STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		(X2) MULTIPLE C A. BUILDING B. WING			
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	•
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		LITTLE LEAGUE BLVD KSVILLE, IN 47129	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE 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		E 0000		
	the survey, the cens	certified beds. At the time of rus was 73 mpleted on 05/02/24			
K 0000	•	•			
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			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG] GNATURE	TITLE	(X6) DATE

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: A8FI21 Facility ID: 000059 If continuation sheet Page 1 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			
		155697	B. WING 04/30/2024			
	ROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTER	517 N	T ADDRESS, CITY, STATE, ZIP COD I LITTLE LEAGUE BLVD RKSVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDERIGINALIA CONDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	found not in complication from Participation in Med Subpart 483.90(a), I 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type V (000) constitution in Med Participation i	Skilled Nursing Center was ance with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and sty was determined to be of ruction 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 con	npleted on 05/02/24				
K 0232 SS=D Bldg. 01	unobstructed) servat least 4 feet and convenient remove on stretchers, exception 19.2.3.4, exception 19.2.3.5 Based on observation	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the all of nonambulatory patients ept as modified by ns 1-5.	K 0232		05/30/2024	
	19.2.3.4(1) for 1 of lounge. LSC 19.2.3.	nent exceptions per LSC 1 corridors near the staff 4(1) requires aisles, corridors, et areas not intended for the		K-232 Based on observation, the fact failed to meet clear width requirements for 1 of 1 corridors		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155697	B. WING		04/30/2024
NAME OF B	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	ROVIDER OR SUFFLIER			LITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	or use of inpatients shall not		near the staff lounge which co	ould
		nes in clear and unobstructed		affect staff only.	
	width. This deficier	nt practice could affect staff		What corrective action(s) wil	I
	only.			be accomplished for those	
				residents found to have been	n
	Findings include:			affected by the deficient	
				practice?	
		on with the Maintenance			
		of the facility on 04/30/2024		No staff were harmed or	
between 12:00 PM and 1:45 PM, 3 cleaning carts			a negative outcome related to	the	
were in the hallway near the staff lounge			alleged deficient practice.		
unattended. Based on interview at the time of			All cleaning carts were		
	· ·	aintenance Director stated		immediately removed from the	9
		at lunch, he knows the carts		corridor and stored in the	
		be stored in the hallway, has		appropriate area.	
		h housekeeping about storing			
		ll when not in use, and		How other residents having	I
		eping to properly put the carts ag staff put the carts in a		the potential to be affected by	·
		ge room a short distance		the same deficient practice v	VIII
	away.	ge room a short distance		corrective action(s) will be	
	away.			taken?	
	This finding was re	viewed with the Maintenance		takeni	
	Director at the exit			All staff could have the	
	21100101 W W. W. C. W.			potential to be affected by the	
	3.1-19(b)			alleged deficient practice.	
	212 27 (2)			All housekeeping staff w	vere
				educated on LSC 19.2.3.4(1)	
				regarding the requirements for	r
				clear and unobstructed width	
				corridors.	
				What measure will be put int	o
				place or what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not occur?	
			All housekeeping staff w	rere	

educated on LSC 19.2.3.4(1)

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/30/2024	
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTE	517 N I	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD (SVILLE, IN 47129		
CLARK I (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	AND SKILLED NURSING CENTE STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			ridor staff wither staff sure	
K 0351	NFPA 101			by the QAPI committee overse by the Executive Director. By what date the systemic changes for each deficiency will be completed May 30, 2024 Attachments: A, A1	een	

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Sprinkler System - Installation

SS=D

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		A. BUILDING <u>01</u> COM		(X3) DATE : COMPL 04/30/	ETED		
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	517	7 N LITT	RESS, CITY, STATE, ZIP COD LE LEAGUE BLVD ILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 01	by construction ty, throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II constituted for sprinklers where state sprinklers. In hospitals, sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 19.3.5.5, 19.4.2, 19.3.5.6 and servation failed to ensure the heads were not obstorage rooms in action NFPA 13, 2010 edisprinklers shall be I obstructions to disce 8.5.5.2 and Section shall be provided to the hazard. Sections permit continuous cless than or equal to deflector or in a hor inches below the sprinklers provided to the spray pattern from the spray p	and hospitals where required be, are protected approved automatic in accordance with NFPA in accordance with the lose inkler protection in specific or local regulations prohibit in accordance with accordance with accordance with accordance with accordance with LSC 19.3.5.1. In accordance with LSC 19.3.5.1. It is accordan	K 0351	Ba int er sp ob of of co re W be re	ased on observation and terview, the facility failed to nsure the spray pattern for orinkler heads were not ostructed in 1 of 1 mop close 1 dry storage rooms and 1 of the supply storage rooms would affect staff, visitors, and sidents in the area. That corrective action(s) will a accomplished for those is idents found to have been fected by the deficient ractice?	of 1 hich	05/30/2024

