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	01/31/2023

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 Nursing Home Complaints IN00381988 and IN00400181. This visit included the Investigation of Residential Complaints IN00388489, IN00393483 and IN00396465. Complaint IN00381988 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00400181 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00388489 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393483 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00396465 - Unsubstantiated due to lack of evidence. Unrelated deficiency cited. Survey dates: January 30 and 31, 2023 Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census bed type: SNF/NF: 22 SNF: 21 Residential: 25 Total: 68	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during complaint survey conducted on 1/31/23. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 18th, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

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.

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	Census payor type: Medicare: 14 Medicaid: 21 Other: 8 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 2, 2023			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident with an identified skin impairment, that was identified as having slough tissue, was followed up with wound assessments for 1 of 3 residents reviewed for skin impairment. (Resident C) Findings include: The clinical record for Resident C was reviewed on 1/31/23 at 12:09 p.m. The diagnoses included, but were not limited to, diabetes mellitus, anemia, disorder of the skin and subcutaneous tissue, and muscle weakness.	F 0684	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident C discharged. **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 with new wounds have the potential to be affected. · DHS or designee will complete an audit of wound events opened in in the last 30 days for in	02/18/2023

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	An Admission (MDS) Minimum Data Set assessment, dated 9/6/22, indicated diabetic foot ulcers were present but no other skin impairments noted. A Quarterly MDS assessment, dated 12/7/22, indicated diabetic foot ulcers were present but no other skin impairments noted. A progress note, dated 9/22/22, indicated the following, "...area on left breast. Area is near nipple of left breast. Resident stated she had been scratching and didn't realize that she had scratched an open area. Measures at 2cm x 2cm [2 centimeters x 2 centimeters]. Area cleansed and bandaid [sic] applied...." An (IDT) interdisciplinary team note, dated 9/28/22, indicated the following, "...IDT review of skin tear event. Resident noted with area on left breast...Resident stated she had been scratching and didn't realize that she had scratched an open area...." A skin event, dated 9/22/22, indicated a skin tear was present to Resident C's left breast. The document indicated that the area was resolved and had "healed" noted under the evaluation notes. A physician order, dated 10/7/22, indicated the following, "...LEFT BREAST WOUND: Cleanse with normal saline, pat dry. Place nickel thick layer of Santyl [medicine that removes dead tissue from wounds so they can start to heal] to slough [the yellow/white material in the wound bed that consists of dead cells] in wound bed. Cover with foam dressing. Change every other day or as needed for soiling/dislodgement...." This order was discontinued on 12/26/22.		house residents to ensure routine wound assessments are documented. **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 in-service licensed nursing staff on the policy Guidelines for General Skin and Wound Care. · DHS or designee will be responsible for auditing new wound events to ensure routine assessments are documented. Audit of 5 residents will be conducted 5 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **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?** ="" span="">For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and	

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	There was no assessment of the status of the wound that had opened to Resident C's left breast that consisted of slough tissue upon the initiation of the wound treatment on 10/7/22. A care plan for skin integrity, dated 9/7/22, indicated Resident C was at risk for skin breakdown. There was no specific care plan for Resident C's skin impairment to her left breast. The electronic medication administration record (EMAR) for October of 2022 indicated the treatment was not signed off, as administered, on 10/19/22 and documented the treatment wasn't due nor completed on 10/31/22 to Resident C's left breast. The EMAR for November of 2022 indicated the treatment was not signed off, as administered, on 11/26/22 to Resident C's left breast. The EMAR for December of 2022 indicated the treatment was not signed off, as administered, on 12/10/22 to Resident C's left breast. Resident C was admitted to the hospital on 12/26/22. The hospital records indicated the following, "...Hospital Course...[Resident C] who presents for worsening left breast wound over last 1-2 weeks. Placed on IV [intravenous] antibiotics with breast surgery consultation due to concern of possible malignancy...Patient has purulence [The condition of containing or discharging pus] did resolve the day after...." The discharge diagnosis included the principal problem of cellulitis of chest wall. The discharge medication list noted Santyl ointment to left breast wound and change every other day. Resident C was discharged back to the facility on 1/1/23.		increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. ="" span="">
5. Date of completion: 2/18/23	

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A physician order, dated 1/2/23, indicated the use of Dakin's Solution (sodium hypochlorite) to Resident C's left breast and change the dressing daily. This order was discontinued on 1/11/23.

