PRINTED: 07/01/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/18/2025		
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
E 0000							
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0000				
	Waters of Clifty Fa with Emergency Pr Medicare and Medi and Suppliers, 42 C The facility has 138 the survey, the cens	00116 155209 266330 Preparedness survey, The Ils was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.					
K 0000							
Bldg. 01							
	Licensure Survey w Department of Head 483.90(a).  Survey Date: 06/18  Facility Number: 0 Provider Number: 100  At this Life Safety	00116 155209	K 0000	DISCLAIMER STATEMENT: 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 correction actions prepared and/or executin compliance with state and federal laws. This plan of	al, not e et		

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

TITLE (X6) DATE

Melinda Alcorn Administrator 06/27/2025

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155209	A. BUILDING 01 COMPLE'  B. WING 06/18/2				
		155209			_	00/16/	2025
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
WATERS	OF CLIFTY FALLS	S, THE			DN, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR Requirements for Pa	LISC IDENTIFYING INFORMATION	17	AG	correction constitutes a writter		DATE
	*	, 42 CFR Subpart 483.90(a),				1	
		re and the 2012 edition of the		allegation of substantial compliance with Federal Medicare			
	•	etion Association (NFPA) 101,			and Medicaid requirements.	Jaio	
		SC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
		ity was determined to be of					
		ruction and fully sprinkled.					
	_	re alarm system with smoke					
		ridors and spaces open to the ty has battery operated smoke					
		nt sleeping rooms. The facility					
	has a capacity of 138 and had a census of 101 at						
	the time of this visit						
		dents have customary access					
	_	all areas providing facility					
	-	kled. The facility has two					
		orage buildings which were					
	not sprinkled.						
	Quality Review con	npleted on 06/23/25					
K 0211	NFPA 101						
SS=E	Means of Egress -	- General					
Bldg. 01							
		on and interview, the facility	K 0211		K211– It is the intent of the fac	cility	07/18/2025
		6 corridor means of egresses			to ensure corridor means of		
	were continuously r				egresses are continuously		
		9.2.3.4 (4) states projections			maintained free of obstructions	s to	
	•	dth shall be permitted for			meet set standards.	/ENI.	
	following condition	, provided that all of the			CORRECTIVE ACTIONS TAK	EN:	
	_	uipment does not reduce the					
	•	corridor width to less than 60			·On 6/19/2025 the Maintena	nce	
	in.(1525 mm).				Supervisor/designee removed		
		occupancy fire safety plan and			PPE carts from the halls by ro		
		dress the relocation of the			221 and 219 / added wheels to		
		during a fire or similar			PPE Carts to meet set		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPL				
		155209	B. Wl	ING		06/18/	2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 CROSS AVE MADISON, IN 47250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT PREFIX  (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI		TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	emergency.				standards. The Administrator		
	* /	ipment is limited to the			verified the work on		
	following:				6/19/2025		
	i. Equipment in use						
		ncy equipment not in use					
	iii. Patient lift and t				·ALL OTHERS WITH		
	-	ice affects 18 residents in the			POTENTIAL TO BE AFFECT	ED:	
	facility.						
	Findings in aluda				·All residents and all staff ar	a d	
	Findings include:						
	Rased on observation	ons and interview during a			visitors have the potential to b	e but	
		with the Maintenance Director			none were.		
		the (1) at 1:03 p.m. Personal					
		ent (PPE) carts were in use but			MEASURES TO DREVEN	F	
		with wheels allowing the carts			·MEASURES TO PREVENT REOCCURRENCE:	l	
		ne halls during an emergency.			REOCCURRENCE:		
		observed by rooms 221 and					
		terview at the time of			On 6/25/2025 the Administra		
		aintenance Director stated the			On 6/25/2025 the Administration of the Maintenance	rator	
	· ·	quipped with wheels and would				thor	
		with a PPE cart with wheels.			Supervisor/designee and all o		
	need to be replaced	with a 11 E cart with wheels.			staff on the requirement to encorridor means of egress are	Suit	
	This finding was as	knowledged by the MD at the			continuously maintained and f	roo	
		and again at the exit			of obstructions to meet set	166	
		Executive Director and			standards.		
	Maintenance Direct				statiualus.		
	manifement Diffeet	or present.					
	3.1-19(b)				·Maintenance Supervisor/all	staff	
					will ensure corridor means of		
					egress are continuously		
					maintained and free of		
					obstructions as a part of the		
					facility's monthly Preventive		
					Maintenance Program and		
					document those inspection re-	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desid		

