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	09/07/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00388643. Complaint IN00388643 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F842. Survey dates: September 6 and 7, 2022. Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census bed type: SNF: 20 SNF/NF: 24 Residential: 18 Total: 62 Census payor type: Medicare: 11 Medicaid: 24 Other: 9 Total: 44 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 9, 2022	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 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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident's fall intervention was in place for 1 of 3 residents reviewed for falls. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/7/22 at 10:58 a.m. The diagnoses included, but were not limited to: dementia, hemiplegia, hemiparesis, and osteoarthritis. An interview was conducted with CNA (Certified Nursing Assistant) 2 on 9/7/22 at 11:49 a.m. She indicated she'd worked at the facility for 3 years and was pretty familiar with Resident D. She transferred herself in and out of her bed and wheel chair. She ate all of her meals in her room. She wouldn't lay down during the day if you asked her. Once she was up, she was up until she went to bed at night. The 6/9/22, 6:42 p.m. fall event indicated she had an unwitnessed fall in her room. She slipped to the floor from her wheel chair. She complained of head pain at a level of 6 on a scale of 1 to 10. She had swelling and a hematoma, and was sent to the emergency department. The 6/9/22, 9:58 p.m. nurse's note read, "Nursing aide called writer into resident room. Resident observed sitting on the floor. She told writer that she slipped from her w/c [wheel chair] and then bumped her head on the floor. Head to toe assessment completed, scalp hematoma noted.	F 0689	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident D had no ill effects. Dycem is present in resident D's wheelchair seat. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Resident with falls have the potential to affected. In house residents with falls in the last 30 days were audited to ensure fall interventions are in place. No concerns noted. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DHS or designee will educate nursing staff on Falls Program Guidelines. DHS or designee will be responsible for auditing 5 random residents to ensure fall interventions are in place. Audits will be conducted 3 days per week times 4 weeks, weekly times 1 month, then monthly for 4 months and until continued compliance is maintained for 2 consecutive quarters (six months).	09/26/2022

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	Vitals obtained, neuro [neurological] checks completed. On call notified, she instructed writer to send resident to the ER [emergency room] to get CT [computed tomography] scan. Family and ADON [Assistant Director of Nursing] notified." The 6/9/22 hospital emergency department after visit summary indicated she was seen for a fall with a diagnosis of injury of head. The 6/10/22, 10:29 a.m. nurse's note, written by the NS (Nursing Supervisor), read, "IDT [Interdisciplinary Team] review of fall. Resident noted to be in room when resident slipped from her wheel chair. Scalp hematoma noted with new orders to send resident to ER for eval [evaluation] and tx [treatment.] Resident returned with no new orders. New intervention: dycem to wheel chair." The 3/5/22 fall care plan indicated she was at risk for falling and had a history of falling. The goal was for her to remain free of falls with major injury. An intervention was dycem to wheel chair, starting 6/10/22. The 8/24/22, 8:35 a.m. fall event indicated she had an unwitnessed fall in her room. She fell asleep in her wheel chair and fell out of her wheel chair. She complained of head pain at a level of 6 on a scale of 1 to 10. She had a laceration to the head and was sent to the emergency department. The new interventions section of the event indicated a new measure taken to prevent reoccurrence was wheel chair modification. The 8/24/22, 8:41 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 4, read, "Writer was alerted to resident's room. Res [Resident] was sitting on the floor by her wheel chair with blood coming out of her head. Resident appear [sic] to		4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? 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. 5. Date of completion: 09/26/22	

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	have fallen out of her wheel chair and hit her head on bedside table. Res was alert and yelling. Res was not moved. Res was bleeding profusely from her head. 911/EMT [Emergency medical technicians] called and pressure dressing applied to head. Vitals 144/92 [blood pressure,] P [Pulse] 112 Res [Respirations] 24 rapid 01 896% RA [room air.] Son notified. NP [Nurse practitioner] notified that writer sent res to ER." The 8/30/22 hospital discharge summary indicated she was admitted on 8/24/22 and discharged on 8/30/22. It read, "...admitted on 8/24/2022 with a complaint of fall from her wheelchair with a head injury. She required scalp lac [laceration] repair in ED [Emergency Department] and lab work was concerning for acute blood loss anemia. Family expressed concerns about worsening confusion for the past 6 months. GEM [Geriatric Emergency Management] team was consulted and consulted palliative care. Family decided to proceed with transition to hospice. She will be discharged to hospice today. Further detailed hospital course as below: 1. Fall with head trauma: Fell out of wheelchair PTA [Post-traumatic amnesia] w/large [with large] laceration prompting ED visit. OAC [oral anticoagulation] discontinued. Palliative care consulted for GOC [goals of care] - family decided to transition to comfort. Hospice admitting today. 2. Anemia secondary to acute blood loss: D/t [due to] above. Lac repaired in ED. Received 1 unit PRBCs [packed red blood cells]...." The 8/25/22 nurse's note, written by the Nursing Supervisor, read, "IDT review of fall. Resident noted with fall occurring out of wheel chair. Resident noted with bleeding from head laceration. C-spine precautions activated with first aide admin [administered] to laceration. EMS activated. New ordered [sic] obtained to send to			

