STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155697	A. BUILDING -- B. WING	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/30/2024 Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560 At this Emergency Preparedness survey, Clark Rehabilitation and Skilled Nursing Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 83 certified beds. At the time of the survey, the census was 73 Quality Review completed on 05/02/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/30/2024 Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560 At this Life Safety Code survey, Clark	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Bricker	Executive Director	05/16/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 01 B. WING	04/30/2024

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CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

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	Rehabilitation and Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 83 and had a census of 73 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/02/24			
K 0232 SS=D Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet clear width requirement exceptions per LSC 19.2.3.4(1) for 1 of 1 corridors near the staff lounge. LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the	K 0232	**K-232** Based on observation, the facility failed to meet clear width requirements for 1 of 1 corridor	05/30/2024

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	155697	A. BUILDING 01 B. WING	04/30/2024

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	housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on a tour of the facility on 04/30/2024 between 12:00 PM and 1:45 PM, 3 cleaning carts were in the hallway near the staff lounge unattended. Based on interview at the time of observation, the Maintenance Director stated housekeeping was at lunch, he knows the carts are not supposed to be stored in the hallway, has communicated with housekeeping about storing their carts in the hall when not in use, and contacted housekeeping to properly put the carts away. Housekeeping staff put the carts in a housekeeping storage room a short distance away. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		near the staff lounge which could affect staff only. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No staff were harmed or had a negative outcome related to the alleged deficient practice. All cleaning carts were immediately removed from the corridor and stored in the appropriate area. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All staff could have the potential to be affected by the alleged deficient practice. All housekeeping staff were educated on LSC 19.2.3.4(1) regarding the requirements for clear and unobstructed width of corridors. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** All housekeeping staff were educated on LSC 19.2.3.4(1)	

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			regarding the requirements for clear and unobstructed width of corridors. Maintenance Director or designee will complete the life safety compliance audit of corridor width of the hallway near the staff lounge daily times 4 weeks, weekly times 1 month, and monthly times 6 months and semiannually thereafter to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** Maintenance Director or designee will complete the life safety compliance audit of corridor width of the hallway near the staff lounge daily times 4 weeks, weekly times 1 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed bi-monthly by the QAPI committee overseen by the Executive Director. **By what date the systemic changes for each deficiency will be completed** May 30, 2024 Attachments: A, A1	
K 0351 SS=D	NFPA 101 Sprinkler System - Installation			

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Bldg. 01	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 mop closets, 1 of 1 dry storage rooms, and 1 of 1 office supply storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff, visitors, and residents in the area.	K 0351	**K-351** Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 mop closet, 1 of 1 dry storage rooms and 1 of 1 office supply storage rooms which could affect staff, visitors, and residents in the area. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No staff, residents, or	05/30/2024

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	Findings include: Based on observations on a tour of the facility on 04/30/2024 between 12:00 PM and 1:45 PM with the Maintenance Director, storage in the mop closet, dry storage room, and office supply storage room had storage less than 18 inches from the ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there was storage in the aforementioned locations less than 18 inches from the ceiling. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		visitors were harmed or had a negative outcome related to the alleged deficient practice. The mop closet, dry storage room and office supply storage rooms were cleared of items obstructing the spray pattern for sprinkler heads. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All staff, residents and visitors have the potential to be affected by the alleged deficient practice. All housekeeping, culinary and administrative staff were educated on LSC 19.3.5.1 NFPA 13, 2010 edition Sections 8.5.5.2 and 8.5.5.3 regarding obstructions more than 18 inches below the sprinkler. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** All housekeeping, culinary and administrative staff were educated on LSC 19.3.5.1 NFPA 13, 2010 edition Sections 8.5.5.2 and 8.5.5.3 regarding obstructions more than 18 inches below the	

