential to be affected by the		
	5.3). The resident w	vas to receive oral potassium			same deficient practice will be		
	tablets, and a BMP	was to be re-drawn on			identified and what corrective		
	05/30/25.				action will be taken:		
	A Progress Note, da	ated 05/30/25 at 5:42 P.M.,			The DON/Designee completed	da	
	indicated the BMP	was obtained on 05/30/25, and			look of lab orders and verified	labs	
	the resident's potass	sium was still critically low at			draw as ordered and notification	on	
	2.7. The NP ordered	d additional oral potassium			completed timely on 6/5/2025		
	tablets, decreased th	ne resident's diuretic			concerns were immediately		
	medication, and ord	lered a repeat BMP on			addressed.		
	05/31/25.						
					What measures will be put in		
		d was reviewed on 06/03/25 at			place and what systemic chan	ges	
		ed the results of the BMP lab			will be made to ensure that the	е	
	that was to be draw	n on 05/31/25.			deficient practice does not rec	ur:	
	-	y, on 06/03/25 at 9:55 A.M., the			The DON/Designee in-service	d all	
		of Nursing (ADON) indicated			nursing staff on Laboratory		
		ained the results were			Services on notification of		
		able to be reviewed in the			physician of lab results and		
	resident's record. So	ometimes STAT (immediate)			obtaining lab as ordered on or		
		vays show up, and nursing			before 6/25/25. any staff mem	ber	
		up with the lab directly. At the			that fails to comply with the po	ints	
	time of the interview	w (06/03/25), the ADON			of this in-service will be further	r	
	manually accessed	the results from the lab drawn			educated and/or disciplined as	6	
	on 05/31/25 and the	e resident's potassium was still			indicated.		
	low at 3.1. The AD	ON indicated nursing staff					

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 30 of 42

STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	ING		06/04/2025	
				CTREET	ADDRESS STEW STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
14/4 TED	0 0 0 1 1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				OSS AVE		
WATERS	S OF CLIFTY FALLS	S, THE		MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T.E.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	should have followe	ed up on the lab. There should			How the corrective action will I	oe	
		ss Note put in the resident's			monitored to ensure the deficie		
		should have been notified.			practice will not recur, i.e. wha		
					quality assurance program will		
	During an interview	v on 06/03/25 at 11:08 A.M., the			put into place:		
	_	e called and notified the NP of			pat into piace.		
		TAT BMP from 5/31/25. There			The DON/Designee will monitor	or	
		up prior to 06/03/25. The NP			Laboratory Services/MD		
	ordered another STAT BMP.				notification daily 5 days a wee	k x	
					4 weeks, then 3 days weekly x		
	A Progress Note. da	ated 06/03/25 at 7:52 P.M.,			weeks, then weekly x 4 month		
	_	nt's potassium level was 2.6.			the facility is within 95%	0. 11	
		receive additional oral			compliance at the end of 6		
		nd the resident's diuretic was			months, will be stopped. Resu	lte	
	•	esident was to continue to be			of the monitoring will be review		
	weighed daily.	estacin was to continue to so			at the monthly QAPI meeting.		
	weighed daily.				concerns will have been	Ally	
	The current facility	policy, titled "GUIDELINES			addressed. However, any patt	orne	
		ULING/TRACKING", dated			will be identified. Any will be	CITIS	
		ided by the Administrator on			written by the QAPI committee		
	_	A.M. The policy indicated,			Any written Action Plan will be		
		se will monitor the scheduled			monitored by the Administrato		
	_	that any collected lab results			weekly until resolved.	•	
	· · · · · · · · · · · · · · · · · · ·	as well as to confirm that			weekly until resolved.		
	received results are						
		any orders received related to					
		arried outAny omitted labs					
		and the lab will be contacted for					
	an explanation as to						
	an explanation as to	the delay					
	2 The clinical recor	rd for Resident 20 was reviewed			Date of Compliance: 7/3/2025		
		P.M. A Quarterly Minimum			Date of Compliance. 1/3/2023		
		t, dated 04/15/25, indicated the					
		ively intact. The resident's					
		but were not limited to,					
	-	order, malnutrition, anxiety,					
	depression, and bip						
	_	otar. ated 05/02/25 at 5:30 P.M.,					
	_	nt had an unwitnessed fall in					
	ner room. The resid	lent had no injuries and					

