| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155265 | A. BUILDING 00<br>B. WING | 08/12/2024 |

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| WEDGEWOOD HEALTHCARE CENTER | 101 POTTERS LN<br>CLARKSVILLE, IN 47129 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00439895.<br><br>Complaint IN00439895 - No deficiencies related to the allegations are cited.<br><br>Survey dates: August 5, 6, 7, 8, 9 and 12, 2024<br><br>Facility number: 000166<br>Provider number: 155265<br>AIM number: 100267080<br><br>Census Bed Type:<br>SNF/NF: 97<br>Total: 97<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 74<br>Other: 19<br>Total: 97<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on August 19, 2024. | 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.**<br>**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.**<br>**The facility would like to respectfully request a desk review.**<br>**Molly Linder HFA** | |
| F 0565<br>SS=E<br>Bldg. 00 | 483.10(f)(5)(i)-(iv)(6)(7)<br>Resident/Family Group and Response<br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Samantha Lawson | RDO | 09/02/2024 |

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| | members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>Based on record review and interview, the facility failed to promptly resolve the grievances and recommendations made by the Resident Council during 12 of 12 meetings and 5 of 7 Food Committee meetings reviewed in that the same issues were being reported as continuing problems. | F 0565 | **1 Corrective action for resident found to have been affected by the alleged deficient practice:**<br>**No residents were harmed by alleged deficient practice.**<br><br>**2 How other resident having** | 09/23/2024 |

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| | Findings include:<br><br>1. The Resident Council meeting, held on 7/25/23, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Clean rooms more.<br>- Better and more snacks for all the halls as residents didn't know where they went..<br>- Be informed about medication changes.<br>- Problem with medications on the 500 Hall.<br>- Asked for help twice and did not get it.<br><br>On 7/25/23, the Director of Nursing (DON) addressed the issue residents were having in getting their showers. No other concerns were addressed.<br><br>2. The Resident Council meeting, held on 8/22/23, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Safety concerns<br>- Bed changes not always occurring.<br>- Need to order medications before they ran out.<br>- Wheelchairs and walkers - who repairs them?<br>- Laundry and clothes were a problem.<br>- Rooms and bathrooms were not cleaned.<br>- Not getting treatments done.<br>- New nurses were messing up their medications and not checking blood pressure or blood sugars.<br>- Not being treated nice by some of the nurse aides.<br>- Staff not knocking on doors before coming in.<br>- Aides not answering call lights timely; staff ignoring or turning the light off; night shift aides a problem.<br>- Water not being passed.<br><br>No response to these concerns could be located | | **the potential to be affected by the same deficient practice will be identified**<br><br>**All residents have the potential to be affected by the alleged deficient practice.**<br><br>**3 Corrective action taken for those residents having the potential to be affected by the same deficient practice.**<br><br>**RDCO educated ED and DON on expectations as it relates to resolving resident concerns and grievance/concern follow-up.**<br><br>**The last 3 months of resident council minutes were reviewed and any outstanding resident council concerns identified provided follow-up.**<br><br>**Resident council meeting held to discuss resolutions.**<br><br>**4 Measure /systemic changes put into place to ensure the deficient practice does not recur?**<br><br>**ED will review resident council minutes monthly to ensure all resident council concerns resolved timely and documentation present.**<br><br>**The ED will present the results** | |

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| | or provided.<br><br>3. The Resident Council meeting, held on 10/24/23, indicated the following concerns were not addressed by the responsible department or resolved:<br>- New trash bags were not being put in empty cans after trash was collected by housekeeping.<br>- Night time snacks.<br>- Dessert serving size.<br><br>No response to these concerns could be located or provided.<br><br>4. The Resident Council meeting, held on 11/21/23, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Bed linens were not being changed on shower days.<br>- Dressing changes not being done.<br>- Medications still not accurate and running out.<br>- Nursing staff attitude.<br><br>No response to these concerns could be located or provided.<br><br>5. The Resident Council meeting, held on 2/19/23, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Showers were not always hot because the valves were turned the wrong way.<br>- Don't just take clothes and make sure they were labeled.<br>- Would like bacon for the hamburgers.<br>- The food carts still showing up late and when they did show up, they would just sit on the hall.<br>- Pill accuracy still remained a problem.<br>- Dressing changes still not being done. | | **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.** | |

