STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearvista Lake Health Campus	8405 Clearvista Place Indianapolis, IN 46256

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure monitoring of the dishwasher sanitation and maintain clean kitchen flooring. This had a potential to effect 44 of 44 residents that reside in the skilled facility. Findings include: An observation of the kitchen was made with the Dietary Manager (DM) on 1/5/26 at 9:43 a.m. The dishwasher was observed during washing and rinsing cycles. The DM had indicated she had been having trouble with the dishwasher for several months. The service technician had been out to service the machine. The dish machine was a high temperature dishwasher, but with the problems it was having the service technician recommended using it as a low temperature dishwasher until replacement. The dishwasher has been working as a low temperature dishwasher for a couple months. The staff were currently utilizing chemical strips to ensure the sanitation was appropriate. The staff use an electronic charting to document the washing and sanitation temperatures. At that time, [NAME] 5 indicated he checks the dishwasher sanitation nightly. During the kitchen tour, the kitchen flooring was observed throughout the kitchen. The dishwasher area flooring behind the dishwasher and sanitation buckets had black debris along the back wall flooring. The kitchen preparation area and the cooking area had black debris observed along the back of the wall flooring An observation was made of the kitchen on 1/5/26 at 2:59 p.m. The kitchen flooring was observed with black debris along the back wall flooring in the dishwasher area and kitchen preparation and cooking areas. The dishwasher wash and sanitation temperature records for each meal were provided by the Executive Director on 1/5/26 at 3:00 p.m. The logs were recorded with no dates and had one temperature recorded for each meal. The dinner log did not have any logged temperatures documented after 12/28/25.The service technician service report, dated 1/2/26, indicated the dish machine's pressure would not stay up. He had set up the dishwasher to function as a low temperature machine. During a kitchen tour, an interview was conducted with DM on 1/6/25 at 10:00 a.m. She indicated the dishwasher wash and sanitation records were printed from 12/5/25 through 1/5/26. The dietary staff should record the sanitation temperatures twice a day. The dietary staff are not recording the sanitation temperatures. An observation was made of the kitchen with the DM on 1/8/25 at 10:44 a.m. The kitchen flooring in the dishwasher area, food preparation and cook areas were observed. The back wall was observed with black debris. The DM indicated the flooring was last deep cleaned in November 2025. The black debris was stuck on the floor. She was unable to remove. A dish machine temp/sanitizer policy was provided by the Executive Director on 1/6/26 at 1:20 p.m. It indicated, .2. Dish machine temperatures and sanitizer concentration will be recorded at each meal. Temperatures will be recorded according to the temperature gauge readings on the outside of the machine during wash and rinse cycles.3.1-21(i)(2)

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self medication assessment was completed timely for 2 of 2 residents randomly observed for self medication (Residents 4 and 14)Findings include: 1 The clinical record for Resident 14 was reviewed on 1/5/26 at 10:20 a.m. The resident's diagnosis included, but was not limited to, hypertension. On 1/5/26 at 10:20 a.m., Resident 14 was observed in her room sitting in her wheelchair. A plastic medication cup with 4 pills inside of it was sitting on her overbed table. Resident 14 indicated the nurse had left her medication for her to take. She then put the 4 pills into her mouth and swallowed them with a drink of water. Resident 14 indicated the nurses' usually left her medication for her to take when she was ready. A Self Administration of Medication Assessment, dated 1/5/26 at 12:51 p.m., indicated Resident 14 could self administer all oral medications and that her medications would be kept on the medication cart. The resident's self administration of medication assessment was conducted after the observation on 1/5/26 at 10:20 a.m. Prior to 1/5/26 at 12:51 p.m., the resident's clinical record lacked a self administration of medication assessment. 