STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARKSVILLE SENIOR LIVING LLC	400 HUNTER STATION ROAD SELLERSBURG, IN 47172

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00410072, IN00410113 and IN00410141. Complaint IN00410072 - State deficiency related to the allegations is cited at R0052 and R0090. Complaint IN00410113 - State deficiency related to the allegations is cited at R0052 and R0090. Complaint IN00410141 - State deficiencies related to the allegations are cited at R0052 and R0090. An unrelated deficiency cited Survey date: June 11, 12 and 13, 2023 Facility number: 013841 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 16, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident (Resident B), on the locked	R 0052	The creation and submission of this Plan of Correction does not constitute an admission by this	07/07/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	memory care unit, did not exit the facility without supervision for 1 of 3 residents reviewed for neglect; and failed to ensure resident to resident physical abuse did not occur for 4 of 6 residents (Residents E, H, K and L) reviewed for abuse. Findings include: 1. The clinical record for Resident B was reviewed on 6/12/23 at 11:07 a.m. The diagnoses included, but were not limited to, dementia and anxiety. On 6/11/23 at 12:16 p.m., the resident was observed sitting in the dining room eating her lunch. The incident report, dated 6/4/23 at 1:02 p.m., indicated Resident B was out of the facility without appropriate supervision. During a confidential interview during the survey period, Staff Member 2 indicated the resident exited the facility through Resident C's window. Resident B broke the lock off, cut the screen, and exited the facility. There were no window stoppers on the window. Staff Member 2 was told a man picked the resident up in his vehicle and brought her back to the facility. The staff did not know the resident was gone. On 6/11/23 at 12:28 p.m., during an observation of the window Resident B exited out of, the left window lock was observed to be broken with a half of a screen in place. The written statement from Receptionist 7, dated 6/6/23 at 1:30 p.m., indicated a gentleman entered the facility around 1:30 p.m. and asked if the facility had a resident by the name of someone that was not on their roster. The gentleman		provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. RO52 Resident Rights What corrective actions will be accomplished for those residents found to have been affected by the finding: For Resident B, representatives and physicians all notified of incident. Resident B was seen by NP on 6/5. No evidence of injury or psychosocial distress noted. No other residents affected. For resident E, resident no longer resides within community. Other affected residents have been seen by NP and show no signs of psychosocial distress or injury. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: Regarding resident B: No other residents were found to be affected Regarding Resident E: Resident no longer resides within community. Utilization of in house mental health resources are available as needed. What measures will be put in place or what systemic changes the facility will make to ensure	

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	mentioned he saw the woman walking along the road by the pizza place alone and looked confused. The receptionist told the gentleman to check and see if the woman had a drivers license, and if so, see it there was an address and try to take her home. He came back in and told her there was no license and he drove her around. The receptionist then saw the passenger and recognized her as Resident B. The receptionist assisted the resident inside and sat her down at the front desk until she could find a memory care employee. During an interview on 6/11/23 at 12:38 p.m., Receptionist 7 indicated a gentleman came and asked if she knew a name she could not remember or recall. She told him no and the gentleman suggested the receptionist call 911. She told him she could not but that he could. She asked him if the person had a wallet to see what address was on the license. He said the person did not have a wallet on them. He walked back out the door, drove off, and then came back at which time she was standing at the door. She could then see who he was talking about and then realized that the resident did belong at the facility. The gentleman brought her in and she had the resident sit at the desk until she could find someone on the memory care unit. Per the gentleman, Resident B was found at the pizza place up the road. On 6/11/23 at 3:15 p.m., with the Executive Director and Memory Care Coordinator, the facility video of the incident on 6/4/23 was observed. On 6/4/23 at 12:37 p.m., Resident B was in the dining room; at 1:28 p.m., the resident was observed to enter Resident C's room; at 1:32 p..m., the resident was observed ambulating on the side road towards the facility entrance; at 1:37 p.m., a black vehicle was observed to pull up to the front door. A		that the deficient practice does not recur: Regarding resident B: Following survey completion Wellness Director, Regional Nurse and Area VP of Operations and Maintenance Director inspected all memory care windows and doors for security. All windows were secured and doors are in proper working order. Regarding resident E: Resident no longer resides in community. Area VP of Operations and Regional Nurse reviewed identification of reportable incidents and timely reporting to ISDH with Executive Director and Wellness Director. Staff will be inserviced on Abuse prevention and interventions, Reporting guidelines and elopement by 7/7/23 by the Executive Director and Wellness Director or designees. The facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse, reporting and elopement for 8 weeks, then 1 X a month for 4 months. Results will be reviewed monthly by W.D and E.D. Maintenance Director or designee	

