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	01/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to follow physician's orders and change treatment orders in a timely manner related to a resident's wound care for 1 of 3 residents reviewed for quality of care. (Resident C)Findings include:The clinical record for Resident C was reviewed on 01/22/2026 at 9:43 A.M. An admission Minimum Data Set (MDS) assessment, dated 09/20/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Deep Vein Thrombosis (DVT- a serious condition where a blood clot forms in one or more of the deep veins) and diabetes. The resident had one venous/arterial ulcer (a painful, slow-healing sore on the lower leg, foot, or toes) on admission.A Wound Nurse Practitioner (NP) Note, dated 09/17/2025, indicated the resident had an arterial ulcer to the left heel that was 7.2 centimeters (cm) x (by) 7.5 cm x 0.4 cm, and was present on admission. The staff were to cleanse the wound with wound cleanser or normal saline, apply betadine, cover with an abdominal pad, and lightly wrap with a rolled gauze. The treatment was to be completed twice per day.The September and October 2025 Electronic Treatment Administration Record (ETAR) indicated the resident had a physician's order, dated 09/17/2025 through 10/20/2025, for staff to cleanse the wound with wound cleanser or normal saline, apply betadine, cover with an abdominal pad, and lightly wrap with a rolled gauze, once a day.A Wound NP Note, dated 10/15/2025, indicated the resident had an arterial ulcer to the left heel that was present on admission. The staff were to cleanse the wound with wound cleanser or normal saline, apply Santyl, cover with an abdominal pad, and lightly wrap with rolled gauze, daily.The October 2025 ETAR indicated the order was not initiated until 10/20/2025.A Wound NP Note, dated 10/29/2025, indicated the resident had an arterial ulcer to the left heel that was present on admission. The staff were to cleanse the wound with wound cleanser or normal saline, apply skin prep to the surrounding tissue or peri-wound, apply Dakins moistened fluffed gauze, and cover with silicone bordered superabsorbent dressing, twice a day.The November 2025 ETAR indicated a physician order, dated 11/04/2025 through 11/10/2025, indicated the staff were to cleanse the wound with wound cleanser or normal saline, apply skin prep to the surrounding tissue or peri-wound, apple Dakins moistened fluffed gauze, and cover with silicone bordered superabsorbent, daily.The order was not changed to twice a day until 11/10/2025.A Wound NP Note, dated 11/20/2025, indicated the resident had an arterial ulcer to the left heel that measured 4.6 cm x 4.0 cm x 0.4 cm and was present on admission. The staff were to cleanse the wound with wound cleanser or normal saline, apply skin prep to the surrounding tissue or peri-wound, apply Dakins moistened fluffed gauze, and cover with silicone bordered superabsorbent dressing, twice a day.During an interview, on 01/22/2026 at 2:24 P.M., Licensed Practical Nurse (LPN) 2 indicated the resident's wound treatments were to be documented in the ETAR. If there was a blank on the ETAR then that would mean the treatment wasn't completed. The Wound NP came to the facility to see residents, and the Assistant Director of Nursing (ADON) would round with her when she came. If she initiated any new orders the ADON would transcribe those orders. During an interview, on 01/22/2026 at 2:28 P.M., the ADON (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the Wound NP would come in and complete her rounds with the residents. The NP would then leave the facility, and he (the ADON), would get a report from the NP within one to two days of her visit. The report wound contain any new orders. Once he got the report then he would change resident's orders if the NP had prescribed new orders. The facility did not go through the resident's primary physician for any new wound treatment orders. They would just follow the order of the Wound NP. The current facility policy titled, Guidelines for Physician Orders-(Following Physician Orders) dated 06/18/2023, was provided by the Director of Nursing on 01/22/2026 at 3:27 P.M. The policy indicated, .It is the policy of the facility to follow the orders of the physician.As assessments are completed, orders will be received from the physician to address significant findings of the assessment.All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received.This citation relates to Intake 2712292. 