STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185469	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Place	106 Padgett Drive Clinton, KY 42031

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents' rights were protected related to meal service for 2 residents out of the 20 sampled residents, (Resident (R)70 and R81).The findings include: Review of the facility policy titled, Resident Rights, dated 01/02/2020, revealed residents had the right to be treated with respect and dignity, including the right to a dignified existence, self-determination, and access to services inside the facility. Observation of the dining service on 08/27/2025 at 11:35 AM, revealed staff were serving the first table with all residents served their meals except R81. Per observation, staff moved to serve residents at the second table before serving R81 the meal. Continued observation revealed all residents at the second table were served their meals except R70 with staff moving to serve another table before R70 received his meal. In interview on 08/27/2025 at 11:40 AM, Certified Nurse Aide (CNA) 1 stated she was aware all residents should be served at one table before moving to serve residents at another table. She reported they had taken the trays from the window that were provided by kitchen staff and believed the kitchen staff had prepared trays according to the meal cards. CNA 1 said she believed the concern was with the meal cards not being in the correct order in the kitchen and that caused the delay in R81's and R70's trays being served. Additionally, she stated staff should follow the guidelines when serving meals to ensure residents were not upset but believed they had corrected the situation as soon as possible. In interview on 08/29/2025 at 9:15 AM, CNA 3 stated she assisted with meal service when needed. She reported every resident had rights in the facility and staff should serve meals to all residents sitting at a table with multiple residents before moving to serve another table. CNA 3 further stated it was important that meal services not exclude residents to ensure their rights were respected and not create unnecessary stress. In an interview on 08/29/2025 at 10:35 AM, the Dietary Manager (DM) stated she was aware all residents should be served at the same table before staff moved to another table. The DM said however, there had been a miscommunication error in the kitchen. She reported R81, who was seated at the first group table served, had ordered food from the alternative menu and she had instructed kitchen staff to put that meal card on the counter, but it had been placed at the bottom of the meal card pile. The DM stated she was responsible for ensuring the meal cards were in order for the groups of residents at each table. She explained she had not been aware until that day, that R70 had also not been served with everyone at the second group table on 08/27/2025. The DM said she understood residents' rights were not respected when that type of thing occurred. She stated when that occurred some residents who were sensitive might feel left out watching others eat while they were not being served. She further stated that was not a normal occurrence and she had apologized to all residents. In interview on 08/29/2025 at 2:30 PM, the Administrator stated her expectations were for staff to serve all residents at one table before moving to another table and that the problem should never have happened. She reported she was aware there had been some confusion with the meal cards being in order due (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to residents ordering from the alternative lunch food. The Administrator said however, the CNAs who were serving residents' trays should have caught that and corrected the issue immediately. She further stated she did not believe harm had occurred, but the residents involved might have gotten upset and felt they had been forgotten and that was certainly not acceptable.

