

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Waters of Clifty Falls, The		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Cross Ave Madison, IN 47250	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34232</p> <p>Based on interview and record review, the facility failed to ensure an alleged violation was reported to the Indiana Department of Health in a timely manner related to an allegation of misappropriation of residents' medications for 1 of 1 allegations of misappropriation of residents' property. (QMA 2)</p> <p>Findings included:</p> <p>During an interview on 07/17/24 at 11:24 A.M., a Complainant indicated someone she associated with told her they were getting residents' medications from a QMA (Qualified Medication Aide) that worked in the facility. It was easy for the QMA to take the medications. The Complainant notified the Facility Administrator of her concerns related to QMA 2. The Administrator told her she would look into the matter.</p> <p>During an interview on 07/17/24 at 2:10 P.M., the Administrator indicated there were no allegations of misappropriation of medications during the few months she had been working in the facility. Someone did call the facility and indicated a QMA 2 was stealing medications from residents and giving them to someone she knew. The facility conducted an investigation. They looked through the narcotic sheets and didn't find any discrepancies. The QMA rarely worked the medication cart. She did not report the allegation of misappropriation to the Indiana Department of Health and she should have reported it. They did not suspend the staff member; she was not working in the facility the day the allegation was made.</p> <p>On 07/17/24 at 4:09 P.M., the Administrator provided the facility's investigation of the abuse allegation of misappropriation of residents' medication. All of the documents provided were a list of the days QMA 2 worked passing medications to residents, the halls the QMA worked passing medications (Split Hall, Front Hall, and Memory Springs Dementia Care Unit), and a drug screen completed for QMA 2 (the QMA tested negative of all substances on 06/24/24).</p> <p>The QMA passed medication to residents on the Split Hall Medication Cart on 04/20/24, 04/21/24, 05/05/24, 05/18/24, 06/10/24, and 06/11/24; on the Front Hall Medication Cart on 05/28/24 and 06/02/24; and on the Memory Springs Dementia Care Medication Cart on 06/24/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Waters of Clifty Falls, The		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Cross Ave Madison, IN 47250	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The current ABUSE PREVENTION PROGRAM policy, dated 10/22/22, was provided by the Administrator on 07/17/24 at 3:21 P.M. The policy indicated, .The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party .IF YOU SUSPECT ABUSE .The Administrator or designee utilizing the ISDH Incident Report form will immediately notify the ISDH by email or fax. The Administrator or designee is then responsible for forwarding a final written report of the results of the investigation and any corrective action taken to the Department of Public Health within five working days of the reported incident . Misappropriation of resident property .is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings .without the cognitively intact resident's consent .When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately .State Licensing and Certification Agency (i.e. ISDH) .Law Enforcement Officials as per the Policy on Reporting Reasonable Suspicions of a crime .</p> <p>This citation relates to Complaint IN00437798.</p> <p>3.1-28(c)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Waters of Clifty Falls, The		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Cross Ave Madison, IN 47250	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38239</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse related to a staff member and misappropriation of medications for 1 of 4 staff reviewed. (QMA 2)</p> <p>Findings include:</p> <p>During an interview on 07/17/24 at 2:10 P.M., the Administrator indicated there were no allegations of misappropriation of medication since she had been working in the facility. Someone did call the facility and indicated a QMA (Qualified Medication Aide) was stealing medications from residents and giving them to someone she knew. The facility conducted an investigation. They reviewed residents' narcotic sheets and didn't see any discrepancies. They checked with the pharmacy and there were no irregularities with medication orders. They interviewed the staff member in question and performed a drug screen on her. The drug screen was negative. They interviewed some staff members that reported no suspicious activity with any other staff members. They did not formally suspend the staff member pending the results of the investigation.</p> <p>During an interview on 07/17/24 at 11:24 A.M., the Complainant indicated someone she associated with told her they were getting residents' medications from a QMA that worked in the facility. It was easy for the QMA to take the medications. The Complainant notified the Facility Administrator of her concerns related to QMA 2. The Administrator told her she would look into the matter.</p> <p>On 07/17/24 at 4:09 P.M., the Administrator provided the facility's investigation of the abuse allegation of misappropriation of residents' medication. All documentation provided consisted of the following items:</p> <ul style="list-style-type: none"> - A list of the days QMA 2 worked passing medications to residents. The QMA worked on three different medication carts in the last few months: - Split Hall Medication Cart on 04/20/24, 04/21/24, 05/05/24, 05/18/24, 06/10/24, and 06/11/24, - Front Hall Medication Cart on 05/28/24 and 06/02/24, and - Memory Springs Dementia Care Medication Cart on 06/24/24. - The current Controlled Drug Receipt Record/Disposition Forms in use for all residents at the time of the abuse allegation. - Facility documentation of drug screening for QMA 2. The document indicated the QMA tested negative for all substances on 06/28/24. - A handwritten document signed by the Administrator that indicated residents' narcotic sheets and pharmacy orders were reviewed with no concerns. The QMA in question was interviewed and a drug screen was performed that was negative. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Waters of Clifty Falls, The		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Cross Ave Madison, IN 47250	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A document signed by the DON (Director of Nursing) that indicated residents' narcotic sheets were reviewed with no suspicious activity noted and staff interviews were conducted with LPN (Licensed Practical Nurse) 3, RN 4, and QMA 5. The staff reported no suspicious activity.</p> <p>- A handwritten document signed by the DON that indicated she interviewed QMA 2 regarding the allegation.</p> <p>The investigation lacked documentation that cognitively intact residents were interviewed related to medication administration or pain management. Cognitively impaired residents were not assessed for signs or symptoms of pain. Staff interviews were not documented in the investigation. There was no indication law enforcement was notified of the suspicion of a crime.</p> <p>The current ABUSE PREVENTION PROGRAM policy, dated 10/22/22, was provided by the Administrator on 07/17/24 at 3:21 P.M. The policy indicated, .The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party .Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution, or disciplinary action against the employee .When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately .Law Enforcement Officials as per the Policy on Reporting Reasonable Suspicions of a crime .Administrator or Director of Nursing will request that a representative of the Social Services department monitor resident's feelings concerning the incident .</p> <p>This citation relates to Complaint IN00437798.</p> <p>3.1-28(d)</p>		