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	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Rehabilitation and Skilled Nursing Center	517 N Little League Blvd Clarksville, IN 47129

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure a physician's order was in place for a resident (Resident B) for an additional dose of a narcotic pain medication and failed to ensure scheduled medications were administered to a resident (Resident C) on dialysis days for 2 of 4 residents reviewed for pharmacy services. Findings include: 1. The clinical record for Resident B was reviewed on 6/30/25 at 10:45 a.m. The resident's diagnoses included, but were not limited to, diabetes, chronic pain and gastrointestinal stromal tumor of the rectum. The physician's order, dated 2/27/25, indicated the resident was to receive Oxycodone (narcotic pain medication) 15 mg (milligrams) every 4 hours for pain at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p. m. and 8:00 p.m. Review of the May 2025 controlled substance record indicated on 5/31/25 at 12:00 a.m., the medication was signed out as given twice by Licensed Practical Nurse (LPN) 4. On 7/1/25 at 9:53 a.m., the Executive Director and Assistant Director of Nursing provided a statement from LPN 4 and indicated the resident received 2 doses of the Oxycodone on 5/31/25 at 12:00 a.m. The written statement from LPN 4, dated 7/1/25 and untimed, indicated she had forgotten that she had already signed out the 12:00 a.m. Oxycodone and then signed out another one. The resident's other medications were on top of the one previously pulled and she did not realize until the resident tipped the pill cup to her mouth. That was when LPN 4 realized she had signed out 2 of them. The clinical record lacked documentation of a physician's order for the additional dose administered on 5/31/25 at 12:00 a.m. On 7/1/25 at 10:47 a.m., Registered Nurse (RN) 3 indicated medications could not be administered without a physician's order in place and physician's orders should be followed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at at 2:20 p.m., the Assistant Director of Nursing provided a current copy of the document titled General Dose Preparation and Medication Administration dated 12/01/07. It included, but was not limited to, This policy .sets forth the procedures to .medication administration .Prior to administration of medication, facility staff should take all measures required by facility policy .including, but not limited to .Verify each time a medication is administered that it is the .correct dose .Administer medications within timeframes On 7/1/25 at 9:53 a.m., the Executive Director provided a current copy of the document titled Medication Errors dated 11/2018. It included, but was not limited to, Policy .It is the policy of this provider to ensure residents residing in the facility are free of medication errors and the facility maintains a medication error rate of less than 5% 2. The clinical record for Resident C was reviewed on 6/30/25 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dependence on renal dialysis, gout, history of myocardial infarction, human immunodeficiency virus (HIV), Gastroesophageal reflux disease (GERD), end stage renal disease and depression. The physician's order, dated 5/27/25, indicated staff were to hold the resident's blood pressure medications on dialysis days every Tuesday, Thursday and Saturday. The June 2025 medication administration record (MAR) indicated the resident was to receive the following medications: - Allopurinol 100 mg daily for gout between 7:00 a.m. and 11:00 a.m. - Aspirin 81 mg daily for myocardial infarction between 7:00 a.m. and 11:00 a.m. - Biktarvy 50-200-25 mg daily for HIV between 7:00 a.m. ad 11:00 a.m. - Eliquis 5 mg twice a day for prophylaxis at 8:00 a.m. and 8:00 p.m. - Omeprazole 20 mg daily for GERD between 7:00 a.m. and 11:00 a.m. - Renvela 