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| | - Smokers blocking the hall at smoking times and smoking where and when they wanted to.<br><br>No response to these concerns could be found or provided.<br><br>6. The Resident Council meeting, held on 2/20/24, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Want to flip their mattresses<br>- Fix broken drawers in several rooms.<br>- Housekeeping needed to take out the trash and clean rooms better.<br>- More snacks need to be available.<br>- Staff need to turn their phones off while at work.<br>- Check and change needed to be every 2 hours and as needed.<br><br>On 2/20/24, RN 1 addressed the concern regarding the Check and Change and indicated the CNAs (Certified Nurse Aide) would be in-serviced.<br><br>On 2/20/24, the Director of Housekeeping addressed the concerns and indicated the manager would in-service the housekeepers on the 5+7 steps of cleaning (the cleaning cheek list step by step) and would ensure the trash was taken out and a final walk through the halls to ensure the rooms were being completed.<br><br>No other concerns were addressed.<br><br>7. The Resident Council meeting, held on 3/19/24, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Ice water at night not being passed.<br>- Would like a newspaper even if it was a day old.<br>- Want old cable company back. | | | |

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| | - Were there any open times in therapy for non-scheduled work outs?<br>- Is there going to be a new schedule for serving in the dining room?<br>- Dresser drawers were still falling apart.<br>- Laundry not able to keep up with their personal clothes - need another aide in there.<br>- Housekeeping still was not cleaning all the rooms.<br>- Dressing changes were still not being completed routinely.<br>- Shift changes were too loud and there was no need to shout.<br>- Want to be spoken to like an adult - not everyone had issues.<br>- Medications were not always accurate, especially when it was a different nurse.<br><br>On 3/18/24, the DON indicated the issues of dressing changes and medication accuracy were being addressed.<br><br>On 3/18/24. the Director of Housekeeping addressed the laundry and housekeeping issues and indicated she would continue to hire a part-time person for laundry. The staff would be in-serviced on proper cleaning techniques, and she will be holding the staff more accountable.<br><br>No other concerns were addressed.<br><br>8. The Resident Council meeting, held on 4/16/24, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Please post a real serving schedule that will be adhered to.<br>- Still having hot water issues resulting in having to take a cold shower.<br>- Would like a new serving time for meals, such as | | | |

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| | 15 minutes earlier.<br>- Please spread out the snacks.<br>- More diabetic friendly meals.<br>- Parties at the nurses station too loud for no reason.<br>- Blood pressure checks were not always being done.<br>- The aides were not doing the check and changing like they should.<br>- Want belongings left in place after cleaning the room.<br>- Felt the facility was making up rules.<br>- Cable was an issue and were not having previous channels.<br><br>On 4/16/24, the Director of Housekeeping responded to the concerns which involved her department in which she indicated mandatory in-servicing of all front line employees and housekeepers on the 5+7 steps of proper cleaning and will be held accountable.<br><br>On 4/17/24, the DON addressed the nursing concerns and indicated staff will be educated on the process of passing ice water at the beginning of day shift and night shift and the DON or designee will monitor. Quiet time hours would be put into effect immediately between 5 to 7 AM. The DON or designee would monitor Q (every) 2 hour rounding sheets were being completed.<br><br>On 4/16/24, the Maintenance Director responded and indicated the dropping off of channels had always been a problem with (name of cable company).<br><br>No other concerns were addressed.<br><br>9. The Resident Council meeting held on 5/21/24, indicated the following concerns were not | | | |

