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	06/21/2024

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 the Investigation of Complaint IN00436179. Complaint IN00436179- Federal/state deficiencies related to the allegations are cited at F0584 and F0684. Unrelated deficiencies are cited. Survey dates: June 21, 2024 Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census Bed Type: SNF/NF: 27 SNF: 10 Residential: 22 Total: 59 Census Payor Type: Medicare: 3 Medicaid: 24 Other: 10 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 27, 2024.	F 0000	p paraid="237829257" paraeid="{f09cbf35-4059-4748-9911-c2d511f8776c}{243}" >The submission of this plan of correction does not indicate an admission by 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 Lake Health Campus. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to provide a comfortable,	F 0584	p paraid="237829257" paraeid="{f09cbf35-4059-4748-991	07/12/2024

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

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	homelike environment for 1 of 37 residents in the facility. (Resident C) Findings include: An observation of Resident C's room was conducted on 6/21/24 at 11:17 a.m. During the observation, two, small crawling insects, which appeared like ants, were crawling up the wall in between the P-Tak (air conditioner/heating unit) and the windowsill in Resident C's room. The two ants on the wall crawled under the windowsill and disappeared. Another small, crawling insect, which appeared like an ant, was found crawling on the floor and disappeared in between the flooring planks. An interview with Nurse Consultant (NC) conducted, on 6/21/24 at 11:03 a.m., indicated the facility did have an issue with ants in a resident's room. The facility had not called out their pest control company to spray the inside of the room, instead they decided to handle it internally and have the maintenance department spray inside the resident's room. NC stated, they (the facility) only had their pest control company treat around the exterior of the building for ants. An interview with Resident C's significant other conducted, on 6/21/24 at 11:17 a.m., indicated the debris that was on the floor in Resident C's room was the same debris that had been there all week. A Work Order, dated 6/4/24, was received, on 6/21/24 at 11:50 a.m., from Executive Director (ED). It indicated the same room that Resident C resides in previously had "ants in room and in resident bed". The work order indicated; a member of the maintenance team had sprayed bug killer around the air unit in the room. No ants were observed at		1-c2d511f8776c}{243}" >F584 Resident C was affected. Resident is without adverse effect. ·All residents have the potential to be affected. A house wide audit was conducted to ensure that all residents' rooms were free from debris on the floor and free of insects. All staff be educated the pest control policy and cleaning procedures. ·As a measure of ongoing compliance, the EDor designee to complete random room audits to ensure resident rooms are free of insects and debris on the floor. Audits to be completed 5 resident rooms weekly x4 weeks; then 3 residents biweekly x, 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.	

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	that time. A Pest Control policy received, on 6/21/24 at 2:54 p.m., indicated the purpose was "to provide guidelines on keeping campuses pest free...maintain an ongoing pest control program to ensure the building is kept free of insects and rodents." This citation relates to Complaint IN00436179. 3.1-19(f)(4)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a resident's wound was maintained free of contamination by ants for 1 of 3 residents reviewed for wounds. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/21/24 at 9:55 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury and seizure disorder. He was receiving hospice care and passed away on 6/6/24. A physician's order, dated 4/5/24, indicated to cleanse the wound on his left knee with normal saline, pat dry, and apply skin prep (skin protecter) around the wound, cover the wound bed with Therahoney (wound treatment gel made of honey), and apply a dry dressing. Instructions were to change the dressing every 3 days. A CAR (Clinically at Risk) note, dated 5/24/24, indicated Resident B's left knee wound was from	F 0684	p paraid="237829257" paraeid="{f09cbf35-4059-4748-9911-c2d511f8776c}{243}" >F684 Resident B was affected. The resident has expired. ·All residents with open wounds have the potential to be affected. All residents with wounds have had treatment change observations to ensure wounds clean and free of insects. ·As a measure of ongoing compliance, DHS or designee random audits of dressing changes to ensure wounds are free of insects. Audits to be completed on 5 residents weeklyx4 weeks; then 5 residents	07/12/2024

