| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155209 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waters of Clifty Falls, The | 950 Cross Ave<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to prevent an accident during a transfer resulting in skin tears requiring sutures for 1 of 3 residents reviewed for accidents. (Resident B)Findings included:During an interview, on 11/18/2025 at 9:27 A.M., Certified Nurse Aide (CNA) 4 indicated Resident B had required a full body mechanical lift for transfers for a while. The resident was not interviewable and was dependent on staff for all other care. Prior to the resident requiring a full body lift she required two physical staff members assistance to pivot and transfer. The resident did not currently have any wounds or skin concerns but did have sutures recently from a skin tear.During an interview, on 11/18/25 at 9:32 A.M., CNA 2 indicated during a transfer on 08/23/2025 Resident B required two staff assistance. When they went to transfer the resident, they stood her up and then her legs got weak. The footrest folded up, and her legs scrapped the metal pieces on the chair. The resident received a skin tear. The resident had to go to the hospital and have sutures. During an observation, on 11/18/2025 at 9:38 A.M., CNA 2 showed on the resident's high back wheelchair where the resident's legs scrapped on the bottom corners under the foot pedal. There were metal edges exposed. The two outer corners of the bottom of the foot pedals were missing the plastic caps and the two inner corners had caps in place. The metal was felt and was rough to the touch. The CNA indicated the resident's legs were healed. The legs were observed with no current open areas. During an interview, on 11/18/2025 at 10:15 A.M., CNA 3 indicated her and CNA 2 were transferring Resident B to her high back wheelchair in the resident's room. When they stood the resident up her legs buckled and when they tried to pull the resident back up her legs got caught on the foot pedals and pushed the entire foot pedal mechanism up. Her legs scrapped the metal on the bottom. There were two metal pieces on the bottom that lined up where the resident's legs were. All the CNAs would inspect resident wheelchairs. If they noticed something wasn't right with them then they would take them to maintenance and get them fixed. She believed maintenance would inspect the wheelchairs daily.During an interview and observation, on 11/18/2025 at 10:28 A.M., the Therapy Manager indicated the resident, nor her wheelchair had been seen by their department since the incident in August. The resident chair should not have been missing the plastic pieces. The clinical record for Resident B was reviewed on 11/18/2025 at 11:05 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/25/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, aphasia, vascular dementia, insomnia, and anxiety. The resident required substantial/maximum assistance with transfers.A Progress Note, dated 08/23/2025 at 7:00 A.M., indicated a CNA reported a skin tear to the nurse. Upon assessment, the nurse noted three small skin tears to the back of the right calf and a large skin tear on the back of the left calf. The areas were cleansed, and a dressing was applied. The Nurse Practitioner was updated, and an order was received to send the resident to the local emergency room. An emergency room Visit Note, dated 08/23/2025, indicated the resident presented to the emergency room when her legs got twisted up in a sharp part of the wheelchair causing some skin tears and lacerations of the lower extremities. The physical exam indicated the resident had a 5 centimeter (cm) circumferential laceration of the right lower leg, one skin tear proximal. On the right leg there were four small skin<br>(continued on next page) |

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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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | tears. All skin tears were 2 cm in length. The 5 cm laceration to the left lower leg was numbed using lidocaine, irrigated with high-pressure irrigation and 2 X (by) 4 sutures were placed in a running fashion to approximate each side. The total of 5 X 2 cm small skin tears were irrigated with normal saline and Dermabond (a skin adhesive to hold wounds together) was placed. A Progress Note, dated 08/23/2025 at 12:00 P.M., indicated the resident returned from the hospital. The resident was noted to have glue to the skin tears on the right calf and six sutures and skin glue to the wound on the left calf. There were new orders to cleanse the areas daily and monitor for redness, discharge, fever, or worsening in condition. The resident family was aware and at bedside. A Wound Assessment Report, dated 08/27/2025, indicated the resident had a skin tear to the left lower posterior leg. The wound measured 6.50 cm X 4.20 cm. The wound had sutures. A Wound Assessment Report, dated 08/27/2025, indicated the resident had a skin tear to the right lower posterior leg. The wound measured 10.10 cm X 2.50 cm. A Wound Assessment Report, dated 09/17/2025, indicated the residents skin tears to the right and left lower legs were healed. The current facility policy titled, GUIDELINES FOR INCIDENTS/ACCIDENTS/FALLS, dated 06/30/2023, was provided by the Administrator on 11/18/2025 at 1:21 P.M. The policy indicated, .The facility will ensure that incidents and accidents that occur involving residents are identified, reported, and resolved.This citation related to Intake 