2. The clinical record for Resident 4 was reviewed on 1/5/24 at 2:46 p.m. The resident's diagnosis included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). A physician order, dated 10/18/25, indicated the resident was to receive 1 cap of Biotene Dry Mouth Oral Rinse three times a day. The resident was to swish and spit the rinse. A physician order, dated 10/24/25, indicated the resident was to receive 2 puffs of 90 micrograms of albuterol inhaler four times daily as needed. An observation was made of a medication administration for Resident 4 with Qualified Medication Aide (QMA) 6 on 1/8/26 at 10:11 a.m. During the preparation of the medications at the medication cart, QMA 6 had indicated Resident 4 self-administers her inhaler and Biotene mouth rinse, so she would not have to administer those medications. QMA 6 did not administer those medications at that time. An observation was made of a medication administration for Resident 4 with License Practical Nurse (LPN) 10 on 1/8/26 at 11:29 a.m. During the medication administration, Resident 4 indicated she did have an albuterol inhaler that was in a plastic container on her bedside table and Biotene mouth rinse was in her bathroom. She did administer both medications herself. At that time, the albuterol inhaler and Biotene mouth rinse were observed in the resident's room. An interview was conducted with LPN 10 on 1/8/26 at 11:32 a.m. She indicated the resident should have a self-medication assessment for the albuterol inhaler and Biotene mouth rinse medications that are in her room. After review of the resident's chart, LPN 10 was unable to find a self-medicate assessment that had been completed in Resident 4's medical chart. An interview was conducted with the Nurse Consultant (NC) on 1/8/26 at 2:34 p.m. She indicated there should be self medication assessments completed for residents that store and self- medicate (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their medications. A self-administration policy was provided by the NC on 1/8/26 at 2:34 p.m. It indicated, .Procedure. 1. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. A. The order should include the type of medication(s) the resident is able to self-medicate.6. A Self-Medication plan of care will be initiated and updated as indicated. 7. The Assessment will be reviewed quarterly, and PRN [as needed] with change of condition. 3.1-11(a)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe method of transfer for 1 of 2 residents reviewed for falls. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 1/5/26 at 1:30 p.m. The diagnoses for Resident 1 included, but were not limited to, vascular dementia, muscle weakness, rheumatoid arthritis and osteoporosis (bone disease that causes bones to become weak, thin and brittle). A Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident 1 needed staff to provide half of the assistance with lifting, holding, and trunk or limb support for the resident in a lying to a sitting position. The staff needed to provide all assistance with lifting, hold and trunk or limb support for the resident sitting to standing position and bed to chair positioning. A fall care plan, dated 2/19/25, indicated Resident 1 was a fall risk related to muscle weakness and dementia. The interventions included but were not limited to, start date: 2/19/25, staff to assist Resident with transfers as needed. A care plan, dated 2/19/25, indicated Resident has a diagnosis of osteoporosis and at risk for fracture and increased weakness. The interventions included but were not limited to, staff was to assist as needed with mobility. A resident care needs profile guide care plan, dated 2/19/25, indicated a start date 2/19/25, Transfers: 2 person with hoyer lift [a mechanical lift that assists with transfers], specific to the is resident d/t [due to] right shoulder pain and mobility issues. A physical therapy evaluation, dated 8/9/25, indicated the resident was currently dependent on staff for all ADLS [Activities of Daily Living] and uses a mechanical lift for safety with all functional transfers. Equipment utilized by resident was wheelchair and stand-up lift. A nursing progress note, dated 10/6/25, indicated the nurse was called to the resident's room. Resident 1 was found sitting on the floor clothed with a gait belt around her waist. She was leaning against Certified Medication Aide (QMA) 4's lower extremities. After assessment, the resident was unable to move her left arm. There was a firm bulge on the top inner side of the left arm. QMA 4 reported, upon transferring resident from bed with gait belt to locked w/c [wheelchair] that resident stood with assistance then went downward BUE [bilateral upper extremities] on [QMA 4's] arms, as [QMA 4] was lowering resident to floor [QMA 4] heard a snap. A reportable incident to the Indiana Department of Health, dated 10/7/25, indicated Resident was being transferred from the bed to the wheelchair using a gait belt when her legs buckled shifting her body weight to the CRCA [Certified Resident Care Associate] who was holding onto the gait belt putting pressure into her armpit/shoulder area. The sudden shifting of her body downwards applied enough pressure to her shoulder area that resulted in acute fracture.Resident