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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 06/18/2025	
	ROVIDER OR SUPPLIES		950 CR	ADDRESS, CITY, STATE, ZIP COD COSS AVE ON, IN 47250	
	OF CLIFTY FALL SUMMARY (EACH DEFICIEN				ator  ittor e e n  VE  be e hly ce g.
				components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.  This plan of correction constit our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.	by n as utes

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209			(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 01 COMPLI  B. WING 06/18/2		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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	failed to ensure the generator was readiwithout a clinical disecurity measures. of egress shall not block that requires the egress side unless of 19.2.2.2.4. Door-lopermitted in accord deficient practice of the permitted in accord deficient practice of the facility of the facility of the generator, mark magnetically locked entering a four-digital was incorrect.	ons and interview during a with the Maintenance Director at 12:30 p.m., the exit door near ed as a facility exit, was d and could be opened by t code but the code posted eknowledged by the MD at the and again at the exit e Executive Director and	K 02	222	p paraid="2061839667" paraeid="{94819598-2e13-45 7b-b05e6610d957}{68}" > K22 is the intent of the facility to ensure the means of egress of the generator is readily accessor residents without a clinical diagnosis required specialized security measures meet set standards.  CORRECTIVE ACTIONS TAKE  On 6/19/2025 the Maintena Supervisor/designee posted of how to obtain the code at the door near the generator to me set standards. The Administrativerified the work on 6/19/2025  ALL OTHERS WITH POTENTIAL TO BE AFFECT  All residents and all staff ar visitors have the potential to be none were. On 6/19/2025 the Maintenance Supervisor/designspected all doors and found other negative findings.	e2- It near sible d  KEN: ance on exit eet ator  ED: nd oe but e gnee	07/18/2025

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/18/2025		
	ROVIDER OR SUPPLIEI		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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				·MEASURES TO PREVEN REOCCURRENCE:	т		
				ol class="NumberListStyle2 SCXW211098386 BCX0" role="list" start="1" style="-webkit-user-drag: nor-webkit-tap-highlight-color: transparent; margin: 0px; pac 0px; user-select: text; cursor: text; list-style-type: lower-alpli overflow: visible;" On 6/25/2025 the Administrathe Maintenance Supervisor/staff/designee to ensure information on how to obtain codes are posted at exit door meet set standards. Maintenance Supervisor/des will ensure information on ho obtain the are posted at exit as a part of the facility's mon Preventive Maintenance Progrand document those inspecti results as appropriate. If an issues are discovered, they waddressed and resolved immediately. The Maintenanc Supervisor/designee will review with the Administrator the inspection results.	dding: ha; tor all the rs to ignee w to doors thly gram on y vill be		
				·The Administrator will mor adherence to the Preventativ Maintenance schedule and the Preventative Maintenance is	e ne		

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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  06/18/2025			ETED		
	PROVIDER OR SUPPLIER		9:	50 CR	DDRESS, CITY, STATE, ZIP COD DSS AVE DN, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					place.  ·MONITORING CORRECTIVE	VΕ	
					ACTION:  The inspection results will be a second of the se		
					presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.  This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.	nly ce cy n s	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure					
		ation and interview, the facility corridor doors to 3 of 3	K 0321	l	p paraid="148101968" paraeid="{94819598-2e13-457	75-9b	07/18/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155209 B. WING 06/18/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 950 CROSS AVE WATERS OF CLIFTY FALLS, THE MADISON, IN 47250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE hazardous rooms were provided with a 7b-b05e6610d957}{205}" >K321- It self-closing device which would cause the door to is the intent of the facility to automatically close and latch into the door frame. ensure corridor doors to This deficient practice could affect 21 residents. hazardous rooms are provided with self-closing device which would Findings include: cause the door to automatically close and latch into the door frame Based on observations and interview during a and to ensure to maintain tour of the facility with the Maintenance Director protection of hot oil popcorn (MD) on 06/18/25 the corridor doors to the popper to meet set standards. following hazardous areas did not meet the requirements for protection of a hazardous area: a) at 12:35 p.m. The kitchen water heater closet, CORRECTIVE ACTIONS which was larger than 50 square feet and TAKEN: contained a gas fired water heater was equipped with a self-closing device but failed to self-close and latch. On 6/19/2025 the Maintenance b) at 1:10 p.m. the Medical Records/Staff Supervisor/designee repaired the Coordinators Office, which was larger than 50 self-closing device at the kitchen square feet and contained over 20 boxes of water heater closet to ensure the supplies, was not self-closing. door self closes and latches into c) at 1:35 p.m. The Director Of Nursing Office, the frame to meet set standards. which was larger than 50 square feet and The Administrator verified the work contained over 8 boxes of supplies, was not on 6/19/2025 self-closing. Based on interview at the time of observation, the Maintenance Director agreed all three rooms were On 6/19/2025 the Maintenance hazardous storage areas, and the doors to the Supervisor/designee removed the rooms were not self-closing or did not latch into combustibles / installed a the frame. self-closing device in the medical records/staff coordinators office to This finding was acknowledged by the MD at the ensure door self closes and time of observation and again at the exit latches into the frame to meet set conference with the Executive Director and standards. The Administrator Maintenance Director present. verified the work on 6/19/2025 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil On 6/27/2025 the Maintenance popcorn popper. This deficient practice could Supervisor/designee removed the affect staff and up to 35 residents' staff and combustibles / installed a

