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	08/11/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident had effective pain management for 1 of 2 residents reviewed for pain management (Resident 43). Findings include:On 8/05/2025 at 2:42 p.m., during an interview, Resident (43) indicated she received pain medication twice daily and indicated it was not helping to control her pain. The resident had asked for an increase in pain medication but was told she could not have more. She indicated they did administer Tylenol, but it was not effective. The resident demonstrated physical signs of pain during interview. On 8/08/2025 at 9:39 a.m., the medical record of Resident 43 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but not limited to displaced intertrochanteric fracture of right femur (fracture of the right thigh bone), subsequent encounter for closed fracture with routine healing, Congestive Heart Failure (CHF) (a condition that develops when your heart doesn't pump enough blood for your body's needs) and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A Minimum Data Set (MDS) assessment, dated 8/1/25, indicated the resident required extensive assistance for daily care needs and was cognitively intact. A 48 hour admission care plan and comprehensive care plan lacked documentation of a care plan for pain management. A physician order, dated 7/26/25, indicated to administer oxycodone (a narcotic pain medication) 5 mg (milligram) tablet twice a day (BID) and hold for sedation. The order was discontinued on 7/29/25. A nurse's note, dated 7/28/25 at 11:41 a.m., indicated Resident is having moderate pain to her right leg throughout this morning. Tylenol has no relief at present. Resident is post-op (post-surgery) right femur (long thigh bone). Resident has an order for oxycodone 5 mg by mouth, bid (twice daily). Resident does not have this prescription active in house. Notified attending physician of new admission to the facility and brief description of her pain and need for medication to be called in to Omnicare Indianapolis. The medical record lacked documentation of physician notification of increased pain. The July 2025 Medication Administration Record (MAR) indicated the facility failed to provide pain medication from 7/26/25 to 7/28/25. The record lacked documentation of notification to the physician of medication availability prior to 7/28/25. A physician order, dated 7/28/25, indicated to administer acetaminophen (Tylenol, a medication used to manage pain or fever) 650 mg orally as needed every 6 hours as needed (PRN) for mild pain or discomfort. Do not exceed 3g (grams) in 24 hours. A physician order, dated 7/29/25, indicated to administer Tramadol (a narcotic pain medication) - Schedule IV tablet 50 mg orally twice a day for pain. Review of the July 2025 Medication Administration Record (MAR) indicated the resident was not administered oxycodone pain medication from 7/26/25 to 7/28/25. The record indicated the medication was not available. The July 2025 MAR indicated Resident 43 received the following pain medications: On 7/28/25 at 9:12 a.m. Tylenol 650 mg was administered, and the PRN response indicated the medication was not effective for the resident's pain. No pain scale rating from 0-10 was provided. On 7/28/25 at 3:59 p.m., Tylenol was then administered, and the PRN response (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the medication was somewhat effective for the resident's pain. No pain scale rating from 0-10 was provided. On 7/29/25 at 1:14 a.m., Tylenol was administered for pain of 8 out of 10 and the PRN response indicated it was effective. No follow up pain scale rating was provided to show the resident's pain level after the medication. On 7/29/25 between 7 a.m. and 11 a.m., Tramadol 50 mg was administered. On 7/29/25 at 3:31 p.m., Tylenol was administered for pain of 9 out of 10 and the PRN response indicated it was effective. No follow up pain scale rating was provided to show the resident's pain level after the medication. On 7/29/25 between 7 p.m. and 11 p.m., Tramadol 50 mg was administered. On 7/30/25 at 5:28 a.m., Tylenol was administered for pain of 8 out of 10 and the PRN response indicated the medication was somewhat effective. No follow up pain scale rating was provided to show the resident's pain level after the medication. On 7/30/25 between 7 a.m. and 11 a.m., Tramadol 50 mg was administered. On 7/30/25 at 12:23 p.m., Tylenol was administered for pain of 8 out of 10 and the PRN response indicated the medication was effective. No follow up pain scale rating was provided to show the resident's pain level after the medication. On 7/30/25 between 7 p.m. and 11 p.m., Tramadol 50 mg was administered. On 7/30/25 at 11:20 p.m., Tylenol was administered for pain of 8 out of 10 and the PRN response indicated the medication was effective. No follow up pain scale rating was provided to show the resident's pain level after the medication. A nurse's note, dated 8/4/25, indicated, Resident frequently stating she has right leg pain. Resident does take Tramadol 50 mg po [by mouth] bid with Tylenol in between. Pending further orders. On 8/8/25 at 10:20 a.m., during an interview Registered Nurse (RN) 7 indicated she would call the physician if a prescription were needed to obtain a narcotic from the Emergency Drug Supply Kit (EDK). If it was on a weekend, they