has a history of degenerative arthritis and osteoporosis in both shoulders with surgical repair of both shoulders noting 6 screws in left shoulder. The acute fracture occurred just distal to the hardware. Resident has limited range of motion in both shoulders with prior therapy treatment. Resident transferred to emergency room and returned to facility same day. New order to wear an immobilizer sling to left arm.hoyer lift for all transfers going forward. The reportable incident's investigation was provided by the Executive Director on 1/8/26 at 1:00 p.m. The investigation included but was not limited to the following: A statement signed by QMA 4, dated 10/7/25, indicated, CRCA [QMA 4] applied the gait belt around the resident's upper waist even with her arms, note her arms have limited range of motion and are in a bent L-shaped contracted state per usual. CRCA counted with resident to 3 to signal to stand, resident started to stand when her legs gave way and she was unable to bear her own weight resulting in her weight relying on the CRCA to hold her up. The CRCA attempted to stabilize and lift the resident with the gait belt by holding onto the sides but with the sudden weight drop the residents body shifted down suddenly and her arms/shoulders shifted up at the same time, the CRCA held on to the gait belt and heard a snap in the shoulder area. CRCA then lowered her to the floor. A point of care history report, dated 9/2/25-10/6/25, indicated Resident 1 was transferred by staff assistance with a mechanical lift (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(stand up lift) for all transfers except 4 times she was transferred manually. An interview was conducted with Resident 1's Representative on 1/6/26 at 11:53 a.m. She indicated Resident 1 had fallen and had fractured her arm due to staff transferring her by gait belt instead of using the stand-up mechanical lift. The resident's chart was not updated or clear which transferring method the staff was to utilize to transfer her. One place in the resident's care plan said she was supposed to be transferred with a gait belt and another area of the plan of care said she was to be transferred by stand-up mechanical lift. Since the incident, the resident was now transferred by hoyer mechanical lift. An interview was conducted with the Director of Rehab on 1/7/26 at 11:20 a.m. She indicated Resident 1 fluctuated on how she transferred. She had good days and bad days. On a good day the staff would be able to transfer Resident 1 by utilizing a gait belt with 1 to 2 staff members, and on bad days the staff would need to use the stand-up lift for transfers. The staff would need to assess the resident prior to transfer if the resident was having a good day or bad day. Resident 1 was a small lady. If the staff member felt they were able to lift her; then it would be the choice of the staff member as long as they used a gait belt. An interview was conducted with Certified Nursing Assistant (CNA) 11 on 1/8/26 at 2:58 p.m. She indicated the CNA staff can either use the resident's electronic record to find out how the resident transfers or a paper was posted at the nursing station how each resident on the hall transferred. She had provided care to Resident 1 prior to the fall on 10/6/25. She had always transferred Resident 1 by stand-up lift, never manually using a gait belt. The resident currently transfers by hoyer lift. A resident care plan profile timeline for Resident 1 was provided by the Executive Director on 1/9/25 at 9:00 a.m. It indicated on 2/19/25 the resident was to be transferred by 1 to 2 staff members assistance. The care profile was updated on 3/17/25 indicating the resident was to be transferred by 1 to 2 staff members assistance with a gait belt. The profile was updated on 10/6/25 after the fall incident indicating the staff was to transfer the resident with 2 staff member with hoyer lift. An interview was conducted with the MDS Coordinator on 1/9/26 at 10:55 a.m. She indicated she was unsure why the resident's care profile care plan indicated Resident 1 was a hoyer mechanical lift as of 2/19/25. That part of the care plan, the CNA staff would not have access to that information. The CNA staff would only see 1-2 person assist with a gait belt. An interview was conducted with QMA 4 on 1/9/26 at 11:05 a.m. She indicated she was the staff member transferring Resident 1 on the morning of 10/6/25. QMA 4 was getting Resident 1 up for the day and was transferring the resident from bed to wheelchair utilizing a gait belt. The resident was confused and yelling out as that behavior was normal for her. During the transfer the resident's legs gave out, and QMA 4 lowered the resident to the floor. The resident was assessed by the nurse. She always transferred the resident by gait belt. In the resident's electronic