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155209		A. BUILDING  B. WING	01	COMPLETED 06/18/2025	
	PROVIDER OR SUPPLIER  OF CLIFTY FALLS		950 CR	ADDRESS, CITY, STATE, ZIP COD ROSS AVE ON, IN 47250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	visitors.  Findings include:  Based on observation tour of the facility work (MD) on 06/18/25 the popcorn popper was where it was not used machine was used the Activities Area. The area is open to the codoor with a self-closs.  This finding was actime of observation	ons and interview during a with the Maintenance Director the (1) at 1:20 p.m. a hot oil is being stored in an area and. When asked where the me MD said it was used in the exaforementioned Activities corridor and did not have a sing device installed.  In the MD at the and again at the exit Executive Director and		self-closing device in the Direct of Nursing office to ensure does self closes and latches into the frame to meet set standards. Administrator verified the work 6/27/2025  'On 6/25/ Maintenance Supervisor/Activities Director/designee relocated the popcorn machine to a hazardarea during use and non-use listential self-closing door closure and linto frame to meet set standared The Administrator verified the on 6/25/2025  'ALL OTHERS WITH POTENTIAL TO BE AFFECTION ALL OTHERS WITH POTENTIAL TO BE AFFECTION Self-closing devices or are free of combusitems to meet set standards.	etor or e The con  ne Dus has a atch rds. work  ED:  rator 'all sure I with

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPL	(X3) DATE SURVEY COMPLETED 06/18/2025		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CC	)D		
WATERS	OF CLIFTY FALLS	S, THE	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 PREF TA	PROVIDER'S PLAN OF CORR.  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION DATE	
AAG	ALGOLATOR I UN			·Maintenance Supervisor/designee will hazardous areas are proportive working self-clot devices or are free of contiems as a part of the farmonthly Preventive Mainer Program and document inspection results as applicately. The Mainer Supervisor/designee will be addressed and resimmediately. The Mainer Supervisor/designee will with the Administrator the inspection results.  The Administrator will adherence to the Preve Maintenance schedule as Preventative Maintenant place.  MONITORING CORFACTION:  ol class="NumberListStyscxw100726870 BCX/role="list" start="1" style="-webkit-user-drag-webkit-tap-highlight-coltransparent; margin: 0p: 0px; user-select: text; citext; list-style-type: lower overflow: visible;" The inspection results we presented by the Mainter	ovided with osing ombustible cility's ntenance those propriate. ered, they esolved tenance II review ne II monitor ntative and the ace is in RECTIVE  yle2 0" g: none; lor: x; padding: ursor: er-alpha; will be		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/18/2025		
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0351	NFPA 101			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correctic developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constituent our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.	thly nce g. n by on as		
SS=E Bldg. 01	failed to ensure the heads were not obst accordance with 19 Section 8.5.5.1 state as to minimize obst defined in 8.5.5.2 as sprinklers shall be proverage of the haz do not permit continuous tructions less that the sprinkler deflect more than 18 inches that prevent the sprinkler sprinkler desprinkler desprinkler that prevent the sprinkler that prevent the sprinkler desprinkler	on and interview, the facility spray pattern for sprinkler cructed in 2 of 2 closets in .3.5.1. NFPA 13, 2010 edition, es sprinklers shall be located so ructions to discharge as and 8.5.5.3 or additional provided to ensure adequate ard. Sections 8.5.5.2 and 8.5.5.3 muous or noncontinuous an or equal to 18 inches below tor or in a horizontal plane is below the sprinkler deflector asy pattern from fully efficient practice could up to 15	K 0351	K351 - It is the intent of the fat to ensure the spray pattern for sprinkler heads not obstructer closets in accordance with 19.3.5.1 to meet set standard CORRECTIVE ACTIONS TAIL ON 6/19/2025 the Maintent Supervisor removed the high storage that was obstructing a sprinkler head in the activities closet and 2 the facilities sprinkler head that was installed within inches of the wall in the linen	or d in ds. KEN: ance the s nkler kler two		

