STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING 00 B. WING	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 29 and 30, June 2, 3, and 4, 2025 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 4 Medicaid: 26 Other: 66 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 12, 2025.	F 0000	Preparation and/or execution of 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 set forth in this statement of deficiencies. The plan of correction and specific corrective actions prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/3/2025. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests desk review in lieu of a post survey review on or after 7/3/2025.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to store medications appropriately for 1 of 1 resident reviewed for self-administering medications. (Resident 7) Findings include: During an observation and interview, on 05/29/25 at 12:04 P.M., Resident 7 was lying in his bed. His	F 0554	F554: Resident Self Administration of Meds It is the policy of this facility to store medications appropriately. What corrective action will be accomplished for those residents	07/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Alcorn	Administrator	06/27/2025

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	over the bed table was sitting beside the bed and contained two medicine cups. One cup had one pill in it and the other had seven pills in it. The resident indicated the medications had been there for some time. He believed the medication was his gabapentin, muscle relaxer, and his cholesterol medications. He was unsure what the others were. There were no nursing staff in the room. The clinical record for Resident 7 was reviewed on 06/02/25 at 9:57 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/17/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, diabetes, hyponatremia, and depression. The clinical record lacked an assessment for the resident to self-administer his medications or a physician order to self-administer medications. During an interview, on 06/03/25 at 2:02 P.M., Licensed Practical Nurse (LPN) 2 indicated if a resident self-administered medications, then they would have a physician's order to do so and have an assessment completed. During an interview, on 06/04/25 at 10:09 A.M., the Assistant Director of Nursing (ADON) indicated the resident did not have an order to self-administer medications and should not have had the medications sitting at his bedside unattended. The current facility policy titled, "Self-Administration of Medications by Residents", dated March 2023, was provided by the Director of Nursing on 06/03/25 at 3:18 P.M. The policy indicated, "...Self-administration medications will be encouraged if it is desired by		found to be affected by the deficient practice? The DON/Designee completed a Medication Self Administration assessment on 06/05/2025 and resident does not to self-administer medications. How other residents of the facility were identified to potentially be affected by the practices are: The DON/Designee completed a Medication Self Administration assessment on residents and any residents that choose to self-administer medications were supplied with a lock box to secure medication, order to self-administer medications and care plans were updated. What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur? The DON/Designee in-serviced all nursing staff on the policy Self Administration of Medications and not medications at bedside on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as needed.	

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	the resident, safe for the resident, and other residents of the facility, ordered by the attending physician, and approved by the Interdisplinary Team...If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted...A physician order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the interdisplinary team. The order is recorded on the MAR [Medication Administration Record]..." 3.1-11(a)		How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DON/Designee will complete room rounds on 20 random residents for medications left at bedside weekly x 4 weeks, then 10 random residents weekly x 4 weeks, then 5 random residents monthly x 4 months. Any concerns noted will be immediately addressed and corrected. If the facility is within 95% compliance, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	
F 0583 SS=E	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records			

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Bldg. 00	Based on observation and interview, the facility failed to keep resident information private related to resident meal tickets and computer screens for 3 of 6 resident confidence of records information observations. (Residents 26, 73, 23, 36, 77, 42, 45, 57, 91, 34, 66 and Split Hall and 100 Hall) Findings include: 1. During an observation, on 05/29/25 at 12:11 P.M., the staff in the dementia unit were serving lunch. The staff members Activity Aide 7, Certified Nurse Aide 10, and Licensed Practical Nurse (LPN) 9, were serving the resident's their meals and then placing the resident meal cards with their names on them in the trash can. During an interview and observation, on 05/29/25 at 12:12 P.M., Activity Aide 7 indicated they had placed the resident's meal tickets in the regular trash can that would have been taken to the dumpster and they should have been placed in the shred container. She removed the following resident meal tickets from the trash can: Residents 26, 73, 23, 36, 77, 42, 45, 57, 91, and 34. During an interview, on 05/29/25 at 12:14 P.M., LPN 9 indicated the resident meal tickets should have been placed in the shred box. 2. During a continuous observation, on 05/29/25 from 2:19 P.M. through 2:23 P.M. the following was observed: - At 2:19 P.M., a computer screen opened on a medication cart in the Split hallway was sitting outside the nurse's station unattended. The computer screen had multiple resident names, pictures and room numbers visible on the screen,	F 0583	F583: Personal Privacy/ Confidentiality of Records: It is the policy of this facility to keep resident information private related to the meal tickets and computer screens. What corrective action will be accomplished for those residents found to be affected by the deficient practice? The DON/Designee assessed resident 26, 73, 23, 36, 77, 42, 45, 57, 91, 34, 66, and split hall and 100 on 06/05/2025 and no negative outcome related to the cited practice. How other residents of the facility were identified to potentially be affected by the practice: All residents have the potential to be affected by the cited this plan of correction applies to all residents. What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur? The DON/Designee in-serviced all staff on the policy of Personal Privacy/Confidentiality of Records, not placing meals tickets in the trash can and placing in shred	07/03/2025

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	- At 2:21 P.M., a resident in a wheelchair propelled by the cart and looked towards the computer and kept going, - At 2:23 P.M., two staff members walked by the cart, and - At 2:24 P.M., a nurse went to the medication cart and closed the computer screen. 3. During a continuous observation, on 05/29/25 from 1:38 P.M. through 1:44 P.M. the following was observed: - At 1:38 P.M., a computer screen was opened on Medication Cart 1 on the 100 Hallway that was sitting between resident Rooms 108 and 109. The screen had Resident 66's name and medication list visible. - At 1:39 P.M., a resident in a wheelchair propelled by the cart and looked towards the computer and kept going, - At 1:40 P.M., LPN 8 who had been standing at Medication Cart 2 outside of Room 110, approximently ten feet from Medication Cart 1, walked into Room 109 next to Medication Cart 1 out of visible sight of both Medication Carts 1 and 2. The LPN did not close the open computer screen on Medication Cart 1. - At 1:41 P.M., a resident in a wheelchair propelled by the cart, - At 1:42 P.M., a staff member walked past the cart, and LPN 8 walked out of room 109 and returned to the second medication cart, - At 1:43 P.M., a resident in a wheelchair propelled		closing the computer/locking screen during medication administration and when not in use on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place? The DON/Designee will monitor meal service meal services to ensure meal tickets are properly removed from trays and placed in the shred container 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. The DON/Designee will monitor computer monitors 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any concerns noted will be immediately addressed and corrected. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be	