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	gentleman got out of the vehicle, went in the building, then exited and got back in his vehicle (the resident was observed in the vehicle on the passenger side) and pulled off; at 1:40 p.m., the gentleman pulled back up to the front of the facility at which time the receptionist was observed to come out of the front door, confirmed to the gentleman that the resident did belong there and the gentleman assisted the resident back into the facility at 1:41 p.m. During a confidential interview during the survey period, Staff Member 3 indicated the window Resident B exited out of did not have any window stoppers. If there were, the resident would not have been able to open it because the staff cannot get them open on the ones that have the plastic stoppers. During a confidential interview during the survey period, Staff Member 4 indicated there were no window stoppers on the window Resident B exited out of prior to the incident. During a confidential interview during the survey period, Staff Member 5 indicated there were no window stoppers on the window Resident B exited out of otherwise, the window would not have opened. During an observation on 6/12/23 at 1:50 p.m., Resident C's room window, on the locked dementia unit, was observed without any holes in the frame where window stoppers would have been screwed in place. During an interview on 6/13/23 at 11:15 a.m., the Maintenance Director indicated the window Resident B exited out of did not have window stoppers in place prior to the incident.		will check memory care doors and windows daily for confirmation of security X 2 weeks and monthly ongoing. Executive Director or designee will confirm and sign checklist weekly for 2 weeks and monthly ongoing. How the corrective action(s) will be monitored to ensure the finding will not recur: Administrator and Wellness Director or designees will review nursing notes daily to ensure reportable incidents are identified and reported in a timely manner per ISDH guidelines. Memory Care window/doors security log will be reviewed and signed daily for 2 weeks and monthly ongoing by ED or designee. By what date the systemic changes will be completed: July 7, 2023	

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	On 6/13/23 at 11:22 a.m., the Maintenance Director indicated they do window checks. On 6/13/23 at 11:48 a.m., the Executive Director provided a copy of the latest window checks, dated 5/8/23. The window check list indicated interior walls and windows will be inspected annually and repaired as necessary to ensure they remain in good condition as well as to create a safe, comfortable and pleasant environment for the building and occupants. The procedure indicated the following: Inspect for cracks or holes in plaster; Inspect for flaking or peeling of paint; Check areas that are in need of repainting; Schedule repairs; Document work performed and maintain records for no less that 2 years unless otherwise indicated. During an observation on 6/13/23 at 1:08 p.m., the distance Resident B traveled on foot off of the facility property to where she was found was one tenth of a mile. On 6/12/23 at 9:38 a.m., the Executive Director provided a current, undated copy of the document titled "Missing Resident - Elopement". It included, but was not limited to, "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents...." 2.a. The clinical record for Resident E was reviewed on 6/12/23 at 11:26 a.m. The diagnosis included, but was not limited to, vascular dementia. The resident was discharged on 6/12/23 to alternate placement. The progress note, dated 12/5/22 at 7:16 p.m., indicated Resident E was standing in the dining			

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	room yelling at staff. The resident started to swing at staff then picked up a cake to throw at the staff. Resident H kicked the resident at which time Resident E started choking Resident H. Resident H was removed from the situation. Resident E's family came to the facility and the decision was made that Resident E's family would take to him to the hospital for psychiatric issues. b. The progress note, dated 3/17/23 at 4:40 p.m., indicated Resident E was yelling at Resident K. Resident E stated "That SOB needs to stay out of my room". Resident E was assisted back to his room and Resident K was assisted to his room. A staff member reported that Resident E slapped Resident K in the back of the head. The progress note, dated 4/1/23 at 3:21 p.m., indicated Resident E grabbed Resident K from behind by the neck while he choked and smacked Resident K in the head. Resident E was sent to the hospital for evaluation. The progress note, dated 4/19/23 at 9:50 a.m., indicated it was reported that Resident E slapped Resident K in the face and then pushed Resident K's wheelchair into the wall. When Resident E was asked why he did that, he responded that Resident K was in his way. While trying to calm resident down, Resident E began to get loud and screamed he would break the other resident's neck as well as the employees. The resident was sent out to the hospital for behaviors. c. The progress note, dated 3/25/23 at 8:57 p.m., indicated Resident E grabbed a hold of Resident L's hair and began shaking her head by her hair. Resident E held down Resident L's arm while he scratched and punched at her arm. Staff separated the two residents. Once separated, Resident E			