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| | addressed by the responsible department or resolved:<br>- Windows were being bolted shut.<br>- No night time supervision.<br>- Nursing station too loud during shift change.<br>- No consistent staffing with the CNAs.<br><br>On /21/24, the Executive Director (ED) indicated the bolting of the windows was only a temporary solution and there would be a permanent solution in the future. There was an evening supervisor on Monday and Tuesday night and there was a weekend supervisor on Friday, Saturday and Sunday. Staff were scheduled on the same hall but were re-assigned when staff were off, and she would continue to work on noise level at the nurse station.<br><br>No other concerns were addressed.<br><br>10. The Resident Council meeting, held on 6/18/24, indicated the following concerns were not addressed by the responsible department or resolved:<br>- Serving in the dining room was not consistent.<br>- No ice water at night.<br>- Wound care not happening consistently.<br>- Call lights being turned off even though help was not given.<br><br>On 6/18/24, the ED addressed the call lights issue and indicated an in-service and re-education to nursing.<br><br>No other issues were addressed.<br><br>11. The Resident Council meeting, held on 7/25/24, indicated the following concerns were not addressed by the responsible department or resolved: | | | |

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| | - Staff not serving in the dining room on the weekends.<br>- No one is picking up the phone when there was a call.<br>- Housekeeping not mopping floors.<br>- More thorough cleaning in the bathrooms.<br>- Water still not being passed.<br>- CNAs yelling into and down the hall.<br>- Trash needs to be taken out twice a day.<br>- Wanted cable in the activity room.<br><br>On 7/18/24, the ED responded to the issue of ice water not being passed and indicated one-on-one education would be done. There would continue to be staff serving in the dining room and the dining room schedule was posted in the dining room and at each nursing station. She would put in a request for IT (computer personnel) to look at getting cable in the activity room.<br><br>No other issues were addressed.<br><br>12. The Resident Council meeting, held on 8/7/24 at 1:30 p.m., indicated the following concerns:<br>- Would not allow any resident who had already served as President to serve again<br>- Residents were not allowed to take the notes during the Resident Council meetings, a staff member was to be there to take the notes.<br>- The remotes to the TVs in the resident rooms did not work separately. One remote worked for both residents in the room and had a tendency to cancel out the other person's TV show if it was pressed.<br>- Waiting a long time for staff to answer the call lights. The aides were turning the lights off without coming in to check on the resident. Lots of call ins on night shift.<br>- Not enough snacks. If one went to an activity or were out of their room, the aides gave out all the | | | |

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| | snacks and there were none left when they returned to their room. Snacks tend to run out.<br>- The aides were still not passing ice water<br>- Wanted to see their physician and not the Nurse Practitioner all the time.<br>- Not ordering medications in a timely manner. The nurses did not explain to the resident when a new order came in, especially if it was a medication.<br>- Wound treatments were not consistently being done.<br>- Housekeeping still were not cleaning properly. They were not mopping the floors or emptying the trash. One housekeeper was observed to clean a resident's commode and then used the same rag to clean the sink. Dirty shower rooms in which some residents refused to go in for their showers.<br>- Staff who had to serve the dining room were frequently complaining about having to do it. They seem to have an attitude problem. The assigned dining room personnel were not always showing up to serve.<br>- Meal tickets did not match what was served, especially if the resident ate in their room.<br>- The residents were not aware of their rights and rules of the facility. Resident 34 indicated that so much paperwork was thrown at them to sign when they were first admitted to the facility, he didn't know what it all was.<br>- If suggestions were made by the residents or Resident Council, they were not followed up on and residents did not know the outcome of the concerns they voiced at the meetings.<br>- Did not know the 1-800 hotline number to the State Department of Health when they wanted to make a complaint.<br><br>The facility's current policy on Resident Council dated effective 4/22/21 as presented by the ED included, but was not limited to, " Policy:...While it is the residents' choice to have in attendance, | | | |