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	by cart, spoke to LPN 8, turned around and went by the open computer screen again, - At 1:44 P.M., Qualified Medication Aide 11 went to the Medication Cart 1 and closed the computer screen. During an interview, on 06/04/25 at 9:41 A.M., LPN 5 indicated the computer screens should always be minimized or hidden from public view when the nursing staff were not at the computers. The current facility policy titled, "MEDICAL RECORDS GUIDELINES", dated 01/09/23, was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...The clinical records of residents are the property of the facility. Residents Rights related to health information are recognized in accordance with the Privacy Rules of Health Insurance Portability and Accountability Act (HIPAA). Clinical records are used by authorized individuals, and stored in an easily accessible area that is protected...and should be locked..." 3.1-3(o)		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 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was transmitted to the Centers for Medicare and Medicaid Services (CMS) in a timely manner for 1 of 20 resident assessments reviewed. (Resident 85) Findings include: The clinical record for Resident 85 was reviewed	F 0640	F640: Encoding/Transmitting Resident Assessments It is the policy of this facility to ensure a Minimum Data Set assessment is transmitted to the Centers of Medicare and Medicaid services timely. What corrective action will be accomplished for those residents	07/03/2025

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	on 06/03/25 at 12:11 P.M. A Discharge assessment, dated 12/28/24, indicated the resident admitted to the facility from the hospital on 12/04/24. The resident discharged from the facility on 12/28/24. The discharge was unplanned, and the resident went home. The assessment history indicated the assessment was never added to a batch to be transmitted to CMS. During an interview on 06/04/25 at 2:36 P.M., the Regional MDS Coordinator indicated it didn't look like the discharge assessment was transmitted. It should have been sent out sooner. The facility did not have a policy related to transmitting MDS assessments. They followed the RAI (Resident Assessment Instrument) manual. 3.1-31(a)		found to be affected by the deficient practice? The MDS Nurse/Designee submitted the Discharge assessment for Resident 85 on 6/4/2025. How other residents of the facility were identified to potentially be affected by are: The MDS Nurse/Designee completed a 90 day look back audit of discharges for submission of the Discharge MDS assessment on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator in- the MDS Coordinator on transmittal requirements on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The MDS Coordinator will monitor transmitted assessments 5 days	

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			a week x 4 weeks, then 3 days a week x 4 weeks: then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, record review, and interview, the facility failed to revise a resident's care plan related to the resident's leg prosthesis for 1 of 20 residents reviewed for care plans. (Resident 75) Findings include: Resident 75 was observed in his room on 05/29/25 at 11:30 A.M. The resident was sitting in his	F 0657	F657: Care Plan Timing and Revision: It is the policy of this facility to revise a care plan related to the leg prosthesis. What corrective action will be accomplished for those residents found to be affected by the deficient practice?	07/03/2025

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	wheelchair. The resident had a below the knee amputation of his left leg and was wearing a prosthetic leg. On 06/02/25 at 10:57 A.M., the resident was observed in his room with a family member. The resident was wearing his prosthetic leg. On 06/03/25 at 12:02 P.M., the resident was in his room with a family member. The resident was wearing his prosthetic leg. The resident indicated he had the prosthetic for 3 or 4 years. He had no problems with it. Nursing staff assisted him with putting it on every day. He did not put it on himself. The clinical record for Resident 75 was reviewed on 06/04/25 at 1:25 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/16/25, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, heart failure, diabetes, non-Alzheimer's dementia, and acquired absence of the left leg. The resident had an impairment on one side of their lower extremity. There was no indication the resident had a limb prosthesis. The resident admitted to the facility on 02/04/25. During an interview on 06/04/25 at 2:30 P.M., the MDS Coordinator indicated the MDS assessment did not indicate the resident wore a prosthetic leg. He didn't wear a prosthesis when he admitted to the facility. The resident did have a care plan for assistance with activities of daily living (ADLs) related to the below the knee amputation. During an interview, on 06/04/25 at 2:38 P.M., Licensed Practical Nurse 5 indicated the resident had worn the prosthetic leg since she had taken care of him.		The MDS Nurse/Designee updated resident ADL's care plan related to his leg prosthesis on 6/05/2025. How other residents of the facility were identified to potentially be affected by this practice are: The MDS Nurse/Designee completed an audit of ADL's care plan and updated as needed on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator in-serviced the DON, ADON and MDS Coordinator on Care Plan Timing and Revisions on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will review care plans of 20 random residents care plans weekly x 4 weeks for revisions and updated with new orders, then 10 random residents	

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	During an interview, on 06/04/25 at 2:40 P.M., Certified Nurse Aide (CNA) 6 indicated she was familiar with the resident. Every time she assisted the resident with care, she would help him get cleaned up and get dressed and put his prosthetic on. The resident's Care Plans were reviewed on 06/03/25 at 3:00 P.M. The resident's Care Plan for assistance with ADLs related to the below the knee amputation lacked any indication the resident had a prosthetic leg. During an interview on 06/04/25 at 3:21 P.M., the Assistant Director of Nursing indicated he was aware that the resident had a prosthetic leg. The resident's Care Plan should reflect the use of the prosthetic; there should be some direction for the CNAs. The current facility policy, titled "Baseline Care Plan Assessment/Comprehensive Care Plans", with a revision date of 03/23/21, was provided by the Regional Director of Operations on 06/04/25 at 3:40 P.M. The policy indicated, "...The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition.." 3.1-35(b)(1)		weekly x 4 weeks, then 5 random residents monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on record review, interview, and observation, the facility failed to follow physician's orders related to cardiac medication hold parameters and follow manufacturer's	F 0684	F684: Quality of Care It is the policy of the facility to follow physician orders related to cardiac	07/03/2025

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	guidelines related to insulin pen usage for 5 of 20 residents reviewed for Quality of Care. (Residents 2, 93, 7, 78, and 29) Findings include: 1. Resident 2's clinical record was reviewed on 06/04/25 at 10:17 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/20/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, hypertension, and chronic kidney disease. An open-ended physician's order, with a start date of 01/31/25, indicated the nursing staff were to administer the resident's Metoprolol 12.5 milligrams (mg) daily at 9:00 A.M. and 9:00 P.M. for hypertension. The medication was to be held if the resident's systolic blood pressure (top number/heart at work) was less than 110, the diastolic blood pressure (bottom number/heart at rest) was less than 60, or the resident's heart rate was less than 60. The May 1 through June 3, 2025 Electronic Medication Administration Record (EMAR) indicated the resident had received the medication twice a day. The record lacked documentation of any assessment of the resident's blood pressure and heart rate for the 9:00 P.M. dose of the medication. The current facility policy titled "PHYSICIAN ORDERS/FOLLOWING PHYSICIAN ORDERS GUIDELINE", with a review date of 02/12/24, was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 2. The clinical record for Resident 93 was reviewed		medications and hold parameters and to follow manufacturer guidelines related to insulin pen usage. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee assessed and updated the physician for resident 2 receiving cardiac medications without document of blood pressure and heart rate, resident 93 for receiving cardiac medication without documentation of blood pressure and heart rate, resident 7 received a cardiac medication outside of the parameters, resident 78 receiving cardiac medication outside of parameters, and resident 29 for not priming the insulin pen on 6/5/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The DON/Designee completed an audit of residents with parameters and medication administered outside of the parameters and notified the MD as needed and for residents receiving insulin via insulin pen and potential of not	

