| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING -- B. WING | 06/18/2025 |

| 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 |
|---|---|---|---|---|
| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 06/18/25<br><br>Facility Number: 000116<br>Provider Number: 155209<br>AIM Number: 100266330<br><br>At this Emergency Preparedness survey, The Waters of Clifty Falls was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 138 certified beds. At the time of the survey, the census was 101.<br><br>Quality Review completed on 06/23/25 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 06/18/25<br><br>Facility Number: 000116<br>Provider Number: 155209<br>AIM Number: 100266330<br><br>At this Life Safety Code survey, The Waters of Clifty Falls was found not in compliance with | 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 corrective actions prepared and/or executed in compliance with state and federal laws. This plan of | |

| 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 101 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage buildings which were not sprinkled.<br><br>Quality Review completed on 06/23/25 | | correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. | |
| K 0211 SS=E Bldg. 01 | NFPA 101<br>Means of Egress - General<br><br>Based on observation and interview, the facility failed to ensure 1of 6 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:<br>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).<br>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar | K 0211 | K211– It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of obstructions to meet set standards.<br>CORRECTIVE ACTIONS TAKEN:<br><br>·On 6/19/2025 the Maintenance Supervisor/designee removed the PPE carts from the halls by rooms 221 and 219 / added wheels to the PPE Carts to meet set | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | emergency.<br>(c)The wheeled equipment is limited to the following:<br>i. Equipment in use and carts in use<br>ii. Medical emergency equipment not in use<br>iii. Patient lift and transport equipment<br>This deficient practice affects 18 residents in the facility.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 the (1) at 1:03 p.m. Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be move out of the halls during an emergency. The PPE carts were observed by rooms 221 and 219. Based on an interview at the time of observations, the Maintenance Director stated the PPE carts are not equipped with wheels and would need to be replaced with a PPE cart with wheels.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>3.1-19(b) | | standards. The Administrator verified the work on 6/19/2025<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were.<br><br>·MEASURES TO PREVENT REOCCURRENCE:<br><br>·On 6/25/2025 the Administrator the Maintenance Supervisor/designee and all other staff on the requirement to ensure corridor means of egress are continuously maintained and free of obstructions to meet set standards.<br><br>·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 results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | will review with the Administrator the inspection results.<br><br>·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.<br><br>·MONITORING CORRECTIVE ACTION:<br><br>·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br><br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 0222 SS=E Bldg. 01 | NFPA 101<br>Egress Doors<br><br>Based on observation and interview, the facility failed to ensure the means of egress near the generator was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 at 12:30 p.m., the exit door near the generator, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code posted was incorrect.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>3.1-19(b) | K 0222 | p paraid="2061839667" paraeid="{94819598-2e13-4575-9b7b-b05e6610d957}{68}" >K222– It is the intent of the facility to ensure the means of egress near the generator is readily accessible for residents without a clinical diagnosis required specialized security measures meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br><br>·On 6/19/2025 the Maintenance Supervisor/designee posted on how to obtain the code at the exit door near the generator to meet set standards. The Administrator verified the work on 6/19/2025<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were. On 6/19/2025 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | ·MEASURES TO PREVENT REOCCURRENCE:<br><br>ol class="NumberListStyle2 SCXW211098386 BCX0" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; list-style-type: lower-alpha; overflow: visible;"<br>On 6/25/2025 the Administrator the Maintenance Supervisor/all staff/designee to ensure information on how to obtain the codes are posted at exit doors to meet set standards.<br>Maintenance Supervisor/designee will ensure information on how to obtain the are posted at exit doors as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br><br>·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | place.<br><br>·MONITORING CORRECTIVE ACTION:<br><br>·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br><br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>1. Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 3 | K 0321 | p paraid="148101968" paraeid="{94819598-2e13-4575-9b | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 21 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area:<br>a) at 12:35 p.m. The kitchen water heater closet, which was larger than 50 square feet and contained a gas fired water heater was equipped with a self-closing device but failed to self-close and latch.<br>b) at 1:10 p.m. the Medical Records/Staff Coordinators Office, which was larger than 50 square feet and contained over 20 boxes of supplies, was not self-closing.<br>c) at 1:35 p.m. The Director Of Nursing Office, which was larger than 50 square feet and contained over 8 boxes of supplies, was not self-closing.<br>Based on interview at the time of observation, the Maintenance Director agreed all three rooms were hazardous storage areas, and the doors to the rooms were not self-closing or did not latch into the frame.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper. This deficient practice could affect staff and up to 35 residents' staff and | | 7b-b05e6610d957}{205}" >K321– It is the intent of the facility to ensure corridor doors to hazardous rooms are provided with self-closing device which would cause the door to automatically close and latch into the door frame and to ensure to maintain protection of hot oil popcorn popper to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br><br>·On 6/19/2025 the Maintenance Supervisor/designee repaired the self-closing device at the kitchen water heater closet to ensure the door self closes and latches into the frame to meet set standards. The Administrator verified the work on 6/19/2025<br><br>·On 6/19/2025 the Maintenance Supervisor/designee removed the combustibles / installed a self-closing device in the medical records/staff coordinators office to ensure door self closes and latches into the frame to meet set standards. The Administrator verified the work on 6/19/2025<br><br>·On 6/27/2025 the Maintenance Supervisor/designee removed the combustibles / installed a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | visitors.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 the (1) at 1:20 p.m. a hot oil popcorn popper was being stored in an area where it was not used. When asked where the machine was used the MD said it was used in the Activities Area. The aforementioned Activities area is open to the corridor and did not have a door with a self-closing device installed.