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	03/25/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00429964. Complaint IN00429964 - No deficiencies related to the allegations are cited. An unrelated deficiency cited. Survey dates: March 22 and 25, 2024 Facility number: 013841 Residential Census: 96 This State residential finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 2, 2024.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. The statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of a revisit.	
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 interview and record review, the facility failed to ensure resident to residents physical abuse did not occur for 4 of 5 residents reviewed for abuse. (Resident C, H, D and E) Findings include: 1. During an observation on 3/22/24 at 2:25 p.m., Resident C was observed ambulating,	R 0052	**Corrective Action(s) for Residents Affected by the Deficient Practice:** Residents C, H, D, and E continue to reside at the community and did not recall any incident. Residents were immediately assessed and no injuries noted. Resident C's care plan was	05/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Jones	Executive Director	04/16/2024

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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	independently, down the hallway to the left of the nurses station. She showed no distress or any behaviors during the observation. There were no staff present at the time of the observation. During an interview on 3/25/24 at 2:45 p.m., the Executive Director indicated she had become more involved with the resident since Resident C's most recent hospital return on 3/7/24. The previous Wellness Director was more involved prior but had since left. The Ed indicated the resident's family member reported prior to admittance the resident was combative towards famiuly. She felt all the incidents that Resident C had been involved in were medication related. Staff would put her medication in ice cream and with her paranoia, the resident would not take the medication thinking they were trying to poison her. A nursing progress note, dated 2/9/24 at 11:30 a.m., indicated Resident C returned to facility from a behavior hospital. New orders were faxed to the pharmacy. Family were aware of the resident's return to facility. A nursing progress note, dated 2/19/24 at 5:07 p.m., indicated Resident C had been combative towards a staff member. The staff member witnessed Resident C take an item from another resident, the staff member tried to redirect Resident C and Resident C slapped the staff member in the face. An incident report, dated 2/24/24 at 12:15 p.m., indicated Resident C hit Resident H in the arm with rolled silverware. A progress note, dated 2/24/24 at 12:22 p.m., indicated Resident C hit Resident H's left lower		updated and reflects her individualized programming needs with increased family involvement. **Corrective Action(s) for Other Residents Potentially Affected:** All other memory care residents have the potential to be affected by this deficient practice; however, none were affected. **Measures to Ensure the Deficient Practice Does Not Recur:** Memory care staff will be educated on the care plan and interventions as well as dementia training including prevention of aggressive behaviors. Education will be presented by the Director of Cognitive Services, the Wellness Director, the Memory Care Coordinator and/or the Executive Director by 5/5/2024. Newly hired memory care staff will be educated during orientation by the Memory Care Director. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur:** The Wellness Director and/or the Executive Director will review residents on memory care to ensure the residents are receiving medications timely per plan of care, individualized interventions are being followed, and staff are aware of any residents being monitored per care tracker and electronic medical record. The audit will include at least 3 residents with documented	

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	arm with rolled silverware. Resident C was removed from the situation. There were no injuries noted to Resident H and she denied any pain or discomfort. Resident C was immediately removed from the situation to calm her down, but continued to be verbally aggressive toward staff and other residents. A progress note, dated 2/24/24 at 6:30 p.m., indicated Resident C was to be on 1 to 1 (one resident to one staff) supervision per the Executive Director. The record for Resident C was reviewed on 3/22/24 at 1:19 p.m. The resident's diagnosis included, but was not limited to, dementia. The record for Resident H was reviewed on 3/25/24 at 12:31 p.m. The resident's diagnosis included, but was not limited to, dementia. 2. An incident report, dated 2/25/24 at 6:10 p.m., indicated Resident C hit Resident D in the stomach after supper in the dining room area. The residents were immediately separated. The witness statement, dated 2/25/24 and untimed, indicated CNA (Certified Nursing Aide) 10 observed Resident C yell at Resident D in the dining area. Resident C punched Resident D in the stomach before CNA 10 could get to her. The residents were separated. Resident C continued to be aggressive towards the staff. The clinical record for Resident D was reviewed on 3/22/24 at 2:02 p.m. The resident's diagnoses included, but were not limited to, dementia and anxiety. A nursing progress note, dated 2/25/24 at 6:11		behaviors each week for 4 weeks then 2 residents weekly for 4 weeks then 1 resident weekly for 4 weeks. The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	p.m., indicated Resident C walked up to Resident D and was verbally aggressive. Before staff could get to the residents, Resident C proceeded to punch Resident D in the stomach. Resident D was assessed with no injures observed. Resident D denied any pain or discomfort. A nursing progress note, dated 2/25/24 at 6:12 p.m., indicated Resident C walked up to and was verbally aggressive towards Resident D. Before staff could get to the residents, Resident C proceeded to punch Resident D in the stomach. Two staff members redirected Resident D as Resident C continued to proceed towards Resident D. Resident C was redirected to the nurse's station where she continued to be verbally aggressive towards the staff. Resident C was placed on one resident to one staff member's supervison (1:1) for 5 (five) minutes. The clinical record lacked documentation of increased supervision for Resident C to prevent further altercations after the 1:1 supervision for 5 minutes was completed on 2/25/24. A nursing progress note, dated 2/26/24 at 3:58 p.m., indicated the psychiatric nurse practitioner was at the facility with a new order for Resident C to be within the line of sight of the staff while she was awake due to aggression. 3. An incident report, dated 2/26/24 at 4:20 p.m., indicated Resident E came to the common area and reported to staff that Resident C was in Resident E's room. Resident C struck Resident E in the back. The clinical record for Resident E was reviewed on 3/22/24 at 2:13 p.m. The diagnoses included, but were not limited to, dementia, atrial fibrillation, history of breast cancer and anxiety.			

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	A facility incident assessment report, dated 2/26/24 at 4:45 p.m., indicated Resident E had red marks on the right side of her face and ear after a resident-to-resident physical altercation with Resident C. The incident task report, dated 2/26/24 at 4:45 p.m., indicated the staff heard Resident E yelling at Resident C down the hallway by Resident E's room. Resident E stated Resident C tried to get in Resident E's room then started hitting and kicking her. Resident E had red marks on the right side of her face and scratches on the right side of her outer ear. The residents were immediately separated. The nursing progress note, dated 2/26/24 at 4:48 p.m., indicated staff heard Resident E yelling at Resident C down the hallway near Resident E's room. LPN (Licensed Practical Nurse) 4 witnessed Resident E standing outside the threshold of her bedroom door, screaming at Resident C to stay out of her room. Resident E reported Resident C tried to get in her room at which time Resident C started hitting and kicking Resident E. The LPN then went to intervene with the resident to resident aggressive behavior. During an interview on 3/25/24 at 2:53 p.m., LPN 4 indicated on 2/26/24, prior to the incident on 2/26/24, the resident had been with activities staff. Resident C had gotten up from the activity, left the activity, and effective continuous supervision to prevent resident-to-resident physicial altercations was not provided. During an interview on 3/25/24 at 2:55 p.m., Activity Assistant 3 indicated on 2/26/24, Resident C did get up and leave the activity. She			

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	could not follow the resident as she had to stay engaged in the activity with the other residents. During an interview on on 3/25/24 at 3:00 p.m., Activity Assistant 5 indicated on 2/26/24, she was in the activity room providing a happy hour activity. She was not aware or see Resident C get up and leave the activity. On 3/25/24 at 12:15 p.m., the Executive Director provided a current copy of the document titled "Resident Neglect, Abuse and Misappropriation of Property" dated 6/2014. It included, but was not limited to, "Policy Statement...Residents will be free from...physical...abuse...."			