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	on 06/02/25 at 10:47 A.M. An Admission MDS assessment, dated 05/01/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension and orthostatic hypotension. An open-ended physician's order, with a start date of 04/25/25, indicated the staff were to administer the resident's Midodrine 5 mg, twice a day for hypotension. The staff were to hold the medication if the resident's systolic blood pressure was greater than 120 or the diastolic was greater than 80. The May and June 2025 EMAR and Vitals Report lacked that the resident had the blood pressure monitored before administration of the medication from 05/07/25 at 9:00 P.M. through 06/03/25 at 9:00 A.M. 3a. The clinical record for Resident 7 was reviewed on 06/02/25 at 9:57 A.M. A Quarterly MDS assessment, dated 04/17/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, diabetes, hyponatremia, and depression. An open-ended physician's order, with a start date of 12/30/24, indicated the staff were to administer the resident's Coreg 25 mg, twice a day for hypertension. The staff were to hold the medication if the resident's systolic blood pressure was less than 110 or the diastolic blood pressure was less than 60. The April and May 2025 EMAR indicated the resident had received the medication when their diastolic blood pressure was less than 60 on the following dates and times:		receiving full does and physician notified on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced all nursing staff on or before 6/25/25 on administering medications outside of hold parameters and priming insulin pens. Additionally, any staff members that fail to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will monitor the EMAR for medications with parameters and following physician orders 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will complete observations for priming insulin pens with 10 random nurses 4 weeks, then 5 random nurses weekly x 4 weeks, then 3 random nurses monthly x 4 months. If the facility is within 95%	

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	- On 04/24/25 at 9:00 A.M., the resident's blood pressure was 200/51. - On 05/07/25 at 5:00 P.M., the resident's blood pressure was 111/58. - On 05/11/25 at 9:00 A.M., the resident's blood pressure was 159/58. - On 05/24/25 at 9:00 A.M., the resident's blood pressure was 113/59. 3b. An open-ended physician's order, with a start date of 05/20/25, indicated the staff were to administer the resident's Lisinopril 10 mg, once a day for hypertension. The staff were to hold the medication if the resident's systolic blood pressure was less than 110 or the resident's heart rate was less than 60. The May 2025 EMAR indicated the resident had received the medication when their heart rate was less than 60 on the following dates: - On 05/24/25 the resident's heart rate was 58. - On 05/25/25 the resident's heart rate was 58. - On 05/31/25 the resident's heart rate was 59. 4. The clinical record for Resident 78 was reviewed on 06/03/25 at 10:03 A.M. A Quarterly MDS assessment, dated 03/12/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, orthostatic hypotension, depression, pressure ulcer to the left buttock, and adult failure to thrive. A current physician'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 hypotension. The staff were to hold the medication when the resident's systolic blood pressure was greater than 100.		compliance at the end of 6 months, will be stopped. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	

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	The April, May, and June EMAR, indicated the resident had received the medication when their systolic blood pressure was greater than 100 on the following dates and times: - On 04/02/25 at 10:00 P.M., the resident's blood pressure was 109/60, - On 04/03/25 at 2:00 P.M., the resident's blood pressure was 101/65 and at 10:00 P.M., when the blood pressure was 112/67, - On 04/04/25 at 2:00 P.M., the resident's blood pressure was 116/79. - On 04/05/25 at 2:00 P.M., the resident's blood pressure was 111/69. - On 04/06/25 at 10:00 P.M., the resident's blood pressure was 116/71. - On 04/10/25 at 2:00 P.M., the resident's blood pressure was 113/72. - On 04/11/25 at 6:00 A.M., the resident's blood pressure was 110/58. - On 04/12/25 at 2:00 P.M., the resident's blood pressure was 110/64. - On 04/13/25 at 10:00 P.M., the resident's blood pressure was 106/68. - On 04/14/25 at 6:00 A.M., the resident's blood pressure was 102/58 and 2:00 P.M., when the resident's blood pressure was 109/66. - On 04/15/25 at 2:00 P.M., the resident's blood pressure was 110/54 and 10:00 P.M., the resident's blood pressure was 109/55. - On 04/16/25 at 10:00 P.M., the resident's blood pressure was 102/66. - On 04/18/25 at 2:00 P.M., the resident's blood pressure was 114/70. - On 04/19/25 at 10:00 P.M., the resident's blood pressure was 108/72. - On 04/22/25 at 2:00 P.M., the resident's blood pressure was 102/56. - On 04/24/25 at 6:00 A.M., the resident's blood			

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	pressure was 116/64. - On 04/25/25 at 6:00 A.M., the resident's blood pressure was 114/62. - On 04/27/25 at 2:00 P.M., the resident's blood pressure was 106/58. - On 05/06/25 at 2:00 P.M., the resident's blood pressure was 102/62. - On 05/08/25 at 6:00 A.M., the resident's blood pressure was 114/62 and 2:00 P.M., the resident's blood pressure was 104/62. - On 05/09/25 at 10:00 P.M., the resident's blood pressure was 102/58. - On 05/12/25 at 2:00 P.M., the resident's blood pressure was 107/64. - On 05/13/25 at 6:00 A.M., the resident's blood pressure was 108/63 and 10:00 P.M., the resident's blood pressure was 108/56. - On 05/15/25 at 2:00 P.M., the resident's blood pressure was 102/55. - On 05/18/25 at 2:00 P.M., the resident's blood pressure was 107/63 and 10:00 P.M., the resident's blood pressure was 103/59. - On 05/22/25 at 6:00 A.M., the resident's blood pressure was 103/53. - On 05/23/25 at 2:00 P.M., the resident's blood pressure was 102/60 and 10:00 P.M., the resident's blood pressure was 102/60. - On 05/25/25 at 2:00 P.M., the resident's blood pressure was 106/60. - On 05/26/25 at 2:00 P.M., the resident's blood pressure was 118/62. - On 05/31/25 at 10:00 P.M., the resident's blood pressure was 112/66. - On 06/01/25 at 6:00 A.M., the resident's blood pressure was 106/64. During an interview, on 06/03/25 at 2:02 P.M., Licensed Practical Nurse (LPN) 2 indicated when a resident's medication had hold parameters, she would obtain the vital sign before giving the			