The EMAR for January of 2023 noted a dressing not signed off, as administered, on 1/10/23.

The Wound Management Detail Report indicated there were 2 wounds to Resident C's left breast. On 1/3/23 the measurement to one of the wounds were 3 centimeters x 3 centimeters with 0.1 centimeters of depth. Another was observed on 1/2/23 with measurements of 5 cm x 5 cm x 0.2 cm of depth noted. The observation of these 2 wounds was discontinued on 1/11/23.

The Wound Management Detail Report, dated 1/11/23, indicated an unspecified ulcer to Resident C's left breast. The measurements consisted of 4 cm x 7 cm x 3 cm of depth. There was 75% slough tissue along with 25% granulation tissue (That part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries forms around the edges of a wound).

A physician order, dated 1/11/23, included the use of solosite wound gel moistened gauze and change daily to Resident C's left breast.

An interview conducted with Corporate Nurse 2, on 1/31/23 at 4:50 p.m., indicated the expectations are for staff to complete the documentation involving the EMARs and ETARs.

An interview conducted with Corporate Nurse 2, on 1/31/23 at 5:40 p.m., indicated there were progress notes to which the staff were documenting on how the status of Resident C's

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	wound had not changed. There were no further assessments prior to Resident C's hospitalization on 12/26/22. The wound was not a pressure area or a traditional diabetic wound. That could have been the reason to why there wasn't extra notes for Resident C. A policy titled "Guidelines for General Wound and Skin Care", dated 5/10/17, was provided by Corporate Nurse 2 on 1/31/23 at 4:50 p.m. The policy indicated the following, "...16. Reevaluate the wound's response to the prescribed treatment. Make recommendations for changes PRN [as needed]. Inform MD [medical director] of changes in wound status...20 Document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet...." This Federal tag relates to Complaint IN00400181. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident			

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	preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure a resident with a history of significant weight loss was assisted with eating timely and provide supplements as ordered for 1 of 3 residents reviewed for weight loss. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/30/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia, congestive heart failure, malnutrition, anorexia, and dysphagia (difficulty or discomfort in swallowing). An Annual (MDS) minimum data set assessment, dated 6/29/22, indicated moderate cognitive impairment, supervision with one staff for eating, and complaints of difficulty or pain with swallowing. A Quarterly MDS assessment, dated 7/28/22, indicated severe cognitive impairment, extensive assistance with one staff for eating, and complaints of difficulty or pain with swallowing. A Quarterly MDS assessment, dated 10/28/22, indicated severe cognitive impairment, extensive assistance with one staff for eating, holding food in mouth/cheeks or residual food in mouth after meals, and coughing or choking during meals or	F 0692	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident B's weight is stable. She is receiving supplements as ordered. **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 supplements have the potential to be affected. · DHS or designee will conduct an audit of residents with supplement orders for the last 30 days to ensure supplements are being administered per order **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 in-service all licensed nursing staff on the policy: High Risk Nutrition Documentation · DHS or designee will be responsible for auditing residents	02/18/2023

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	when swallowing medication. A Significant Change MDS assessment, dated 12/30/22, indicated severe cognitive impairment, extensive assistance with 2 staff for eating, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medication. A nutrition care plan, dated 2/28/22, indicated Resident B had experienced significant weight loss, decreased intakes and difficulty swallowing. The interventions were listed to provide diet, supplements, medications, adaptive equipment, and snacks as ordered. Also, offer encouragement and assistance with eating PRN (as needed). Another nutrition care plan, revised 5/3/22, indicated an approach to have Resident B up in wheelchair in main dining room for breakfast, lunch and dinner. A speech therapy discharge summary, dated 6/23/22, indicated the following, "...Comments: Safest diet is for pureed solids and thin liquids with supervision/A [assistance] for all intake and cues from caregivers for use of CSS [communication severity scales] in order to adequately clear bolus and decrease aspiration risks...." A physician note, dated 6/24/22, indicated the following, "...Syncopal episode...Noted in MDR [main dining room] on 6/22/2022...6/24/2022: No further episodes; labs unremarkable; encourage adequate PO [by mouth] intake...." A nutritional progress note, dated 8/10/22, indicated the following, "...weight down 5.7% x30 days...Meal consumption has		receiving supplements to ensure supplements are being administered. Audit of 5 residents will be conducted 5 times a week times 4 weeks, two times a week times 2 months, weekly times 3 months and then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **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?** For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. **5. Date of completion: 2/18/23**	

