STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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 IN00437398, IN00438131, IN00438235, IN00438764 and IN00439287. Complaint IN00437398 - Federal/State deficiency related to the allegations is cited at F684. Complaint IN00438131 - No deficiencies related to the allegations are cited. Complaint IN00438235 - No deficiencies related to the allegations are cited. Complaint IN00438764 - No deficiencies related to the allegations are cited. Complaint IN00439287 - Federal/State deficiencies related to the allegations are cited a F684 and F690. Unrelated deficiency cited. Survey dates: July 23, 24, 25 and 26, 2024 Facility number: 000166 Provider number: 155265 AIM number: 100267080 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 3 Medicaid: 78 Other: 11 Total: 92	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on August 1, 2024** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Molly Linder HFA**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Lawson	RDO	08/18/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 1, 2024.			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to follow medication administration parameters (Residents B, D and H); obtain blood pressure as ordered for 7 days (Resident F); and complete non-pressure wound treatments as ordered (Residents B and D) for 4 of 6 residents reviewed for quality of care. Findings include: 1.a. The clinical record for Resident B was reviewed on 7/24/24 at 1:35 p.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, and morbid obesity. The care plan, dated 10/27/23, indicated the resident had hypertension (high blood pressure) and staff were to administer the resident's medications as ordered by the medical provider. The physician's order, dated 11/21/23, indicated the resident was to receive Carvedilol 12.5 mg	F 0684	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have orders with blood pressure parameters or medications/treatment orders could be affected by the alleged deficient practice. A 30- day lookback of all medications with blood pressure parameters was completed to ensure medications had been administered according to physician orders. A 30-day	08/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	(milligrams) twice daily at 8:00 a.m. and 8:00 p.m. for hypertension. Staff were to hold the resident's medication for a SBP (systolic blood pressure) less than 110 or a pulse less than 60. The resident's May and June 2024 MAR (medication administration record) indicated the following: - On 5/06/24 at 8:00 p.m., the resident's Carvedilol was administered with no blood pressure or pulse obtained. - On 6/17/24 at 8:00 p.m., the resident's Carvedilol was administered with no blood pressure or pulse obtained. - On 6/23/24 at 8:00 p.m., the resident's Carvedilol was administered with no blood pressure or pulse obtained. The physicians' order, dated 11/20/23, indicated the resident was to receive Hydralazine HCl (hydrochloride) 50 mg every 8 hours at 7:00 a.m., 3:00 p.m., and 11:00 p.m. Staff were to hold the resident's medication if the resident's SBP was less than 115. The resident's May and June 2024 MAR indicated the following: - On 5/06/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 5/25/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 5/26/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 6/01/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 6/05/24 at 11:00 p.m., the resident's		lookback of all medication records and treatment records was completed to ensure all treatments and medications were completed and documented per physician orders. Any identified concerns were immediately addressed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to the “medication administration” policy and procedures including administering blood pressure medications with parameters according to physician orders. The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to completion of documentation on the medication and treatment administration records. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DNS/designee will audit 5 residents a weeks x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	Hydralazine was administered with no documented blood pressure. - On 6/10/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 6/17/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 6/23/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. - On 6/24/24 at 11:00 p.m., the resident's Hydralazine was administered with no documented blood pressure. 1.b. The care plan, dated 11/20/23, indicated the resident was at risk for impaired skin integrity and staff were to administer treatments as ordered by the medical provider. The physician's order, dated 1/10/24, indicated Nystatin External cream was to be applied to the resident's abdominal folds and groin area every day and night shift due to moisture associated skin damage and fungal infection. Review of the June 2024 treatment administration indicated the resident's treatment was not completed on the following days: - 6/02/24 on night shift - 6/05/24 on day shift - 6/09/24 on night shift - 6/11/24 on day shift - 6/20/24 on day shift - 6/23/24 on day shift - 6/24/24 on day shift - 6/29/24 on day shift - 6/30/24 on day shift During an interview on 7/26/24 at 1:25 p.m., LPN		ensure blood pressure medication with parameters are administered per physician order. The DNS/designee will audit all medication and treatment administration records daily for no less than 3 months to ensure completion and compliance is maintained with documentation. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	(Licensed Practical Nurse) 6 indicated the physician orders should be followed. If parameters were set by the physician for a resident's blood pressure medication, the resident's blood pressure should have been obtained prior to the medication administration. If the blood pressure was out of the parameters, the medication should have been held. When medications or treatments are administered/completed, the medication record and treatment record should have been initialed. On 7/25/24 at 1:48 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled "Medication Administration". It included, but was not limited to, "MAR: Medication Administration Record - the legal documentation for medication administration...Policy...It is the policy of this facility to provide resident centered care...Administer medication only as prescribed by the provider...Medications will be charted when given...Record pertinent information prior to giving medication...Blood pressure...Apical pulse...Blood sugar...Documentation of medication will be current for medication administration...." 2.a. The clinical record for Resident D was reviewed on 7/24/24 at 1:59 p.m. The resident's diagnoses included, but were not limited to, hypertension and surgical incision. The care plan, dated 5/31/24, indicated the resident had hypertension and staff were to administer the resident's medications per the medical provider's order. The June 2024 MAR indicated the resident was to receive Metoprolol Tartrate (antihypertensive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	medication) 50 mg two times a day at 8:00 a.m. and 8:00 p.m. The resident's medication was to be held by staff for a SBP less than 110 or a pulse of less than 60. Review of the resident's June 2024 MAR indicated the following: - On 6/05/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 6/10/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 6/17/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 6/23/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 6/24/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. Review of the resident's July 2024 MAR indicated the following: - On 7/02/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 7/08/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 7/15/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 7/22/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained. - On 7/23/24 at 8:00 p.m., the resident's Metoprolol Tartrate was administered with no blood pressure or pulse obtained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	2.b. The care plan, dated 6/7/24, indicated the resident had a surgical incision to the abdomen and staff were to administer treatments as ordered by the medical provider Review of the June 2024 TAR indicated staff were to cleanse the resident's abdominal incision with normal saline and apply a dry dressing daily. The June 2024 TAR lacked documentation that the treatment was completed on the following days: 6/5/24, 6/7/24, 6/11/24, 6/13/24, 6/20/24, 6/23/24, 6/24/24, 6/29/24 and 6/30/24. 3. The clinical record for Resident F was reviewed on 7/24/24 at 2:40 p.m. The resident's diagnosis included, but was not limited to, hypertension. The care plan, dated 11/15/22, indicated the resident had hypertension and staff were to observe the resident for signs/symptoms of elevated blood pressure. The June 2024 medication administration record indicated the resident's blood pressure was to be checked daily in the morning, from 6/20/24 through 6/26/24, due to an elevated blood pressure. The resident's clinical record lacked documentation of the resident's blood pressure from 6/23/24 through 6/26/24. 4. The clinical record for Resident H was review on 7/24/24 at 1:00 p.m. The resident's diagnosis included, but was not limited to, hypertension. The care plan, dated 1/30/23, indicated the resident had hypertension and staff were to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	administer the resident's medications per the medical providers orders. The physician's order, dated 5/28/23, indicated the resident was to receive Coreg (medication for high blood pressure) 6.25 mg twice daily at 8:00 a.m. and 8:00 p.m.. Staff were to hold the resident's medication for a SBP less than 110 or a pulse less than 60. Review of the resident's May 2024 MAR indicated the following: - On 5/02/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 109. - On 5/04/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 100 and a pulse of 59. - On 5/05/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 102. - On 5/08/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 5/10/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 107. - On 5/15/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 5/20/24 at 8:00 a.m., the resident's Coreg was administered when the resident's pulse was 59. - On 5/23/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. Review of the resident's June 2024 MAR indicated the following: - On 6/06/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 6/19/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 107.