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	trauma. The wound had 70% necrotic (dead) tissue and 30 % granulation tissue (new tissue). A Hospice LPN (Licensed Practical Nurse) Visit with Wound note, dated 6/5/24, indicated the following, "...SN [Skilled Nursing] routine visit this date. Pt [sic] resting in bed upon SN arrival. Facility aide reports to writer that he found ants around pts [sic] catheter line. Writer went into pts [sic] room and pulled back the blankets. Ants are in pts [sic] bed and on pt [sic]. Writer removed pts [sic] dressing to left knee and found ants on pt [sic] wound. DON, facility wound nurse and writer's CC [sic] notified. Writer and wound nurse both assessed pts [sic] left knee wound and saw the ants on the dressing. Wound care completed to knee by writer. Facility wound nurse reports that pts [sic] room was sprayed yesterday and planning to spray today. Pt [sic] has no s/s [signs and symptoms] of pain..." A progress note, dated 6/6/24 at 10:59 a.m., indicated the following, "...Writer contacted resident sister regarding ants found in resident [Resident B] room. Resident room has been sprayed x2 [two times] for ants. Writer noted ants to bed and bed frame during assessment on shift today. Writer to get resident up in broda chair and completely clean bed frame and mattress..." During an interview, on 6/21/24 at 10:09 a.m., FM (Family Member) 10 indicated, on 6/6/24, they came to visit Resident B and found ants in his bed and crawling on him. FM 10 removed the dressing to his left knee and the dressing was "full of ants". The floor to Resident B's room was "filthy". The facility had told FM 10 that Resident B's roommate frequently dropped food on the floor when he ate, and that was causing the ants. FM 10 was very upset and disturbed that Resident B		biweekly x, 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. p paraid="1697900413" paraeid="{1722006c-1498-4e29-aac7-b2d83fa56c57}{226}" >	

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	had to lay in a bed with ants crawling on him during his last days of life. On 6/21/24 at 1:30 p.m., the NC (Nurse Consultant) provided a copy of the investigation file for the ants in Resident B's room. The investigation file contained a Statement of Witness Form, dated 6/6/24, which indicated that the WN (Wound Nurse) had been interviewed. The WN completed wound care for Resident B on 6/4/24. While completing the wound care on that day the WN had assessed the wound and dressing to ensure that there were no ants in the dressing or on Resident B's wound bed. A Statement of Witness Form, dated 6/6/24, indicated the ADPO (Assistant Director of Plant Operations) had been interviewed. The ADPO had treated Resident B's room for ants on 6/6/24 at 3:00 p.m. The ADPO had sprayed Resident B's room every day that week for ants and had only seen one ant that week. Resident B's room was being deep cleaned by multiple staff members and Resident B's family member. The investigation file also contained work orders, dated 6/5/24 and 6/6/24. The work order, dated 6/5/24, indicated ants in Resident B's room. The priority was critical, and the category was cleaning. The comments were that a staff member had sprayed. The work order, dated 6/6/24, indicated ants in Resident B's room and that additional spray/treatment needed to be done. The priority was critical, and the category was cleaning. The comments indicated that a staff member had sprayed the room. During an interview, on 6/21/24 at 3:30 p.m., RN 4 indicated that Resident B's roommate ate breakfast in his room daily and ate snacks. The roommate			

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	often dropped food while eating. RN 4 had seen ants on the wall in Resident B's room about a week before the ants were found on Resident B and the room had been treated at that time. During an interview on, 6/21/24 at 3:26 p.m., the Director of Nursing (DON) indicated that the Hospice Nurse had informed her about the ants on 6/5/24. On 6/21/24 at 2:45 p.m., the NC provided the Guidelines for Weekly Measurements policy, last revised 5/22/18, which indicated the following, "...In addition to Weekly Assessment by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and peri-care and notify the nurse if an area is identified..." On 6/21/24 at 3:31 p.m., the Executive Director provided the Guidelines for General Wound and Skin Care policy, last revised 2/23/23, which read "... Reevaluate dressing and skin integrity every shift..." This citation relates to Complaint IN00436179. 3.1-37(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review the facility failed to ensure a wound treatment order was placed timely for 1 of 3 residents reviewed for wound care. (Resident C) Findings include: An observation of Licensed Practical Nurse (LPN)	F 0842	p paraid="237829257" paraeid="{f09cbf35-4059-4748-9911-c2d511f8776c}{243}" >F842 ol class="NumberListStyle1 SCXW244256738 BCX0" role="list" start="9"	07/12/2024