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	attempted to charge at Resident L again. Resident E was visibly agitated with a very red face, pacing and hands shaking. Resident E stated the next time he got to Resident L he would choke her. An order was received to send Resident E to the hospital for evaluation. The clinical record lacked any documentation of interventions implemented to protect the other residents after each incident. During a confidential interview during the survey period, Staff Member 9 indicated Resident E went after residents that were in wheelchairs, were defenseless and felt most of the shift was used to redirect Resident E's behaviors which left less time to provide care needed to the other residents. During an interview on 6/13/23 at 11:58 p.m., the Memory Care Coordinator indicated before she came on, the staff would do visual 15 minute checks. Once she started, she implemented paper charting for the 15 minute checks however she could not remember when she started it. During an interview on 6/13/23 at 2:08 p.m., the Executive Director indicated after the incident on 4/1/23, he had reached out to the family with regards to alternate placement. On 6/12/23 at 11:59 a.m., the Executive Director provided a current copy of the document titled "Resident Neglect, Abuse and Misappropriation of Properly" dated 2/2022. It included, but was not limited to, "Policy Statement...Residents will be free from...physical...abuse.... 3. The clinical record for Resident H was reviewed on 6/12/23 at 2:45 p.m. The diagnosis included, but was not limited to, dementia with behavioral			

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	disturbance. The progress note, dated 12/5/22 at 7:42 p.m., indicated Resident H started kicking Resident E when observed swinging at staff. Resident E began choking Resident H. It took 4 staff members to separate Resident E and Resident H. 4. The clinical record for Resident K was reviewed on 6/12/23 at 2:26 p.m. The diagnoses included, but were not limited to, mild memory loss and history of cerebral infarction. The progress note, dated 3/17/23 at 3:59 p.m., indicated Resident E slapped Resident K in the back of the head. The residents were separated and no injuries observed. The progress note, dated 4/1/23 at 1:43 p.m., indicated Resident E was observed with his hands wrapped around Resident K's neck as he choked him and smacked him in the back of the head. The progress note, dated 4/19/23 at 9:50 a.m., indicated Resident E was observed too slap Resident K in the face and then pushed Resident K's wheelchair into the wall. 5. The clinical record for Resident L was reviewed on 6/12/23 at 3:01 p.m. The diagnoses included, but were not limited to, vascular dementia and depression. The progress note, dated 3/25/23 at 6:30 p.m., indicated staff reported Resident E to be physically aggressive towards Resident L. The resident was observed to have scratches to her right arm from the other resident. Resident E approached Resident L, grabbed her by the hair, then scratched and punched her right arm.			

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	Resident L was assisted to the nurse station and provided one on one with staff. This State tag relates to Complaint IN00410072, IN00410113 and IN00410141			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:			

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	(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility management failed to ensure an unusual occurrence of resident to resident abuse was reported, as required, to the Indiana Department of Health for 4 of 5 incidents reviewed for abuse. (Residents E, H, K and L) Findings include: 1. The clinical record for Resident E was reviewed on 6/12/23 at 11:26 a.m. The diagnosis included, but was not limited to, vascular dementia. The progress note, dated 12/5/22 at 7:16 p.m., indicated Resident E was standing in the dining room yelling at staff. The resident started to swing at staff then picked up a cake to throw at the staff. Resident H kicked the resident at which time Resident E started choking Resident H. Resident H was removed from the situation. Resident E's family came to the facility and the decision was made that Resident E's family would take to him to the hospital for psychiatric issues.	R 0090	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. R 090 What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were found to be affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All nursing observation notes will be reviewed daily by W.D and/or E.D. or designee. No other residents were found to be	07/07/2023

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	The progress note, dated 3/17/23 at 4:40 p.m., indicated Resident E was yelling at Resident K. Resident E stated "That SOB needs to stay out of my room". Resident E was assisted back to his room and Resident K was assisted to his room. A staff member reported that Resident E slapped Resident K in the back of the head. The progress note, dated 3/25/23 at 8:57 p.m., indicated Resident E grabbed a hold of Resident L's hair and began shaking her head by her hair. Resident E held down Resident L's arm while he scratched and punched at her arm. Staff separated the two residents. Once separated, Resident E attempted to charge at Resident L again. Resident E was visibly agitated with a very red face, pacing and hands shaking. Resident E stated the next time he got to Resident L he would choke her. An order was received to send Resident E to the hospital for evaluation. The progress note, dated 4/19/23 at 9:50 a.m., indicated it was reported that Resident E slapped Resident K in the face and then pushed Resident K's wheelchair into the wall. When Resident E was asked why he did that, he responded that Resident K was in his way. While trying to calm the resident down, Resident E began to get loud and screamed he would break the other resident's neck as well as the employees. The resident was sent out to the hospital for behaviors. Review of the reportables lacked documentation that the above abuse incidents were reported to the Indiana Department of Health. 6/13/23 at 11:10 a.m., the Executive Director indicated all abuse and alleged abuse should have been reported to the State.		affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All nursing observation notes will be reviewed daily and all reportable incidents found will be reported to ISDH within 24 hours. Staff will be inserviced on identification and proper reporting of all incidents. Area VP of Operations and Regional Nurse reviewed identification of reportable incidents and timely reporting to ISDH with Executive Director and Wellness Director. A daily log will be kept and signed of observation note review and signed by ED or designee ongoing. Staff will be inserviced on Abuse prevention and interventions, Reporting guidelines and elopement by 7/7/23 by the Executive Director and Wellness Director or designees. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse, reporting and elopement for 8 weeks, then 1 X a month for 4 months. Daily log will be kept regarding review of observation notes to identify reportable incidents, ongoing. How the corrective action(s) will be monitored to ensure the finding will	

