STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00387130, IN00387751, IN00391544, IN00392845, IN00393007 and a COVID-19 Infection Control Survey. Complaint IN00387130 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387751 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00391544 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00392845 - Substantiated. Federal/State deficiency related to the allegations is cited at F759. Complaint IN00393007 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency cited Survey dates: October 28, 31 and November 1, 2022 Facility number: 000166 Provider number: 155265 AIM number: 100267080 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 58	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 000	Continued From page 1 Other: 16 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 3, 2022.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff removed all transdermal patches prior to applying a new patch for 1 of 3 residents reviewed for medication errors. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/28/22 at 1:48 p.m. The diagnoses included, but were not limited to, lung cancer, liver cancer and malignant neoplasm of the brain. The incident report, dated 10/19/22 at 5:28 p.m., indicated the night shift nurse (LPN [Licensed Practical Nurse] 6) discovered two Fentanyl Patches (narcotic transdermal patch) in place on a resident during walking rounds. The resident's clinical record indicated the resident was only prescribe one pain patch every	F 759	Past noncompliance: no plan of correction required.	

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F 759	Continued From page 2	F 759		

72 hours.

The physician's order, dated 9/27/22, indicated the resident was to have a Fentanyl patch 25 mcg (micrograms)/hour applied transdermally every 72 hours for pain and to remove per schedule.

The progress noted, dated 10/19/22 at 2:39 a.m., indicated the resident's Fentanyl patch was applied on day shift (10/18/22). The old patch was removed ,on 10/19/22, by LPN 5. LPN 6 and LPN 5 found an old patch on the shoulder dated 10/15/22. The patch was removed and the current patch remained in place.

During an interview on 11/1/22 at 11:20 a.m., the Director of Nursing indicated LPN 5 had lifted up Resident D's shirt, removed the patch she had seen, applied a new patch, then put the residents shirt back down. LPN 6 had recalled that the resident's patch was higher on the shoulder than what was reported to her by LPN 5. Both of the nurses went and looked and found 2 patches on the resident and removed the old patch. Neither could recall the date on the old patch that was removed.

On 10/28/22 at 3:40 p.m., the Director of Nursing provided a current copy of the document titled "Fentanyl Transdermal Patch" dated 9/22/2017. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Procedure...Application...Remove previous patch...Validate there is no patch on the skin prior to applying the next patch...."

This Federal tag relates to Complaint IN00392845

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F 759	Continued From page 3 3.1-48(a)(1)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation on the narcotic count sheet of administered narcotics was accurate for 1 of 3 residents reviewed for medication storage. (Resident C) Findings included:	F 761	Past noncompliance: no plan of correction required.	

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F 761	Continued From page 4	F 761		

The clinical record for Resident C was reviewed on 10/31/22 at 11:48 a.m. The diagnoses included, but were not limited to, panic disorder and anxiety disorder.

The incident report, dated 9/30/222 at 1:22 p.m., indicated LPN (Licensed Practical Nurse) 2 reported to the Director of Nursing that she went on break and gave her cart keys to RN (Registered Nurse) 4. Upon return from break, two of Resident C's Clonazepams were missing and that the Clonazepam narcotic count was correct during the count at shift change.

The physician's order, dated 7/12/22, indicated the resident was to receive Clonazepam (anti-anxiety) 0.5 mg (milligrams) three times a day.

The September 2022 medication administration record indicated the resident was to receive the Clonazepam at 6:00 a.m., 2:00 p.m. and 10:00 p.m. and on 9/29/22, the resident received all scheduled doses.

The progress note, dated 9/30/22, indicated the resident had missed the 2:00 p.m. and 10:00 p.m. dose of Clonazepam on 9/30/22.

The controlled drug administration record indicated the resident received the Clonazepam on 9/29/22 at 5:00 a.m. with an ending count of 22 Clonazepams. On 9/30/22 at 2:00 a.m., the narcotic count was corrected with 20 Clonazepams as the ending count. There was not another entry for administration of the medication until 9/30/22 at 5:23 a.m., with an ending count of 19 Clonazepams.

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F 761	Continued From page 5 During an interview on 10/28/22 at 2:50 p.m., the Director of Nursing indicated she could not prove the medication was taken, however two Clonazepams were missing. The Executive Director indicated they viewed the video footage at the time the incident was reported and did not see any medications diverted. On 10/31/22 at 2:28 p.m., the Director of Nursing provided a current copy of the document titled "Medication Administration" dated 8/3/2010. It included, but was not limited to, "Policy...It is the policy of the facility to provide resident centered care...Narcotics will be signed out when given...." 3.1-25(b)(3)	F 761		