STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING **01** B. WING _____	R **11/02/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/05/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).

Survey Date: 11/02/23

Facility Number: 013019
Provider Number: 155815
AIM Number: 201251520

At this PSR survey, Clearvista Lake Health Campus was found in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This facility, located on the first floor of a two-story building, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. Because of COVID-19 the following rooms were not a part of this Life Safety Code Survey: #103, #211 through #222, #416, #419, #420, and #421. The facility has a capacity of 70 and had a census of 56 at the time of this visit.

All areas where the residents have customary access were sprinklered. All areas providing

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
	155815	A. BUILDING **01** B. WING _____	R **11/02/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	Continued From page 1 facility services were sprinklered. Quality Review completed on 11/03/23	{K 000}		