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	On 6/12/23 at 2:05 p.m., the Executive Director provided a current copy of the document titled "Reportable Occurrence" dated 2/2022. It included, but was not limited to, "Policy...It is the policy of this community to report...the unusual occurrences per IDOH policy...Procedure...The following occurrences will be reported to IDOH...within 24 hours of occurrence...Occurrence that directly threatens the welfare, safety...of a resident, including...Abuse...physical...." 2. The clinical record for Resident H was reviewed on 6/12/23 at 2:45 p.m. The diagnosis included, but was not limited to, dementia with behavioral disturbance. The progress note, dated 12/5/22 at 7:42 p.m., indicated Resident H started kicking Resident E when observed swinging at staff. Resident E began choking Resident H. It took 4 staff members to separate Resident E and Resident H. 3. The clinical record for Resident K was reviewed on 6/12/23 at 2:26 p.m. The diagnoses included, but were not limited to, mild memory loss and history of cerebral infarction. The progress note, dated 3/17/23 at 3:59 p.m., indicated Resident E slapped Resident K in the back of the head. The residents were separated and no injuries observed. The progress note, dated 4/19/23 at 9:50 a.m., indicated Resident E was observed too slap Resident K in the face and then pushed Resident K's wheelchair into the wall. 4. The clinical record for Resident L was reviewed on 6/12/23 at 3:01 p.m. The diagnoses included, but was not limited to, vascular dementia.		not recur: Administrator and Wellness Director or designees will review nursing notes daily to ensure reportable incidents are identified and reported in a timely manner per ISDH guidelines. Daily log of review will be kept and review and signed by AVP of Ops monthly. By what date the systemic changes will be completed: 7/7/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The progress note, dated 3/25/23 at 6:30 p.m., indicated staff reported Resident E to be physically aggressive towards Resident L. The resident was observed to have scratches to her right arm from the other resident. Resident E approached Resident L, grabbed her by the hair, then scratched and punched her right arm. Resident L was assisted to the nurse station and provided one on one with staff. This State tag relates to Complaints IN00410072, IN00410113 and IN00410141			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure a resident (Resident G) on the memory care unit did not have access to chemicals for 1 of 3 residents reviewed for chemical storage.	R 0148	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	07/07/2023

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	Findings include: The clinical record for Resident G was reviewed on 6/13/23 at 11:42 a.m. The diagnosis included, but was not limited to, dementia. On 6/11/23 at 1:06 p.m., during an observation of Resident G's apartment, wet paper towels were observed on the floor along the left side of the resident's dresser. Ants were observed crawling on the floor beside the dresser, on top of the dresser, and on the base board behind the dresser. The resident went to her bathroom and returned with Comet multi-surface spray cleaner (warning label indicated to avoid contact with eyes and maybe harmful if swallowed). She sprayed the floor and the top of her dresser, then wiped the top of the dresser with her hand to spread the spray around to kill the ants. She could not recall where she obtained the spray. On 6/11/23 at 1:15 p.m., during an observation and interview Staff Member 2 was informed of the chemical spray and ants in the resident's room. Staff Member 2 indicated she did not believe the resident should have had the spray in her room. On 6/11/23 at 1:55 p.m., during an interview, when the management staff arrived, the Memory Care Coordinator indicated she was not aware of the chemical spray in the resident's room. The residents on the dementia unit were not suppose to have chemicals in their rooms. On 6/11/23 at 2:12 p.m., during an observation of Resident G's apartment the chemical spray was still observed in the resident's room. On 6/11/23 at 2:15 p.m., during an interview and observation Staff Members 2 and 3 indicated the		R148 What corrective actions will be accomplished for those residents found to have been affected by the finding: No residents were affected. How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All MC rooms were checks and no harmful chemicals were found. No other residents affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Following survey completion all MC rooms were checked for harmful chemicals. Checks will take place by W.D, ED or designee daily X 2 week and monthly ongoing. Any harmful chemical or other items found to be harmful will be removed immediately. How the corrective action(s) will be monitored to ensure the finding will not recur: Log of checks will be kept, reviewed and signed by ED or	

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	Memory Care Coordinator asked them to remove the chemical from Resident G's apartment. The two staff members were walking towards the resident room to remove the chemical. On 6/13/23 at 2:05 p.m., the Executive Director indicated they did not have a policy for chemical storage.		designee daily X 2 weeks and monthly ongoing. By what date the systemic changes will be completed: 07/07/2023	