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| | Administration should ask permission to attend (even for a short appearance) to assure residents that all grievances and concerns are as important to management as they are to the resident...4. Document the Resident Council on the Resident Council Minutes Form. Any concerns voiced at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head..."<br><br>3.1-3(k)<br>3.1-3(l)<br>3.1-7(a)(2) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interview, the facility failed to ensure smoking materials were secured in a locked area when not in use for 5 of 25 smokers reviewed for accidents hazards. (Residents 6, 46, 54, 72, and 86)<br><br>Findings include:<br><br>1. During an observation on 8/9/24 at 10:00 a.m., Resident 6 had her cigarettes and lighter laying on the bedside table. The resident was sound asleep sitting up in her wheelchair.<br><br>During am observation on 8/9/24 at 1:00 p.m., | F 0689 | **F689**<br>**1 Corrective action for resident found to have been affected by the alleged deficient practice:**<br><br>**No residents were harmed by alleged deficient practice.**<br><br>**2 How other resident having the potential to be affected by the same deficient practice will be identified** | 09/23/2024 |

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| | Resident 6 had her cigarettes and lighter laying on her bedside table. She had just finished eating her lunch.<br><br>During an interview on 8/11/24 at 12:55 p.m., Resident 6 indicated she did not lock up her lighter. She indicated "the staff trust me with my lighter" When she left her room, she would hide her lighter and cigarettes underneath her left leg where no one could see them.<br><br>During an observation on 8/12/24 at 8:30 a.m., Resident 6 had her cigarette lighter laying on her bedside table.<br><br>2. During an interview on 8/9/24 at 1:00 p.m., Resident 54 indicated she had her cigarettes and lighter in her purse. She would keep her purse in bed with her so no one would steal it.<br><br>3. During an interview on 8/9/24 at 2:30 p.m., Resident 46 indicated he did go outside to smoke. He would keep his cigarettes and lighter in his beside dresser or in his pocket. He did not lock up his lighter and there wasn't a lock on the dresser drawers.<br><br>4. During an interview on 8/9/24 at 2:50 p.m., Resident 86 indicated she kept her cigarettes and lighter in her room. She indicated they were not locked up. The resident had her lighter laying on the picnic table while outside smoking.<br><br>5. During an interview on 8/9/24 at 3:00 p.m., Resident 72 indicated she was a smoker, and she kept her cigarettes and lighter in her purse. She had no way to lock up her lighter, so she slept with her purse which contained her cigarettes and lighter. | | **All residents have the potential to be affected by the alleged deficient practice.**<br><br>**3 Corrective action taken for those residents having the potential to be affected by the same deficient practice.**<br><br>**ED educated staff on smoking policy as it relates to securing smoking materials in a locked area when not in use. All appropriate independent residents were educated and provided with locking bag to secure smoking materials when not in use.**<br><br>**Resident council meeting held to discuss resolutions.**<br><br>**4 Measure /systemic changes put into place to ensure the deficient practice does not recur?**<br><br>**ED/Designee will observe 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks , then one time weekly x 4 weeks to ensure smoking materials secured in locked bag when not in use.**<br><br>**The ED 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** | |

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| | During an interview on 8/9/24 at 1:30 p.m., Social Services Director indicated the social service staff would do the smoking evaluation on the residents that smoke. The residents were allowed to keep their cigarettes and lighter in their rooms. The lighters were not locked up. The residents kept their lighters with them. The residents would turn in their lighters at bedtime. She indicated there were residents that resided on all the floors that were independent smokers.<br><br>The review of the residents on Halls 100, 300, 400, and 500, there were 25 residents that smoked. Each resident had their own cigarettes and lighter. There were 8 residents that resided on the units that were confused and had a diagnosis of dementia.<br><br>The Resident/Patient Smoking policy, dated 3/25/18, included, but was not limited to, "...a. Secure smoking materials in a locked area when not in use by the resident/patient for both independent and supervised smokers ..."<br><br>3.1-45(a) | | **Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.**<br><br>- | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on record review and interview, the facility failed to ensure a dialysis access site was monitored and the physician was notified for 1 of 2 resident reviewed for dialysis. (Resident 51) | F 0698 | **1 Corrective action for resident found to have been affected by the alleged deficient practice:**<br>**Resident 51 received a full** | 09/23/2024 |