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	2 preparing to complete wound care on Resident C was conducted on 6/21/24 at 11:17 a.m. LPN 2 began by pulling out the supplies and medications needed to complete Resident C's wound care. In doing so, LPN 2 had pulled from the medication/treatment cart three tubes of medication and dispensed a small amount from each tube into its own medication cup. Upon entering Resident C's room, Resident C was lying on his bed and was turned towards the wall. Resident C's wounds on his buttocks were visible. The wounds on his buttocks had opened areas that were red in color. The clinical record for Resident C was reviewed on 6/21/24 at 12:08 p.m. Resident C's diagnoses included, but not limited to, weakness and a contracture of right knee (inability to move). A physician's order, dated 6/13/24, indicated to apply Silvadene cream 1% (an antimicrobial topical cream used to treat a wound or burn) in conjunction with miconazole nitrate 2% cream (a cream used to treat fungal infections) and triamcinolone acetonide 0.5% cream (a cream used to relieve redness, itching, swelling of skin conditions) to Resident C's buttock wounds three times a day every day. A physician's note, dated 6/18/24, for Resident C indicated, "Resident admitted to facility with shearing injuries to B/L [sic, bilateral] buttocks...Larger area to left buttock is comprised of 4 small areas that are circumferential to one another...Will start treating shearing injuries to B/L [sic] buttocks with collagen and cover with foam border dressing with changes 3x [sic, three times] weekly...Right Buttock: Apply collagen cut to size to affected area. Cover with foam border dressing. Change Tue. [sic, Tuesday], Thur [sic,		style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" Resident C was affected. Orders verified to be correct treatment order in place. All residents with treatment orders by the wound NP have the potential to be affected. All residents being followed by Wound NP had review to ensure timely order transcription. Education provided to all nurses regarding timely order transcription. ·As a measure of ongoing compliance, DHS or designee to complete audits of treatment orders provided by Wound NP to ensure orders transcription same day. Audits to be completed on all new treatment orders weekly x 4 weeks; then biweekly x, then 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.	

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	Thursday], and Sunday. Left Buttock: Apply collagen cut to size to affected area. Cover with foam border dressing. Change Tue [sic], Thur [sic], and Sunday." A review of Resident C's orders was conducted again on 6/21/24 at 1:53 p.m. The order for Resident C's bilateral buttock wounds had been changed since the first review. The new physician's order for Resident C's bilateral buttock wounds were placed, on 6/21/24 at 12:35 p.m., and stated to cleanse wound with wound cleanser or normal saline, apply skin prep, apply collagen to wound bed, cover with foam dressing, and change daily and as needed. An interview with LPN 2 conducted, on 6/21/24 at 2:00 p.m., indicated he had just placed the new wound care orders for Resident C. When asked why the order had not been changed, on 6/18/24, when the order was written by the wound care Nurse Practitioner, he indicated sometimes the Scribe (a person who serves as a professional copyist or writer) places the orders into the computer system, but that time the Scribe had not and it wasn't until LPN 2 audited the orders, did he find the new order had not been placed into the computer system so he placed it in then. The new wound care orders, according to LPN 2, also needed to be updated again since the order was for the buttock wound dressings to be changed 3 times a week and not daily. 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	F 0880	ol class="NumberListStyle1	07/12/2024