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	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	Findings include:  Based on observation tour of the facility wo (MD) on 06/18/25 to closet had storage wo head. Based on interest observation, the Manacknowledged the and was obstructed. (2) between RR# 212 at that was installed worth The MD stated the esprinkler head diffurinches.  This finding was act time of observation.	ons and interview during a with the Maintenance Director the (1) at 1:01 p.m. the Activities within 4 inches of the sprinkler review at the time of intenance Director forementioned sprinkler head at 1:40 p.m. the Linen Closet d RR# 213 had a sprinkler head ithin two inches of the wall. distance from the wall to the ser was approximately two	TAG	closet between RR#212 and RR#213 to meet set standard The Administrator verified the on 6/19/  ALL OTHERS WITH POTENTIAL TO BE AFFECT  All residents and all staff at visitors have the potential to be none were.  MEASURES TO PREVENT REOCCURRENCE:  On 6/25/2025 the serviced Maintenance Supervisor/designee/all staff to ensure sprinkler heads are no obstructed to meet set standard.	ED:  the  o ot
				·Maintenance Supervisor/designee/all staff of ensure sprinkler heads are not obstructed as a part of the facility's Monthly Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designate will review with the Administration of the supervisor results.	sults are ssed ne gnee

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155209	A. BUILDING B. WING	01	COMPLETED 06/18/2025	
	PROVIDER OR SUPPLIES		950 CF	ADDRESS, CITY, STATE, ZIP COD ROSS AVE SON, IN 47250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE	
				The Administrator will monit adherence to the Preventative Maintenance schedule and the Preventative Maintenance is ir place.  MONITORING CORRECTIVACTION:		
				·The inspection results will b presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	nily ce cy	
				This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.	utes	
K 0353	NFPA 101					

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Sprinkler System - Maintenance and Testing

SS=E

Bldg. 01

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155209 B. WING 06/18/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 950 CROSS AVE WATERS OF CLIFTY FALLS, THE MADISON, IN 47250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0353 p paraid="1651565902" 07/18/2025 failed to maintain 1 of 1 sprinkler system in paraeid="{83ebfd6e-7257-4346-9c7 accordance with LSC 9.7.5. LSC 9.7.5 requires all 9-e4bb2cde74e0}{55}" >K353 - It automatic sprinkler systems shall be inspected is the intent of the facility to and maintained in accordance with NFPA 25, ensure to maintain the sprinkler Standard for the Inspection, Testing, and systems in accordance with LSC Maintenance of Water-Based Fire Protection 9.7.5 to meet set standards. Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or CORRECTIVE ACTIONS TAKEN: hung from the pipe. This deficient practice could affect 15 residents in one smoke compartment. On 6/26/2025 the Maintenance Findings include: Supervisor/designee relocated the HVAC trunk line to ensure it was Based on observations and interview during a not laying on, touching and tour of the facility with the Maintenance Director placing pressure on the sprinkler (MD) on 06/18/25 the (1) at 2:15 p.m. the In pipe in the motion boiler room attic Motion Boiler Room attic had an HVAC trunk line to meet set standards. The laying on the sprinkler pipe. The HVAC line had Administrator verified the work on previously been suspended by left over wire 7/18/2025. however the HVAC air flow line was laying on, touching and placing pressure on the sprinkler ·ALL OTHERS WITH pipe. POTENTIAL TO BE AFFECTED: This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and ·All residents and all staff and Maintenance Director present. visitors have the potential to be but none were. 3.1-19(b) ol class="NumberListStyle1 SCXW122689607 BCX0" role="list" start="3" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;"

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	OF CORRECTION	IDENTIFICATION NUMBER  155209	A. BUILDING  B. WING	01	COMPLETED 06/18/2025		
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	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	MEASURES TO PREVENT REOCCURRENCE: Administrator in serviced the Maintenance Supervisor/desig on the requirement to ensure t maintain the sprinkler system a ensure no pipes are laying on, touching and placing pressure the sprinkler pipes to meet set standards.  ·Maintenance Supervisor/designee will ensur maintain the sprinkler system a ensure no pipes are laying on, touching and placing pressure the sprinkler pipes as a part of facility's Annual Preventive Maintenance Program and document those inspection res as appropriate. If any issues	nee o and on the sults are		
				discovered, they will be address and resolved immediately. The Maintenance Supervisor/design will review with the Administrathe inspection results.  The Administrator will monit	e nee tor		
				adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.			
				·MONITORING CORRECTIVACTION:	VE		