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	decreased...Nutrition interventions in place (Ensure Clear TID)[three times daily]...Med-Pass [supplement] was increased 6/30/22 to 120 ml [milliliters] QID [four times daily]...Recommend to increase Med-Pass to 180 ml QID from 120 ml QID to help prevent further weight loss...." A physician order, dated 5/2/22, was noted for Resident B to be up in chair in the main dining room for breakfast, lunch and dinner. A physician order, dated 4/6/22, was noted for Ensure clear three times a day. A duplicate physician order, dated 9/28/22, was noted for Ensure Clear three times daily. A physician order, dated 8/10/22, was noted for MedPass 2.0, 180 milliliters, four times a day. An observation was conducted of Resident B, on 1/30/23 at 1:28 p.m., to where she was lying in bed with the head of the bed elevated with appearance of sleep. There was no staff present and she had taken a couple of bites of what appeared to be puree sweet potatoes. At 1:35 p.m., the resident was alert and attempting to feed herself a bite of the puree sweet potatoes but was only able to move at a slow pace. There was a beverage on her meal tray that had not been consumed thus far. She stopped while attempting to feed herself and placed the spoon of sweet potatoes back on her plate. At, 1:45 p.m., a staff member ((qualified medication assistant (QMA) 4)) entered Resident B's room after picking up meal trays down the hallway. After QMA 4 entered Resident B's room Resident B commented "I'm trying to eat". QMA 4 left to get Resident B a straw for her ensure clear drink since one wasn't placed in there previously. She returned at 1:48 p.m. to place a straw in the			

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	ensure clear drink and proceeded to assist Resident B with drinking her beverages. There appeared to be some of her lemonade consumed as well as the ensure clear. An interview conducted with QMA 4, during the observation, indicated she usually works upstairs on the Assisted Living part of the facility and wasn't familiar with Resident B's ability to feed herself. On 1/30/23 at 1:51 p.m., QMA 4 indicated she asked the staff, and they told her the nursing staff would assist Resident B was eating if she wasn't feeling well and/or showing an inability to feed herself. An interview conducted with QMA 5, on 1/31/23 at 12:50 p.m., indicated the nursing staff will pass meal trays, set up that meal tray, and go back to follow up to see the progress with Resident B's ability to feed herself. If they need further assistance the nursing staff would offer it at that time. It can vary by the day with Resident B but there are times where she needs more assistance. Approximately 2 to 3 times a week on average. An observation conducted of Resident B on 1/31/23 at 12:55 p.m. with Hospice Nurse 6 present and feeding Resident B. Resident B was alert and taking bites of food with no difficulty. An interview conducted with Hospice Nurse 6 at that time, she indicated the last time she was here to visit Resident B there was food on her chest from attempting to feed herself. She usually assists Resident B with eating due to her pain medication having the tendency to make her tired sometimes. "She seems to eat well with assist", per Hospice Nurse 6. Upon review of Resident B's weights, that included, but were not limited to, the following:			

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	6/1/22 of 110 lbs. (pounds), 6/7/22 of 106.8 lbs., 6/27/22 of 102.8 lbs., 7/13/22 of 100.4 lbs., 7/25/22 of 98.8 lbs., 8/9/22 of 99.2 lbs., 9/6/22 of 95.3 lbs., 10/11/22 of 95.3 lbs., 11/3/22 of 89.2 lbs., 12/1/22 of 98 lbs., 12/12/22 of 88 lbs., 1/5/23 of 88.2 lbs., & 1/24/23 of 88 lbs. The electronic medication administration record (EMAR) for January of 2023 was reviewed and indicated the Ensure Clear order, dated 9/28/22, was signed off as "not administered" due to the item not being available on 14 occasions in January of 2023, thus far. The EMAR for January of 2023 was reviewed and indicated the order for Resident B to be up in a chair in the main dining room for all meals was not conducted on 46 occasions in January, thus far. The EMAR for January of 2023 was reviewed and indicated the Med Pass supplement, 180 mLs, four times a day was signed off as "not administered" due to the item not being available on 23 occasions in January of 2023, thus far. There was no follow up noted in Resident B's clinical record in regard to not receiving supplements on numerous occasions. An interview conducted with Corporate Nurse 2, on 1/31/23 at 5:40 p.m., indicated the Nurse Practitioner documented in the notes, in June of			