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| | Findings Include:<br><br>The record for Resident 51 was reviewed on 8/8/24 at 10:56 a.m. The diagnoses included, but were not limited to, peripheral vascular angioplasty with implants and grafts, anemia in chronic kidney disease, hypo-osmolality and hyponatremia, chronic kidney disease, diabetes, and acute kidney failure.c<br><br>The physician orders, dated 4/15/24,indicated staff were to monitor the dialysis site for signs and symptoms of infection, monitor the graft site for signs and symptoms of infection, and monitor for thrill and bruit every shift.<br><br>The physician's order, dated 4/25/24, indicated the resident was to receive hemodialysis every Tuesday, Thursday, and Saturday.<br><br>The Annual MDS (Minimum Data Set) assessment, dated 5/10/24, indicated the resident was cognitively intact.<br>,<br>The care plan, initiated on 4/16/24 and revised on 8/7/24 indicated, Resident 51 was currently on dialysis therapy. He had a newly placed AV (Arteriovenous) fistula in his left arm; however, dialysis was currently still being performed per port in his upper right chest. The dialysis port was resolved on 8/7/24. The interventions included, but were not limited to, administer medications per physician orders, and report abnormal findings, evaluate the AV fistula and chest port for bleeding, monitor the access site for signs and symptoms of infection, and report the abnormal findings to the physician.<br><br>The nurse's note, dated 6/16/24 at 10:00 p.m., indicated Resident 51 was informed of swelling at | | **nursing assessment and observation of status of AV fistula. The MD was notified of status. The resident was not harmed by alleged deficient practice.**<br><br>**2 How other resident having the potential to be affected by the same deficient practice will be identified**<br><br>**All residents receiving were reviewed and assessed.**<br><br>**3 Corrective action taken for those residents having the potential to be affected by the same deficient practice.**<br><br>**DON educated staff on the current Hemodialysis Care and Monitoring policy.**<br><br>**Resident council meeting held to discuss resolutions.**<br><br>**4 Measure /systemic changes put into place to ensure the deficient practice does not recur?**<br><br>**DON/Designee will audit 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks , then one time weekly x 4 weeks to ensure hemodialysis care and monitoring policy followed.**<br><br>**The DON will present the** | |

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| | his AV fistula and his upper left arm when he got back from his dialysis on Saturday. The AV fistula appeared to be swollen. The resident preferred to wait and inform the NP (Nurse Practitioner) in the a.m.<br><br>The clinical record lacked documentation indicating the NP was notified and the dialysis site was monitored every shift per physician orders.<br><br>The review of MAR (Medication Administration Record) indicated the following related to the nursing assessment of the resident's bruit and thrill (Assessing a bruit and thrill in a dialysis fistula helps determine if the fistula is working and to identify potential issues):<br><br>- On 6/5/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/7/24, 6:00 p.m. to 6:00 a.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/11/24,6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/13/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/20/24,6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/23/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/24/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/25/24, 6:00 p.m. to 6:00 a.m., the MAR | | **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.** | |

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| | lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/29/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br>- On 6/39/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of bruit and thrill.<br><br>The review of the MAR indicated the following related to the nursing assessment of the resident's dialysis site for signs of infection:<br><br>- On 6/5/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/7/24, 6:00 p.m. to 6:00 a.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/11/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/13/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/20/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/23/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/24/24, 6:00 a.m. to 6:00 p.m., and 6:00 p.m. to 6:00 a.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/25/24, 6:00 p.m. to 6:00 a.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br>- On 6/29/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site. | | | |