2598682.3.1-45(a)(1)3.1-45(a)(2) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>Based on observation and interview, the facility failed to ensure resident care equipment was in safe operating condition for 1 of 2 high back wheelchairs reviewed.Findings include:During an interview, on 11/18/25 at 9:32 A.M., Certified Nurse Aide (CNA) 2 indicated during a transfer on 08/23/2025 Resident B required two staff assistance. On this day when they went to transfer the resident, they stood her up and then her legs got weak. The footrest folded up, and her legs scrapped the metal pieces on the chair causing a skin tear. The resident did have to go to the hospital and have sutures.During an observation, on 11/18/2025 at 9:38 A.M., CNA 2 indicated the location on the resident's specialized high back wheelchair where the resident's legs scrapped on the bottom corners where there was exposed metal. The two outer corners of the bottom of the foot pedals were missing the plastic caps, the two inner corners had caps in place. The metal was felt and was rough to the touch. The CNA indicated the resident's legs were healed. The legs were observed with no current open areas.During an interview, on 11/18/2025 at 10:15 A.M., CNA 3 indicated her and CNA 2 were transferring Resident B to her specialized high back wheelchair in the resident's room. When they stood the resident up her legs buckled and when they tried to pull the resident back up her legs got caught on the foot pedals and pushed the entire foot pedal mechanism up. Her legs scrapped the metal on the bottom. There were two metal pieces on the bottom that lined up where the resident's legs were. All the CNAs would inspect resident wheelchairs. If they noticed something wasn't right with them then they would take them to maintenance and get them fixed. She believed maintenance would inspect the wheelchairs daily.During an interview and observation, on 11/18/2025 at 10:28 A.M., the Therapy Manager indicated the resident, nor her wheelchair had been seen by their department since the incident in August. The resident's chair should not have been missing the plastic pieces. During an interview, on 11/18/2025 at 10:44 A.M., the Maintenance Director indicated the residents specialized high back wheelchairs were inspected by him if nursing requested for them to be looked at or if there was a work order for it. There wasn't a checklist to check off unless there was a work order. After Resident B's incident he did look at the resident's chair. He determined there were no adjustments needed to the chair. He didn't see anything wrong with the chair, nothing was out of place, and there were not any missing pieces. He transferred the chair back to the nursing department to reevaluate. During an observation and interview, on 11/18/2025 at 10:51 A.M., of Resident B's chair with the Maintenance Director, the chair was missing the black corner plastic pieces under the foot pedals. The Maintenance Director indicated that the pieces should have been on the chair. During an interview, on 11/18/2025 at 11:53 A.M., the Maintenance Director indicated he had spoke with the specialize high back wheelchair company and they told him that the black pieces that were missing from the chair were to just block water and dust plugs and were not a protector. He did not have a work order or any indication that he had inspected the resident's chair after the incident. He was the weekend manager on the day the incident happened, so he just looked at it at that time. During an interview, on 11/18/2025 at 11:59 A.M., a Representative with the specialized high back wheelchair company indicated the black cover pieces were used as water and dust covers. The plugs sit in the metal on the bottom of the foot pedal; she believed the plugs would help the skin from rubbing the metal because if the plugs were not in place the metal could be sharp from paint build up. It was the facilities responsibility to ensure the plugs were in place. If the pieces were missing, then they should have them replaced as it was part of the quality check when the chair was shipped. An emergency room Visit Note, dated 08/23/2025 indicated the resident presented to the emergency room when her legs got twisted up in a sharp part of the wheelchair causing some skin tears and lacerations of the lower extremities. The physical exam indicated the resident had a 5 centimeter (cm) circumferential laceration of the right lower leg, 1 skin tear proximal. On the right leg there were four small skin tears. All skin tears were 2 cm in length. The 5 cm laceration to the left lower leg was numbed using lidocaine, irrigated with high-pressure irrigation and 2 X (by) 4 sutures<br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were placed in a running fashion to approximate each side. The total of 5 X 2 cm small skin tears were irrigated with normal saline and Dermabond (a skin adhesive to hold wounds together) was placed. A Progress Note, dated 08/23/2025 at 12:00 P.M., indicated the resident returned from the hospital. The resident was noted to have glue to the skin tears on the right calf and six sutures and skin glue to the wound on the left calf. There were new orders to cleanse the areas daily and monitor for redness, discharge, fever, or worsening in condition. The resident family was aware and at bedside.The current, undated, facility policy titled, Nursing-Annual Inspections, was provided by the Administrator on 11/18/2025 at 1:21 P.M. The policy indicated, .Wheelchairs: Check all wheelchairs for proper operation and needed repairs.This citation related to Intake 2598682.3.1-19(bb) |