PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/12/2025	
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER				517 N L	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD SVILLE, IN 47129	<u> </u>	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC! I		DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.		E 0000				
	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 survey, the cens	certified beds. At the time of sus was 68. mpleted on 06/18/25					
	Quality Review cor	npieted on 06/18/23					
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR	K 00	000			
	Survey Date: 06/12	2/25					
	Facility Number: 0 Provider Number: AIM Number: 100	155697					
	At this Life Safety	Code survey, Clark					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Holly Bricker Executive Director 07/03/2025

Any defiency statement 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 disclodays 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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	FOF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039	
			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/12/2025		
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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
K 0363 SS=E	Rehabilitation and S found not in compli Participation in Mes Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type V (000) const sprinklered. The fa with hard wired smand spaces open to operated smoke det rooms. The facility census of 68 at the st All areas where resi were sprinklered an services were sprinklered an	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 ity was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors the corridors, plus battery ectors in all resident sleeping has a capacity of 83 and had a time of this survey.						
Bldg. 01	Based on observation failed to ensure 2 of impediment to closiframe and would re	on and interview, the facility f over 50 corridor doors had no ong and latching into the door sist the passage of smoke. ice could affect 6 staff and 15	K 0	363	K-363 Based on observation and interview, the facility failed to ensure 2 of over 50 corridor do had no impediment to closing latching into the door frame ar would resist the passage of smoke. This deficient practice	and nd	06/20/2025	

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Based on observations during a tour of the facility

the following corridor doors failed to latch

positively into their respective door frames:

with the Maintenance Director (MD) on 06/12/25.,

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residents.

could affect 6 staff and 15

What corrective action(s) will

residents found to have been

be accomplished for those

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPL	COMPLETED	
155697		B. WING 06/12/2025			2025		
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER							
CLARK	NETIABILITATION A	IND SKILLED NORSING CENTER		CLARKSVILLE, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	a) at 12:30 p.m. tl	he Pantry Door near the nurses			affected by the deficient		
	station failed to late	h positively into the door			practice?		
	frame. The MD stat	ed that carts had apparently					
	damaged the striker	plate.			No residents, visitors or	staff	
	b) at 12:24 p.m. tl	he Therapy door did not latch			were harmed or had a negative	е	
	positively into the d	oor frame.			outcome related to the alleged		
					deficient practice.		
	This finding was ac	knowledged by the MD at the			The pantry door near the		
		and again at the exit			nurses station and the therapy		
	conference with the	MD and Executive Director			door have both been repaired.		
	present.				Both close and latch properly i	nto	
					the door frame so that they res	sist	
	3.1-19(b)				the passage of smoke.		
					All corridor doors were		
					inspected and no additional		
					corridor doors were found to h	ave	
					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 w	rill	
					be identified and what		
					corrective action(s) will be		
					taken?		
					All residents, visitors and		
					staff could have the potential to		
					affected by the alleged deficien	nt	
					practice.		
					Maintenance staff educa		
					on life safety regulation 19.3.6		
					42 CFR Parts 403, 418, 460, 4	82,	
					483, and 485 related to		
					appropriate closing and latchir	ig of	
					corridor doors.		
					Miles de conservation de la cons		
					What measure will be put into) 	

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/12/2025		
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER			R	STREET ADDRESS, CITY, STATE, ZIP COD 517 N LITTLE LEAGUE BLVD CLARKSVILLE, 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
					place or what systemic changes will be made to ensure that the deficient practice does not occur?				
				Maintenance staff education on life safety regulation 19.3.6 42 CFR Parts 403, 418, 460, 4483, and 485 related to appropriate closing and latchin corridor doors. Maintenance Director or designee will complete Quality Control Environment Checklis Maintenance which includes corridor door closure/latches weekly times 4 weeks, monthly times 6 months and semi-ann thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAP committee overseen by the Executive Director.	3.3, 482, ng of / t for y ually ce.				
					How the corrective action(s) will be monitored to ensure to deficient practice will not recur, ie., what quality assurance program will be p into place? Maintenance Director or designee will complete Quality Control Environment Checklis Maintenance which includes corridor door closure/latches	ut			

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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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	(X2) MULT A. BUILD B. WING	DING	INSTRUCTION 01	(X3) DATE COMPL 06/12 /	ETED
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	STATEMENT OF DEFICIENCIE	П	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
					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		

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