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 31 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	BUILDING 00 COMPLETE		ETED	
		155209	B. WI	NG	06/04/2		2025
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OSS AVE		
\A/ATEDO	OF CLIETY EALLS	S THE			OSS AVE ON, IN 47250		
WATERS	OF CLIFTY FALLS	o, Inc		MADISC	JN, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		seizure. The resident's					
	•	nents were initiated, and all					
	appropriate persons	were notified.					
		Team Note, dated 05/05/25 at					
		d the resident had a fall on					
		juries. The fall was related to					
	•	new intervention was					
	-	ain a Vimpat (a seizure					
	medication) level to	check for a therapeutic range.					
		lacked any indication a Vimpat					
	level had been obtain	ned.					
	D :	06/04/05 + 2.00 P.M. 4					
	-	on 06/04/25 at 3:09 P.M., the					
		e resident did not have a					
	-	ed after the fall and they					
	should have.						
	3.1-49(a)						
	3.1-45(a)(2)						
	3.1-43(a)(2)						
F 0812	483.60(i)(1)(2)						
SS=E	Food						
Bldg. 00		e/Prepare/Serve-Sanitary					
2.49.00		on and interview, the facility	F 08	12	F812: Food Procurement,		07/03/2025
		appropriately to prevent	1 00	12	Store/Prepare/Serve-Sanitary		07/03/2023
		of 2 kitchen observations.			It is the policy of the facility to		
					store appropriately to prevent		
	Findings included:				contamination.		
	6						
	1. The initial kitche	n tour was conducted on					
		M., and the following was	1				
	observed:	Č	1		What corrective action will be		
			1		accomplished for those reside	nts	
	- A large clear plast	ic container sitting on a metal			found to have been affected by		
		r. The lid was ill-fitting and	1		deficient practice:	•	
	not designed for the		1		•		
	-		1		The Dietary Manager/Designe	е	
	- A large clear plast	ic container sitting on a metal			disposed of the flour and suga		

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 32 of 42

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155209	B. W	ING		06/04/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u>.                                    </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ROSS AVE		
WATERS	S OF CLIFTY FALL	S THE			ON, IN 47250		
WAILING		O, 111E		WIADIO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ar with a plastic scoop sitting			6/4/2025.		
	inside.						
					How other residents having th		
	_	v on 05/29/25 at 10:50 A.M.,			potential to be affected by the		
	1	dicated the scoop should not			same deficient practice will be	<b>;</b>	
		e sugar and the lids were not			identified and what corrective		
	the right ones for the	ne containers.			action will be taken:		
	During the initial k	itchen tour, the noon time meal			The Dietary Manager complet	ed	
	was completely pre	pared and no staff were			an audit of the foods stored in		
	actively using the f	lour or sugar. An exterior door			plastic to ensure labels with da	ate,	
	was within ten feet	of the inappropriately sealed			and no scoop stored in the pla	astic	
	flour and sugar bin	s.			containers on 6/5/2025.		
	•	policy titled, "Food Storage			What measures will be put in		
		and Frozen)", dated 08/12/23,			place and what systemic char	ıges	
		e Administrator on 06/04/25 at			will be made to ensure that the	е	
	_	licy indicated, "5. All open			deficient practice does not rec	:ur:	
		will be sealed (rolled closed,					
		th lids closed, etc.) to ensure			The Administrator/Designee in		
		contamination against pest or			Dietary staff on Food Storage		
	_	ored outside of bin in clean,			or before 6/25/25. Additionally	′,	
	designated space'	•			any staff member that fails to		
	2.1.21(1)(2)				comply with the points of this		
	3.1-21(i)(3)				in-service will be further educa		
					and/or disciplined as indicated	1.	
					How the corrective action will	be	
					monitored to ensure the defici		
					practice will not recur, i.e. wha		
					quality assurance program wil		
					put into place:		
					The Dietary Manager will audi	t the	
					Food Storage daily 5 days a v		
					for 4 weeks, then 3 times wee		
					x 4 weeks, then once a week	-	
					months. If the facility is within		
					95% compliance at the end of	6	
					months, will be stopped. Resu		