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2024	
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	517 N	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD KSVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation 04/30/2024 between the Maintenance Discloset, dry storage r storage room had st the ceiling. Based of observations, the Maintenance Discrete was storage in less than 18 inches	ons on a tour of the facility on a 12:00 PM and 1:45 PM with rector, storage in the mop oom, and office supply orage less than 18 inches from an interview at the time of the aintenance Director agreed the aforementioned locations from the ceiling.		visitors were harmed or had a negative outcome related to the alleged deficient practice. The mop closet, dry stor room and office supply storage rooms were cleared of items obstructing the spray pattern it sprinkler heads. How other residents having the potential to be affected to the same deficient practice to 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, culinate and administrative staff were educated on LSC 19.3.5.1 NF 13, 2010 edition Sections 8.5. and 8.5.5.3 regarding obstruct 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, culinate and administrative staff were educated on LSC 19.3.5.1 NF 13, 2010 edition Sections 8.5. and 8.5.5.3 regarding obstructions 8.5. and 8.5.5.5.3 regarding obstructions 8.5. and 8.5.5.5.5.3 regarding obstructions 8.5. and 8.5.5.5.5.5 regarding obstructions 8.5. and 8.5.5.5.5 regard	rage e for Py will PA 5.2 tions e TO PA 5.2 tions

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED
		155697	B. W	ING		04/30/	2024
				CTDEET 4	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CLADIZE		AND SKILLED MUDSING OFFITED			ITTLE LEAGUE BLVD		
CLARK F	KEMABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					sprinkler.		
					Maintenance Director or		
					designee will complete the life		
					safety compliance audit of the		
					mop closet, dry storage room	and	
					office supply storage room dai	ily	
					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 t	he	
					deficient practice will not		
					recur, ie., what quality		
					assurance program will be p	ut	
					into place?		
					Maintenance Director or		
					designee will complete the life		
					safety compliance audit of the		
					mop closet, dry storage room		
					office supply storage room dai	•	
					times 4 weeks, weekly times 1		
					month, and monthly times 6		
					months and semiannually		
					thereafter to ensure compliand	ce.	
					The results of the audits will b		
					reviewed bi-monthly by the QA	\PI	
					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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697			UILDING	nstruction 01	(X3) DATE COMPI 04/30	LETED	
	PROVIDER OR SUPPLIEF	R AND SKILLED NURSING CENTER	₹	517 N L	ADDRESS, CITY, STATE, ZIP COD ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0363	NFPA 101	CESC IDENTIFTING INFORMATION	+	IAU			DATE
SS=D	Corridor - Doors						
Bldg. 01	Corridor - Doors						
Diag. 01	_	corridor openings in other					
		losures of vertical openings,					
	I	is 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 containir						
		rials have positive latching					
		atches are prohibited by					
		These requirements do not					
	_	spaces that do not contain					
	flammable or com	-					
		en bottom of door and floor					
		ceeding 1 inch. Powered					
		with 7.2.1.9 are permissible					
		device capable of keeping					
	I -	then a force of 5 lbf is					
		no impediment to the					
	1 ' '	rs. Hold open devices that					
	ı ~	door is pushed or pulled are					
		ed protective plates of					
	_ =	re permitted. Dutch doors					
		6 are permitted. Door					
		beled and made of steel or					
	other materials in	compliance with 8.3,					
	unless the smoke	compartment is					
	sprinklered. Fixed	fire window assemblies are					
	1 -	n sprinklered compartments					
	· ·	ictions in area or fire					
	resistance of glas	s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/30/2024 155697 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129 CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 K-363 05/30/2024 failed to ensure 1 of 1 Dutch doors to resident Based on observation, the facility sleeping rooms on the ground floor fully latched failed to ensure 1 of 1 Dutch doors into the door frame. This deficient practice could to resident sleeping rooms on the affect up to 2 residents, staff and visitors. ground floor fully latched into the door frame which could affect up Findings include: to 2 residents, staff and visitors. What corrective action(s) will Based on observations on 04/30/2024 between be accomplished for those 12:00 PM and 1:45 PM with the Maintenance residents found to have been Director, room 4 was equipped with a Dutch door affected by the deficient which allowed the top half and bottom half of the practice? doors to open independently. There was a sliding lock to connect the top and bottom halves of the No staff, residents, or doors which also had the capability to be visitors were harmed or had a unlocked. The bottom half of the door was able to negative outcome related to the latch in the frame, however the top half of the alleged deficient practice. door did not have a latching mechanism. This was Room 4 Dutch door acknowledged by the Maintenance Director at the adjusted to fully latch into door time of the observation. frame. Audit of all other Dutch This finding was reviewed reviewed with the doors completed to ensure all Maintenance Director at the exit conference. latch fully into door frame with no issues found. 3.1-19(b) 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