record, it indicated the resident was to be transferred by gait belt with 1 to 2 staff members. That was the information she used, but there was also a posted paper at the nurse's station. It indicated Resident 1 was to be transferred by stand-up lift. An interview was conducted with CNA 5 on 1/9/26 at 1:30 p.m. She indicated she had worked here for a few years. She had always transferred Resident 1 with a stand-up lift. She never would transfer her manually using a gait belt. Since the resident's fall she currently was a hoyer lift. A fall management policy was provided by the Nurse Consultant on 1/8/25 at 10:21 a.m. It indicated, Purpose Statement. The purpose of this policy is to: Trilogy health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury. 3.1-45(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely notify a physician of a resident with pain, timely receive scheduled pain medications from the pharmacy, and to assess pain level, location of pain, and non-pharmacological interventions attempted prior to administering prn medications for 2 of 2 residents reviewed for pain. (Residents 26 and 63) Findings include: 1. The clinical record for Resident 63 was reviewed on 1/5/26 at 1:54 p.m. The resident's diagnosis included, but were not limited to, back pain and lumbar post-laminectomy syndrome (persistent pain or neurological symptoms in the back or extremities after spinal surgery). She was admitted to the facility on [DATE]. Resident 63 had an intrathecal pain pump (device that delivers pain medication to the fluid around the spinal cord) which delivered hydromorphone (narcotic pain medication) due to chronic pain. A physician's order, dated 12/26/25, indicated she was to receive cyclobenzaprine (Flexeril muscle relaxer) 10 mg tablet three times a day. A physician's order, dated 12/26/25, indicated she was to receive Lyrica (medication to treat nerve pain) 200 milligram (mg) one tablet by mouth three times a day. The December 2025 Medication Administration Record (MAR) indicated Resident 63 did not receive Lyrica 200 mg on the following days and time: On 12/26/25 at 6:00 p.m. and at 10:00 p.m., dose not given due to being on hold pharmacy to deliver; on 12/27/25, all the three scheduled doses not administered due to being on hold; on 12/28/25 at 6:00 a.m. and 10:00 a.m., dose not administered due to being on hold. A physician's order, dated 12/26/25, indicated to monitor pain times 72 hours post admission. The December 2025 MAR indicated the resident's pain levels were as follows: 12/26/25 evening shift 0, night shift 0, 12/27/25 day shift 6 described as generalized, evening shift 4 described as generalized, night shift 5 described as generalized, 12/28/26 day shift 4 described as generalized, evening shift 10 described as generalized, night shift 0, 12/29/25 day shift 10 described as generalized, evening shift 0, and night shift 0. Pain scale of 0 to 10, 0 being no pain and 10 being severe pain. The clinical record did not include what non-pharmacological interventions were attempted to assist with pain management or that the physician had been notified of the resident's pain. On 12/27/25, Resident 63 called emergency medical services due to pain and requested to be taken to the hospital for pain management. The emergency room History and Physical, dated 12/27/25 at 9:19 a.m., indicated Resident 63 did not receive her medications last night and was informed that there would be a delay in medication administration this morning. The physical exam indicated she was not in acute distress and had diffuse pain to palpation. The Medical Decision Making indicated Resident 63 received a one time dose of oxycodone (narcotic medication) and a dose of Flexeril (muscle relaxer) and she would be discharged with a prescription for Flexeril. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physical Therapy Evaluation and Plan of Treatment, completed 12/28/25, indicated Resident 63 had pain that interfered/ limited functional activities. Patient reports 1000/10 pain upon evaluation. She declined all functional mobility and transfers due to pain. She had pain that interfered with sleep. She verbalized pain level. A care plan, initiated 12/30/25, indicated she was at risk for pain r/t chronic low back pain, Lumbar Post-Laminectomy Syndrome, migraines, fibromyalgia, seizures, and asthma. The goal was for her pain to be at a tolerable level. The approaches were to administer medications as ordered and notify MD (physician) for any side effects observed or lack of effectiveness, attempt non-pharmacological interventions, notify MD of increased pain, observe for and record verbal and non-verbal signs of pain, and reposition as needed. A Brief Interview for Mental Status (BIMS) Assessment, dated 12/31/25, indicated Resident 63 was cognitively intact. A Physical Medicine and