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

PRINTED: 07/02/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/04/2025
	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 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
				of the monitoring will be review at the monthly QAPI meeting. concerns will have been addressed. However, any pat will be identified. Any will be written by the QAPI committed Any written Action Plan will be monitored by the Administrator weekly until resolved.	Any terns e.
F 0842 SS=D	483.20(f)(5), 483.7	70(h)(1)-(5) - Identifiable Information		Date of Compliance: 7/3/2029	5
Bldg. 00	Based on record rev	view, interview, and ility failed to document 1 of 25 residents' records	F 0842	842: Resident Records-Identif Information It is the policy of this facility th Colostomy care is documente	at 0776372623
	on 06/02/25 at 11:00 Minimum Data Set indicated the resident impaired. The resident were not limited to, ganglia, non-Alzhei	for Resident 26 was reviewed 8 A.M. A Significant Change assessment, dated 04/07/25, nt was severely cognitively ent's diagnoses included, but degenerative disease of basal mer's dementia, Parkinson's pression, bipolar, psychotic		What corrective action will be accomplished for those reside found to have been affected be deficient practice:	ents
	disorder, schizophre	enia, oppositional defiant ectual disabilities, and		Resident 26's colostomy appliance was changed on 6/4/2025 by the DON/Designe	ee.

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 34 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE STATEMENT OF DEFICIENCIES	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPL	ETED
155209 B. WING 06/04/	2025
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  950 CROSS AVE	
WATERS OF CLIFTY FALLS, THE MADISON, IN 47250	
WATERO OF OUR FEED, THE WIADISON, IN 47200	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
colostomy status. The resident had an ostomy.	
How other residents having the	
An open-ended physician's order, with a start potential to be affected by the	
date of 09/15/21, indicated the staff were to same deficient practice will be	
change the resident's colostomy appliance as identified and what corrective	
needed. action will be taken:	
The clinical record lacked documentation that the The DON/Designee completed an	
resident's colostomy appliance had been changed audit of residents with colostomy	
in the months of March, April, May, or as of June for documentation of colostomy	
3, 2025. care on 6/5/ any concerns were	
immediately addressed.	
During an interview, on 06/03/25 at 1:45 P.M.,	
Licensed Practical Nurse 9 indicated the resident  What measures will be put in	
had a colostomy and the appliance would get place and what systemic changes	
changed a lot. They should have documented that will be made to ensure that the	
it had been changed. deficient practice does not recur:	
During an interview, on 06/03/25 at 1:50 P.M.,  The DON/Designee in-serviced the	
Certified Nurse Aide 11 indicated the resident had nursing staff on documenting	
a colostomy. The aides would change the colostomy care on 6/25/2025.	
appliance when it needed to be done. They  Additionally, any staff member	
documented each shift indicating the resident had that fails to comply with the points	
a colostomy and the amount of stool in it.  of this in-service will be further	
educated and/or disciplined as	
The resident's colostomy appliance was observed indicated.	
on 06/04/25 at 2:25 P.M., with Qualified	
Medication Aide 14. The colostomy was clean  How the corrective action will be	
and appeared free of infection.	
practice will not recur, i.e. what	
During an interview, on 06/04/25 at 10:06 A.M., quality assurance program will be	
the Assistant Director of Nursing indicated put into place:	
colostomy care was completed daily, and the	
appliance should be changed every three days.  The DON/Designee will audit	
All residents' with a colostomy should have had documentation of colostomy care	
an order to change the colostomy appliance. The five times a week x 4 weeks, then	
I CHINCALICCOLA SHOULA HAVE HAA QOCAHICHIAHOH I I I SHIMES A WEEK X 4 WEEKS THEN	
related to the resident's colostomy care staff provided.  3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance	

PRINTED: 07/02/2025

	I OF HEALTH AND HU R MEDICARE & MEDIC					MB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209				IPLE CONSTRUCTION ING <u>00</u>	(X3) DAT	(X3) DATE SURVEY  COMPLETED  06/04/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			9	TREET ADDRESS, CITY, STATE, ZIP CO 50 CROSS AVE IADISON, IN 47250	DD		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORR FIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL AG DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE	
	The current facility policy titled, "Colostomy and Ileostomy Care", was provided by the Director of Nursing on 06/03/25 at 3:18 P.M. The policy indicated, "The pouch should be changed every 3 to 7 days)  3.1-50(a)(2)			will be reviewed at the QAPI meeting. Any conhave been addressed. any patterns will be ide will be written by the Queommittee. Any written Plan will be monitored I Administrator weekly unresolved.	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.  Date of Compliance: 7/3/2025		
F 0880 SS=E Bldg. 00	review, the facility control guidelines in urinary catheter tube. Enhanced Barrier Fresidents reviewed (Residents 31, 84, Findings include:  1. On 05/29/25 at 1 observed propelling resident's urinary cher wheelchair, and	on & Control  on, interview, and record failed to follow infection related to the placement of bing and drainage bag and Precautions (EBP) for 4 of 20 for infection control.	F 0880	F880: Infection Prevent Control: It is the policy of the fact follow infection control or related to placement of catheter tubing and drawand Enhanced Barrier Precautions.  What corrective action accomplished for those found to have been affect deficient practice:  The DON/Designee assets	cility to guidelines furinary ainage bag will be e residents ected by the	07/03/2025	

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

yellow urine was observed in the bag and tubing.

