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	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Clifty Falls, The	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to ensure an anti-anxiety medication was administered to a resident within the appropriate time frame and failed to ensure behaviors were documented prior to the administration of an anti-anxiety medication for 1 of 3 residents reviewed for significant medication errors.Findings Include:The clinical record for Resident B was reviewed on 7/10/25 at 10:04 a.m. The resident's diagnosis included, but was not limited to, restlessness and agitation.The progress note, dated 6/17/25 at 8:00 p.m., indicated the resident was in the dining room and stated, I want to leave. The resident was observed to be physically aggressive with staff. At approximately 7:30 p.m., the resident kicked the side window in the dining room. He then picked up a chair and attempted to throw it at the window. The staff grabbed the chair, and the resident put it down. He then flipped tables in the dining room in anger. He went to his room and attempted to open his window. After that, he picked up another chair and attempted to swing it at the exit doors. The resident then walked to the courtyard door and went outside, accompanied by two staff members. The resident then walked back to the dining room. The nurse practitioner was notified with a new order for Lorazepam (narcotic anti-anxiety medication), 0.5 mg (milligrams) intramuscularly (IM) every 8 hours as needed for anxiety.The June 2025 medication administration record indicated the resident received the IM Lorazepam at 8:15 p.m. The next dose, if needed, could be administered at 3:15 a.m. on 6/18/25.The progress note dated 6/17/25 at 10:51 p.m., indicated the staff were 1:1 supervision with the resident until he calmed down. He had been asleep since approximately 9:30 p.m. He aroused easily to verbal stimuli, and his speech was clear. He remained very confused and disoriented to place and time. He had no further aggression observed. The resident's insulin was not administered at bedtime.The June 2025 medication administration record indicated the resident received the Lorazepam on 6/18/25 at 2:30 a.m.The clinical record lacked documentation of the resident's behaviors to account for the second dose of Lorazepam administered on 6/16/25 at 2:30 a.m. During a telephone interview, on 7/14/25 at 10:02 a.m., Registered Nurse (RN) 5 indicated resident behaviors should be documented in the nurses' notes and medications can be administered an hour before or an hour after the time they are due.On 7/14/25 at 9:29 p.m., the Clinical Support provided a current, undated copy of the document titled Psychotropic Medication. It included, but was not limited to, Psychoactive medications include anti-anxiety.Nursing.Monitors for presence of target behaviors.and documents the same.On 7/10/25 at 3:16 p.m., the Clinical Support provided a current copy of the document titled Medication Administration dated 1/25/19. It included, but was not limited to, Procedure.Medications are administered in accordance with written orders of the physician.Medications are administered within 60 minutes of scheduled time.This Citation relates to Complaint IN004630313.1-37

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a long-acting insulin order was accurately transcribed for 1 of 3 residents reviewed for significant medication errors.Findings Include:The clinical record for Resident B was reviewed on 7/10/25 at 10:04 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes. The hospital discharge order, dated 6/17/25, indicated the resident was to receive insulin glargine (long-acting insulin) 100 unit/ml (milliliters), 5 units at bedtime. The insulin was not to be mixed with other insulins. If the resident's blood glucose was less than 70, the staff were to follow the hypoglycemia protocol for glycemic control.The facility admission order, dated 6/17/25, indicated the resident was to receive insulin glargine, 70 units subcutaneously at bedtime. If the resident's blood glucose was less than 70, the facility protocol was to be implemented. The order was transcribed by Licensed Practical Nurse (LPN) 3. On 6/18/25 at 10:23 p.m., the order for the insulin glargine, 70 units at bedtime, was discontinued and not administered by RN (Registered Nurse) 5. A new order was implemented for the medication by RN 5 to be administered in the morning at 9:00 a.m.On 6/19/25 at 9:00 a.m., review of the June 2025 medication administration record indicated the resident received insulin glargine, 70 units subcutaneously to the right upper quadrant of the abdomen for diabetes. The resident's blood glucose was 164 at this time. The medication was administered by LPN 4.The progress note, dated 6/19/25 at 3:16 p.m., indicated the resident was alert to his surroundings and cooperative with care. The resident was assessed with no pain, agitation or diabetic distress observed.The progress note, dated 6/19/25 at 5:42 p.m., indicated the resident was found unresponsive in his bed and snoring. He was unable to be aroused. His blood pressure was 80/48, respirations 18, pulse 58 and oxygen saturation was 80% on room air. The family was notified and wanted the resident sent to the emergency department. The resident's granddaughter was at his bedside. The progress note, dated 6:10 p.m., indicated emergency medical services (EMS) were at the facility. The resident's blood glucose was 58 at this time and the resident was transferred to the hospital.The progress note, dated 6/19/25 at 11:44 p.m., indicated the family called the facility and reported the resident would be transferred to a different hospital. The resident had been intubated (mechanical ventilation used to assist with breathing) due to non-responsiveness.During a telephone interview, on 7/10/25 at 1:41 p.m., LPN 3 indicated he had been working a lot of night shifts at the facility. The only rationale thing he could think of was that he saw the 70 and put the order in wrong. He did not know why it was not caught in the chart check during the morning meeting the next day. During an interview, on 7/10/25 at 1:45 p.m., LPN 4 indicated she did administer the 70 units of insulin to Resident B on the morning of 6/19/25. LPN 4 did question the amount of insulin in her head, however, that was what the order was written for.During an interview, on 7/10/25 at 3:10 p.m., the Director of Nursing indicated that due to working night shifts, the chart review had been missed prior to the resident's hospitalization.On 7/14/25 at 9:42 a.m., a current copy of the document titled Guidelines for Physician Orders (Following Physician Orders) dated August 2017. It included, but was not limited to, Policy.It is the policy of the facility to follow the orders of the physician.Two nurses will review admission.order to serve as a double check for the accuracy of the orders.This Citation relates to Complaint IN004630313.1-48(a)(1)