STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00460697, IN00460788, and IN00461234. Complaint IN00460697 - No deficiencies related to the allegations are cited. Complaint IN00460788 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00461234 - No deficiencies related to the allegations are cited. Survey dates: June 9 and 10, 2025 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 3 Medicaid: 45 Other: 23 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2025.	F 0000	The filing of this plan of correction does not constitute an admission that the deficiencies did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records	F 0755	·No residents had a negative	07/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Brewer	Executive Director	06/25/2025

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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	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		outcome related to the alleged deficient practice ·All residents who receive medications from staff have the potential to be affected by the alleged deficient practice. ·The DNS/designee will provide education to licensed nurses and QMA's on medication administration procedure on or before 7/3/25 ·The DNS/designee will provide education to licensed nurses and QMA's on medication administration procedure on or before 7/3/25 ·The staff administering a medication will administer the medication per order and document that the medication was administered after the actual administration ·Once weekly, the Staff Development Coordinator/designee will observe one medication administration for each shift ·Medication Administration skills validation check will be completed on all shifts daily for one week, bi weekly for 1 week, weekly times 2 week, and monthly for six months by DNS/Designee . Results of the skills validation will be reviewed by the QAPI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance.	

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	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. 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		Deficiency in this practice will result in disciplinary action up to and including termination of the employee responsible.	

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	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)			