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	ED for eval and tx. New intervention-send to ED for eval and tx." An interview was conducted with CNA 2 on 9/7/22 at 11:49 a.m. She indicated she was at the facility when Resident D fell on 8/24/22. She did not find her on the floor, but assisted afterwards. When she went into the room, blood was running down her face. Resident D currently had a cushion in her wheel chair, but was unsure if there was dycem underneath. An observation of Resident D in her wheel chair in her room was conducted with CNA 2 on 9/7/22 at 11:53 a.m. CNA 2 slowly assisted Resident D into a standing position in front of her wheel chair. CNA 2 removed the wheel chair cushion from the seat of the wheel chair. There was no dycem on the wheel chair seat or underneath the wheel chair cushion. An interview was conducted with CNA 2 on 9/7/22 at 11:56 a.m. in the presence of LPN 4. LPN 4 was informed there was no dycem on Resident D's wheel chair seat. CNA 2 indicated Resident D's fall on 8/24/22 was in her room before breakfast. It was typical for Resident D to be in her wheel chair in her room. She ambulated on her own. She would go to the therapy room sometimes, but didn't come to the nurse's station often or hang out in the common areas. If she came to the nurses station, it was because she wanted something. An interview was conducted with LPN 4 on 9/7/22 at 11:56 a.m. in the presence of CNA 2. LPN 4 indicated she'd worked at the facility for 4 years. When she completed the fall event, she thought Resident D may need a different type of wheel chair, because she "falls forward in it when she			

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	falls asleep." It had happened before, maybe in June, 2022. She was not a part of the IDT discussion regarding Resident D's 8/24/22 fall. She indicated she thought Resident D still would have fallen on 8/24/22, even if there was dycem in the seat, and that when she arrived to the room, her wheel chair cushion was still in the wheel chair. An interview was conducted with CNA 5 on 9/7/22 at 2:35 p.m. She indicated she didn't usually care for Resident D, but when she did, she was usually up in her wheel chair, moving around, not usually asleep, when she would peak in on her or bring her her meal tray. On 8/24/22, she was walking down the hall when she heard moaning from Resident D's room. When she entered the room, Resident D was in the middle of the floor. It looked like she fell out of her wheel chair. "She falls asleep in it, I guess." It seemed like she hit her head on the end of the bedside table. She was unsure where the wheel chair cushion was, whether it was on the floor, still in the chair, or where it was. She didn't remember seeing any dycem in the wheel chair or anything about the wheel chair. There was "just so much blood", she went to get the nurse. An interview was conducted with the Nursing Supervisor on 9/7/22 at 1:02 p.m. She indicated the new intervention after Resident D's 8/24/22 fall was to send her to the ED for evaluation and treatment. She did not remember discussing wheel chair modification, referenced in the 8/24/22 fall event, at the IDT discussion of the fall. She worked the floor yesterday, and Resident D's dycem was underneath her wheel chair cushion yesterday. An observation of Resident D in her wheel chair in her room was conducted with the Nursing			

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	Supervisor on 9/7/22 at 1:12 p.m., one hour and 19 minutes after the observation with CNA 2. The NS slowly assisted Resident D to a standing position in front of her wheel chair. The NS removed the wheel chair cushion from the seat of the wheel chair. There was still no dycem on the wheel chair seat or underneath the wheel chair cushion. The Fall Management Program Guidelines policy was provided by the AIT (Administrator in Training) on 9/7/22 at 11:27 a.m. It read "Purpose: [Name of facility] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. [Abbreviation of facility name] recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury....Should the resident experience a fall the attending nurse shall complete the Fall Event. This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions." This Federal tag relates to Complaint IN00388643. 3.1-45(a)(2)			
F 0842 SS=A Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the			

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	agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure complete and accurate documentation of the MAR (medication administration record) for 1 of 3 residents reviewed for pain. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/6/22 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension. He was admitted to the facility on 8/15/22. The physician's orders indicated to monitor pain daily and rate starting 8/16/22; and to administer 650 mg of acetaminophen every 4 hours PRN (as needed) for pain or fever, starting 8/15/22.	F 0842	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident D had no ill effects. The PRN medication is documented in the resident's record. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents receiving PRN medications have the potential to affected. Progress notes for the last 14 days were reviewed to ensure PRN medications are documented per policy. No	09/26/2022

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	The 8/16/22, 8:04 a.m. fall event, completed by LPN (Licensed Practical Nurse) 3, indicated he had an unwitnessed fall in his room and had pain in his right shoulder at a level 2 on a scale of 1 to 10. The 8/16/22, 8:00 a.m. progress note, written by LPN 3, read, "...informed that resident had fallen on the floor...verbalized slight pain in right shoulder, but stated it was not distressing....Writer administered morning medications and gave PRN tylenol for pain..." The August, 2022 MAR indicated a pain rating of 2 in his right shoulder on 8/16/22 and that no PRN acetaminophen was administered on 8/16/22. An interview was conducted with LPN 3 on 9/7/22 at 9:58 a.m. She indicated Resident B complained of a little right shoulder pain after his fall on 8/16/22. She gave him his morning medications and PRN acetaminophen. She could not recall whether she documented the administration of the PRN acetaminophen on the MAR, but normally she would. The Administration of PRN Medications policy was provided by the CNS (Clinical Nurse Consultant) on 9/7/22 at 2:18 p.m. It read, "Prior to administration of PRN medication, the nurse shall review the physician orders and note any parameter for administration....Documentation should reflect the reason for administrating [sic] the PRN medication." This Federal tag relates to Complaint IN00388643. 3.1-50(a)(1) 3.1-50(a)(2)		concerns noted. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DHS or designee will educate licensed nurses on Guidelines for Medication Administration. DHS or designee will be responsible for auditing 5 random residents to ensure PRN medications documented in the progress notes are also documented on the MAR. Audits will be conducted 3 days per week times 4 weeks, weekly times 1 month, then monthly for 4 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? 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. 5. Date of completion: 09/26/22	