

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Clearvista Lake Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 8405 Clearvista Place Indianapolis, IN 46256	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess, monitor, and complete a timely Interdisciplinary Team (IDT) review of a resident's skin condition, per facility policy, for 1 of 3 residents reviewed for assistance with transfers. (Resident D) Findings include: The clinical record for Resident D was reviewed on 7/20/26 at 11:20 a.m. Resident D's diagnoses included, but were not limited to, dementia (decline in mental ability severe enough to interfere with daily life). Resident D was admitted to the facility on [DATE]. The Hospice Residential Communication Form, dated 6/19/26, from Resident D's hospice binder located at the nurses' station indicated, Shower complete. New bruising reported to facility ED [Executive Director] and [name of hospice company] nurses. Patient daughter notified as well. The form was signed by Hospice Aide (HA) 2. There was no assessment, monitoring, or IDT review documentation in Resident D's clinical record of the bruising referenced in the above communication form. The June and July, 2026 grievances and incident reports were provided by the ED on 7/20/26 at 2:00 p.m. None of these referenced Resident D's bruising found by HA 2 on 6/19/26. An interview was conducted with HA 2 and the Hospice Manager of Clinical Services (HMCS) on 7/20/26 at 2:13 p.m. HA 2 indicated about a month ago, when she was assisting Resident D with a shower, Resident D lifted her left arm to show bruising on the top of her left forearm. Resident D pointed out an aide, who worked at the facility, as the one who caused the bruising during a transfer. HA 2 informed the hospice nurse and Executive Director (ED) of the facility of Resident D's bruising. The ED looked at Resident D's bruising after being informed. The HMCS indicated there were two primary bruises on Resident D's left forearm. One was approximately 1.5 inches by 0.75 inches, and the other one was an inch away, about the size of a half-dollar coin. An interview was conducted with the ED on 7/20/26 at 1:30 p.m. The ED indicated HA 2 reported to her that Resident D had bruising. The ED went to the nurse's station to look at the bruising afterwards. The ED pulled up Resident D's sleeve and saw a slight bruise on her left forearm. The ED thought she had one of the nurses look at the bruising. An interview was conducted with the Director of Nursing (DON) on 7/20/26 at 1:00 p.m. The DON indicated Resident D had bruising on her left forearm about a month ago. By the time the DON saw the bruise, it had faded, like it could have been there for a while. The DON discussed the bruising with Resident D's family member as well. If bruising was found on a resident, they continued to monitor it. Beyond that, she was unsure of any additional assessment and review required and would need to refer to the facility's policy. An interview was conducted with the DON on 7/20/26 at 3:16 p.m. The DON indicated they had no verification of assessment, monitoring, and review of Resident D's bruising found on 6/19/26. On 2/21/26 at 9:51 a.m., the Nurse Consultant provided a bruising event assessment for Resident D, dated 2/20/26, from previous bruising found on Resident D. It included the date, time, and location where the bruising was found; what immediate treatments were given; how many bruises there were; where each bruise was located; measurements (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of each bruise; whether each bruise was present on admission; measures taken to prevent reoccurrence; physician notification; whether an investigation was completed; whether the resident was sent to the hospital; whether it was considered a major injury; whether the incident was reported to the state agency; and whether a root cause was determined and documented in an IDT note. The Bruise, Rash Lesion, Skin Tear, Laceration Assessment Guidelines policy was provided by the DON on 7/21/26 at 10:00 a.m. It indicated, Bruise. If skin alteration occurs post admission, follow the below steps: a. Complete Bruise incident in EHR (electronic health record) by an RN [Registered Nurse]/LPN [Licensed Practical Nurse] along with the template/assessment progress note. IDT should review this timely and wound nurse or designee complete an assessment in wound management. b. Continue to monitor weekly in wound management. c. Must review for at least 1 week in wound management. Once wound nurse/designee determines that the wound is healing as expected, resolved or becomes a chronic skin condition this wound nurse/designee may heal the wound in wound management. This Federal citation is related to Intake 3054488. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		