

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 10/29/2025
NAME OF PROVIDER OR SUPPLIER Clark Rehabilitation and Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 N Little League Blvd Clarksville, IN 47129	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure misappropriation of residents' property did not occur for 3 of 4 residents reviewed for abuse. (Residents B, C, and D) Findings include:1.The clinical record for Resident B was reviewed on 10/29/25 at 11:14 a.m. The residents' diagnoses included, but were not limited to, fibromyalgia, depression and chronic pain syndrome. The resident's admission minimum data set assessment indicated the resident's cognition was intact. The physician's order, dated 10/6/25, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg (milligrams) every 8 hours as needed for pain.Review of the October 2025 controlled substance record indicated on 10/9/25 at 4:00 a.m., the resident was administered a dose of the narcotic pain medication from Licensed Practical Nurse (LPN) 10.The October 2025 medication administration record, dated 10/9/25 at 4:53 a.m., indicated LPN 10 documented the administration of the resident's narcotic pain medication.Review of the timeline provided by the Executive Director on 10/29/25 at 2:26 p.m., indicated the following:-On 10/9/25 at 12:30 p.m., Resident B indicated she did not receive a dose of her narcotic pain medication on 10/9/25 at 4:00 a.m., but did confirm she received a dose at 10:00 p.m. on 10/8/25-On 10/9/25 at 1:15 p.m., video footage was reviewed from 3:00 a.m. to 6:30 a.m. on 10/9/25. LPN 10 did not enter the resident's room to provide any medication.During an interview, on10/29/25 at 2:42 p.m., Resident B indicated she had requested her pain medication in the morning and was told she could not have any yet because she had received pain medication at 4:00 a.m. She did not request her pain medication at that time nor did she receive one. The last pain medication she had requested was the night before. The nurse had given her nighttime medications, but her pain medication was not with the other medications. She requested her pain medication at that time, which was the last time she had received her medication until she requested it the next morning.During a telephone interview, on10/29/25 at 1:48 p.m., the Regional Nurse Consultant indicated she reviewed the video with the Executive Director and LPN 10 never entered Resident B's room to administer the pain medication that was signed out and documented. During an interview, on 10/29/25 at 3:00 p.m., the Executive Director indicated the timeline provided was accurate and with the new video system, it only held the video for 10 days.2. The clinical record for Resident C was reviewed on 10/29/25 at 11:26 a.m. The resident's diagnosis included, but was not limited to, rheumatoid arthritis. The resident's annual minimum data set assessment, dated 10/21/25, indicated the resident's cognition was intact.Resident C was unavailable for interview, on 10/29/25, due to a planned appointment.The physician's order, dated 4/22/25, indicated the resident was to receive Hydrocodone-Acetaminophen 5-325 mg every 8 hours as needed for pain.The October 2025 controlled substance record indicated Resident C was administered the narcotic pain medication from LPN 10 on 10/8/25 at 12:00 a.m. and on 10/9/25 at 2:00 a.m.The October 2025 medication administration record indicated the medication was administered by LPN 10 on 10/7/25 at 11:38 p.m. The narcotic medication administration was not documented as administered on 10/9/25.Review of the timeline provided by the Executive Director, on 10/29/25 at 2:26 p.m., indicated the following:-Camera footage for both administrations documented by LPN 10 indicated between 11:00 p.m. and 3:30 a.m., LPN 10 did not enter the resident's room.The written statement interview by Resident C, dated 10/19/25 at 4:15 p. m., indicated Resident C had not requested any pain medication on night shift between 10/7/25 and 10/9/25. During an interview on 10/29/25 at 1:48 p.m., the Regional Nurse Consultant indicated, per the video reviewed between 10/7/25 and 10/9/25 from 11:00 p.m. to 3:30 a.m., LPN 10 did not enter the resident's room to administer any medications. 