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	OF CORRECTION	IDENTIFICATION NUMBER  155209	A. BUILDING B. WING	01	COMPLETED 06/18/2025		
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.  This plan of correction constitution of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.	nly ce		
K 0921 SS=F Bldg. 01	interview, the facilit required maintenand documentation of in Related Electrical E 2012 edition, section physical integrity, re touch current tests f is performed as requare established with PCREE used in pati	ent - Testing and view, observation, and ry failed to conduct the re and maintain complete spections for Patient Care quipment (PCREE). NFPA 99 rs 10.3 and 10.5 states the resistance, leakage current, and ror fixed and portable PCREE rired in 10.3. Testing intervals policies and protocols. All rent care rooms is tested in 3.5.4 or 10.3.6 before being put	K 0921	p paraid="2007515785" paraeid="{83ebfd6e-7257-434 9-e4bb2cde74e0}{208}" >K92 is the intent of the facility to ensure to conduct the required maintenance complete documentation of inspections Patient Care Related Electrica Equipment (PCREE) to meet s standards.	1 – It d for II		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155209		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  B 01	(X3) DATE SURVEY  COMPLETED  06/18/2025	
NAME OF P	ROVIDER OR SUPPLIER	• 8		ET ADDRESS, CITY, STATE, ZIP COD	•
				CROSS AVE	
WATERS OF CLIFTY FALLS, THE			MAC	DISON, IN 47250	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPRO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		er any repair or modification. ing of several electrical		CORRECTIVE ACTIONS	IAKEN:
		rates compliance with NFPA			
		stem. Service manuals,		On 7/11/2025 the faciliti	AS
		ocedures provided by the		trained Regional Property	
	_	de information as required by		will conduct PCREE testing	-
		considered in the development		other PCREE in the facility	-
		ectrical equipment maintenance.		electric beds, nebulizers, o	
		nt instructions and maintenance		concentrators, vital sign me	onitors,
		available, and safety labels		and other electrical medica	
	_	rating instructions on the		equipment to meet set star	
		e. A record of electrical		The Administrator will verif	y the
	equipment tests, repairs, and modifications is			work on 7/14/2025	
	maintained for a period of time to demonstrate				
	compliance in accordance with the facility's			ALL OTHERS WITH	
	policy. Personnel responsible for the testing, maintenance and use of electrical appliances			·ALL OTHERS WITH POTENTIAL TO BE AFFE	CTED:
		training. This deficient		FOTENTIAL TO BE AFFE	CIED.
	practice affects all residents.				
	praesios arrosas arr			·All residents and all staf	f and
	Findings include:			visitors have the potential	
				none were.	
	Based on records review, interview and facility tour with the Maintenance Director (MD) on 06/18/25 at 10:10 a.m., no documentation was				
				·MEASURES TO PREVE	ENT
	available for review for the testing of the PCREE in			REOCCURRENCE:	
	_	facility, as required by section			
		9, Health Care Facilities Code.		On 0/05/0005 #s - A ! .	-itt
	_	the building tour revealed that d electric beds for all residents.		On 6/25/2025 the Admir	nistrator
		PCREE such as nebulizers,		the Maintenance	to
		rs and other electrical medical		Supervisor/DON/designee ensure the testing of the P	
		sent and in use at the facility.		is conducted and documer	
	1 1 proc			all PCREE equipment to m	
	This finding was ac	knowledged by the MD at the		standards.	
	_	nd again at the exit conference			
	with the MD and A	dministrator present.			
				·Maintenance	
	3.1-19(b)			Supervisor/designee will electing of the PCREE is	nsure

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> B. WING		COMPLETED 06/18/2025		
		155209	B. WI			2025	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WATERS OF CLIFTY FALLS, THE					OSS AVE ON, IN 47250		
	Г		1		JIN, IIN 71200		Г
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
					CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)  conducted and documented of PCREE equipment as a part of facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results.  The Administrator will monite adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.  MONITORING CORRECTIVACTION:  The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting	n all of the sults are ssed e gnee tor  tor e n	COMPLETION DATE
					Inspection results and system components will be reviewed the QA/PI Committee with	ру	
					subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.		
	I		1				I

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155209	` <i>′</i>	JILDING	onstruction 01	(X3) DATE COMPL 06/18/	ETED
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	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
					This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025.		

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