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| | - On 6/39/24, 6:00 a.m. to 6:00 p.m., the MAR lacked documentation related to the monitoring of the resident's dialysis site.<br><br>During an interview on 8/12/14 at 8:30 a.m., LPN (Licensed Practical Nurse) 5 indicated the dialysis fistula or catheter should be assessed every shift. If there were any signs and symptoms of edema, she would immediately call the physician. She would never let the resident decide when to call the physician.<br><br>During an interview on 8/12/24 at 9:18 a.m., Regional Director of Clinical Operations (RDCO) indicated she did not see a follow up note where the nurse called the physician about the fistula edema. She should not have let the resident make the decision when to call the physician.<br><br>The current Hemodialysis Care and Monitoring policy indicated ..." Residents may have specific signs/symptoms on non-dialysis days or on dialysis days that may include but are not limited to: i. Nausea above baseline ii. Fatigue greater than baseline iii. Pain iv. Pruritus [itchy] skin: 1. Lotion or emollient may relieve v. Reduced cognition or mental clarity from baseline vi. Thrombosis at or near site 1. Felt as a hard knot, may include pain, redness or swelling: a. Do not massage b. Contact physician..."<br><br>3.1-37(a) | | | |
| F 0812<br>SS=E<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources | | | |

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| | approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, record review, and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 4 of 4 kitchen observations. This deficient practice had the potential to affect all 97 residents currently residing at the facility.<br><br>Findings include:<br><br>1. During the initial tour of the kitchen, on 8/5/24 at 9:30 a.m., while accompanied by the Dietary Manager and the Regional Dietary Manager, the following concerns were observed:<br><br>In the Dry Storage Room the following was observed:<br>- Three (3) of three (3) food shelves had crumbs under them - raisin bran. pieces of paper and spaghetti noodles.<br>- A small blue cup was in the large sugar bin - (the Regional Dietary Manager indicated this was not supposed to be left in there and removed it). | F 0812 | **1 Corrective action for resident found to have been affected by the deficient practice:**<br>**No resident were harmed by this alleged deficient practice.**<br><br>**All sanitization concerns were identified and immediately corrected. All areas reviewed for appropriate food storage per facility policy.**<br><br>**2 How other resident having the potential to be affected by the same deficient practice will be identified**<br><br>**All residents have the potential to be affected by the** | 09/23/2024 |

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| | - The top of the large seasoning storage bin was heavily soiled with brown drips and food particles on it and down the sides.<br><br>In the Walk in freezer the following was observed:<br>- There was a 2 foot by 2 foot area of ice under the milk crates below the condenser unit, which was approximately 3/4 inch thick. Two cup sized thick ice spots were observed under the right shelving on the floor. The Dietary Manager indicated there was a repair last week on the unit and they had to clean it up every day and she didn't have time yet to clean it up this morning. The Maintenance Director also indicated that the unit was functioning fine, but the ice would appear every time after the unit went on the defrost cycle. The freezer was currently on the defrost cycle and the food remained frozen.<br><br>In the Walk in refrigerator the following was observed:<br>- There were large containers of peas, rice and gravy were on the shelf with a use-by date of 8/1/24. The Dietary Manager indicated the facility's policy was after 3 days, the items got thrown away.<br><br>In the Kitchen the following was observed:<br>- Plastic cup lids, a wadded piece of paper, and food crumbs were under the steam table, the table holding the coffee pot, the prep table and toaster.<br>- One sink and the eye wash station had heavy soil of whitish/black dirt with a "sand-like texture".<br>- The left side of the reach-in refrigerator had red spills under the rack containing juices.<br>- The shelf below the steamer and the shelf holding the steamer had multiple white dried water spots.<br>- The top of the steamer had a heavy build up of grease with food crumbs in it. | | **deficient practice-**<br><br>**3 Corrective action taken for those residents having the potential to be affected by the same deficient practice.**<br><br>**Internal Sanitization audit was completed and any concerns that were identified were immediately corrected.**<br><br>**DM and Dietary staff were educated on sanitary conditions and food storage expectations.**<br><br>**4 Measure /systemic changes put into place to ensure the deficient practice does not recur?**<br><br>**DM/Designee will completed quick round sheet daily x 4 weeks, 3 x a week x 4 weeks and 2 x a week for 4 weeks until compliance is met**<br><br>**The ED/Dietary Manager 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** | |