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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 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, interview, and facility policy review, the facility failed to store medication in accordance with accepted standards of practice, which had the potential to affect 83 out of 83 facility residents. The findings include: Observation of the facility's Long Hall medication storage room on 08/28/2025 at 9:00 AM revealed seven tablets of Ondansetron (Zofran) 4 milligrams (mg) in a blister pack, not labeled with a resident's name, and with no expiration date on it. Further observation revealed that the Ondansetron was located in a plastic bin containing miscellaneous items, such as a flashlight and a toothpaste tube, stored above the sink. In interview on 08/29/2025 at 10:28 AM, Licensed Practical Nurse (LPN) 2 reported that the pharmacy checked the facility's emergency boxes. The LPN said the night shift nurses were supposed to check for expired medications in the medication rooms. LPN 2 stated the night shift nurses were also to maintain medications by ensuring the medication was labeled and ensure expired medications in the medication room was discarded. The LPN further stated, however, the entire night shift staff were new and were learning the facility's process. In interview on 08/29/2025 at 10:55 AM, the Director of Nursing (DON) reported that the nurses who were on shift were supposed to be checking the medication room for expired and unlabeled medications and maintaining the organization of the rooms. In interview on 08/29/2025 at 2:21 PM, the Administrator stated that medications should be stored in their proper place and that expired medications should be removed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to store food in accordance with professional standards for food service safety, which had the potential to affect 20 of the facility's 83 residents. The findings include: Review of the facility policy titled, Food Safety Requirements reviewed 06/2025, revealed the facility was to store food in accordance with professional standards for food service safety. Further review revealed refrigerated items should include labeling and dating of the food items, so it was used by its use-by date. Observation of the nutrition refrigerator on the facility's Lighthouse Unit on 08/28/2025 at 9:15 AM, revealed two opened Thickened Water with Lemon containers dated with received dates of 06/17/2025 and 07/08/2025, with no documented opened date. Per observation, additional opened items that were undated, and unlabeled included: a container of Crangrape juice that was half full; a half full container of Electrolit beverage; an opened, uncovered stick of butter; a 12-ounce bottle of Coke, and two water bottles that were half full. Continued observation revealed a ham sandwich and a pimento cheese sandwich that were undated and unlabeled, and a small bowl of pudding covered with plastic wrap that was unlabeled and undated. Further observation revealed a pitcher of lemonade with a preparation date of 08/21/2025 and a use-by date of 08/25/2025. In interview on 08/28/2025 at 9:57 AM, Registered Nurse (RN) 3 stated she thought the facility's policy stated a container could be opened and used for up to two (2) months after being opened. She said different people were responsible for cleaning out the refrigerator, and there was no one in particular assigned to that task. RN 3 further said outdated food or drinks had the potential to cause a food borne illness, and she didn't want anybody to get sick. In interview on 08/29/2025 at 1:35 PM, the Dietary Manager (DM) stated it sounded like the bowl of pudding in the Lighthouse Unit nutrition refrigerator had came off of a resident's meal tray, aa when pudding was sent for a snack, it was sent in pre-packaged containers. She said the nectar liquids were dated with the received date; however, there was not an opened date as required. The DM reported once opened, the nectar liquids were good for seven days according to the printed manufacturer's recommendation on the container. She further stated when the sandwiches were sent out for the unit refrigerators, the tray was dated with the preparation date and the end of use date. In addition, the DM stated there was a potential for food borne illness if food was eaten after the beyond use date. In interview on 08/29/2025 at 1:40 PM, the Director of Operations for the contract dietary company, stated one tray of sandwiches had been misdated for four days. The Director of Operation further stated the sandwiches were good for seven (7) days after prepared. In interview on 08/20/2025 at 1:45 PM, the Director of Nursing (DON) stated food beyond the use-by date should be removed to avoid serving it to residents to avoid causing a resident to become sick. She stated it would be important for items to be labeled and dated to know when to remove items from the refrigerator. In interview on 08/29/2025 at 2:21 PM, the Administrator stated there were risks for using food or drinks past the beyond use date. The Administrator further stated however, she did not know what the risks would be if the food was used past the beyond use date. She also said the beyond use dates were in place to safeguard residents against food borne illnesses.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to ensure all bathrooms were equipped with call lights at each toilet that was accessible to residents who sustained a fall, and was lying on the floor. The findings include: Review of the facility policy titled, Call Lights: Accessibility and Timely Response reviewed 06/2025, revealed the call system must be accessible to the resident at each toilet and was to be accessible to a resident lying on the floor. Observation on 08/26/2025 at 3:50 PM and on 08/29/2025 at 11:12 AM, revealed the call lights in the bathroom of resident rooms [ROOM NUMBERS] were not equipped with cords to ensure a resident lying in the floor could summon assistance. During interview with the Director of Nursing (DON) on 08/29/2025 at 1:45 PM, she stated call lights were important for the resident to be able to call for help in the bathroom if needed. In interview with the Administrator on 08/29/2025 at 2:21 PM, she stated she was not aware the cords were missing from the call lights (in rooms 119 ad 127).