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	2022, in regard to her weight loss. A policy titled "High Risk Nutrition-Documentation", review date of 11/11/22, was provided by Corporate Nurse 2 on 1/31/23 at 4:50 p.m. The policy indicated the following, "...To assure the resident maintains acceptable parameters of nutritional status considering resident's clinical condition and appropriate interventions and follow up are documented by Nutrition Professional...HIGH NUTRITIONAL RISK CRITERIA...Significant weight loss: 5% in 30 days, 7.5% in 90 days, or 10% in 180 days...2. Nutrition professional will routinely monitor identified nutrition risk residents. The high risk tracking tool can be utilized to organize residents, documentation, and interventions...." This Federal tag relates to Complaint IN00381988. 3.1-46(a)(1)			
F 0842 SS=D 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 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;			

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	155815	A. BUILDING 00 B. WING	01/31/2023

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	(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. §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-			

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	(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 completed documentation of the electronic medication administration record (EMAR) and electronic treatment administration record (ETAR), and not completing a readmission assessment for a resident that returned from the hospital for 2 of 3 residents reviewed for documentation. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 1/30/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia, congestive heart failure, malnutrition, anorexia, and dysphagia (difficulty or discomfort in swallowing). A nutrition care plan, dated 2/28/22, indicated Resident B had experienced significant weight loss, decreased intakes and difficulty swallowing. The interventions were listed to provide diet, supplements, medications, adaptive equipment, and snacks as ordered. Also, offer encouragement and assistance with eating PRN (as needed). Another nutrition care plan, revised 5/3/22, indicated an approach to have Resident B up in	F 0842	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident C has discharged. · Resident B EMAR was reviewed to ensure documentation is complete. **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 that are admitted to the campus and residents receiving supplements have the potential to be affected. · Audit of in-house residents admitted in the last 30 days to ensure admission assessment is completed · Audit of in house residents with orders for supplements to ensure that administrations are documented **3: What measures will be put into place or what systemic**	02/18/2023

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	wheelchair in main dining room for breakfast, lunch and dinner. A nutritional progress note, dated 8/10/22, indicated the following, "...weight down 5.7% x30 days...Meal consumption has decreased...Nutrition interventions in place (Ensure Clear TID)[three times daily]...Med-Pass [supplement] was increased 6/30/22 to 120 ml [milliliters] QID [four times daily]...Recommend to increase Med-Pass to 180 ml QID from 120 ml QID to help prevent further weight loss...." A physician order, dated 5/2/22, was noted for Resident B to be up in chair in the main dining room for breakfast, lunch and dinner. A physician order, dated 4/6/22, was noted for Ensure clear three times a day. A duplicate physician order, dated 9/28/22, was noted for Ensure Clear three times daily. A physician order, dated 8/10/22, was noted for MedPass 2.0, 180 milliliters, four times a day. The electronic medication administration record (EMAR) for January of 2023 was reviewed and indicated the Ensure Clear order, dated 9/28/22, was signed off as "not administered" due to the item not being available on 14 occasions in January of 2023, thus far. The EMAR for January of 2023 was reviewed and indicated the order for Resident B to be up in a chair in the main dining room for all meals was not conducted on 46 occasions in January, thus far. The EMAR for January of 2023 was reviewed and indicated the Med Pass supplement, 180 mLs, four		**changes will be made to ensure that the deficient practice does not recur?** · DHS or designee will in-service licensed nursing staff on the policy titled Guidelines for Admission Observation and Data Collection and Nutrition Documentation Policy · DHS or designee will be responsible for auditing residents receiving supplements to ensure administrations are documented. Audits of 5 random residents will be conducted 5 days a week times 4 weeks, two times a week times 2 months, weekly times 3 months and then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. · DHS or designee will be responsible for auditing newly admitted residents to ensure admission observation is completed. Audits of 5 random residents will be conducted 5 days a week times 4 weeks, two times a week times 2 months, weekly times 3 months and then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: How the corrective action will be monitored to ensure the**	