Rehabilitation Initial Encounter note, dated12/29/2025 at 10:11 a.m., indicated Resident 63 seen lying comfortably resting in bed. Patient reports experiencing chronic generalized pain, reporting pain most severe to low back, rating pain 10/10 on pain scale, described as aching/throbbing sensation. Patient reports since being released from hospital her pain continues to remain exacerbated, reports during hospital she felt her pain was better managed. Patient notes following with pain management provider notes that since having spinal fusion she has experience chronic pain. of note patient does have intrathecal pain pump, reports pump has not been managing pain. She reports during hospitalization she was receiving Tylenol and oxycodone which were effective for pain management. Patient does note history of constipation, reports at home taking stool softeners twice a day and is agreeable for regimen to be added at facility. Reports fair sleep and fair appetite. No acute concerns noted per nursing or therapy services. Pain management secondary to adjacent segment disease of lumbar spine with history of fusion procedure, chronic back pain, lumbar post laminectomy syndrome. Patient has intrathecal pain pump that delivers 2.5 mcg every 6 hours. Patient reporting exacerbated pain. We will start regimen that patient was on at hospital as patient reporting pain adequately managed during recent hospitalization. Start oxycodone 10 mg every 4 hours as needed, schedule acetaminophen TID. Continue Flexeril 10 mg TID and start voltaren 1% topical ointment twice a day. We will continue to monitor for increase/unmanage pain. A physician's order, dated 12/29/25, indicated Resident 63 was to receive acetaminophen (Tylenol) 500 mg tablets. 2 tablets (1000mg) three times a day. A physician's order, dated 12/29/25, indicated she was to receive oxycodone 10 mg every four hours as needed for pain. A physician's order, dated 12/29/25, indicates she was to receive voltaren 1% topical ointment (pain ointment) twice daily. The December and January MAR indicated she had received oxycodone 10 mg on the following days and times: -12/29/25 at 12:10 p.m., 5:43 p.m., 10:15 p.m. -12/30/25 at 3:00 a.m., 8:38 a.m., (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/31/25 at 12:45 a.m., 7:53 a.m., and 8:11 p.m., -1/1/26 at 9:05 a.m., 1:21 p.m., 5:40 p.m., and 9:39 p.m., -1/2/26 at 5:40 a.m., 10:06 a.m., 3:04 p.m., and 8:10 p.m., --1/3/26 at 1:16 a.m., 8:26 a.m., 12:54 p.m., 5:03 p.m., and 9:11 p.m., -1/4/26 at 2:08 a.m., 9:21 a.m., 1:44 p.m., and 1/5/25 at 2:08 a.m., 9:12 a.m., 1:26 p.m., and 9:45 p.m. The December and January MAR did not include information of pain intensity at time of administration of the oxycodone, location of pain, or non-pharmacological interventions attempted prior to administering pain medications. During an interview on 1/5/26 at 1:54 p.m., Resident 63 indicated she was admitted to the facility on [DATE]. She had chronic pain and her tolerable pain level was 6 to 7 out of 10. She had a pain pump to assist in controlling her pain and received Lyrica routinely . She had several falls prior to being hospitalized which had made her pain worse. While she was at the hospital prior to her admission to the facility, she had received Tylenol 1000 mg three times a day and oxycodone 10 mg as needed. The combination of the pain pump, Tylenol, and oxycodone had controlled her pain so that she could participate in therapy and get out of bed. When she arrived at the facility on 12/26/25, she did not receive her pain medications. The staff had told her that the pharmacy had not delivered her medications and gave her other excuses as to why her pain medications were not available. On Saturday 12/27/25, she had call 911 to go to the hospital because of her pain. The hospital had given her a one time dose of oxycodone and Flexeril, which had helped ease her pain briefly. Her pain had been 10 out of 10 from Saturday 12/27/25 until Monday 12/29/25, when she was seen by a Nurse Practitioner (NP) who had prescribed her oxycodone and Tylenol. She had been unable to participate in therapy due to the pain. During an interview on 1/7/26 at 10:31 a.m., Licensed Practical Nurse (LPN) 3 indicated he had cared for Resident 27 the weekend she was admitted . Resident 63 was in pain as soon as she got to the facility. She is in pain all of the time. Resident 63 had went to the hospital due to pain and was sent back with a prescription for Flexeril. Her concern about pain had been put in the concern book because it had not met the criteria for when to contact the on-call physicians. As soon as the physician came in on Monday she was started on oxycodone. During an interview on 1/07/2026 at 2:00 p.m., Physical Therapist (PT) 12 indicated she had performed the Physical Therapy Evaluation on 12/28/25. Resident 63 