During an interview, on 05/29/25 at 2:05 P.M., the

Event ID:

YJOB11

Facility ID: 000116

residents 31, 84, 52 and 78 on 6/5/2025 and no negative outcome

related to the cited practice.

If continuation sheet

Page 36 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
155209		B. W	B. WING 06/04/2025			/2025	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ROSS AVE		
WATERS OF CLIFTY FALLS, THE					ON, IN 47250		
WATER	3 OF CLIFTT FALL	3, ITIE		IVIADIS	ON, IN 47230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
		staff always assisted her into					
	her wheelchair and	placed her catheter bag under			How other residents having th	e	
	the wheelchair. The	e catheter bag was always			potential to be affected by the		
	dragging. The resid	lent propelled herself around in			same deficient practice will be	<del>;</del>	
	her room and the d	rainage bag was hanging close			identified and what corrective		
	to the wheel of the	wheelchair, dragging on the			action will be taken:		
	floor. She wanted a	leg bag, and they tried it once,					
	but they taped it to	her leg and that didn't work			All residents have the potentia	al to	
	out. They've never	used a dignity pouch; they did			be affected by the cited this pl	an	
	put the drainage ba	g inside a plastic bag once.			of correction applies to all		
	She had a urinary t	ract infection last month.			residents.		
	The resident's clini	cal record was reviewed on					
	06/04/25 at 2:14 P.	M. A Quarterly Minimum Data					
	Set (MDS) assessm	nent, dated 03/06/25, indicated			What measures will be put in		
	the resident was co	gnitively intact. The resident's			place and what systemic char	iges	
	diagnoses included	, but were not limited to,			will be made to ensure that the	e	
	stroke, hypertensio	n, and diabetes.			deficient practice does not rec	:ur:	
	On 06/02/25 at 10:	27 A.M., the resident was			The DON/Designee in-service	d all	
	observed in her roo	om sitting in her wheelchair.		staff on the facilities Infectio			
	The resident's catho	eter bag was hanging under		Prevention & Control Policy,			
	the wheelchair. The	e bag was folded over, with		placement of the catheter tubing			
	several inches of it	resting on the floor.			and Enhanced Barrier Precau	tions	
					on or before 6/25/25. Addition	ally,	
		5 P.M., the resident was			any staff member that fails to		
	observed propelling	g herself in her wheelchair in			comply with the points of this		
	the main dining roo	om. The resident's catheter bag			in-service will be further educated		
	and tubing were dr	agging on the floor under the			and/or disciplined as indicated	i.	
	wheelchair as she v	vent by.					
					How the corrective action will	be	
	On 06/04/25 at 2:1	0 P.M., the resident was			monitored to ensure the defici	ent	
	observed with the	Assistant Director of Nursing			practice will not recur, i.e. wha	at	
	(ADON). The resid	lent was in her wheelchair in the		quality assurance program will be		l be	
	hallway near her room. The resident's drainage				put in place:		
	bag was hanging un	nder the wheelchair. The					
	catheter tubing was	s resting on the floor. The			The DON/Designee will monit	or	
		s yellow and cloudy with			donning and doffing of PPE fo		
		ing. The ADON walked by the			residents in Enhanced Barrier		
	resident and indicated the resident's catheter				Precautions for 10 staff memb		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  06/04/2025				
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 REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION bag should not touch the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  per week x 4 weeks; then 5 si	DATE			
	floor. The ADON in resident's hallway to	o reposition the resident's bing off of the floor.		members per week x 4 weeks then 3 staff members monthly months.	3			
	FOR INDWELLIN dated 10/16/24, was Director of Operation The policy indicates proper indwelling for the proper indwelling f	policy, titled :GUIDELINES G FOLEY CATHETER CARE", s provided by The Regional ons on 06/04/25 at 2:56 P.M. d, "The main purpose of oley catheter care is to prevent urinary tract infections"		The DON/Designee will audit residents with foley catheters proper placement of tubing, a privacy bag five times a week weeks, then 3 times a week x once a week x 4 months.	for nd x 4			
	06/02/25 at 2:44 P.1 assessment, dated 0 was moderately cog resident's diagnoses limited to, traumatic respiratory failure. 'urinary catheter, a g tracheostomy, a per	And the resident was reviewed on M. A Quarterly MDS 2/27/25, indicated the resident spiritively impaired. The included, but were not be brain injury, quadriplegia, and The resident had an indwelling spatrostomy tube (G-tube), a ipherally inserted central or, and pressure ulcers.		If the facility is within 95% compliance at the end of 6 months, will be stopped. Rest of the monitoring will be revie at the monthly QAPI meeting. concerns will have been addressed. However, any pat will be identified. Any will be written by the QAPI committe Any written Action Plan will be monitored by the Administrate weekly until resolved.	wed Any terns e.			
	but were not limited a start date of 04/14 Precautions even							
	the resident's door he staff were to "STOI" "ENHANCED BAI must wear a gown a resident care activit to, "Wound Care: a dressing". Supplies were in a plastic conthe resident's room.	on on 06/03/25 at 1:49 P.M., and a sign on it that indicated "and that the resident was in RRIER PRECAUTIONS". Staff and gloves for high contact ies, including but not limited my skin opening requiring a including gowns and gloves ntainer with drawers outside Nurse Practitioner (NP) 16 and Nurse (LPN) 17 entered the		Date of Compliance: 7/3/2025	5			