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	review, the facility failed to maintain an infection prevention and control program by touching the tip of a medication tube with a bare finger, not performing hand hygiene with glove use, and not wearing proper personal protective equipment (PPE) when providing incontinence care to a resident in enhanced barrier precautions (EBP) (an infection control strategy to reduce the spread of multi-drug resistant organisms during high-contact care activities) for 1 of 3 residents reviewed for wounds. (Resident C) Findings include: An observation of Licensed Practical Nurse (LPN) 2 preparing to complete wound care on Resident C was conducted, on 6/21/24 at 11:17 a.m. LPN 2 began by pulling out the supplies and medications needed to complete Resident C's wound care. LPN 2 pulled from the medication/treatment cart three tubes of medication and dispensed a small amount from each tube into its own medication cup. However, when doing so, the tube of miconazole nitrate still had the foil seal attached to the tube partially and LPN 2 moved the foil seal away from the opening with his bare finger and touching the tube opening without performing hand hygiene after touching the top of the medication/treatment cart, drawer handles, and the medication tubes. After dispensing some of the miconazole cream into the medication cup, LPN 2 then used his bare finger again to squash the foil back over the tube opening. After placing the cap back on the miconazole tube, LPN 2 donned (put on) a pair of gloves, removed the cap to the miconazole tube, removed the foil seal, replaced the cap, doffed (took off) his gloves then picked up some supplies on the cart. LPN 2 did not perform hand hygiene prior to donning or after doffing the		SCXW244256738 BCX0" role="list" start="13" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" Resident C was affected. Education was immediately provided to CRCA 3 and LPN2 on infection control practices and enhanced barrier precautions. All residents have the potential to be affected. All staff the hand hygiene policy, enhanced barrier precaution policy and infection control policy. ·As a measure of ongoing compliance, DHS or complete audits to ensure enhanced barrier precautions are followed. Audits to be completed for 5 residents weekly x 4 weeks, then every other week x then monthly x 3 months. In addition, the DHS or will complete audits for proper infection control and hand hygiene. Audits to be completed for 5 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	

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	gloves. An observation of Certified Resident Care Assistant (CRCA) 3 was made, on 6/21/24, upon entering Resident C's room at approximately 11:24 a.m. CRCA 3 was already in Resident C's room when LPN 2 had entered. CRCA 3 had just completed incontinence care for Resident C and was wearing just a pair of gloves. When asked if he, CRCA 3, knew Resident C was on enhanced barrier precautions, he indicated he did, and when asked what should staff wear when providing high-contact care activities such as providing incontinence care, he indicated, a gown and gloves. CRCA 3 was then asked where his gown was he replied, "I forgot". While performing the observations with LPN 2 and CRCA 3, it was observed that Resident C's room had a sign on the door indicating that enhanced barrier precautions were needed when providing high-contact care activities. There was no PPE supply of gowns located outside of Resident C's room nor were gowns located in the room. A physician's order, dated 6/13/24, for Resident C indicated staff were to use enhanced barrier precautions wearing a gown and gloves at minimum during high-contact care activities. An Infection Control policy received, on 6/21/24 at 2:54 p.m., from Nurse Consultant (NC) indicated its purpose was "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 diseases and infections."		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	An Enhanced Barrier Precautions (EBP) Standard Operating Procedure received, on 6/21/24 at 2:54 p.m., from NC indicated, "1. Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO [sic, Multi-drug resistant organisms) acquisition which include: i. All Residents with chronic wounds, including but not limited to, pressure ulcers... ii. All Resident with indwelling medical devices 1. Includes but not limited to: catheters... 2. Personal Protective Equipment (PPE) should be used even if blood and bodily fluid exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high-contact care activities... 3. High-contact care activities include but are not limited to: morning and evening ADL [sic, Activities of Daily Living] care, toileting, and showers." A Standard Precautions Guidelines policy received, on 6/21/24 at 2:54 p.m., from NC indicated, "Standard precautions include but are not limited to hand hygiene...proper use of PPE (e.g., gloves, gowns, and masks)...In addition to proper hand hygiene, it is important for staff to use appropriate protective equipment as a barrier to exposure to any body fluids (whether known to be infected or not)." The Centers for Diseases and Control website at https://www.cdc.gov/clean-hands/hcp/clinical-safety/; Last Reviewed: February 27, 2024, last accessed 6/24/24, titled "Clinical Safety: Hand Hygiene for Healthcare Workers" indicated to			

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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
	wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(l)			