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	medication. If the vital was outside the 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 test...Always do a safety test before each injection to: Check your pen and the needle to make sure they are working properly...Make sure that you can get the correct LANTUS dose...Select 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	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record	F 0686	F686: Treatment/Services to	07/03/2025

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	review, the facility failed to follow physician's orders related to wound treatments for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers. (Resident 78) Findings include: Resident 78 was observed on 06/03/25 at 1:52 P.M., with the Wound Nurse Practitioner (NP) and the Assistant Director of Nursing (ADON). The resident had a wound to the left ischium (lower hip bone area) that had no signs of infection and measured 0.5 centimeters (cm) by (X) 0.3 cm X 0.2 cm, and the resident had a wound to the sacrum (bottom of the spine) that measured 0.8 cm X 0.8 cm X 0.4 cm. The clinical record for Resident 78 was reviewed on 06/03/25 at 10:03 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/12/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, orthostatic hypotension, depression, pressure ulcer to the left buttock, and adult failure to thrive. A Wound NP Assessment Report, dated 10/28/24, indicated the resident had a Stage 4 (full-thickness tissue loss with exposed muscle, tendon, or bone) pressure ulcer to the left ischium. The wound measured 1 cm X 0.6 cm X 0.3 cm. The treatment order was to be changed to cleanse the wound with Dakins solution, apply collagen to the wound bed, and cover with border gauze, daily. The physician's order, dated 10/28/24, was not initiated untill 11/08/24. A Wound NP Assessment Report, dated 12/16/24, indicated the resident had a Stage 4 pressure ulcer		Prevent/Heal Pressure Ulcer It is the policy of this facility to follow orders of the physician related to wound treatments for pressure ulcers. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee notified the Wound NP to clarify resident 78's wound treatments orders on DATE 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: The DON/Designee completed 7 look back of the Wound NP notes for correct treatment orders in PCC on 6/5/2025 concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: All licensed nursing was	

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	to the left ischium. The wound measured 0.6 cm X 0.5 cm X 0.2 cm. The treatment order was to be changed to cleanse the wound with Dakins solution, apply collagen with silver, and cover with border gauze, daily. The physician's order, dated 12/16/24, was not initiated untill 12/20/24. A Wound NP Assessment Report, dated 01/08/25, indicated the resident had a Stage 4 pressure ulcer to the left ischium. The wound measured 1.4 cm X 1 cm X 0.5 cm. The treatment order was to be changed to cleanse the wound with Dakins solution, apply Dakins moistened fluffed gauze to the wound, and cover with border gauze, twice a day. The physician's , dated 01/08/25, was not initiated untill 01/12/25. A Wound NP Assessment Report, dated 01/20/25, indicated the resident had a Stage 4 pressure ulcer to the left ischium. The wound measured 1.4 cm X 1 cm X 0.8 cm. The treatment order was to be changed to cleanse the wound with Dakins solution, apply collagen particles, and cover with border gauze, daily. The physician's order, dated 01/20/25, was transcribed for a twice a day treatment instead of daily. A Wound NP assessment Report, dated 02/26/25, indicated the resident had a Stage 4 pressure ulcer to the left ischium. The wound measured 1.8 cm X 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, three times a week.		in-serviced by the DON/Designee on or before 6/25/27 on the policy physician orders, signing the TAR, completing treatments as ordered and timely transcription of orders and in-serviced the ADON on timely transcription of treatment orders by the wound NP on 6/5/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How corrective action will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will audit the wound NP notes weekly for timely transcription of treatment orders x 6 months. The DON/Designee will audit the TAR for nurse electronic signature five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI	

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	The order was transcribed to cleanse the wound with wound cleanser, apply collagen particles, and cover with border gauze every 12 hours from 02/27/25 through 03/14/25. A Wound NP assessment Report, dated 03/05/2025, indicated the resident had a Stage 4 pressure ulcer to the left ischium. The wound measured 1.8 cm X 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. The order for the wound was not changed until 03/15/25. The December 2024 through May 2025 Electronic Treatment Administration Record (ETAR) lacked documentation for Resident 78's left ischium being completed on the following dates: - 12/07/24, - 12/12/24, - 12/19/24, - 01/03/25, - 01/20/25 at evening, - 01/30/25 at evening, - 02/09/25, - 05/08/25, - 05/16/25, - 05/19/25, and - 05/23/25. During an interview, on 06/04/25 at 10:04 A.M., the ADON indicated they would follow the orders of the Wound NP. The Wound NP came to the building weekly. Within 24 hours of her visit, she would send him (the ADON) new orders or		committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	

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	recommendations. He would transcribe and implement the new orders within 24 hours of receiving them. During an interview, on 06/04/25 at 2:57 P.M., the ADON indicated the resident's treatments should have been followed per the Wound NP's orders. They were either transcribed wrong or not implemented timely. If there was a blank in the ETAR it meant the treatment was not completed. The current facility policy titled "PHYSICIAN ORDERS/FOLLOWING PHYSICIAN ORDERS GUIDELINE", with a review date of 02/12/24, was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-40 (a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and record review, the facility failed to ensure splint devices were in applied as ordered for 1 of 1 resident reviewed for range of motion. (Resident 84) Findings include: Resident 84 was observed in his room on 05/29/25 at 11:00 A.M. The resident was in bed and the head of his bed was elevated. The resident was not wearing hand or elbow splints. During an interview, on 05/30/25 at 10:51 A.M., the resident's family member indicated the resident never wore his hand or elbow splints. The splints were up in the closet, and they were supposed to	F 0688	F688: Increase/Decrease in ROM/Mobility It is the policy of the facility to ensure splints devices are applied as ordered. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Therapy assessed resident 84 for bilateral hand and arm splints on 6/5/2025, order received to	07/03/2025

