STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 6, 7, 8, and 12, 2024 Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census Bed Type: SNF/NF: 25 SNF: 9 Residential: 25 Total: 59 Census Payor Type: Medicare: 5 Medicaid: 22 Other: 7 Total: 34 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 14, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Clearvista Lake Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Clearvista Lake Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to apply TED hose (stockings that help prevent blood clots and	F 0684	div=""> p="" paraid="448583103" paraeid="{3057d1af-9d37-4dc4-bfd9-7b330ccdcde7}{151}">Residents	11/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Mevzek	Executive Director	11/22/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	swelling in the legs) as ordered for 1 of 1 resident reviewed for edema and to hold blood pressure medication, as ordered by the physician, for 2 of 5 residents reviewed for unnecessary medications. (Resident 3, Resident 9, and Resident 13) Findings include: 1. The clinical record for Resident 13 was reviewed on 11/7/24 at 10:53 a.m. The diagnoses included, but were not limited to, edema. A care plan, dated 9/23/24, indicated the resident was to wear TED hose to her legs. A physician order, dated 9/17/24, indicated the staff was to apply TED hose to the resident's legs in the morning and remove them at night. Observations were made of Resident 13 on 11/7/24 at 10:53 a.m., 11/7/24 at 2:15 p.m., 11/8/24 at 9:38 a.m., and 11/8/24 at 1:21 p.m. The resident was observed wearing shoes, but she was not wearing TED hose. An observation was made of Resident 13 in her room with Certified Resident Care Associate (CRCA) 5 on 11/8/24 at 1:23 p.m. The resident was observed in her room sitting in her wheelchair. At that time, CRCA 5 had opened a drawer and located a package of TED hose. CRCA 5 indicated Resident 13 will wear the TED hose if staff applies. She normally wore them daily. 2. The clinical record for Resident 3 was reviewed on 11/8/24 at 10:29 a.m. The diagnoses included, but were not limited to, hypertension and congestive heart failure. A physician's order, dated 5/2/24, indicated he was to receive carvedilol tablet (blood pressure		3, 9, and 13 were affected. Residents are without adverse effect. MD was notified with no new orders received All residents have the potential to be affected. A house wide audit was conducted to ensure that all residents with orders for TED hose and/or hold blood pressure medication parameter orders were in place and educated to staff responsible for carrying out those orders. MD was made aware of medications given outside of v/s parameters. As a measure of ongoing compliance, the DHS or designee to complete random audits to ensure residents with TED hose orders are applied per order AND, complete random audits of EMAR to ensure residents with hold blood pressure medication parameter orders are being followed. Audits to be completed on 5 residents weekly x4 weeks; then 3 residents biweekly x8 weeks, then 3 residents monthly x3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication) 3.125 milligram (mg) twice daily. Instructions were to hold the medication for a heart rate less than 60 beats per minute. A care plan, last reviewed 11/2/24, indicated Resident 3 had a potential for cardiovascular distress related to his diagnoses of heart failure and hypertension. The goal was for him to be free from signs and symptoms of cardiovascular distress. The interventions included, but were not limited to, administer medications as ordered and observe for and report side effects as needed, and obtain vital signs as ordered and needed. The Medication Administration Record (MAR) for October 2024 and November 2024 indicated the carvedilol 3.125 mg was administered when resident 3's heart rate was below 60 on the following day(s) and time(s): 10/3/24-evening shift, 10/4/24- evening shift, 10/10/24- evening shift, 10/14/24- evening shift, 10/19/24- day and evening shift, 10/20/24- day and evening shift, 10/21/24- evening shift, 10/29/24- evening shift, 11/1/24- evening shift, and 11/3/24- evening shift. 3. The clinical record for Resident 9 was reviewed on 11/08/24 at 2:49 p.m. The diagnosis included, but were not limited to, hypertension. A physician's order, dated 9/29/2023, indicated she was to receive metoprolol tartrate tablet (blood pressure medication) 25 mg twice daily. Instructions were to hold the medication when systolic (top number of blood pressure reading) is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	less than 110. A care plan, last reviewed 8/30/24, indicated Resident 9 had a potential for cardiovascular distress. The goal was for her to be free from signs and symptoms of cardiovascular distress. The interventions included, but were not limited to, obtain vital signs as ordered and administer medications as ordered. The November 2024 MAR indicated the metoprolol tartrate was administered when the systolic blood pressure reading was below 110 on the following day(s) and time(s): 11/3/24- evening shift, 11/4/24- evening shift, and 11/9/24- evening shift. During an interview on 11/08/24 at 1:27 p.m., the Nurse Consultant (NC) 4 indicated the medication should have been held, as ordered by the physician. On 11/8/24 at 2:12 p.m., the NC 4 provided the Guidelines for Medication Orders policy, last reviewed 12/31/23, which read, "...Purpose To establish uniform guidelines in the receiving and recording of medication orders... A current list of orders will be maintained in the electronic clinical record of each resident..." 