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	08/19/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/19/2024 Facility Number: 000166 Provider Number: 155265 AIM Number: 100267080 At this Emergency Preparedness survey, Wedgewood Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 124 certified beds. At the time of the survey, the census was 105. Quality Review completed on 08/22/24	E 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**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/19/2024 Facility Number: 000166	K 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**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Lawson	RDO	09/16/2024

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.

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	Provider Number: 155265 AIM Number: 100267080 At this Life Safety Code survey, Wedgewood Healthcare Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in resident sleeping rooms 501 through 512 and has battery operated smoke alarms installed in all other resident sleeping rooms. The facility has a capacity of 124 and had a census of 105 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/22/24		**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**	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 300 hall bathrooms, 1 of 1 100 hall bathrooms, 1 of 1 lobby bathrooms, 1 of 1 therapy bathrooms, and 1 of 1 activities bathrooms were able to be unlocked from the outside in case of fire or other emergencies were readily accessible in accordance with LSC 7.1.10.1.	K 0200	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice.	09/23/2024

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	This deficient practice could affect up to 5 staff, residents, and visitors occupying the bathrooms. Findings include: Based on observation on 08/19/2024 between 1:15 PM and 3:45 PM with the Director of Plant Operations and Former Director of Plant Operations, the 300 hall bathroom, 100 hall bathroom, lobby bathroom, and therapy bathroom were observed to have a key lock and slide lock on the doors, additionally the activities bathroom was observed to have a key lock and a chain lock on the door. The slide locks and chain lock on the bathroom doors do not allow the doors to be opened from the outside in the event of an emergency. Based on interview at the time of observation, the Director of Plant Operations and Former Director of Plant Operations agreed there were locks on the inside of the doors in the aforementioned locations. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b)		**Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Locks on the inside of the door were removed and installed new compliant door locks. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** Administrator educated Maintenance Director on K 200 requirements as it relates to being able to access all bathrooms in case of fire or emergency. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit the 5 bathrooms monthly to ensure access in case of emergency X 3 months. The results of these audits monthly to the QAPI committee for not 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.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure the cook top for 1 of 1	K 0324	**Corrective action for the residents found to have been**	09/23/2024

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	stoves/ovens in the therapy room and 1 of 1 stoves/ovens in the conference room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to 15 residents, staff and visitors in the therapy room and conference room. Findings include: Based on observation on 08/19/2024 between 1:15 PM and 3:45 PM with the Director of Plant Operations and Former Director of Plant Operations, the stove/oven disconnect for the stoves/ovens in the conference room and the therapy room were both located in the hallway in a breaker box. The stove/oven display on the stove/oven in the conference room was flashing "PF" indicating the stove/oven had power. . Based on interview at the time of observation, the Director of Plant Operations and Former Director		**affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Switches/shutoffs moved from corridor to within the rooms where the stove/oven are located. Stove/oven observed to ensure off when not in use. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED educated Maintenance Director on requirements for LSC 19.3.2.5.4. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will observe stoves/ovens 5 x per week x 4 weeks, then 3 x per week x 4 weeks, then 1 time weekly x 4 weeks to ensure switch off when not in use and secured within room where stove/oven are located. 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 is ongoing monitoring is required.	

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	of Plant Operations stated the disconnect for both appliances was in the hallway breaker box. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0331 SS=D Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish on the business manager's office had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect 3 staff in the	K 0331	**K 331** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Flame spread documentation obtained for interior finish on the business manager's office. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED educated Maintenance Director on requirements for NFPA 101 10.2, 19.3.3.1, 19.3.3.2 **Corrective actions to be monitored to ensure the deficient practice will not**	09/23/2024

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	business manager's office. Findings include: Based on observation on 08/19/2024 between 1:15 PM and 3:45 PM with the Director of Plant Operations and Former Director of Plant Operations, the business manager's office had rock paneling on 1 wall. Based on interview at the time of observation, the Director of Plant Operations and Former Director of Plant Operations stated they did not have documentation regarding the flame spread rating of the paneling and it had not been treated to their knowledge. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b)		**recur:** The Administrator/Designee will audit life safety book monthly to ensure flame spread information maintained on record. 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 is ongoing monitoring is required.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 08/19/2024 at 1:44 PM with the Director of Plant Operations and Former Director of Plant Operations, the 500 hall fire	K 0345	**K 345** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Time corrected on fire panel and annunciator. **Measures/systemic changes put**	09/23/2024

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	panel, the fire panel indicated the time was 12:53 PM. Based on interview at the time of observation, the Director of Plant Operations and Former Director of Plant Operations agreed the time on the fire panel was incorrect. Based on observation during a tour of the facility on 06/11/2024 at 11:20 AM with the Executive Director and Rolling Hills Maintenance Director, the fire alarm annunciator located in the 400 hall displayed the time as 10:25 AM and at 10:43 AM the fire alarm control panel in the central circular area displayed 9:49 AM. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed the time displayed on the fire panel and annunciator was incorrect. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 08/19/2024 between 1:15 PM and 3:45 PM with the Director of Plant Operations and Former Director of Plant Operations, the 500 hall fire panel was in a trouble mode. Based on interview at the time of		**into place to ensure the deficient practice does not recur:** ED educated Maintenance Director on requirements for NFPA, 19.3.4 and 9.6 and NFPA 72 **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit time display on fire panel and annunciator weekly X 4 weeks, then monthly thereafter. 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 is ongoing monitoring is required.	

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	observation, the Director of Plant Operations stated 2 modules are causing the trouble mode and the contractor is coming this week to replace the modules and reset the fire panel. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview; the facility failed to ensure 1 of 1 500 hall janitor's closest sprinkler heads and covered with rust/corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect up to 2 staff. Findings include: Based on observation on 08/19/2024 between 1:15 PM and 3:45 PM with the Director of Plant Operations and Former Director of Plant Operations, the 500 hall janitor's closest sprinkler head was corroded. Based on interview at the time of observation, the Director of Plant Operations and Former Director of Plant Operations agreed there was corrosion on the sprinkler head in the	K 0353	**K 353** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Safe Care contacted to clean and replace sprinkler head in janitor's closet on 8/21/24. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED educated Maintenance Director on requirements for K 353 as it relates to maintenance of sprinkler heads. **Corrective actions to be monitored to ensure the deficient practice will not recur:**	09/23/2024

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	aforementioned location. This finding was reviewed with the Executive Director in Training, Director of Plant Operations, and Former Director of Plant Operations at the exit conference. 3.1-19(b)		The Administrator/Designee will audit 5 areas in the facility for sprinkler head corrosion weekly X 4 weeks, then monthly thereafter. 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.	