would call the on-call physician to obtain an order. She indicated she would notify the Director of Nursing if pain medication was not effective. She had notified the physician the previous week regarding Resident 43's increased pain and advised the physician medication was not effective. She did not recall when she had the conversation with the physician and acknowledged she had not documented the notification to the physician. On 8/8/25 at 10:30 a.m., during interview the Director of Nursing (DON) indicated she did not know why the Oxycodone was not administered or why the documentation of pain medication lacked follow up pain scale to determine if medication was effective and pain was relieved. On 8/8/2025 at 11:57 a.m., the Administrator provided a document titled, Pain management policy, dated 7/2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure 1. Residents are assessed for pain upon admission, weekly and during medication administration as outlined below. 2. The following will be used when assessing pain.ongoing nursing assessments can also be documented in matrix progress notes or matrix vitals. 3. Interviewable resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10).Mild=(1-2) Moderate = (3-5) Severe = (6-8) Very severe, horrible = (9-10).5. The physician will be notified of unrelieved or worsening pain.9. Additional information including, but not limited to reasons for administration, and effectiveness of pain medication will be documented on the Electronic Medication Administration Record (EMAR). On 8/8/2025 at 11:57 a.m., the Administrator provided a document titled, Medication Shortages/Unavailable Medications, dated 1/1/13, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.3. If a medication shortage is discovered after normal pharmacy hours.3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action.5. If the medication is unavailable from the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacy or a Third [NAME] Pharmacy, and cannot be supplied from the manufacturer, facility should obtain alternate Physician/Prescriber orders as necessary. 3.1-37(a)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to administer medication according to physician orders and held medications without a physician order for 1 of 5 residents reviewed for unnecessary medications (Resident 6). Findings include:On 8/7/25 at 11:00 a.m., the medical record of Resident 6 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, Cerebral Vascular Accident (CVA) (stroke), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high).A physician order, dated 7/16/25, indicated to administer insulin glargine (the process of administering the hormone, insulin to a person, by injection to help regulate their blood sugar levels) 100 unit/mL (milliliter) (3 mL); amount: 10 units; subcutaneous (under the skin) twice a day.A physician, dated 3/27/25, indicated to administer lispro insulin 100 unit/mL; amt: 8 units; subcutaneous four times a day.A physician order, dated 3/27/25, indicated to administer lispro insulin 100 unit/mL; subcutaneous four times a day, amt: Per Sliding Scale (a measurement to determine amount of insulin to be administered based on the blood sugar reading). If Blood Sugar is 141 to 180, give 1 Units. If Blood Sugar is 181 to 220, give 1 Units. If Blood Sugar is 221 to 260, give 2 Units. If Blood Sugar is 261 to 300, give 3 Units. If Blood Sugar is 301 to 340, give 4 Units. If Blood Sugar is 341 to 380, give 5 Units. If Blood Sugar is 381 to 420, give 6 Units. If Blood Sugar is 421 to 460, give 7 Units. If Blood Sugar is greater than 460, call MD (medical doctor).Review of the Electronic Medication Administration Record (EMAR) from 7/1/25 to 7/31/25 indicated the resident was to be administered insulin twice daily and sliding scale insulin coverage four times per day. The record indicated the resident refused insulin 39 times and the scheduled insulin and sliding scale insulin was held (not administered) 46 times. The EMAR from 8/1/25 to 8/6/25 indicated the resident's insulin was held 10 times and the resident refused insulin 24 times. The physician orders lacked documentation of an order to hold insulin. The record indicated a space was provided on the EMAR to record if the physician was notified. Each entry indicated the physician was not notified.A quarterly Minimum Data Set (MDS) assessment, dated 6/25/25, indicated the resident was severely cognitively impaired. The resident was administered daily insulin and was on the following high risk medications, hypoglycemic medications (medications administered to control diabetes), anticoagulant (blood thinner medication), and diuretic medication medications to reduce the excess fluid in the body). A care plan, dated 3/28/25, indicated resident was at risk for adverse effects of hyperglycemia (high blood sugar), or hypoglycemia (low blood sugar) related to use of glucose lowering medication and/or diagnosis of diabetes mellitusInterventions, dated 3/28/2025, included but were not limited to. Diet as ordered, monitor intakes and offer replacements for 50% or less consumption, medications as ordered, monitor blood sugars as ordered, document abnormal findings, and notify physician.The care plan lacked documentation of medication refusal or interventions.On 8/7/25 at 10:05 a.m., during an interview, the Unit Manager indicated if a resident refused