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practice.

affected by the alleged deficient

Maintenance Director

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 04/30/2024
	ROVIDER OR SUPPLIEI	NAND SKILLED NURSING CENTER	517 N	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD KSVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				educated on LSC 3.1-19(b) regarding Dutch doors.	
				What measure will be put implace 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 of designee will complete Qualit Control Environment Checklis Maintenance which includes corridor door closure/latches weekly times 4 weeks, month times 6 months and semiannous thereafter to ensure complian The results of the audits will be reviewed monthly by the QAF committee overseen by the Executive Director. How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be printo place? Maintenance Director of designee will complete Qualit Control Environment Checklis Maintenance which includes	the
				corridor door closure/latches weekly times 4 weeks, month times 6 months and semiannuthereafter to ensure complian. The results of the audits will be	ually ce.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		A. BUILDING B. WING	<u>01</u>	COMPLETED 04/30/2024	
	ROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				reviewed monthly by the QAP 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	Barrie Subdivision of Buil Barrier Constructio 2012 EXISTING Smoke barriers sh 1/2-hour fire resist barriers shall be po- atrium wall. Smoke in duct penetration systems where an is installed for smot to the smoke barrie 19.3.7.3, 8.6.7.1(1 Describe any med system in REMAR Based on observation failed to ensure 2 of protected to maintai smoke barrier. LSC smoke barriers to be with LSC Section 8. hour fire resistive ra	all be constructed to a ance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.) hanical smoke control	K 0372	K-372 Based on observation and interview, the facility failed to ensure 2 of 4 smoke barrier wwere protected to maintain the smoke resistance of the smok barrier which could affect over residents, as well as staff and	e e

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2024		
	REHABILITATION A	ND SKILLED NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Findings include: Based on observation 12:00 PM and 1:45 with the Maintenance noted: a. The smoke barried doors between the 6 Station area had 2 p was not properly firm b. The smoke barried doors between the 1 Station had a 0.5 includes was not properly firm Based on interview observation the Maintenance were penetratical locations and provides.	ons on 04/30/2024 between PM during a tour of the facility the Director, the following was r wall above the smoke barrier 0 hall and the center Nurses' the enetrations of 1 inch each that the stopped. r wall above the smoke barrier hall and the center Nurses' the by 1 inch penetration that the stopped. at the time of each intenance Director agreed ons in the aforementioned ded the measurements.			visitors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, visitors or were harmed or had a negative outcome related to the alleged deficient practice. The 2 barriewalls were repaired to the specifications required to ensure protection and maintain the same resistance of the smoke barriewall. How other residents having the potential to be affected by the same deficient practice where identified and what corrective action(s) will be taken? All residents, visitors and staff could have the potential to affected by the alleged deficient practice. Life safety compliance a on smoke barrier penetrations	staff e t er ure noke er y vill d o be nt	
					smoke barrier areas identified inspected and all met the compliance requirements of regulation. Maintenance staff educa on life safety regulation related appropriate sealing of smoke barrier penetration. What measure will be put interested in the complex of t	ited d to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155697	B. WING			04/30/	04/30/2024	
MARGORE	ADOLUDED OF CURPY YES			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	C			ITTLE LEAGUE BLVD			
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ļ	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	place or what systemic		DATE	
					changes will be made to			
					ensure that the deficient			
					practice does not occur?	ļ		
					Maintenance staff educa			
					on life safety regulation related	סז ג		
					appropriate sealing of smoke barrier penetration.			
					Maintenance Director or			
					designee will complete the life			
					safety compliance audit of sm			
					barrier penetrations weekly tin			
					4 weeks, monthly times 6 mor			
					and semiannually thereafter to)		
					ensure compliance.			
					How the corrective action(s)			
					will be monitored to ensure t	he		
					deficient practice will not			
					recur, ie., what quality assurance program will be p			
					into place?	ut		
					Maintenance Director or			
					designee will complete the life			
					safety compliance audit of sm			
					barrier penetrations weekly tin			
					4 weeks, monthly times 6 mor			
					and semiannually thereafter to ensure compliance. The result			
					the audits will be reviewed mo			
					by the QAPI committee overse	-		
					by the Executive Director.			
					By what date the systemic			
					changes for each deficiency will be completed			
					May 30, 2024			
					Attachments: D, E			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

A8FI21

Facility ID: 000059

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES							D 110. 0730-037
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER			a. building <u>01</u>		COMPLETED	
	155697		B. WI	B. WING		04/30/2024	
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION					DATE

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