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 38 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 00 COMPLET				
		155209	B. WING			06/04/	/2025
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
\\/\ <u>\</u> \\\	OF CLIFTY FALLS	S THE			OSS AVE ON, IN 47250		
	ı			טוט	JIN, IIN 47230		ī
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAC		CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		
TAG		provided wound care to the	IAC	_			DATE
		ilcer without donning gowns.					
	_	rd for Resident 52 was reviewed					
	on 06/03/25 at 2:08	P.M. A Quarterly MDS					
	assessment, dated 0	2/24/25, indicated the resident					
		act. The resident's diagnoses					
		not limited to, a stroke,					
	depression, obesity,	, and weakness.					
	An open-ended phy	sician's order, with a start					
		2:31 P.M., indicated the					
	resident was in enha	anced barrier precautions for a					
	pressure wound.						
		ion, on 06/03/25 at 2:09 P.M.,					
		nad a sign on it that indicated					
		P" and that the resident was in RRIER PRECAUTIONS". Staff					
		and gloves for high contact					
	_	ies, including but not limited					
		ny skin opening requiring a					
		, including gowns and gloves					
		ntainer with drawers outside					
	the resident's room.	LPN 17 and NP 16 entered the					
	resident's room and	provided wound care to the					
	_	lcer without donning gowns.					
		rd for Resident 78 was reviewed					
		3 A.M. A Quarterly MDS					
		3/12/25, indicated the resident					
		ively impaired. The resident's					
	cerebral palsy, ortho	but were not limited to,					
	depression, pressure ulcer to the left buttock, and adult failure to thrive.						
	Laure Parior Co till V						
	An open-ended phy	sician's order, with a start					
		dicated the resident was in					
	_	ecautions for a pressure					
	wound.						
l	I		1				I

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 39 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	COMPLETED				
		155209	B. WING	06/04/2025			
		1	CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
\\\\ATEDS	OF CLIETY EALL	S THE					
WATERS	OF CLIFTY FALL	S, THE	MADISON, IN 47250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	During an observat	ion, on 06/03/25 at 1:52 P.M.,					
	the resident's door	had a sign on it that indicated					
	staff were to "STO	P" and that the resident was in					
		RRIER PRECAUTIONS". Staff					
	-	and gloves for high contact					
		ties, including but not limited					
		ny skin opening requiring a					
	•	, including gowns and gloves					
	•	ntainer with drawers outside					
		. NP 16 and LPN 17 entered the					
		l provided wound care to the					
	resident's pressure	ulcer without donning gowns.					
	D	06/02/25 + 2.20 P.M 4					
	_	v, on 06/03/25 at 2:38 P.M., the					
		nat Residents 84, 52, and 78					
		staff, providing wound care, gowns and gloves while in the					
	room providing dir	<del>-</del>					
	100m providing dir	ect care.					
	The current facility	policy titled, "Guidelines for					
	-	ecautions", was provided by					
		rsing on 06/03/25 at 3:18 P.M.					
		ed, "It is the policy of the					
		at additional and appropriate					
		ective Equipment] is utilized,					
	_	prevent the spread of					
		OrganismsEnhanced Barrier					
	Precautions are def	ined as the use of PPE [gowns					
		high-contact resident care					
	activities"	-					
	3.1-18(b)						
F 0921	483.90(i)						
SS=D	Safe/Functional/S	Sanitary/Comfortable Environ					
Bldg. 00							
		on and interview, the facility	F 0921	F921:	07/03/2025		
	-	sanitary homelike environment		Safe/Functional/Sanitary/Com	forta		
	tor 1 of 20 resident	s reviewed. (Resident 53)		ble Environment:			
				It is the policy of the facility to			