3. The clinical record for Resident D was reviewed on 10/29/25 at 1:30 p.m. The residents' diagnoses included, but were not limited to, Parkinson's disease, chronic pain, depression and peripheral vascular disease.The physician's order, dated 7/30/25, indicated the resident was to receive Hydrocodone-Acetaminophen 5-325 mg every 6 hours at 12:00 p.m., 6:00 p.m., 12:00 a.m. and 6:00 a.m. for chronic pain.Review of the October 2025 controlled substance record indicated LPN 10 signed out the narcotic pain medication as administered on the following dates and times:-10/7/25 at 10:00 p.m. -10/8/25 at 2:00 a.m.-10/8/25 at 10:00 p.m.-10/9/25 at 2:00 a.m.Review of the timeline provided by the Executive Director on 10/29/25 at 2:26 p.m. indicated the following:-The video camera footage reviewed indicated on 10/7/25 at 9:13 p.m., LPN 10 entered Resident D's room with a medication cup and then exited at 9:17 p.m. From 9:17 p.m. on 10/7/25 to 3:30 a.m. on 10/8/25, LPN 10 did not enter the resident's room. -The video camera footage reviewed indicated, on 10/8/25 at 9:38 p.m., LPN 10 entered Resident D's room with a medication cup and water and exited at 9:38 p.m. From 9:38 p.m. on 10/8/25 to 3:30 a.m. on 10/9/25</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure a staff followed the scope of practice for certified nursing assistants for 1 of 3 residents reviewed for services provided. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/29/25 at 11:14 a.m. The residents' diagnoses included, but were not limited to, fibromyalgia, depression and chronic pain syndrome. During an interview, on 10/29/25 at 1:48 p.m., the Regional Nurse Consultant indicated it was identified that on 10/8/25, Licensed Practical Nurse (LPN) 10 provided Certified Nursing Assistant (CNA) 11 with a resident's pain medication in a cup and CNA 11 entered Resident B's room with the medication cup. Review of the timeline provided by the Executive Director on 10/29/25 at 2:26 p.m., indicated the following: -The video footage was reviewed starting on 10/8/25 at 10:30 p.m., LPN 10 entered Resident B's room at 10:40 p.m. with a medication cup and water. LPN 10 exited the room in less than a minute and then entered another resident's room, at which time, Resident B turned her call light on. After exiting the other resident's room, LPN 10 went to the medication cart. CNA 11 entered Resident B's room, turned the call light off, exited the room and walked to the medication cart where LPN 10 was and said something to her. LPN 10 pulled open a drawer on the medication cart and withdrew a medication cup which she handed to CNA 11 along with a cup of water. CNA 11 took both the medication cup and water into Resident B's room and came out of the room empty handed. The undated written statement from CNA 11 indicated, on 10/8/25, she had answered the call light for Resident B who told CNA 11 that LPN 10 brought in her medication but left before she could ask for pain medication. Resident B asked CNA 11 to ask LPN 10 for a pain pill. CNA 11 found LPN 10 to let her know Resident B wanted pain medication. LPN 10 told CNA 11 that she had a feeling she was going to ask for that. LPN 10 told CNA 11 she had the pain medication right here and would CNA 11 mind to walk the medication to Resident B. CNA 11 told her she did not mind and took the medication and water to Resident B. During an interview, on 10/29/25 at 2:50 p.m., CNA 7 indicated that CNA's could not administer medication to residents as it was not in their scope of practice. During an interview, on 10/29/25 at 2:52 p.m., LPN 5 indicated that nurses could not give medications to the CNA's to administer to residents. On 10/29/25 at 2:27 p.m., the Executive Director provided a current copy of the document titled Certified Nursing Assistant (CNA) dated 10/14/25. It included, but was not limited to, Summary of Position Functions. The Certified Nursing Assistant provides nursing and nursing related services to residents. Essential Position Functions. Provides direct care. Bathing. Dressing. Elimination/Toileting. Mobility. Transfer. Eating. Grooming. The Past noncompliance began on 10/9/25 at 10:41 p.m. The deficient practice was corrected by 10/14/25 after the facility implemented a systemic plan that included that included the following: All nursing staff were educated on medication administration and scope of practice for Certified Nursing Assistants (10/9/25); One on one education completed with CNA 11 related to scope of practice and violation of company policy for completing a task outside of the scope of practice (10/14/25). 3.1-35(g)(2)</p>		