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	be on his arms. The resident was observed in his room on 06/02/25 at 9:16 A.M. The resident was in bed. There were no hand or elbow splints in place. The resident was observed in his room on 06/02/25 at 10:48 A.M. The resident's arms were folded over his chest. There were no splint devices in place. The resident was observed in his room on 06/03/25 at 9:14 A.M. The resident was in bed. There were no splint devices in place. The resident was observed in his room on 06/03/25 at 2:00 P.M. The resident was in bed. There were no splint devices in place. The resident was observed in his room on 06/04/25 at 9:30 A.M. The resident was in bed. There were no splint devices in place. The resident's clinical record was reviewed on 06/02/25 at 2:44 P.M. A Quarterly Minimum Data Set assessment, dated 02/27/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, traumatic brain injury, quadriplegia, and respiratory failure. Mobility in the resident's upper and lower extremities was impaired on both sides, and the resident was dependent on staff for all activities of daily living. The resident's current physician's orders included, but were not limited to the following: - An open-ended order, with a start date of 02/25/25, for the resident to wear bilateral hand splints. The splints were to be applied in the		continue with current splints. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Therapy completed an audit and assessment on residents with splints and braces on 6/6/2025 concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced all nursing staff on or before 6/25/25 orders for splints/ROM and donning and doffing splints and braces as ordered. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will monitor residents with splints and braces five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months for	

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	morning for 3 hours and then removed, and - An open-ended order, with a start date of 02/25/25, for the resident to wear bilateral elbow splints. The elbow splints were to be applied after the hand splints were removed and were to be worn for 3 hours. Nursing staff documented in the resident's Electronic Treatment Administration Record (ETAR) for May and June 2025 that the resident's hand splints and elbow splints had been applied every day. During an interview, on 06/04/25 at 10:58 A.M., Licensed Practical Nurse 4 indicated the CNAs were the ones that applied the splints, but the nurses signed the ETAR indicating the arm and elbow splints were applied. She signed off that the splints were applied that morning. It had been a long time since she had observed the resident wearing hand or elbow splints. During an interview, on 06/04/25 at 9:35 A.M., Certified Nurse Aide (CNA) 3 indicated she was familiar with the resident. He did not wear splints or braces on his arms or elbows. He wore them when he first came to the facility. It had been a few months since he worn them. The splints were observed on a table in the resident's room. The CNA Task Charting for May and June 2025 was reviewed and included, but was not limited to, the following tasks: - NURSING REHAB: Assistance with Splint. The resident was participating in a splint program to prevent further contracture to bilateral hands and elbows. The splint should be applied after Passive Range of Motion (PROM). Bilateral hand splints		braces and splints being donned and doffed per physician orders. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were to be applied for 3 hours daily and after they were removed, bilateral elbow splints were to be applied for 3 hours. If the resident had a Peripherally Inserted Central Catheter in one arm, the elbow splint was not to be applied to that extremity. The Task record for May and June 2025 documentation indicated the CNAs applied the hand and elbow splints daily. CNA 3 documented that she had applied the splints that morning. . During a follow-up interview, on 06/04/25 at 9:51 A.M., CNA 3 reviewed her charting and indicated when she entered a time and initialed the section about splint usage earlier that morning, she was referring to the PROM exercises she performed with the resident. She did not apply a brace or splint device. She did document PROM in a different section that was designated for that specific task as well. The resident hasn't used the splints in a long time. There were times before that he was resistant to wearing the brace. If a resident resisted or refused care, it should be documented as such. If they continued to refuse, they would let the nurse know. The current facility policy titled "PHYSICIAN ORDERS/FOLLOWING PHYSICIAN ORDERS GUIDELINE", with a review date of 02/12/24, was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-42(a)(2)			
F 0732 SS=C Bldg. 00	483.35(i)(1)-(4) Posted Nurse Staffing Information			

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	155209	A. BUILDING 00 B. WING	06/04/2025

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WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

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	Based on observation and interview, the facility failed to post nurse staffing accurately for 2 of 6 staff posting observations. Findings include: During an observation, on 05/29/25 at 10:44 A.M., the nurse staff posting was sitting on the desk at the nurse's station by the front door visible for visitors to see. The staff posting was dated 04/22/25. During an observation, on 05/29/25 at 3:00 P.M., the nurse staff posting was sitting on the desk at the nurse's station by the front door visible for visitors to see. The staff posting was dated 04/22/25. During an interview, on 06/04/25 at 10:16 A.M., the Assistant Director of Nursing indicated the nurse staff posting should be changed daily. No facility policy was provided for nurse staff posting.	F 0732	F732: Posted Nursing Staffing Information It is the intent of this facility to post staffing accurately. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents that reside in the facility have the potential to be affected by the alleged deficient therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator in-serviced the DON, ADON and scheduler on 6/25/25 on the requirements for Posted Nursing Staffing Information daily. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The Administrator will audit the Posted Nursing Staffing Information 5 days a week x 4 weeks, then 3 days a week x 4	07/03/2025

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			weeks, then weekly x 4 months. If 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 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on record review and interview, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents reviewed for drug regimen review. (Resident 75) Findings include: The clinical record for Resident 75 was reviewed on 06/04/25 at 1:25 P.M. A Quarterly Minimum Data Set assessment, dated 05/16/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, diabetes, non-Alzheimer's dementia, anxiety, and depression. A pharmacy recommendation, dated 02/15/25, indicated the resident was currently receiving citalopram (an antidepressant) 40 milligrams (mg) twice a day. The dose exceeded the maximum	F 0756	F756: Drug Regiment Review It is the policy of the facility to ensure pharmacy recommendations are . What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 75's Citalopram recommendation was completed on 3/12/2025. How other residents having the potential to be affected by the same deficient practice will be	07/03/2025

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	recommended dose of 40 mg per day. The resident was receiving double the recommended dose and the pharmacist recommended reducing the order to 40 mg per day. The Nurse Practitioner agreed with the recommendation on 02/26/25. The resident's Electronic Medication Administration Record (EMAR) for February and March 2025 indicated the resident continued to receive 40 mg of citalopram twice a day from 02/15/25 through 03/11/25. On 03/12/25 the pharmacy recommendation from 02/15/25 for the order to change the resident's citalopram from twice a day to daily was changed. During an interview on 06/04/25 at 11:50 A.M., the Clinical Corporate Support Nurse indicated pharmacy recommendations should be addressed timely. The medication order should have been changed sooner than it was. The current, undated facility policy, titled "Policy and Procedure--Pharmacy Recommendation" was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...A response as to the action to be taken regarding the Pharmacy Consultant's recommendation will be documented within 7 days of the receipt of the recommendation..." 3.1-25(3)(i)		identified and what corrective action will be taken: The DON/Designee completed a 90 day look back at pharmacy recommendations, any concerns will immediately on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator in-serviced the DON and ADON on or before 6/25/25 on completing Pharmacy Recommendations timely. Additionally, any staff member that fails to comply with the this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will monitor pharmacy recommendations are completed timely monthly x 6 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring will be stopped. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been	