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	times a day was signed off as "not administered" due to the item not being available on 23 occasions in January of 2023, thus far. There was no follow up noted in Resident B's clinical record in regard to not receiving supplements on numerous occasions. 2. The clinical record for Resident C was reviewed on 1/31/23 at 12:09 p.m. The diagnoses included, but were not limited to, diabetes mellitus, anemia, disorder of the skin and subcutaneous tissue, and muscle weakness. A progress note, dated 9/22/22, indicated the following, "...area on left breast. Area is near nipple of left breast. Resident stated she had been scratching and didnt realize that she had scratched an open area. Measures at 2cm x 2cm [2 centimeters x 2 centimeters]. Area cleansed and bandaid [sic] applied...." An (IDT) interdisciplinary team note, dated 9/28/22, indicated the following, "...IDT review of skin tear event. Resident noted with area on left breast...Resident stated she had been scratching and didn't realize that she had scratched an open area...." A physician order, dated 10/7/22, indicated the following, "...LEFT BREAST WOUND: Cleanse with normal saline, pat dry. Place nickel thick layer of Santyl [medicine that removes dead tissue from wounds so they can start to heal] to slough [the yellow/white material in the wound bed that consists of dead cells] in wound bed. Cover with foam dressing. Change every other day or as needed for soiling/dislodgement...." This order was discontinued on 12/26/22.		**deficient practice will not recur i.e. what quality assurance program will be put into place?** For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. **5. Date of completion: 2/18/23**	

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	The electronic medication administration record (EMAR) for October of 2022 indicated the treatment was not signed off, as administered, on 10/19/22 and documented the treatment wasn't due nor completed on 10/31/22 to Resident C's left breast. The EMAR for November of 2022 indicated the treatment was not signed off, as administered, on 11/26/22 to Resident C's left breast. The EMAR for December of 2022 indicated the treatment was not signed off, as administered, on 12/10/22 to Resident C's left breast. Resident C was admitted to the hospital on 12/26/22. The hospital records indicated the following, "...Hospital Course...[Resident C] who presents for worsening left breast wound over last 1-2 weeks. Placed on IV [intravenous] antibiotics with breast surgery consultation due to concern of possible malignancy...Patient has purulence [The condition of containing or discharging pus] did resolve the day after...." The discharge diagnosis included the principal problem of cellulitis of chest wall. The discharge medication list noted Santyl ointment to left breast wound and change every other day. Resident C was discharged back to the facility on 1/1/23. There was no readmission assessment conducted by the facility upon Resident C's return from the hospital on 1/1/23. A physician order, dated 1/2/23, indicated the use of Dakin's Solution (sodium hypochlorite) to Resident C's left breast and change the dressing daily. This order was discontinued on 1/11/23. The EMAR for January of 2023 noted a dressing			

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	not signed off, as administered, on 1/10/23. An interview conducted with Corporate Nurse 2, on 1/31/23 at 4:50 p.m., indicated the expectations are for staff to complete the documentation involving the EMARs and ETARs. A policy titled "Guidelines for Admission Nursing Assessment and Data Collection", dated 8/1/16, was provided by Corporate Nurse 2 on 1/31/23 at 4:50 p.m. The policy indicated an admission observation and data collection form was to be completed in the electronic health record by a licensed nurse. 3.1-50(a)(1) 3.1-50(a)(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaints IN00388489, IN00393483, and IN00396465. This visit included the Investigation of Nursing Home Complaints IN00381988 and IN00400181. Complaint IN00388489 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393483 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00396465 - Unsubstantiated due to lack of evidence. Complaint IN00381988 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692.	R 0000		

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	Complaint IN00400181 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: January 30 and 31, 2023 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 Investigation of Residential Complaints IN00388489, IN00393483, and IN00396465. Quality review completed on February 2, 2023			