had verbalized pain during the evaluation as 1000/10. She did attempt to participate in the evaluation, but when attempting to stand or move she refused. There were no non-verbal signs or symptoms of pain. Resident 63 had asked about pain medications and was educated to talk with the Nurse Practitioner and the nursing staff. PT 12 could not recall if she had informed the nursing staff of Resident 63's pain. During an interview on 1/7/25 at 2:05 p.m., the Director of Therapy indicated she had asked the NP to see Resident 63 the morning of 12/29/25 to see if anything could be done to address her pain, since it was interfering with therapy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/26 at 10:18 a.m., the Medical Nurse Practitioner indicated she did not recall anything of the on-call log indicating the on-call providers had been informed of Resident 63's pain from 12/26/25 through 12/28/25. She believed it was preferable to call the on-call provider about uncontrolled pain instead of a resident going to the hospital due to pain. The standing orders in the communication books were guidelines regarding acute verse's chronic and up to interpretation by the nursing staff. If non- pharmacological interventions had not worked to lessen pain, then calling the on-call provider could have been appropriate. On 1/8/26 at 10:41 a.m., the Director of Nursing Services (DNS) provided the Standing Orders and Notification Guidance which read .Pain Immediate Notification [call]: Severe joint/ hip pain associated with a fall Noticeable change in alignment ability to perform ROM [sic] in extremity Headache with altered vision, change in mental status, 'sudden onset headache' 'Worse headache of my life' Pain with change in mental status Abdominal pain with guarding/ rigidity . Routine Notification [designated folder/ clipboard/ book]: persistent mild to moderate pain in spite of interventions . 2. The clinical record for Resident 26 was reviewed on 1/5/26 at 3:30 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, amputation of left toe and stroke. The Minimum Data Set (MDS) assessment, dated 12/12/25, indicated Resident 26 was cognitively intact. A pain care plan, dated 6/11/25, indicated Resident 26 was at risk for pain related to having a diagnosis of Osteomyelitis, 3rd/4th toe amputated, neuropathy, past history of a left shoulder closed fracture and chronic pain. The interventions included but were not limited to, the staff was to attempt non-pharmacological interventions for pain relief and administer pain medications with notification to the medical provider if pain medications were not effective. A physician order, dated 12/1/25, indicated the resident was to receive 500 milligrams/15 milliliters of acetaminophen every 6 hours for pain. A physician order, dated 12/1/25, indicated the resident was to receive 5-325 milligrams of hydrocodone for moderate to severe pain every 12 hours as needed. The January 2026 MAR indicated the resident had received the 15 milliliters of acetaminophen and the 5-325 milligrams of hydrocodone on the following days and times: Acetaminophen: 1/2/26 at 7:26 a.m., and 5:38 p.m. 1/3/25 at 11:18 a.m., 1/5/26 at 8:25 a.m., and 1/6/26 at 8:25 a.m. Hydrocodone: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearvista Lake Health Campus	8405 Clearvista Place Indianapolis, IN 46256

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/2/26 at 7:26 a.m., 1/4/26 at 6:35 a.m., and 1/5/26 at 10:02 a.m. The January 2026 MAR for Resident 26 did not include nursing assessments indicating the resident's pain location, non-pharmacological interventions attempted prior to medicating nor how much pain the resident was having utilizing a pain scale. An interview was conducted with Resident 26 on 1/5/26 at 3:30 p.m. She indicated she was always in pain even after pain medication. The staff are aware her pain was not controlled. The resident was a 9 out of 10 utilizing a pain scale of 1 being the least amount of pain to 10 being the worst amount of pain. An interview was conducted with the Director of Nursing Services on 1/7/26 at 9:31 a.m. She indicated when the physician order was ordered in Resident 26's electronic record the pain scale was not clicked in error. The pain scale box was not showing up in the resident's MAR. The nursing staff should know how to assess the resident's pain when giving as needed medications. She was unsure why the nursing staff were placing an x in the box instead of indicating what non-pharmacological intervention that had been attempted prior to medicating the resident. A pain management policy was provided by the Nurse Consultant (NC) on 1/7/26 at 10:19 a.m. It indicated, .Purpose Statement. The purpose of this policy is to: To ensure each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the needs of each individual. 3.1-37(a)