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| | - The stove top burners had a heavy build up of orange food particles and black crust.<br><br>2. During a second kitchen observation on 8/5/24 at 11:40 a.m., while Cook 3 was getting the meal ready, the following concerns were observed:<br>- The same issues identified at 9:30 a.m. remained.<br><br>3. During a kitchen observation on 8/8/24 at 10:15 a.m., while accompanied by the Dietary Manager, the following concerns were observed:<br>- In the walk-in freezer, the floor under the condenser unit and milk crates had a half inch area of thick ice covering half the area under the crates.<br>- In the walk-in refrigerator, there was a large container of BBQ chicken on the shelf with a storage date of 8/5/24 and a use-by date of 8/7/24.<br>- The stove had the same dried food particles and black crust.<br>- Plastic cup lids, a wadded piece of paper, and food crumbs were under the steam table, the table holding the coffee pot, the preparation table and toaster.<br>- The shelf below the steamer and the shelf holding the steamer had multiple white dried water spots. The top of the steamer had a heavy build up of grease with food crumbs in it.<br>- The left side of the reach-in refrigerator had red spills under the rack containing juices.<br><br>- At 10:30 a.m., in the serving area of the dining room, a large container of bleach wipes were next to the china cups in the cabinet for the residents' use. The Dietary Manager indicated they were used by nursing and never should have been in that cabinet next to the coffee cups.<br><br>4. During a kitchen observation on 8/12/24 at 10:30 a.m., the ice remained on the floor inside the walk-in freezer under the milk crates and | | **when 100% compliance is achieved or if ongoing monitoring is required.** | |

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| | condenser unit as previously seen on 8/8/24 at 10:15 a.m. The Dietary Manager indicated that the ice had been removed and was no longer an issue. When shown the ice on the floor, she indicated she thought the ice was on the condenser pipes and was not aware of it being on the floor.<br><br>The current Cleaning Log for the Prep Cook indicated her responsibilities for Monday through Friday included, but were not limited to the following:<br>- Sweep and mop dry storage room<br>- Make sure all bins were closed in dry stock room.<br>- Sweep and organize the walk in (remove all out dated items).<br><br>The current Cleaning Log for the Main Cook indicated her responsibilities for Monday through Sunday daily included, but were not limited to the following:<br>- Sweep floor from the plate holder to the sink.<br>- Remove all food and liquids that were visible.<br><br>The current Monday through Friday, tasks which were to be completed on any of those days:<br>- Deep clean the steam table and fryer<br><br>The Cleaning Log for Aide One/Dishwasher indicated her responsibilities for Monday through Sunday daily included, but were not limited to,<br>- Sweep and mop from double doors, to the back door and around the dish room area.<br><br>The Cleaning Log for the 2nd Aide indicated her responsibilities for Monday through Sunday daily included, but were not limited to,<br>- Clean both sinks (eye wash station)<br>- Sweep and mop from toaster around to the sink. | | | |

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| | The Monday through Friday tasks were to be completed on any day of those days:<br>- Deep clean inside and out of the reach in - remove any outdated items<br><br>Review the Cleaning logs, dated 8/4/24 through 8/11/24, indicated all tasks had been completed as assigned for Aide One's and 2nd Aide's Monday through Sunday cleaning logs.<br><br>During an interview with the Dietary Manager on 8/8/24 at 1:30 p.m., she indicated she did not have policies which addressed Leftovers and the Cleaning of the kitchen.<br><br>3.1-21(i)(3) | | | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | | | |

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| | 155265 | A. BUILDING 00<br>B. WING | 08/12/2024 |

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

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| | based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | | | |