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			sprinkler. Maintenance Director or designee will complete the life safety compliance audit of the mop closet, dry storage room and office supply storage room daily times 4 weeks, weekly times 1 month, and monthly times 6 months and semiannually thereafter to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** Maintenance Director or designee will complete the life safety compliance audit of the mop closet, dry storage room and office supply storage room daily times 4 weeks, weekly times 1 month, and monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed bi-monthly by the QAPI committee overseen by the Executive Director. **By what date the systemic changes for each deficiency will be completed** May 30, 2024 Attachments: B, B1	

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K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 Dutch doors to resident sleeping rooms on the ground floor fully latched into the door frame. This deficient practice could affect up to 2 residents, staff and visitors. Findings include: Based on observations on 04/30/2024 between 12:00 PM and 1:45 PM with the Maintenance Director, room 4 was equipped with a Dutch door which allowed the top half and bottom half of the doors to open independently. There was a sliding lock to connect the top and bottom halves of the doors which also had the capability to be unlocked. The bottom half of the door was able to latch in the frame, however the top half of the door did not have a latching mechanism. This was acknowledged by the Maintenance Director at the time of the observation. This finding was reviewed reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0363	**K-363** Based on observation, the facility failed to ensure 1 of 1 Dutch doors to resident sleeping rooms on the ground floor fully latched into the door frame which could affect up to 2 residents, staff and visitors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No staff, residents, or visitors were harmed or had a negative outcome related to the alleged deficient practice. Room 4 Dutch door adjusted to fully latch into door frame. Audit of all other Dutch doors completed to ensure all latch fully into door frame with no issues found. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All staff, residents and visitors have the potential to be affected by the alleged deficient practice. Maintenance Director	05/30/2024

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			educated on LSC 3.1-19(b) regarding Dutch doors. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** Maintenance Director educated on LSC 3.1-19(b) regarding Dutch doors. Maintenance Director or designee will complete Quality Control Environment Checklist for Maintenance which includes corridor door closure/latches weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** Maintenance Director or designee will complete Quality Control Environment Checklist for Maintenance which includes corridor door closure/latches weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be	

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			reviewed monthly by the QAPI committee overseen by the Executive Director. **By what date the systemic changes for each deficiency will be completed** May 30, 2024 Attachments: C, C1, D	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 2 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, as well as staff and visitors.	K 0372	**K-372** Based on observation and interview, the facility failed to ensure 2 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier which could affect over 20 residents, as well as staff and	05/30/2024

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	Findings include: Based on observations on 04/30/2024 between 12:00 PM and 1:45 PM during a tour of the facility with the Maintenance Director, the following was noted: a. The smoke barrier wall above the smoke barrier doors between the 60 hall and the center Nurses' Station area had 2 penetrations of 1 inch each that was not properly fire stopped. b. The smoke barrier wall above the smoke barrier doors between the 1 hall and the center Nurses' Station had a 0.5 inch by 1 inch penetration that was not properly fire stopped. Based on interview at the time of each observation the Maintenance Director agreed there were penetrations in the aforementioned locations and provided the measurements. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		visitors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, visitors or staff were harmed or had a negative outcome related to the alleged deficient practice. The 2 barrier walls were repaired to the specifications required to ensure protection and maintain the smoke resistance of the smoke barrier wall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, visitors and staff could have the potential to be affected by the alleged deficient practice. Life safety compliance audit on smoke barrier penetrations. All smoke barrier areas identified, inspected and all met the compliance requirements of regulation. Maintenance staff educated on life safety regulation related to appropriate sealing of smoke barrier penetration. **What measure will be put into**	

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			place or what systemic changes will be made to ensure that the deficient practice does not occur? Maintenance staff educated on life safety regulation related to appropriate sealing of smoke barrier penetration. Maintenance Director or designee will complete the life safety compliance audit of smoke barrier penetrations weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** Maintenance Director or designee will complete the life safety compliance audit of smoke barrier penetrations weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Executive Director. **By what date the systemic changes for each deficiency will be completed** May 30, 2024 Attachments: D, E	

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