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			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 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medication carts (Split Cart and Living Well Cart) reviewed and 1 of 2 medication rooms (Dementia Unit) reviewed. Findings include: 1. The Split Medication Cart was observed on 06/04/25 at 10:26 A.M., with Licensed Practical Nurse (LPN) 12. The medication cart contained an unopened and undated Fiasp insulin pen that belonged to Resident 22. The LPN indicated she was unsure when the insulin pen was removed from the refrigerator as she had not been the one to remove it, and it should have stayed in the refrigerator untill it was needed. 2. The Living Well Medication Cart was observed on 06/04/25 at 10:46 A.M., with LPN 4. The cart	F 0761	F761: Label/Storage Drugs and Biologicals It is the policy of this facility to store medications appropriately. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee disposed of residents insulin for resident disposed of resident 12's Combivent and resident 301's Ellipta inhaler on 6/5/ medications were re-ordered. The DON/Designee disposed of the	07/03/2025

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	contained the following: - An opened Combivent inhaler that belonged to Resident 12 with no open date, and - An opened Ellipta inhaler that belonged to Resident 301 with no open date. The current "Fiasp" insulin pen package insert was provided by the Regional Clinical Consultant on 06/04/25 at 11:38 A.M. The insert indicated, "...Not-in-use (unopened)...single-patient-use Fiasp FlexTouch pen...Room temperature...28 days..." The current "Combivent package insert was provided by the Assistant Director of Nursing (ADON) on 06/04/25 at 3:59 P.M. The insert indicated, "...should be discarded at the latest 3 months after first use..." The current "Ellipta" package insert was provided by the ADON on 06/04/25 at 3:59 P.M. The insert indicated, "...Discard...6 weeks after opening the foil tray..." 3. The Dementia Unit's medication room was observed on 06/04/25 at 10:37 A.M., with Qualified Medication Aide (QMA) 14. The following items were in the medication room refrigerator: - A bottle of tuberculin serum that was half full and had an open date of 04/18/25, and - Six acetaminophen suppositories, 650 milligrams. The suppositories were not in any bag or labeled with a resident's name. At the time of the observation QMA 14 indicated the suppositories should have had a resident's name on them.		tuberculin solution, acetaminophen suppositories on the Dementia medication cart on 6/5/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The DON/Designee completed audits on medication carts for dated medications and labeled with name concerns were immediately addressed on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced all nursing staff on proper medication storage, dating medications when opened and labeled with resident's name on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:	

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	During an interview on 06/04/25 at 10:46 A.M., LPN 4 indicated inhalers should be dated when they were opened and the tuberculin serum was only good for 30 days after it was opened. The Tuberculin Serum package insert was provided by the Regional Clinical Consultant on 06/04/25 at 11:38 A.M. The directions for storage indicated, "...vials in use more than 30 days should be discarded..." The current facility policy titled, "Medication Storge in the Facility" dated, February 2017, was provided by the Clinical Support Consultant on 06/04/25 at 11:38 A.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly..." 3.1-25(o)		The DON/Designee will monitor Medication carts and medication room storage, dates on opened and labeled with name five times a week x 4 weeks; then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to ensure that critical laboratory (lab) test results were received and reported to the physician in a timely manner; and a lab test was completed after a fall related to seizure medication for 2 of 6 residents reviewed for lab services. (Residents 11 and 20) Findings include:	F 0770	F770: Laboratory Services: It is the policy of this facility to ensure critical laboratory test results are received and reported to the physician in a timely manner. What corrective action will be	07/03/2025

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	1. Resident 11's clinical record was reviewed on 06/02/25 at 1:02 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/05/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, renal insufficiency, and diabetes. A Progress Note, dated 05/28/25 at 6:29 P.M., indicated the Nurse Practitioner (NP) reviewed the resident's recent Basic Metabolic Panel (BMP) lab results. The resident's potassium level was critical at 2.4 (the normal range for potassium was 3.5 to 5.3). The resident was to receive oral potassium tablets, and a BMP was to be re-drawn on 05/30/25. A Progress Note, dated 05/30/25 at 5:42 P.M., indicated the BMP was obtained on 05/30/25, and the resident's potassium was still critically low at 2.7. The NP ordered additional oral potassium tablets, decreased the resident's diuretic medication, and ordered a repeat BMP on 05/31/25. The resident's record was reviewed on 06/03/25 at 9:30 A.M. and lacked the results of the BMP lab that was to be drawn on 05/31/25. During an interview, on 06/03/25 at 9:55 A.M., the Assistant Director of Nursing (ADON) indicated when labs were obtained the results were automatically available to be reviewed in the resident's record. Sometimes STAT (immediate) lab results didn't always show up, and nursing staff had to follow up with the lab directly. At the time of the interview (06/03/25), the ADON manually accessed the results from the lab drawn on 05/31/25 and the resident's potassium was still low at 3.1. The ADON indicated nursing staff		accomplished for those residents found to have been affected by the deficient practice: The DON/Designee notified the physician of resident 11's BMP results on 6/3/2025. The DON/Designee notified the physician of the missed level for on 6/5/2025, no new orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The DON/Designee completed a look of lab orders and verified labs draw as ordered and notification completed timely on 6/5/2025 concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced all nursing staff on Laboratory Services on notification of physician of lab results and obtaining lab as ordered on or before 6/25/25. any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.	

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	should have followed up on the lab. There should have been a Progress Note put in the resident's record and the NP should have been notified. During an interview on 06/03/25 at 11:08 A.M., the ADON indicated he called and notified the NP of the results of the STAT BMP from 5/31/25. There had been no follow up prior to 06/03/25. The NP ordered another STAT BMP. A Progress Note, dated 06/03/25 at 7:52 P.M., indicated the resident's potassium level was 2.6. The resident was to receive additional oral potassium tablets and the resident's diuretic was discontinued. The resident was to continue to be weighed daily. The current facility policy, titled "GUIDELINES FOR LAB SCHEDULING/TRACKING", dated 09/01/23, was provided by the Administrator on 06/04/25 at 11:10 A.M. The policy indicated, "...The Charge Nurse will monitor the scheduled labs daily to ensure that any collected lab results are received timely as well as to confirm that received results are reported to the physician...and that any orders received related to the lab results are carried out...Any omitted labs will be researched and the lab will be contacted for an explanation as to the delay..." 2. The clinical record for Resident 20 was reviewed on 06/03/25 at 2:53 P.M. A Quarterly Minimum Data Set assessment, dated 04/15/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, seizure disorder, malnutrition, anxiety, depression, and bipolar. A Progress Note, dated 05/02/25 at 5:30 P.M., indicated the resident had an unwitnessed fall in her room. The resident had no injuries and		How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will monitor Laboratory Services/MD notification daily 5 days a week x 4 weeks, then 3 days weekly x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	

