STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Gardens	375 S 11th St Clinton, IN 47842

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 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 observation, record review, and interview, the facility failed to ensure a physician ordered medication was administered and documented appropriately for 1 of 3 residents reviewed for quality of care. (Resident B) Findings include: During an interview on 6/9/25 at 1:35 p.m., Resident B indicated he had not received his nicotine patch 3-4 days last week and then again today. During the interview with Resident B, QMA 3 entered the room with his pain medication and indicated she had not applied his nicotine patch this morning because he had been in therapy. During a follow-up interview on 6/9/25 at 2:20 p.m., Resident B indicated QMA 3 had returned to his room, around 1:40 p.m., shortly after the initial interview and applied his nicotine patch. The clinical record for Resident B was reviewed on 6/9/25 at 12:21 p.m. Diagnoses included displaced right hip fracture with routine healing following surgical intervention, chronic obstructive pulmonary disease, and adjustment disorder with depressed mood. Current signed physician's orders for the resident included, Nicotine patch 21 mg (milligram)/24 hours, apply one patch daily between 7:00 a.m. and 11:00 a.m. Special instructions indicated to remove old patch before applying a new one and to rotate administration sites. The order was dated 5/30/25. A Proof of Delivery record, dated 4/30/25 to 6/9/25, for Resident B included Nicotine 21 mg/24 hour patch, shipped 30 patches on 5/30/25 and received 5/31/25 at 3:32 a.m. A review of the residents electronic medication administration record (eMAR) indicated the nicotine patch had been administered daily per physician's order, beginning on 5/31/25. An administration history record, provided by the DON on 6/9/25 at 3:14 p.m., indicated the nicotine patch had been administered on 6/9/25 at 10:44 a.m. by QMA 3, not the actual administration time of 1:40 p.m. A medication count for Resident B's nicotine patches was completed with QMA 6 on 6/9/25 at 2:05 p.m. QMA 6 indicated there were 23 patches remaining in the medication sleeve. The count according to the eMAR and administration history record, should have been 20 patches remaining in the medication sleeve. (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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(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	During a telephone interview on 6/10/25 at 4:01 p.m., QMA 3 indicated she had administered Resident B's medications at 10:44 a.m., but had forgotten to open the nicotine patch to place on the resident. When she returned to the resident's room, he had gone to therapy and she forgot about it until later in the day. It had been documented as given because she had intended to apply the patch at the time. She realized the medication should not be documented as given until it was administered. The eMAR for the administrations from the previous week was documented accurately and she had provided the patch to the resident. She had no knowledge of the patch not being administered as ordered. During an interview on 6/10/25 at 3:14 p.m., the DON indicated the patch had been pulled from the medication cart with the oral medications on 6/9/25 and had not been administered with his oral medications because he had gone to therapy. She must have forgotten and applied it after 1:00 p.m. and marked it as administered at 10:44 a.m. They prefer staff mark as administered following administration of the medications. She had interviewed the previous week's nursing staff who had documented administering the nicotine patch, and all had indicated they had administered the patch. She could not explain why there were three patches that were unaccounted as being administered remaining in the medication cart. A current facility policy, revised 6/30/23, titled, General Dose Preparation and Medication Administration, provided by the Administrator on 6/9/25 at 3:26 p.m., included the following: Procedure 7. After medication administration, the community should: 7.1 Document necessary medication administration/assistance/observation/treatment information (e.g., when medications are opened, when medications are give, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms or electronic medication records. This citation relates to Complaint IN00460788. 3.1-25(a)