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| | §483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed for proper procedures during 2 of 2 observations of incontinence care related to infection control. (Resident 196)<br><br>Findings include:<br><br>1. The record for Resident 196 was reviewed on 8/7/24 at 11:00 a.m. The resident's diagnoses included, but were not limited to, encephalopathy, acute kidney failure, dementia, anxiety disorder, intellectual disabilities, muscle weakness, abnormalities of gait and mobility, lack of coordination, and cognitive communication deficit.<br><br>The Admission MDS (Minimum Data Set) assessment, dated 7/26/24, indicated the resident was severely cognitively impaired. He was frequently incontinent of bowel and bladder.<br><br>The care plan, dated 8/1/24, indicated the resident was incontinent of bowel and bladder due to impaired cognition and impaired mobility. The interventions, dated 8/1/24, indicated for staff to apply barrier creams as needed, check the resident for incontinence., wash, rinse, and dry the perineum. | F 0880 | **1 Corrective action for resident found to have been affected by the deficient practice:**<br>**No resident were harmed by this alleged deficient practice. Residents 196 was assessed and provided incontinence care per policy.**<br><br>**All sanitization concerns were identified and immediately corrected. All areas reviewed for appropriate food storage per facility policy.**<br><br>**2 How other resident having the potential to be affected by the same deficient practice will be identified**<br><br>**All residents have the potential to be affected by the deficient practice-**<br><br>**3 Corrective action taken for those residents having the** | 09/23/2024 |

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| | During an observation of wound care for Resident 196 on 8/9/24 at 10:21 a.m., Wound Nurse and LPN (Licensed Practical Nurse) 7, both performed hand hygiene. LPN 7 turned off the faucet with her bare hand. They both applied gloves. LPN 7, cleaned the shaft of the resident's penis with 7 swipes of the same area of the wipe in a downward motion. She obtained another wipe and with 7 swipes with the same area of the wipe, cleaned down on the resident's penis shaft. She obtained another wipe and with 12 swipes with the same area of the wipe, cleaned the penis tip and continued with 4 swipes on the creases and scrotum, with the same area of the wipe. The resident was rolled and with the wipe, she cleaned the rectal area, using a back to front motion, pulling around the wound dressing, toward the scrotum on the resident's left buttock. One side of the dressing was loose. The right buttock was not cleaned. The resident wasn't dried, and no barrier cream was applied.<br><br>2. During an observation of incontinence care for Resident 196 on 8/9/24 at 1:46 p.m., CNA (Certified Nurse Aide) 9 and CNA 8 performed hand hygiene. The staff both applied gloves. CNA 9 obtained wipes and with 5 swipes on the same area of the wipe, she cleaned the resident's penis, she folded the wipe and with 1 swipe, cleaned the penis and folded the wipe again and cleaned the penis. She performed hand hygiene and applied gloves. She indicated the resident's brief was dry. The wound dressing to the sacral wound was observed to be folded on one side and was hanging loose. No barrier cream was applied, and the resident wasn't dried. CNA 9 indicated the barrier cream was out of stock, but was ordered. She felt she performed good incontinence care for the resident.<br><br>During an interview on 8/9/24 at 2:05 p.m., CNA 9 | | **potential to be affected by the same deficient practice.**<br><br>**All direct care staff received incontinence care expectations education and competencies.**<br><br>**4 Measure /systemic changes put into place to ensure the deficient practice does not recur?**<br><br>**DON/Designee will observe incontinence care 5 x per week x 4 weeks, then 3 times per week, x 4 weeks, and then 1 time per week x 4 weeks.**<br><br>**The DON/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.** | |

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| | indicated the resident was not a heavy wetter. She indicated she would fold the wipe with each swipe to clean the resident during care.<br><br>During an interview on 8/9/24 at 2:08 p.m., CNA 8 indicated the amount the resident urinated varied on how much the resident drank. The CNA did not want to answer if while they were performing incontinence care staff had used the same area of the wipes multiple times.<br><br>The current Perineal Care-Male and Female policy, included, but was not limited to, " ... 9. Gently dry the perineum following the same sequence [penis, scrotum and inner thighs] ... 13. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. 14. Dry area thoroughly ..."<br><br>3.1-18(a) | | | |