3.1-37(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record review, the facility failed to ensure a resident's	F 0697	p="" paraid="1255247191" paraeid="{3057d1af-9d37-4dc4-bfd9-7b330ccdcde7}{228}">Resident	11/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pain was assessed for severity of her pain for 1 of 3 residents reviewed for catheter. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 11/6/24 at 12:20 p.m. The diagnoses included, but were not limited to, diabetes mellitus with diabetic polyneuropathy. A care plan for pain, dated 12/18/23, indicated "At risk for pain r/t [related to] diabetic polyneuropathy, depression, repeated falls." The approach included, but was not limited to, observe for and record verbal and non-verbal signs of pain. A physician order, dated 10/2/24, indicated the staff was to administer five milligrams of oxycodone prior to wound care once a day as needed. A physician order, dated 11/5/24, indicated the staff was to cleanse wounds on Resident 25's right and left heels with anasept (wound cleanser); apply skin prep to peri-wounds; apply collagen to wound beds; cover with absorbent dressings; and wrap with kerlix and secure with tape. The dressing changes were scheduled for Tuesdays, Thursdays, and Saturdays. The November 2024 Medication Administration Record and Treatment Administration Record (MAR/TAR) indicated the following days the five milligrams of oxycodone was administered for pain: 11/2/24 (Saturday) at 6:45 p.m. - reason for medication use: pain and pain medication were effective,		25 was affected. Resident was assessed for pain, physician notified and resident's pain was treated per orders. All residents have the potential to be affected. All resident orders have been audited for pain scale & effectiveness. Licensed clinical staff educated on guidelines for pain observation and management. As a measure of ongoing compliance, DHS or designee to complete random audits of EMAR documentation for pain medication administration to ensure pain scale is utilized for assessment for PRN analgesics. Audits to be completed on 5 residents weekly x4 weeks; then 5 residents biweekly x8 weeks, then 5 residents monthly x3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11/3/24 (Sunday) at 12:32 p.m. - reason for medication use: pain and pain medication were effective, and 11/12/24 (Tuesday) at 8:02 a.m. - reason for medication use: leg pain and pain medication were effective. The resident's clinical record did not include the resident's severity of her pain on 11/2/24, 11/3/24, and 11/12/24. An observation was made of Resident 25 on 11/12/24 at 11:27 a.m. The resident was observed lying in bed with complaints of pain to her legs and arm. She denied pain from her wounds. She indicated the nurse had administered her pain medication early that morning, and it had not helped. At that time, her pain was rated at a nine, utilizing one being the least amount of pain to ten being the most amount of pain. An interview was conducted with the Director of Nursing on 11/12/24 at 1:28 p.m. She indicated she was unable to provide assessments of the severity of the resident's pain prior to administering the five milligrams of oxycodone. The five milligrams of oxycodone was ordered once a day as needed for pain control during Resident 25's wound treatments. A pain policy was provided by Clinical Support 4 on 11/12/24 at 1:52 p.m. It indicated, "...Purpose: To ensure each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the needs of each individual..." 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure the medication and/or supply storage rooms did not contain expired supplies for 1 of 2 medication rooms observed and 1 of 2 central supply rooms observed. Findings include: An observation was conducted of the central supply room on Tinsley unit with the Director of Nursing (DON) on 11/7/24 at 9:40 a.m. There were 16 cartons of Osmolite 1.5 (feeding solution) with an expiration date of 11/1/24. The DON indicated the facility did not have any residents currently receiving Osmolite 1.5. The Scheduler was responsible for supply storage. An observation was conducted, on 11/7/24 at 9:55 a.m., of the medication storage room on the Hinkle unit with Licensed Practical Nurse (LPN) 2. A cabinet contained ten COVID tests that had expired in 2023. A policy titled "MEDICATION STORAGE IN THE FACILITY", revised 11/18, was provided by the DON on 11/7/24 at 1:48 p.m. The policy indicated the following, " ...E. The medication administration personnel will check the expiration date of each medication before administering it ...F. No expired medication will be administered to a resident ...G. All expired medications will be removed from the active supply and destroyed in the facility ...." 