to take their medication she would notify the physician after several refusals. She indicated she would hold insulin if a resident refused or if they were not eating. She indicated she would notify the doctor.On 8/7/25 at 10:17 p.m., during an interview, Licensed Practical Nurse (LPN) 3 indicated if the resident refused insulin she would notify physician and document the refusal and notification in the nurses' notes. She would hold insulin if there was an order to hold it based on the physician order. She would contact the physician before holding. If the resident refused insulin she would notify physician immediately.On 8/7/25 at 10:20 p.m., during an interview, Qualified Medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aide (QMA) 4 indicated that if a resident refused medications she would document the refusal and ask the nurse to notify the physician if needed.On 8/7/25 at 10:28 a.m., during an interview, the Director of Nursing (DON) indicated the resident refused medications often and the physician was aware.On 8/7/25 at 12:04 p.m., during phone interview with the resident's Physician she indicated she was aware the resident had refused his medications and his insulin numerous times. She indicated she had asked pharmacy to review the medications to determine what could be reduced. She acknowledged she had not given an order to hold insulin if the resident did not eat or to hold insulin if there was a change in condition.The facility was unable to provide a specific policy for notification of refusal of medications or parameters and/or physician orders to hold medications.3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure a medication prescription label matched the physician's order for 1 of 35 medication administrations observed (Resident 28). Findings include:On 8/8/25 at 8:47 a.m. Qualified Medication Aide (QMA) 9 administered mirtazapine (antidepressant) 15 milligrams (mg), 2 tablets to Resident 28. The label on the mirtazapine medication card, dated 7/8/25, indicated mirtazapine 15 mg, 1 tablet by mouth daily. There was no directions changed sticker or indication that two tablets were ordered. At the same time, QMA 9 indicated the medication order was changed to two tablets on 8/4/25. Resident 28's record was reviewed on 8/8/25 at 2:39 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/23/25, indicated the resident had a moderate cognitive impairment and received an antidepressant during the assessment look-back period. A physician's order, dated 7/9/25 and discontinued on 7/15/25, indicated mirtazapine 15 mg by mouth once daily for appetite stimulation A physician's order, dated 7/15/25 and discontinued on 8/4/25, indicated mirtazapine 7.5 mg by mouth once daily for appetite stimulation. A physician's order, dated 8/4/25, indicated mirtazapine 30 mg by mouth once daily for appetite stimulation. During an interview, on 8/8/25 at 2:26 p.m., QMA 8 indicated when a medication order was changed, and the order on the medication card was different than the physician's order, there should have been a directions changed sticker placed on the card. This alerted the staff of an order change. When the new medication card came in, the old one should have been removed from the medication cart. On 8/8/25 at 2:50 p.m., the Administrator provided a document titled, Reordering, Changing, and Discontinuing Orders, last revised on 1/1/13, and indicated it was the policy currently being used by the facility. The policy indicated, .Change Orders: Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order.If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a ‘Change in Directions' sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. 3.1-25(j)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an influenza vaccination was offered or administered to 1 of 5 residents reviewed for immunizations (Resident 1). Findings include:Resident 1's record was reviewed on 8/11/25 at 10:39 a.m. Census information indicated the resident was hospitalized from [DATE] to 9/17/24, 10/31/24 to 11/1/24, and 11/17/24 to 11/18/24. The resident's preventative health care record, dated 10/31/24, indicated the influenza vaccine was not administered related to other-transferred to hospital for further evaluation. The preventative health care record lacked further documentation regarding the resident's influenza vaccine. Progress notes, dated September 2024 to December 2024, lacked documentation the influenza vaccine was offered or declined during the flu season, or evidence it was clinically contraindicated. During an interview, on 8/11/25 at 1:25 p.m., the Director of Nursing Services (DNS) indicated the resident was not given an influenza vaccine because of her condition. The DNS indicated the resident was hospitalized several times and had nausea and vomiting so it was not administered, but there was no documentation in the resident's record to support the vaccine was clinically contraindicated. It should have been documented. On 8/11/25 at 2:18 p.m., the Administrator provided a document titled, Employee Influenza (Flu) Vaccine Policy, last revised on 9/13/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: The Centers for Disease Control (CDC) recommend that all persons aged 6 months and older get vaccinated against influenza unless there are specific medical contraindications as to why they should not. 3.1-13(a)(1)