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	indicated she had a seizure. The resident's neurological assessments were initiated, and all appropriate persons were notified. An Interdisciplinary Team Note, dated 05/05/25 at 9:23 A.M., indicated the resident had a fall on 05/02/25 with no injuries. The fall was related to seizure activity. A new intervention was implemented to obtain a Vimpat (a seizure medication) level to check for a therapeutic range. The clinical record lacked any indication a Vimpat level had been obtained. During an interview on 06/04/25 at 3:09 P.M., the ADON indicated the resident did not have a Vimpat level obtained after the fall and they should have. 3.1-49(a) 3.1-45(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to store foods appropriately to prevent contamination for 1 of 2 kitchen observations. Findings included: 1. The initial kitchen tour was conducted on 05/29/25 at 10:48 A.M., and the following was observed: - A large clear plastic container sitting on a metal shelf contained flour. The lid was ill-fitting and not designed for the container, - A large clear plastic container sitting on a metal	F 0812	F812: Food Procurement, Store/Prepare/Serve-Sanitary It is the policy of the facility to store appropriately to prevent contamination. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Dietary Manager/Designee disposed of the flour and sugar on	07/03/2025

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	shelf contained sugar with a plastic scoop sitting inside. During an interview on 05/29/25 at 10:50 A.M., Dietary Aide 13 indicated the scoop should not have been left in the sugar and the lids were not the right ones for the containers. During the initial kitchen tour, the noon time meal was completely prepared and no staff were actively using the flour or sugar. An exterior door was within ten feet of the inappropriately sealed flour and sugar bins. The current facility policy titled, "Food Storage (Dry, Refrigerated and Frozen)", dated 08/12/23, was provided by the Administrator on 06/04/25 at 10:50 A.M. The policy indicated, "...5. All open products (as able) will be sealed (rolled closed, wrapped closed, with lids closed, etc.) to ensure quality and prevent contamination against pest or rodents...Scoops stored outside of bin in clean, designated space..." 3.1-21(i)(3)		6/4/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The Dietary Manager completed an audit of the foods stored in plastic to ensure labels with date, and no scoop stored in the plastic containers on 6/5/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator/Designee in- all Dietary staff on Food Storage on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The Dietary Manager will audit the Food Storage daily 5 days a week for 4 weeks, then 3 times weekly x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results	

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			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 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on record review, interview, and observation, the facility failed to document colostomy care for 1 of 25 residents' records reviewed. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 06/02/25 at 11:08 A.M. A Significant Change Minimum Data Set assessment, dated 04/07/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, degenerative disease of basal ganglia, non-Alzheimer's dementia, Parkinson's disease, anxiety, depression, bipolar, psychotic disorder, schizophrenia, oppositional defiant disorder, mild intellectual disabilities, and	F 0842	842: Resident Records-Identifiable Information It is the policy of this facility that Colostomy care is documented. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 26's colostomy appliance was changed on 6/4/2025 by the DON/Designee.	07/03/2025

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	155209	A. BUILDING 00 B. WING	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

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	colostomy status. The resident had an ostomy. An open-ended physician's order, with a start date of 09/15/21, indicated the staff were to change the resident's colostomy appliance as needed. The clinical record lacked documentation that the resident's colostomy appliance had been changed in the months of March, April, May, or as of June 3, 2025. During an interview, on 06/03/25 at 1:45 P.M., Licensed Practical Nurse 9 indicated the resident had a colostomy and the appliance would get changed a lot. They should have documented that it had been changed. During an interview, on 06/03/25 at 1:50 P.M., Certified Nurse Aide 11 indicated the resident had a colostomy. The aides would change the appliance when it needed to be done. They documented each shift indicating the resident had a colostomy and the amount of stool in it. The resident's colostomy appliance was observed on 06/04/25 at 2:25 P.M., with Qualified Medication Aide 14. The colostomy was clean and appeared free of infection. During an interview, on 06/04/25 at 10:06 A.M., the Assistant Director of Nursing indicated colostomy care was completed daily, and the appliance should be changed every three days. All residents' with a colostomy should have had an order to change the colostomy appliance. The clinical record should have had documentation related to the resident's colostomy care staff provided.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The DON/Designee completed an audit of residents with colostomy for documentation of colostomy care on 6/5/ any concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced the nursing staff on documenting colostomy care on 6/25/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will audit documentation of colostomy care five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance at the end of 6 months, will be	

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	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)		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	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to the placement of urinary catheter tubing and drainage bag and Enhanced Barrier Precautions (EBP) for 4 of 20 residents reviewed for infection control. (Residents 31, 84, 52, and 78) Findings include: 1. On 05/29/25 at 1:59 P.M., Resident 31 was observed propelling herself in her wheelchair. The resident's urinary catheter bag was hanging under her wheelchair, and the bag and tubing were dragging on the floor under the chair. Cloudy yellow urine was observed in the bag and tubing. During an interview, on 05/29/25 at 2:05 P.M., the	F 0880	F880: Infection Prevention & Control: It is the policy of the facility to follow infection control guidelines related to placement of urinary catheter tubing and drainage bag and Enhanced Barrier Precautions. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee assessed residents 31, 84, 52 and 78 on 6/5/2025 and no negative outcome related to the cited practice.	07/03/2025

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	resident indicated staff always assisted her into her wheelchair and placed her catheter bag under the wheelchair. The catheter bag was always dragging. The resident propelled herself around in her room and the drainage bag was hanging close to the wheel of the wheelchair, dragging on the floor. She wanted a leg bag, and they tried it once, but they taped it to her leg and that didn't work out. They've never used a dignity pouch; they did put the drainage bag inside a plastic bag once. She had a urinary tract infection last month. The resident's clinical record was reviewed on 06/04/25 at 2:14 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/06/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, hypertension, and diabetes. On 06/02/25 at 10:27 A.M., the resident was observed in her room sitting in her wheelchair. The resident's catheter bag was hanging under the wheelchair. The bag was folded over, with several inches of it resting on the floor. On 06/02/25 at 1:55 P.M., the resident was observed propelling herself in her wheelchair in the main dining room. The resident's catheter bag and tubing were dragging on the floor under the wheelchair as she went by. On 06/04/25 at 2:10 P.M., the resident was observed with the Assistant Director of Nursing (ADON). The resident was in her wheelchair in the hallway near her room. The resident's drainage bag was hanging under the wheelchair. The catheter tubing was resting on the floor. The resident's urine was yellow and cloudy with sediment in the tubing. The ADON walked by the resident and indicated the resident's catheter		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the cited this plan of correction applies to all residents. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced all staff on the facilities Infection Prevention & Control Policy, placement of the catheter tubing and Enhanced Barrier Precautions on or before 6/25/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place: The DON/Designee will monitor donning and doffing of PPE for residents in Enhanced Barrier Precautions for 10 staff members	

