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	06/12/2025

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: 06/12/25 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 68. Quality Review completed on 06/18/25	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: 06/12/25 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	07/03/2025

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.

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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 68 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 06/18/25			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 06/12/25., the following corridor doors failed to latch positively into their respective door frames:	K 0363	**K-363** Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. **What corrective action(s) will be accomplished for those residents found to have been**	06/20/2025

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	a) at 12:30 p.m. the Pantry Door near the nurses station failed to latch positively into the door frame. The MD stated that carts had apparently damaged the striker plate. b) at 12:24 p.m. the Therapy door did not latch positively into the door frame. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**affected by the deficient practice?** No residents, visitors or staff were harmed or had a negative outcome related to the alleged deficient practice. The pantry door near the nurses station and the therapy door have both been repaired. Both close and latch properly into the door frame so that they resist the passage of smoke. All corridor doors were inspected and no additional corridor doors were found to have impediments to closing and latching into the door frame resulting in them resisting the passage of smoke **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. Maintenance staff educated on life safety regulation 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 related to appropriate closing and latching of corridor doors. **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 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 related to appropriate closing and latching of corridor 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 semi-annually 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 semi-annually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI	

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			committee overseen by the Executive Director. **By what date the systemic changes for each deficiency will be completed** June 20, 2025 Attachments A, B, C, D	