800 mg three times a day for end stage renal disease at 7:00 a.m., 11:00 a.m. and 4:00 p.m. - Zoloft 50 mg daily for depression between 7:00 a.m. and 11:00 a.m. The June 2025 MAR indicated the above medications were not administered on the following mornings due to the resident was unavailable dialysis: - On 6/03/25 - Tuesday - On 6/05/25 - Thursday - On 6/07/25 - Saturday - On 6/12/25 - Thursday (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 6/14/25 - Saturday - On 6/17/25 - Tuesday - On 6/19/25 - Thursday - On 6/21/25 - Saturday - On 6/28/25 - Saturday The clinical record lacked documentation of the administration of the resident's medications upon the resident's return from dialysis. During an interview, on 7/1/25 at 9:50 a.m., the Assistant Director of Nursing indicated Resident C had dialysis on Tuesday, Thursday and Saturday. The resident left around 6:50 a.m. and returned to the facility at 11:30 a.m. During an interview, on 7/1/25 at 11:46 a.m., the Executive Director indicated she could not find any supporting documentation that the resident's morning medications were administered upon return from dialysis. During an interview, on 7/1/25 at 12:33 p.m., Resident C indicated he did not receive any medications prior to going to dialysis. When he returned, he was only given his Renvela that he takes before his meals. This Citation relates to Complaint IN00462112 3.1-25(b)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure medication administration records accurately reflected the administration of controlled substances 4 of 4 residents reviewed for medical records. (Resident B, C, D and E) Findings include: 1. The clinical record for Resident B was reviewed on 6/30/25 at 10:45 a.m. The resident's diagnoses included, but were not limited to, diabetes, chronic pain and gastrointestinal stromal tumor of the rectum. The June 2025 medication administration (MAR) record indicated the resident was to receive Oxycodone 15 mg (milligrams) every 4 hours for pain at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p. m. The June 2025 controlled substance record indicated the resident received the Oxycodone on the following dates and times: - 6/02/25 at 8:00 p.m. - 6/03/25 at 8:00 p.m. - 6/04/25 at 12:00 a.m. - 6/05/25 at 12:00 a.m. and 8:00 p.m. - 6/06/25 at 12:00 a.m., 8:00 a.m. and 8:00 p.m. - 6/07/25 at 4:00 a.m. and 8:00 a.m. On 6/9/25, the resident was admitted to the hospital and returned on 6/16/25. The physician's order, dated 6/20/25, indicated the resident was to receive Oxycodone 15 mg (milligrams) every 4 hours for pain at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:00 p.m. The June 2025 controlled substance record indicated the resident received the Oxycodone on the following dates and times: - 6/21/25 at 2:00 a.m. and 10:00 a.m. - 6/22/25 at 2:00 a.m. The June 2025 MAR lacked documentation of the administration of the resident's Oxycodone on the above dates and times. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 7/1/25 at 10:47 a.m., Registered Nurse (RN) 3 indicated when routine and as needed narcotics were administered, the medication administration record should be initialed by the nurse that administered the medication. 2. The clinical record for Resident C was reviewed on 6/30/25 at 11:20 a.m. The resident's diagnoses included, but were not limited to, displaced fracture of olecranon and left femur, gout, and depression. The physician's order, dated 4/30/25, indicated the resident was to receive Percocet 7.5-325 mg every 4 hours as needed for pain. The June 2025 Controlled Substance Record indicated the resident received the Percocet on the following dates and times: - 6/01/25 at 7:00 a.m. and 8:00 p.m. - 6/02/25 at 8:00 p.m. - 6/03/25 at 6:00 a.m., 7:50 p.m. and 10:15 p.m. - 6/04/25 at 8:00 p.m. - 6/06/25 at 7:30 p.m. and 11:30 p.m. - 6/07/25 at 6:00 a.m. - 6/10/25 at 11:30 a.m. and 7:30 p.m. - 