

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 02/25/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50498</p> <p>Based on interview, and record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed. (Resident B)</p> <p>Finding included:</p> <p>A progress note, dated 01/22/25 at 3:30 P.M., indicated a Qualified Medical Assistant (QMA) reported that she witnessed another staff member tell Resident B, you are a fat a** and referred to the resident by calling her [the name of a weight loss spokesperson].</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 12/10/24, indicated Resident B was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, contracture, and adult failure to thrive.</p> <p>During an interview, on 02/24/2025 at 10:24 AM, QMA 3 indicated Certified Nurse Aide (CNA) 4 called Resident B a Fat a** while they assisted her pulling up her pants. Then the CNA referred to the resident as [the name of a weight loss spokesperson] before laying her back down. The resident didn't really react due to her level of cognition. After care was provided, QMA 3 immediately notified management and CNA 4 was sent home and the CNA no longer worked at the facility.</p> <p>The current facility policy titled Dignity, was provided by the Administrator on 02/24/25 at 1:12 P.M., dated 08/09/23. The policy indicated, .1. Staff will be polite and respectful at all times- and will be positive in their approach to residents .3. Staff will not use any profanity or vulgar words in the presence of the resident and under no circumstances directed at the resident .</p> <p>This deficient practice was corrected, on 01/23/25, prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan of all residents assessed, re-educated staff on dignity and respect, and implemented a monitory system.</p> <p>This citation relates to Complaint IN00451819.</p> <p>3.1-3(t)</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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50498</p> <p>Based on observation, interview, and record review, the facility failed to provide functioning bathroom call lights for 4 of 6 residents reviewed for resident call system. (Residents D, E, F, and G)</p> <p>Findings include:</p> <p>1.a. During an observation and interview, on 02/24/25 at 2:57 P.M., Resident D indicated her bathroom call light had been broken for two weeks. Earlier that morning she had to hit the call light by her bedside for her roommate who was in the bathroom and needed help getting off the toilet. An observation of the bathroom indicated there was an open electrical box with five wires hanging out loosely situated left of the residents' toilet. The wires had blue caps on the ends of each wire. There was no bell or alternative alert system in sight or within reach when the resident was in the bathroom.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 12/12/24, indicated Resident D was cognitively alert and oriented. The resident's diagnoses included, but were not limited to, anemia, arthritis, and heart failure. The resident required partial/moderate staff assistance with toileting; adjusting clothing before and after toilet use; and lower body dressing. The resident used a wheelchair for mobility.</p> <p>b. During an interview, on 02/24/25 at 3:00 P.M., Resident E indicated she had to wait in the bathroom for twenty minutes for help to get off the toilet, and back into her wheelchair. She was in luck that her roommate could hear her and hit the light in their room for her to get staff to come help. The bathroom was a shared bathroom with the room next door. Four residents used the shared bathroom.</p> <p>A Quarterly MDS assessment, dated 11/22/24, indicated Resident E was cognitively alert and oriented. The resident's diagnoses included, but were not limited to, orthostatic hypotension, End Stage Renal Disease, and diabetes. The resident required partial/moderate staff assistance with toileting; and adjusting clothing before and after toilet use. The resident required substantial/maximal staff assistance for lower body dressing. The resident used a wheelchair for mobility.</p> <p>c. During an interview, on 02/24/25 at 3:52 P.M., Resident F indicated the call light in their room and bathroom was broken and had been broken for about two weeks. The facility gave us one little bell to ring, and I tried to use it, but nobody could hear us all the way down the hall. Usually, she had to go find someone to help her and her roommate. Her roommate needed help getting on and off the toilet, but her roommate had been getting herself on and she would go find a staff member down the hallway to come help her get off. Resident F had previously used her call light for help when she felt wobbly or needed help changing, but now she had to go find help.</p> <p>A Quarterly MDS assessment, dated 11/21/24, indicated Resident F was cognitively alert and oriented. The resident's diagnoses included, but were not limited to, stroke, hypertension, and diabetes mellitus. The resident required substantial/maximal staff assistance with toileting; and adjusting clothing before and after toilet use. The resident required total staff assistance for lower body dressing. The resident used a wheelchair for mobility.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 02/24/25 at 3:15 P.M., Certified Nurse Aide (CNA) 2 indicated maintenance was working on the call lights on the one hundred hallway. They would light up but didn't ring to the nurse's station. It had been going on for a few days. The bathroom light in Resident D's room was what started all the problems. Originally it was only an issue in just that bathroom, but when maintenance tried to fix it, the repair caused all the other rooms to stop sounding.</p> <p>d. A Quarterly MDS assessment, dated 1/18/25, indicated Resident G was cognitively alert and oriented. The resident's diagnoses included, but were not limited to, hypertension, anemia, renal insufficiency, anxiety, and depression. The resident required total staff assistance with toileting; adjusting clothing before and after toilet use; and lower body dressing. The resident used a wheelchair for mobility.</p> <p>During an interview, on 02/24/25 at 3:20 P.M., the Maintenance Director indicated the bathroom call light went out in Resident D's bathroom four days ago. He attempted to fix the light with supplies available, but he was unable to. A custom part was ordered for the bathroom. Resident D and Resident E's room call light was working, but the bathroom call light was not. The adjacent room with the shared bathroom had Resident F and Resident G. Resident F and Resident G's call light in their room was not working. They have a bell in that room. All other call lights were working.</p> <p>During an observation, on 02/24/25 at 3:59 P.M., a resident in room [ROOM NUMBER] triggered her bedside call light. The light turned on above her room door in the hallway, but no tone was heard.</p> <p>During an observation and interview, on 02/24/25 at 4:22 P.M., the Maintenance Director pressed the call light button in room [ROOM NUMBER]. He verified there was no sound from the call light being pressed and he was unaware of the problem.</p> <p>The current, undated, facility policy titled, Loss of Call Light System was provided by the Assistant Director of Nursing (ADON) on 02/25/25 at 1:33 P.M. The policy indicated, .In the event of the failure of the overall facility call light system, an alternative resident monitoring system will be implemented .1. All residents will be monitored by nursing staff at least every hour unless it has been determined that more frequent monitoring is necessary. If so 15-minute spot checks will be conducted. 2. Nursing staff is responsible for documenting hour or 15-minute spot checks .</p> <p>3.1-19(u)</p>		