3.1-25(j)	F 0761	p="" paraid="897075247" paraeid="{b81611fe-695f-42a5-8bba-adf3bcee12fa}{160}">No residents were affected. A campus wide audit was completed to ensure that no other expired covid tests or enteral feedings were in house. DHS or Designee to conduct weekly observations of each supply storage room and medication room to ensure that any/all expired items are discarded promptly. Audits will continue weekly until 100% compliance is met for 3 consecutive months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance improvement meetings. The plan will be reviewed and updated as warranted.	11/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure residents' medical records were complete and accurate with behavior monitoring and documentation of urine characteristics after insertion of a Foley catheter for 2 of 5 residents reviewed for unnecessary medications and 1 of 3 residents reviewed for catheters. (Residents' 11, 25, and 26) Findings include: 1a. The clinical record for Resident 25 was reviewed on 11/6/24 at 12:20 p.m. The diagnoses included, but were not limited to, diabetes mellitus with diabetic polyneuropathy and obstructive and reflux uropathy (blocks the flow of urine). A physician order, dated 5/8/24, indicated the staff was to change the resident's Foley catheter every 30 days. The November 2024 Treatment Administration Record indicated the resident's Foley catheter was changed on 11/8/24. A nursing progress note, dated 11/8/24, indicated the following, "Anchored 16 FR [French] 10 cc [cubic centimeter] bulb catheter change for the month. Resident tolerated it well." Resident 25's clinical record did not include characteristics of the resident's urine at the time of changing the Foley catheter on 11/8/24. An interview was conducted with the Director of Nursing on 11/12/24 at 3:34 p.m. She indicated	F 0842	p="" paraid="323261506" paraeid="{b81611fe-695f-42a5-8bba-adf3bcee12fa}{41}">Residents 11, 25, and 26 were affected. Resident 25's foley catheter was changed on 11/19/24 with accurate and complete documentation noted. Resident 11 and 26 targeted behavior documentation were reviewed with nursing staff to ensure accurate coding is followed. All residents with catheters or targeted behaviors have the potential to be affected. All residents with catheter orders will have accurate and complete documentation noted. All residents with targeted behaviors will have accurate and complete documentation noted. Education provided to all nurses regarding Insertion of Foley catheter policy AND Targeted Behavior Documentation including the scale to follow. As a measure of ongoing compliance, DHS or designee will audit catheter change documentation for accuracy and completeness x 4 weeks; then biweekly x8 weeks, then monthly x3 months. DHS or designee will conduct random audit for compliance with targeted behavior documentation of 5 residents weekly x 4 weeks, then 5 residents biweekly x 3 weeks,	11/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 25's urine characteristics were chronic. An insertion of a Foley catheter policy was provided by the Clinical Support 4 on 11/12/24 11:53 a.m. It indicated, "...3. Steps in the procedure...4. After completion of procedure...5. The following information should be recorded in the resident's medical record: a. The date and time the procedure was performed. b. All assessment date (e.g. character, color, clarity, etc.) obtained during the procedure. c. The size of the Foley catheter inserted and the amount of fluid used to inflate the balloon. d. How the resident tolerated the procedure..." 1b. A physician order, dated 7/17/24, indicated "order set target behavior - Resident currently has an active order of Bupropion for s/s [signs and symptoms] of depression aeb [as evidenced by] social withdrawal, being down on herself, and or feeling like a bother to others. At the end of each shift mark frequency - how often behavior occurred & Intensity - how resident responded to redirection. Intensity code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff was to document three times a day. The November 2024 Medication/Treatment Administration Record (MAR/TAR) indicated the behavior monitoring for depression was documented as NA (not applicable) on the following day(s) and time(s): 11/3/24 - 6:00 a.m. - 10:00 a.m., 11:00 a.m. - 1:30 p.m., and 11/8/24 - 6:00 a.m. - 10:00 a.m., 11:00 a.m. - 1:30 p.m. 2. The clinical record for Resident 11 was reviewed on 11/6/24 at 1:00 p.m. The diagnoses included, but were not limited to, stroke.		