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	- On 6/19/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 6/28/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 6/30/24 at 8:00 a.m., the resident's Coreg was administered when the resident's SBP was 108 and a pulse of 58. Review of the resident's July 2024 MAR indicated the follwing: - On 7/03/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 7/04/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. - On 7/17/24 at 8:00 p.m., the resident's Coreg was administered with no blood pressure or pulse obtained. This Citation relates to Complaints IN00437398 and IN00439287 3/1-37			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to ensure Indwelling catheter care was completed for 1 of 1 residents reviewed for Indwelling catheters. (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/24/24 at 3:03 p.m. The resident's diagnosis included, but was not limited to, sacral region pressure ulcer, stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle). The care plan, dated 2/15/23, indicated the resident required a condom catheter due to impaired skin integrity and staff were to provide	F 0690	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have Indwelling/condom catheters could be affected by the alleged deficient practice. A 30- day lookback of all	08/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	catheter care every shift. The March 2024 treatment administration record (TAR) indicated staff were to cleanse the resident's condom catheter with soap and water every shift and to change the drainage bag weekly on Mondays. The resident's March 2024 TAR indicated the resident's condom catheter care was not completed on the following dates and shifts: - 3/01/24 - 3/02/24 on day shift - 3/04/24 on night shift - 3/05/24 on day shift - 3/07/24 on day shift - 3/10/24 on day shift - 3/11/24 on day and night shift - 3/13/24 on night shift - 3/15/24 on night shift - 3/17/24 and 3/18/24 on night shift - 3/21/24 on day shift - 3/28/24 on night shift - 3/30/24 on night shift - 3/31/24 on day shift The resident's March 2024 TAR indicated the resident's drainage bag was not changed on 3/11/24 at 9:00 a.m. The resident's April 2024 TAR indicated staff were to cleanse the resident's condom catheter with soap and water every shift and to change the drainage bag weekly on Mondays. The resident's April 2024 TAR indicated the resident's condom catheter care was not completed on the following dates and shifts: - 4/02/24 on night shift - 4/08/24 on day shift - 4/09/24 on night shift		residents with an Indwelling or condom catheter completed to ensure each resident has documentation of cleaning and drainage bag changes per MD order. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to the "Catheter Care" policy and procedures including catheter care and drainage bag changes. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DNS/designee will audit 5 residents a weeks x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure catheter care is completed and drainage bag changes are carried out per physician order. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	- 4/10/24 on day shift - 4/15/24 on day shift - 4/16/24 on night shift - 4/23/24 on night shift - 4/28/24 on night shift - 4/30/24 on day shift The resident's April 2024 TAR indicated the resident's drainage bag was not changed as ordered on 4/8/24, 4/15/24 and 4/22/24. During an interview on 7/26/24 at 1:25 p.m., LPN (Licensed Practical Nurse) 6 indicated when a nurse completes any treatment, it should have been signed off on the treatment administration record. On 7/25/24 at 1:48 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled "Catheter Care". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident care...Catheter care is performed at least twice daily on residents...for as long as the catheter is in place...." This Citation relates to Complaint IN00439287 3.1-41		QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure a staff member followed infection control practices for 1 of 5 observations related to infection control. (CNA 4) Findings include: During an observation on 7/23/24 at 8:13 p.m., CNA (Certified Nursing Aide) 4 was observed to exit a resident's room wearing gloves and carrying a soiled brief in one gloved had and a soiled pair of pants in the other. During an interview on 7/26/24 at 12:34 p.m., CNA 5 indicated after resident care was provided, soiled briefs should be placed in a bag and soiled clothing in a separate bag. Soiled gloves should have been removed prior to exiting the resident's	F 0880	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who received care from CNA 4 could be affected. A walking round was completed immediately to ensure no further infection control issues were identified throughout the facility.	08/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEDGEWOOD HEALTHCARE CENTER	101 POTTERS LN CLARKSVILLE, IN 47129

(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
	room and all soiled clothing should be in a bag. The bagged items should then be placed in the soiled utility room. On 7/25/24 at 1:48 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Infection Prevention Program" effective 3/9/2000. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Residents have the right to reside in a safe environment that...reduces the risk of acquiring infections...The facility infection prevention program...addresses...prevention and control of infections among residents and employees...." 3.1-18(a)		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DNS/Designee held an in-service for all staff to provide education and expectations as it relates to the “Infection Prevention Program” policy and procedures as it relates to proper disposal of soiled briefs and clothes. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DNS/designee will observe 5 staff members a weeks x 4 weeks, then 3 staff members a week x 4 weeks, then 1 staff member a week x 4 weeks for no less than 3 months and compliance is maintained to ensure staff are adhering to the infection control policy. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	