

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 08/30/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>50498</p> <p>Based on record review and interview, the facility failed to ensure misappropriation of a resident medication did not occur for 1 of 3 residents reviewed for misappropriation. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 08/30/24 at 4:35 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/14/24, indicated the resident was cognitively intact. The diagnosis included, but were not limited to, diabetes mellitus, manic depression, psychotic disorder, and schizophrenia.</p> <p>A facility incident report, dated 08/29/24 at 7:01 A.M., indicated upon shift change, a narcotic medication card and narcotic count sheet were unable to be located.</p> <p>A current physician's order, with a start date of 10/10/23, indicated the staff were to administer Percocet (a pain medication), 7.5-325 mg (milligrams), 1 tablet by mouth every six hours as needed for pain.</p> <p>A current physician's order, with a start date of 09/28/23, indicated the staff were to administer morphine sulfate (a pain medication) oral tablet, 30 mg by mouth, three times a day for chronic pain.</p> <p>During an interview on 08/30/24 at 2:00 P.M., the DON (Director of Nursing) indicated the pharmacy had delivered three cards that contained a total of 84 morphine tablets for Resident D. The medication was incorrect due to an order being put in wrong by the facility staff, so the medication was never used. All three cards were placed in the back of the narcotic box with the resident's other narcotic medications. An additional medication card of Percocet was delivered from the pharmacy. LPN (Licensed Practical Nurse) 4 went to put the Percocet in the medication cart, but she never added the Percocet card into the medication card count. During shift change the next morning LPN 5 realized the card count was the exact same as the day before, but she knew there was a new card of Percocet added the day before. Upon further investigation it was discovered there was a card of morphine missing and the paper documenting it was missing as well. LPN 4 never signed in or out that she had received another narcotic medication card.</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
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Pharmacy Record, dated 08/02/24 at 5:37 A.M., indicated three cards of morphine sulfate 30 mg ER were delivered with the identification numbers 8673***/001, 8673***/002, and 8673***/003 for Resident D.</p> <p>A pharmacy record, dated 08/28/24 at 5:32 P.M., indicated one card of Percocet tablet 7.5-325 were delivered with the identification number 86761***/001 for Resident D.</p> <p>During an interview on 08/30/24 at 3:59 p.m., with the DON and ADON (Assistant Director of Nursing) they indicated that when pharmacy comes in the front door, they would locate a nurse and then both verify medications received and sign off on pharmacy's tablet. Narcotics were in plastic bags that were sealed. Two nurses would verify and sign off that the medications were correct then go to the cart and add them in. On 08/02/24 those three cards of morphine should have been added. It should be on the sheet, but they didn't have the sheet. They could not locate the sheet or the second card of morphine (card 8673***/002).</p> <p>The current facility policy titled, Controlled substances, dated May 2019, was provided by the Administrator on 08/30/24 at 4:45 P.M. The policy indicated, .While a controlled substance is in use the nursing staff with maintain the following medication records: .Controlled Substance Count Sheet .</p> <p>The current facility policy titled, Delivery Manifest, dated May 2019, was provided by the Administrator on 08/30/24 at 4:45 P.M. The policy indicated, .The contents of the facility's delivery will be reviewed by facility staff. This review will be documented on a delivery manifest form .The contents will be taken to their intended storage area .</p> <p>This Citation relates to Complaint IN00439099.</p> <p>3.1-28(a)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34232</p> <p>Based on record review and interview, the facility failed to store medications in a secure manner related to medications left on top of the medication cart unattended for 1 of 3 medication carts reviewed. (Living Well Long Hall Cart)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 08/30/24 at 10:15 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/14/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, osteomyelitis, bipolar disorder, psychotic disorder, psychoactive substance abuse, and schizophrenia.</p> <p>The Progress Notes for Resident D were provided by the Administrator on 08/30/24 at 3:28 P.M., and included, but not limited to, the following:</p> <ul style="list-style-type: none"> - A Nursing Progress Note, dated 08/21/24 at 12:02 A.M., indicated Resident D was following a QMA (Qualified Medication Aide) during medication pass, even after being asked multiple times to keep going down the hallway. The QMA turned to take a resident's blood pressure when Resident D took a cup of pills off of the medication cart. A CNA (Certified Nurse Aide) saw the resident in front of the cart, reaching up for medication cup. When asked, the resident denied taking the medications. Resident D was searched, and nothing was found on his person. After returning to the medication cart, a medication cup with 2 pills (Metformin and Lamictal) was found on the cart. The only pills that were missing were a Clonazepam (an antianxiety medication) 0.5 mg (milligrams) and a Tamsulosin (Flomax). The resident was put on checks every four hours for vital signs and observation. - A Nursing Progress Note, dated 8/20/24 at 9:24 P.M., indicated the MD was notified of the resident grabbing medications that were not his and taking only the Clonazepam and the Terazosin (an antihypertensive) from the cup per the nursing staff. New orders were received to monitor the resident for any adverse side effects for 24 hours, and to obtain vital signs every four hours. The resident and family were updated. <p>During an interview on 08/30/24 at 1:56 P.M., the DON (Director of Nursing) indicated Resident J's medications were left in a cup on top of the medication cart. A QMA was on the cart administering residents' medications. The QMA turned around, and Resident D took the cup of medications. It happened on 08/20/24 at around 9:00 P.M. Resident D apparently took two medications out of the cup because they found the others in his room. The Clonazepam and Tamsulosin were missing. The MD was notified. Resident D was monitored. The same incident was documented by LPN (Licensed Practical Nurse) 2. The facility completed a risk management assessment, watched the resident, called the doctor, and called their Corporate Associate. The Corporate Associate indicated the facility did not need to report the incident to the Indiana Department of Health because Resident D had no adverse reactions from taking Resident J's medications. Staff educated Resident D and monitored him for adverse side effects. No other interventions were put into place for Resident D.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/30/24 at 3:17 P.M., QMA 3 indicated she had set up Resident J's pills in a cup on top of the medication cart in the hallway. She turned around and went into Resident J's room to take his vital signs. She knew she should have not left the medication unsecured on top of the medication cart. While she was turned around, Resident D took the cup of pills off the cart and headed towards his room. One of the CNAs went down and asked Resident D if he had taken the medications. Then, later two of the pills magically appeared on top the medication cart lying loosely. She did not see Resident D bring the medications back. Resident D asked, about an hour later, if she was mad at him. She reported the incident to her nurse, LPN 2.</p> <p>The current undated Medication Storage in the Facility policy was provided by the Administrator on 08/30/24 at 3:26 P.M. The policy indicated, .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .</p> <p>The current Drug Administration - General Guidelines policy, dated May 2019, was provided by the Administrator on 08/30/24 at 3:28 P.M. The policy indicated, .Medications are administered as prescribed, in accordance with good nursing principles and practices .No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by .When medication administration is dependent upon vital sign measures, this monitoring should be performed before the administration of the prescribed medication .</p> <p>This citation relates to Complaint IN00442221.</p> <p>3.1-25(m)</p>		