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	tubing and drainage bag should not touch the floor. The ADON instructed the CNA on the resident's hallway to reposition the resident's drainage bag and tubing off of the floor. The current facility policy, titled :GUIDELINES FOR INDWELLING FOLEY CATHETER CARE", dated 10/16/24, was provided by The Regional Director of Operations on 06/04/25 at 2:56 P.M. The policy indicated, "The main purpose of proper indwelling foley catheter care is to prevent catheter associated urinary tract infections..." 2. Resident 84's clinical record was reviewed on 06/02/25 at 2:44 P.M. A Quarterly MDS assessment, dated 02/27/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, traumatic brain injury, quadriplegia, and respiratory failure. The resident had an indwelling urinary catheter, a gastrostomy tube (G-tube), a tracheostomy, a peripherally inserted central catheter (PICC line), and pressure ulcers. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 04/14/25 for Enhanced Barrier Precautions every shift. During an observation on 06/03/25 at 1:49 P.M., the resident's door had a sign on it that indicated staff were to "STOP" and that the resident was in "ENHANCED BARRIER PRECAUTIONS". Staff must wear a gown and gloves for high contact resident care activities, including but not limited to, "Wound Care: any skin opening requiring a dressing". Supplies, including gowns and gloves were in a plastic container with drawers outside the resident's room. Nurse Practitioner (NP) 16 and Licensed Practical Nurse (LPN) 17 entered the		per week x 4 weeks; then 5 staff members per week x 4 weeks then 3 staff members monthly x 4 months. The DON/Designee will audit residents with foley catheters for proper placement of tubing, and privacy bag five times a week x 4 weeks, then 3 times a week x once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	

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	resident's room and provided wound care to the resident's pressure ulcer without donning gowns. 3. The clinical record for Resident 52 was reviewed on 06/03/25 at 2:08 P.M. A Quarterly MDS assessment, dated 02/24/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, a stroke, depression, obesity, and weakness. An open-ended physician's order, with a start date of 06/02/25 at 2:31 P.M., indicated the resident was in enhanced barrier precautions for a pressure wound. During an observation, on 06/03/25 at 2:09 P.M., the resident's door had a sign on it that indicated staff were to "STOP" and that the resident was in "ENHANCED BARRIER PRECAUTIONS". Staff must wear a gown and gloves for high contact resident care activities, including but not limited to, "Wound Care: any skin opening requiring a dressing". Supplies, including gowns and gloves were in a plastic container with drawers outside the resident's room. LPN 17 and NP 16 entered the resident's room and provided wound care to the resident's pressure ulcer without donning gowns. 4. The clinical record for Resident 78 was reviewed on 06/03/25 at 10:03 A.M. A Quarterly MDS assessment, dated 03/12/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, orthostatic hypotension, depression, pressure ulcer to the left buttock, and adult failure to thrive. An open-ended physician's order, with a start date of 03/10/24, indicated the resident was in enhanced barrier precautions for a pressure wound.			

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	During an observation, on 06/03/25 at 1:52 P.M., the resident's door had a sign on it that indicated staff were to "STOP" and that the resident was in "ENHANCED BARRIER PRECAUTIONS". Staff must wear a gown and gloves for high contact resident care activities, including but not limited to, "Wound Care: any skin opening requiring a dressing". Supplies, including gowns and gloves were in a plastic container with drawers outside the resident's room. NP 16 and LPN 17 entered the resident's room and provided wound care to the resident's pressure ulcer without donning gowns. During an interview, on 06/03/25 at 2:38 P.M., the ADON indicated that Residents 84, 52, and 78 were on EBP. The staff, providing wound care, should have worn gowns and gloves while in the room providing direct care. The current facility policy titled, "Guidelines for Enhance Barrier Precautions", was provided by the Director of Nursing on 06/03/25 at 3:18 P.M. The policy indicated, "...It is the policy of the facility to ensure that additional and appropriate PPE [Personal Protective Equipment] is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms...Enhanced Barrier Precautions are defined as the use of PPE [gowns and gloves] during high-contact resident care activities..." 3.1-18(b)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to provide a sanitary homelike environment for 1 of 20 residents reviewed. (Resident 53)	F 0921	F921: Safe/Functional/Sanitary/Comfortable Environment: It is the policy of the facility to	07/03/2025

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	During an observation and interview, on 06/02/25 at 10:26 A.M., Resident 53 was lying in bed and her eyes were closed. She opened her eyes and denied any concerns. On the floor approximately ten inches from the foot of her bed were a stack of linens that included, but were not limited to, a sheet and a pair of disposable underwear that smelled strongly of urine. The resident was lying on clean sheets. During an observation, of Resident 53's room, on 06/02/25 at 10:47 A.M., on the floor approximately ten inches from the foot of bed remained a stack of linens that included, but were not limited to, a sheet and a pair of disposable underwear that smelled strongly of urine. During an interview, on 06/02/25 at 10:51 A.M., Licensed Practical Nurse (LPN) 8, indicated the Certified Nurse Aide (CNA) had been around to check on the resident recently. The dirty linens should not have been placed directly on the floor or left on the floor after the staff left the room. The clinical record for Resident 53 was reviewed on 06/02/25 at 11:06 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/17/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, renal insufficiency, obstructive uropathy, dementia, anxiety, and depression. The resident requires substantial assistance for Activities of Daily Living (ADL) including personal hygiene. The resident used a wheelchair. During an interview, on 06/04/25 at 9:50 A.M., Qualified Medication Aide (QMA) 15 indicated the resident would not be able to take dirty linens off her bed by herself.		ensure to provide a homelike environment. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The DON/Designee removed the soiled linens from resident 53's room on 6/2/2025. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: All have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in- nursing staff to not place soiled linens on the floor on or before 6/25/25. Additionally, any staff member that fails to comply with points of this in-service will be further educated and/or as indicated. How the corrective action will be	

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	The current facility policy titled, "GUIDELINES FOR HOMELIKE ENVIRONMENT", dated 06/20/23, was provided by the Regional Director of Operations on 06/04/25 at 4:07 P.M. The policy indicated, "...It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable..."		monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The DON/Designee will complete room rounds for all facility rooms no linens on the floor 5 days a week x 4 weeks; then 3 days a week x 4 weeks; then once weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 7/3/2025	