then 5 residents monthly x 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician order, dated 11/6/24, indicated "order set target behavior - aggressive behavior expressions. At the end of each shift mark frequency - how often behavior occurred & intensity - how resident responded to redirection. Intensity Code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff were to document three times a day. A physician order, dated 11/6/24, indicated "order set target behavior - social isolation, withdrawal. At the end of each shift mark frequency - how often behavior occurred & intensity - how resident responded to redirection. Intensity Code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff were to document three times a day. The November 2024 MAR/TAR for Resident 11 indicated the behavior monitoring for aggressive, social isolation and withdrawal behaviors was documented as NA (not applicable) on the following day(s) and time(s): 11/8/24 - 6:00 a.m. - 10:00 a.m. and 11:00 a.m. - 1:30 p.m. 3. The clinical record for Resident 26 was reviewed on 11/6/24 at 2:00 p.m. The diagnoses included, but were not limited to, anxiety disorder. A physician order, dated 12/7/23, indicated "order set target behavior - anxiety. At the end of each shift mark frequency - how often behavior occurred & intensity - how resident responded to redirection. Intensity Code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff were to document three times a day.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician order, dated 7/17/24, indicated "order set target behavior - Resident currently has an active order of trazadone for s/s of insomnia aeb social withdrawal, sleeping throughout the day and awoke at night, and being extremely tired. At the end of each shift mark frequency - how often behavior occurred & intensity - how resident responded to redirection. Intensity Code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff were to document three times a day. A physician order, dated 7/17/24, indicated "order set target behavior - Resident currently has an active order of zoloft for s/s depression aeb social withdrawal, being down on himself, and or believing he is a failure. At the end of each shift mark frequency - how often behavior occurred & intensity - how resident responded to redirection. Intensity Code: 0 = did not occur; 1 = easily altered; 2 = difficult to redirect." The staff were to document three times a day. The November 2024 MAR/TAR for Resident 26 indicated the following day(s) and time(s) the monitoring of insomnia and depression behavior were documented as NA (not applicable): 11/3/24 - 6:00 a.m. -10:00 a.m., 11:00 a.m. - 1:30 p.m., and 11/8/24 - 6:00 a.m. -10:00 a.m., 11:00 a.m. - 1:30 p.m. An interview was conducted with Clinical Support 4 on 11/12/24 at 11:55 a.m. She indicated the staff documented "NA" for behavior monitoring meant the behavior was not observed during that shift. A nursing job description summary was provided by the Clinical Support 4 on 11/12/24 at 2:00 p.m. It indicated, "...Role and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Responsibilities...Administer and document medication and treatments per the physician's order and accurately record all care provided..." 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained with hand hygiene during Foley catheter care for 1 of 3 residents reviewed for catheters. (Resident 3) Findings include: The clinical record for Resident 3 was reviewed on 11/7/24 at 11:00 a.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and stage 3 kidney disease. A care plan, dated 6/10/24, indicated the "Resident uses a suprapubic or Foley catheter for dx [diagnosis] of: Neurogenic Bladder." The approaches included, but were not limited to, "Provide assist with catheter care and change Foley catheter per physician orders". A physician order, dated 6/10/24, indicated the staff was to provide catheter care to Resident 3 three times a day. An observation was conducted of Foley catheter care with Certified Resident Care Associate (CRCA) 3 and the Director of Nursing on 11/12/24 at 1:43 p.m. CRCA 3 was observed washing his hands and donning on gloves prior to catheter	F 0880	p="" paraid="1047505582" paraeid="{b81611fe-695f-42a5-8bba-adf3bcee12fa}{96}">Resident 3 was affected but without adverse effect . Education was immediately provided to CRCA 3 on infection Prevention and Control Program and hand hygiene. All residents have the potential to be affected. All staff educated on hand hygiene policy and infection prevention and control policy. As a measure of ongoing compliance, DHS or designee to complete audits to ensure hand hygiene protocols are followed. Hand Hygiene Audits to be completed for 5 staff weekly x 4 weeks, then every other week x 8 weeks then monthly x 