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

Event ID:

YJOB11

Facility ID: 000116

If continuation sheet

Page 40 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155209	B. WING			06/04/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				OSS AVE		
WATERS	OF CLIFTY FALLS	S, THE			ON, IN 47250		
			1		,		OVE)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		on and interview, on 06/02/25		TAG			DATE
		dent 53 was lying in bed and			ensure to provide a homelike environment.		
	· ·	d. She opened her eyes and			environment.		
	-	s. On the floor approximately					
	-	foot of her bed were a stack of					
		, but were not limited to, a			What corrective action will be		
		lisposable underwear that			accomplished for those reside	ents	
	_	urine. The resident was lying			found to have been affected b		
	on clean sheets.	, ,			deficient practice:	,	
					· '		
	During an observati	on, of Resident 53's room, on			The DON/Designee removed	the	
	06/02/25 at 10:47 A	.M., on the floor approximately			soiled linens from resident 53'		
	ten inches from the foot of bed remained a stack				room on 6/2/2025.		
	of linens that includ	ed, but were not limited to, a					
	sheet and a pair of c	lisposable underwear that			How other residents having th	e	
	smelled strongly of	urine.			potential to be affected by the		
					same deficient practices will b	е	
	-	y, on 06/02/25 at 10:51 A.M.,			identified and what corrective		
		Nurse (LPN) 8, indicated the			action will be taken:		
		e (CNA) had been around to					
		nt recently. The dirty linens			All have the potential to be		
		n placed directly on the floor			affected by the alleged deficie		
	or left on the floor a	ifter the staff left the room.			practice, therefore, this plan o		
	The clinical records	for Resident 53 was reviewed			correction applies to all reside	ents	
		6 A.M. A Quarterly Minimum			that reside in the facility.		
		sessment, dated 05/17/25,			What measures will be put in		
	` ′	nt was moderately cognitively			place and what systemic chan	nnes	
		ent's diagnoses included, but			will be made to ensure that the	-	
	-	stroke, renal insufficiency,			deficient practice does not rec		
	· ·	y, dementia, anxiety, and			action practice account for		
		ident requires substantial			The DON/Designee in- nursing	a	
	-	ities of Daily Living (ADL)			staff to not place soiled linens	•	
		nygiene. The resident used a			the floor on or before 6/25/25.		
	wheelchair.				Additionally, any staff member		
					that fails to comply with points		
	During an interview	y, on 06/04/25 at 9:50 A.M.,			this in-service will be further		
	Qualified Medication	on Aide (QMA) 15 indicated			educated and/or as indicated.		
	the resident would r	not be able to take dirty linens					
	off her bed by herse	elf.			How the corrective action will	be	

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

Event ID:

YJOB11 Facility ID: 000116

If continuation sheet Page 41 of 42

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

PRINTED: 07/02/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED		
155209		B. WING			06/04/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE			STREET ADDRESS, CITY, STATE, ZIP COD  950 CROSS AVE  MADISON, IN 47250				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	•	ID	ADDITION AND OF CONDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	] ]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	ATE.	DATE
	The current facility FOR HOMELIKE I 06/20/23, was provi of Operations on 06 indicated, "It is th	policy titled, "GUIDELINES ENVIRONMENT", dated ded by the Regional Director //04/25 at 4:07 P.M. The policy e policy of the facility to ronment provided by the			monitored to ensure the defici practice will not recur, i.e. what quality assurance program will put into place:  The DON/Designee will comproom rounds for all facility room on linens on the floor 5 days aweek x 4 weeks; then 3 days week x 4 weeks; then once weekly x 4 months. If the facil within 95% compliance at the of 6 months, will be stopped. Results of the monitoring will reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, are patterns will be identified. Any be written by the QAPI commany written Action Plan will be monitored by the Administrator weekly until resolved.  Date of Compliance: 7/3/2025	lete ms a a ity is end be l ve ny v will ittee.	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YJOB11 Facility ID: 000116 If continuation sheet Page 42 of 42