3.1-37(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow physician's orders related to treatments for 1 of 3 residents reviewed for pressure ulcers. (Resident B)Findings include:The clinical record for Resident B was reviewed on 01/22/2026 at 10:05 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/20/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, malnutrition, and depression. The resident had one Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed) pressure ulcer that was present on admission. A Wound Nurse Practitioner (NP) Note, dated 08/27/2025, indicated the resident had a Stage 4 pressure ulcer to the sacrum the wound measured 5.4 centimeters (cm) x (by) 6.5 cm x 5.0 cm. There was undermining from from 6 o'clock to 4 o'clock, at 6.4 cm. The wound was present on admission on [DATE]. A Wound NP Note, dated 09/17/2025, indicated the resident had a Stage 4 pressure ulcer to the sacrum that was present on admission. A new wound treatment order indicated the staff were to cleanse the wound with Dakins solution, apply collagen, calcium alginate, and cover with a bordered dressing. The treatment was to be completed daily. The September 2025 Electronic Treatment Administration Record (ETAR) indicated the treatment was not initiated until 09/23/2025. A Wound NP Note, dated 10/22/2025, indicated the resident had a Stage 4 pressure ulcer to the sacrum that was present on admission. A new wound treatment order indicated the staff were to cleanse the wound with Dakins solution, apply collagen particles, and apply continuous wound vac therapy. The treatment was to be completed three times per week. The October 2025 ETAR indicated the resident had an order, from 10/22/2025 through 11/09/2025 to change the wound vac dressing to the coccyx every three days. The order lacked indication to cleanse the wound with Dakins solution or apply collagen particles. A Wound NP Note, dated 10/29/2025, indicated the resident had a Stage 4 pressure ulcer to the sacrum that was present on admission. A new wound treatment order indicated the staff were to cleanse the wound with Dakins solution, apply collagen particles, and apply continuous wound vac therapy. The treatment was to be completed on Wednesdays and Saturdays. The October ETAR lacked the treatment order was changed on 10/29/2025. A different treatment order was put into place on 11/12/2025.A Wound NP Note, dated 12/10/2025, indicated the resident had a Stage 4 pressure ulcer to the sacrum that was present on admission. A new wound treatment order indicated the staff were to cleanse the wound with Dakins solution, apply skin prep to the surrounding tissue or periwound, apply collagen with silver, calcium alginate, and cover with a silicone bordered superabsorbent dressing. The treatment was to be completed daily. The December 2025 ETAR indicated the treatment order was not initiated until 12/19/2025, and lacked documentation the treatments were completed on the following dates:-On 12/22/2025, -On 12/27/2025, -On 12/28/2025, and -On 12/29/2025.A Wound NP Note, dated 01/21/2026, indicated the resident had a Stage 4 pressure ulcer to the sacrum. The wound measured 4.3 cm x 4.0 cm x 3.4 cm. The wound had undermining from 3 o'clock to 8 o'clock at 4.8 cm. The wound was present on admission. During an interview, on 01/22/2026 at 2:24 P.M., Licensed Practical Nurse (LPN) 2 indicated resident wound treatments were to be documented in the ETAR. If there was a blank on the ETAR then that would mean the treatment wasn't completed. The Wound NP came to the facility to see residents, and the Assistant Director of Nursing (ADON) would round with her when she came. If the Wound NP initiated any new orders the ADON would transcribe those orders. During an interview, on 01/22/2026 at 2:28 P.M., the ADON indicated the Wound NP would come in and complete her rounds with the residents. The NP would then leave the facility, and he, the ADON, would get a report from the NP within one to two days of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her visit. The report wound contain any new orders. Once he got the report then he would change resident's orders if the NP had prescribed new orders. The facility did not go through the resident's primary physician for any new wound treatment orders. They would just follow the order of the Wound NP. The current facility policy titled, Guidelines for Physician Orders-(Following Physician Orders) dated 06/18/2023, was provided by the Director of Nursing on 01/22/2026 at 3:27 P.M. The policy indicated, .It is the policy of the facility to follow the orders of the physician.As assessments are completed, orders will be received from the physician to address significant findings of the assessment.All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received.The current facility policy titled, Guidelines for Prevention/Treatment of Pressure Injuries dated 10/09/2023 was provided by the Director of Nursing on 01/22/2026 at 3:27 P.M. The policy indicated, .In accordance with Federal Regulations and based on resident assessment, the facility will ensure: 2) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections and prevent new ulcers from developing .This citation relates to Intake 2712292. 3.1-40(a)(2)