6/11/25 at 12:01 a.m. and 8:00 p.m. - 6/12/25 at 6:00 a.m. and 7:25 p.m. - 6/13/25 at 12:00 a.m., 8:00 p.m. and 11:30 p.m. - 6/14/25 at 6:05 a.m. - 6/15/25 at 9:00 a.m. - 6/16/25 at 9:00 p.m. - 6/17/25 at 6:00 a.m. and 8:00 p.m. - 6/18/25 at 1:35 a.m. - 6/19/25 at 5:00 a.m. - 6/20/25 at 11:30 a.m., 5:30 p.m. and 7:00 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/21/25 at 12:00 a.m., 6:00 a.m., 7:19 p.m. and 11:30 p.m. - 6/23/25 at 8:00 p.m. - 6/24/25 at 6:00 a.m. and 7:00 p.m. - 6/25/25 at 9:00 p.m. - 6/26/25 at 6:00 a.m., 11:00 a.m. and 8:00 p.m. - 6/27/25 at 12:30 a.m., 2:00 p.m. and 8:00 p.m. - 6/28/25 at 12:00 a.m. and 8:45 a.m. - 6/29/25 at 12:00 p.m. The resident's June 2025 medication administration lacked documentation of the administered Percocet on the above dates and times. 3. The clinical record for Resident D was reviewed on 6/30/25 at 2:32 p.m. The resident's diagnoses included, but were not limited to, depression and chronic pain. The physician's order, dated 5/12/25, indicated the resident was to receive Oxycodone 5 mg every 8 hours as needed for pain. The June 2025 controlled substance record indicated the resident received the Oxycodone on the following dates and times: - 6/01/25 at 8:00 a.m. - 6/02/25 at 8:00 a.m. and 8:00 p.m. - 6/04/25 at 8:00 p.m. - 6/05/25 at 8:00 p.m. - 6/06/25 at 8:00 p.m. - 6/10/25 at 9:00 p.m. - 6/11/25 at 9:00 p.m. - 6/13/25 at 10:30 p.m. - 6/17/25 at 7:00 p.m. and 9:30 p.m. - 6/18/25 at 8:00 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/21/25 at 12:30 a.m. - 6/23/25 at 9:00 p.m. - 6/24/25 at 9:00 p.m. - 6/25/25 at 9:00 p.m. - 6/26/25 at 8:15 p.m. - 6/27/25 at 8:00 p.m. The resident's June 2025 medication administration lacked documentation of the administered Oxycodone on the above dates and times. 4. The clinical record for Resident E was reviewed on 6/30/25 at 2:54 p.m. The resident's diagnoses included, but were not limited to, diaphragmatic hernia, wedge compression fracture of the first lumbar vertebra and low back pain. The physician's order, dated 5/29/25, indicated the resident was to receive Lorazepam (antianxiety medication) 0.25 ml (milliliters) at bedtime for agitation/restlessness between 7:00 p.m. and 11:00 p.m. The June 2025 controlled substance record indicated the Lorazepam was administered on the following dates at bedtime: - 6/05/25 - 6/06/25 - 6/12/25 - 6/17/25 - 6/20/25 - 6/21/25 The resident's June 2025 medication administration lacked documentation of the administered Lorazepam on the above dates. The physician's order, dated 6/5/25, indicated the resident was to receive morphine (narcotic pain medication) 5 mg every 6 hours for pain at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The June 2025 controlled substance record indicated the resident received the morphine on the following dates and times: - 6/07/25 at 6:00 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/10/25 at 10:00 p.m. - 6/13/25 at 12:00 a.m. - 6/14/25 at 12:00 a.m. - 6/18/25 at 12:00 a.m. - 6/19/25 at 12:00 a.m. - 6/20/25 at 12:00 a.m. and 12:00 p.m. - 6/21/25 at 12:00 a.m. - 6/22/25 at 12:00 a.m. - 6/24/25 at 6:00 a.m. - 6/25/25 at 12:00 a.m. - 6/26/25 at 6:00 a.m. - 6/27/25 at 12:00 p.m. and 6:00 p.m. The resident's June 2025 medication administration lacked documentation of the administered morphine on the above dates and times. On 6/30/25 at 3:13 p.m., the Assistant Director of Nursing provided a current copy of the document titled Controlled Substances: Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destruction) dated 11/24. It included, but was not limited to, Purpose of Policy .To prevent diversion, improper use and accidents related to controlled substances .Documentation .When a controlled substance is administered to a resident, it must be recorded in the resident's Medication Administration Record (MAR) This Citation relates to Complaint IN00462112 3.1-50(a)(1) 3.1-50(a)(2)