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>3.1-19(b) | | self-closing device in the Director of Nursing office to ensure door self closes and latches into the frame to meet set standards. The Administrator verified the work on 6/27/2025<br><br>·On 6/25/ Maintenance Supervisor/Activities Director/designee relocated the popcorn machine to a hazardous area during use and non-use has a self-closing door closure and latch into frame to meet set standards. The Administrator verified the work on 6/25/2025<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were.<br><br>·MEASURES TO PREVENT REOCCURRENCE:<br><br>·On 6/25/2025 the Administrator the Maintenance Supervisor/ /all staff on the requirement to ensure hazardous areas are provided with properly working self-closing devices or are free of combustible items to meet set standards. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | ·Maintenance Supervisor/designee will ensure hazardous areas are provided with properly working self-closing devices or are free of combustible items as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br><br>·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.<br><br>·MONITORING CORRECTIVE ACTION:<br><br>ol class="NumberListStyle2 SCXW100726870 BCX0" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; list-style-type: lower-alpha; overflow: visible;"<br>The inspection results will be presented by the Maintenance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |
| K 0351<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Installation<br><br>Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 2 of 2 closets in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could up to 15 residents. | K 0351 | K351 - It is the intent of the facility to ensure the spray pattern for sprinkler heads not obstructed in closets in accordance with 19.3.5.1 to meet set standards.<br>CORRECTIVE ACTIONS TAKEN:<br><br>·On 6/19/2025 the Maintenance Supervisor removed the high storage that was obstructing the sprinkler head in the activities closet and 2 the facilities sprinkler contractor relocated the sprinkler head that was installed within two inches of the wall in the linen | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 the (1) at 1:01 p.m. the Activities closet had storage within 4 inches of the sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was obstructed. (2) at 1:40 p.m. the Linen Closet between RR# 212 ad RR# 213 had a sprinkler head that was installed within two inches of the wall. The MD stated the distance from the wall to the sprinkler head diffuser was approximately two inches.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>3.1-19(b) | | closet between RR#212 and RR#213 to meet set standards. The Administrator verified the work on 6/19/<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were.<br><br>·MEASURES TO PREVENT REOCCURRENCE:<br><br>·On 6/25/2025 the serviced the Maintenance Supervisor/designee/all staff to ensure sprinkler heads are not obstructed to meet set standards.<br><br>·Maintenance Supervisor/designee/all staff will ensure sprinkler heads are not obstructed as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | ·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.<br><br>·MONITORING CORRECTIVE ACTION:<br><br>·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br><br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |
| K 0353<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 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 hung from the pipe. This deficient practice could affect 15 residents in one smoke compartment.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 06/18/25 the (1) at 2:15 p.m. the In Motion Boiler Room attic had an HVAC trunk line laying on the sprinkler pipe. The HVAC line had previously been suspended by left over wire however the HVAC air flow line was laying on, touching and placing pressure on the sprinkler pipe.<br><br>This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and Maintenance Director present.<br><br>3.1-19(b) | K 0353 | p paraid="1651565902" paraeid="{83ebfd6e-7257-4346-9c79-e4bb2cde74e0}{55}" >K353 – It is the intent of the facility to ensure to maintain the sprinkler systems in accordance with LSC 9.7.5 to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br><br>·On 6/26/2025 the Maintenance Supervisor/designee relocated the HVAC trunk line to ensure it was not laying on, touching and placing pressure on the sprinkler pipe in the motion boiler room attic to meet set standards. The Administrator verified the work on 7/18/2025.<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were.<br><br>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;" | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | MEASURES TO PREVENT REOCCURRENCE:<br>Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to maintain the sprinkler system and ensure no pipes are laying on, touching and placing pressure on the sprinkler pipes to meet set standards.<br><br>·Maintenance Supervisor/designee will ensure to maintain the sprinkler system and ensure no pipes are laying on, touching and placing pressure on the sprinkler pipes as a part of the facility's Annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br><br>·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.<br><br>·MONITORING CORRECTIVE ACTION: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | ·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br><br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |
| K 0921 SS=F Bldg. 01 | NFPA 101<br>Electrical Equipment - Testing and Maintenanc<br>Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put | K 0921 | p paraid="2007515785" paraeid="{83ebfd6e-7257-4346-9c79-e4bb2cde74e0}{208}" >K921 – It is the intent of the facility to ensure to conduct the required maintenance complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standards. | 07/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.<br><br>Findings include:<br><br>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 available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The MD stated that PCREE such as nebulizers, oxygen concentrators and other electrical medical equipment was present and in use at the facility.<br><br>This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Administrator present.<br><br>3.1-19(b) | | CORRECTIVE ACTIONS TAKEN:<br><br>·On 7/11/2025 the facilities trained Regional Property Manager will conduct PCREE testing on the other PCREE in the facility electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator will verify the work on 7/14/2025<br><br>·ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br><br>·All residents and all staff and visitors have the potential to be but none were.<br><br>·MEASURES TO PREVENT REOCCURRENCE:<br><br>·On 6/25/2025 the Administrator the Maintenance Supervisor/DON/designee to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards.<br><br>·Maintenance Supervisor/designee will ensure testing of the PCREE is | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | conducted and documented on all PCREE equipment as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br><br>·The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.<br><br>·MONITORING CORRECTIVE ACTION:<br><br>·The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. BUILDING 01<br>B. WING | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF CLIFTY FALLS, THE | 950 CROSS AVE<br>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 |
|---|---|---|---|---|
| | | | This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/18/2025. | |