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	11/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care. Then, he turned on the faucet, filled a basin of water and walked to the resident's bed side. At that time, CRCA 3 raised the resident's bed up with a bed remote. After, CRCA 3 was observed providing catheter care to Resident 3. There was no observation of doffing his gloves and utilizing hand hygiene after he touched the faucet in the sink and bed remote. An interview was conducted with Clinical Support 4 on 11/12/24 at 2:15 p.m. She indicated CRCA 3 should have set up his supplies then utilized hand hygiene and donned gloves prior to providing catheter care. An infection control policy was provided by the Clinical Support 4 on 11/12/24 at 2:25 p.m. It indicated, "...Purpose. To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections..." A urinary catheter care policy was provided by the Clinical Support 4 on 11/12/24 at 11:53 a.m. It indicated, "...Overview. To prevent infection of the resident's urinary tract. SOP [Standard Operating Procedure] Details...18. Gather equipment and supplies to perform this procedure...20. To perform the procedure... a. Place the clean equipment on the bedside stand or over bed table. Arrange the supplies so they can be easily reached. b. Wash and dry hands thoroughly..." 3.1-18(b)(1) 3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based in observation, interview, and record review, the facility failed to ensure resident rooms were in good repair for 2 of 3 resident rooms reviewed for environment (Resident 15 and 29). Findings include: 1a. Resident 15's room was observed on 11/7/24 at 9:51 a.m. The drywall behind her bed had been patched. The area was unpainted and appeared bumpy and uneven. On 11/12/24 at 2:28 p.m., Resident 15's room was observed with the Executive Director (ED). The ED indicated the drywall behind Resident 15's bed had been patched. The wall had been repaired multiple times. Resident 15 utilized a trapeze to assist with bed mobility and the trapeze stand caused the drywall to become scratched. 1b. Resident 29's room was observed on 11/7/24 at 11:00 a.m. The wall behind his bed had an irregularly shaped white area present on it. On 11/12/24 at 2:40 p.m., Resident 29's room was observed with the ED and the Director of Plant Operations (DOP). The DOP indicated the white area on the wall behind the bed was from the bed scraping against the wall. The paint had been worn away. The DOP was unsure how long the area had been there. During an interview on 11/12/24 at 2:53 p.m., the DOP indicated they generally did room repairs when a room was being "flipped" for a new admission or when a work order was submitted for	F 0921	ol class="NumberListStyle1 SCXW7296782 BCX0" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" Residents 15 and 29 were affected. Both residents' rooms were repaired by 11/19/24. ol class="NumberListStyle1 SCXW7296782 BCX0" role="list" start="2" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" All residents have the potential to be affected. All resident rooms were audited with noted findings for repairs the work order system and completion dates. As a measure of ongoing compliance, the DPO or will conduct monthly audits of all resident rooms noting any repairs needed and complete those repairs within one week of finding. The DPO or designee will enter all repairs into the work order system for documentation. ·As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly in the campus	11/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a repair. On 11/12/24 at 3:05 p.m., the ED provided a Rounding Observation form, dated 11/1/24, which indicated Resident 15's room had been found to have exposed drywall behind the bed. The area had been mudded and fixed drywall. On 11/12/24 at 3:05 p.m., the ED provided a Work Order, dated 1/3/24, which indicated Resident 29's room had been made ready for a resident and the work was completed on 1/5/24. On 11/12/24 at 3:20 p.m., Nurse Consultant 4 provided the TELS policy, last revised 2/9/2018, which read, "...Trilogy utilizes the TELS program to maintain and track capital assets, aide with Life Safety compliance, and work order tracking... Work orders are maintenance issues that arise at the campus. Department heads and line staff can enter work orders at any time in TELS..." 3.1-19(f)(5)		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 6, 7, 8, and 12, 2024 Facility number: 013019 Residential Census: 25 Clearvista Lake Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the	R 0000	The submission of this plan of correction does not indicate an admission by Clearvista Lake Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Clearvista Lake Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	State Residential Licensure Survey. Quality review completed on November 14, 2024.		services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	