PRINTED: 09/23/2024

DEPARTMENT	FO	FORM APPROVED							
CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	ESURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMP	LETED		
		155265	B. WING			08/19	08/19/2024		
NAME OF PROVIDER OR SUPPLIER WEDGEWOOD HEALTHCARE CENTER			•	101 PO	ADDRESS, CITY, STATE, ZIP COD TTERS LN SVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI		COMPLETION		

WEDGE	WOOD HEALTHCARE CENTER	CLARK	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			
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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i '		, ,				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155265		A. BUILDING 01  B. WING			COMPLETED 08/19/2024	
		155205				06/19/	2024	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
WEDGEV	WOOD HEALTHCA	RE CENTER			TTERS LN SVILLE, IN 47129			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	DI	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
	Provider Number:	155265			executed solely because it is	;		
	AIM Number: 1002	267080			required by the position of			
	A.d. T.C.C.C.	0 1 W 1 1			Federal and State Law.			
	-	Code survey, Wedgewood vas found not in compliance			The Plan of Correction is submitted in order to respon			
	with Requirements	-			to the allegation of	u		
	-	, 42 CFR Subpart 483.90(a),			noncompliance cited during			
	-	ire and the 2012 Edition of the			the complaint survey			
		ction Association (NFPA) 101,			conducted on August 1,	_		
	•	LSC), Chapter 19, Existing ancies and 410 IAC 16.2.			2024 Please accept this plan	of		
	Tieatui Care Occupa	ancies and 410 IAC 10.2.			correction as the provider's credible allegation of			
	This one story facili	ity was determined to be of			compliance.			
	• • • •	ruction and fully sprinklered.			The facility would like to			
		re alarm system with smoke			respectfully request a desk			
		ridor and in all areas open to acility has smoke detectors			review. Molly Linder HFA			
		re alarm system installed in			Molly Lilider HFA			
		oms 501 through 512 and has						
		oke alarms installed in all						
	_	ing rooms. The facility has a						
	capacity of 124 and time of this visit.	had a census of 105 at the						
	time of this visit.							
	All areas where the	residents have customary						
	*	ered and all areas providing						
	facility services wer	re sprinklered.						
	Quality Review con	npleted on 08/22/24						
K 0200	NFPA 101							
SS=E		Requirements - Other						
Bldg. 01								
		on and interview, the facility f 1 300 hall bathrooms, 1 of 1	K 020	00	Corrective action for the	.	09/23/2024	
		, 1 of 1 lobby bathrooms, 1 of 1			residents found to have beer affected by the deficient	1		
		and 1 of 1 activities			practice:			
		e to be unlocked from the			No residents were affected by	the		
		re or other emergencies were			alleged deficient practice.			
	readily accessible in	accordance with LSC 7.1.10.1.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPLETED	
		155265	B. WING	G		08/19/	2024
			<del></del>	CTREET A	ADDRESS OF A STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
WEDGE	MOOD LIEALTHOA	DE CENTED			TTERS LN		
WEDGE	WOOD HEALTHCA	RE CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	This deficient pract	ice could affect up to 5 staff,			Corrective action taken for		
	residents, and visito	ors occupying the bathrooms.			those residents having the		
					potential to be affected by th	е	
	Findings include:				same deficient practice:		
					Locks on the inside of the doo	r	
		on on 08/19/2024 between 1:15			were removed and installed no	€W	
		ith the Director of Plant			compliant door locks.		
	-	mer Director of Plant					
	_	hall bathroom, 100 hall			Measures/systemic changes	put	
		throom, and therapy bathroom			into place to ensure the		
		ave a key lock and slide lock			deficient practice does not		
		onally the activities bathroom			recur:		
		ve a key lock and a chain lock			Administrator educated		
		de locks and chain lock on the			Maintenance Director on K 20		
		not allow the doors to be			requirements as it relates to b	-	
	_	tside in the event of an			able to access all bathrooms i	n	
		on interview at the time of			case of fire or emergency.		
		rector of Plant Operations and					
		Plant Operations agreed there			Corrective actions to be		
		nside of the doors in the			monitored to ensure the		
	aforementioned loc	ations.			deficient practice will not		
	Th: - C. 1:	ani arang di araigh, ghi a Erra arainna			recur:	.:11	
		viewed with the Executive g, Director of Plant Operations,			The Administrator/Designee w		
	1	•			audit the 5 bathrooms monthly	' το	
	conference.	or of Plant Operations at the exit			ensure access in case of		
	Conference.				emergency X 3 months. The	, to	
	3.1-19(b)				results of these audits monthly the QAPI committee for not less		
	3.1-17(0)				than 3 months. Any patterns t		
					are identified will have an Acti		
					Plan initiated. The QAPI	ווכ	
					committee will determine when	n	
					100% compliance is achieved		
					ongoing monitoring is required		
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01							
	Based on observation	on and interview, the facility	K 032	24	Corrective action for the		09/23/2024
	failed to ensure the	cook top for 1 of 1			residents found to have beer	ı	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155265	B. Wl	NG		08/19/	/2024
				CEREE	ADDRESS CITY CTATE TIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
WEDCE	WOOD HEALTHOA	DE CENTED			OTTERS LN		
WEDGEWOOD HEALTHCARE CENTER			CLARK	(SVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	stoves/ovens in the	therapy room and 1 of 1			affected by the deficient		
	stoves/ovens in the	conference room was shut off			practice:		
	at the switch when	not in use. LSC 19.3.2.5.4			No residents were affected by	the	
	states within a smo	ke compartment, residential or			alleged deficient practice.		
	commercial cooking	g equipment that is used to			Corrective action taken for		
	prepare meals for 3	0 or fewer persons shall be			those residents having the		
	permitted, provided	that the cooking facility			potential to be affected by th	e	
	complies with all th	ne following conditions:			same deficient practice:		
	(1) The space conta	aining the cooking equipment			Switches/shutoffs moved from	1	
	is not a sleeping ro	om.			corridor to within the rooms wl	here	
	(2) The space conta	aining the cooking equipment			the stove/oven are located.		
	shall be separated f	from the corridor by partitions			Stove/oven observed to ensur	e off	
	complying with 19	.3.6.2 through 19.3.6.5.			when not in use.		
	(3) The requirement	ats of 19.3.2.5.3(1) through (10)			Measures/systemic changes	put	
	and (13) are met.				into place to ensure the	•	
	19.3.2.5.3(9) states	A switch meeting all the			deficient practice does not		
	following is provid	ed:			recur:		
	(a) A locked switch	n, or a switch located in a			ED educated Maintenance		
	restricted location,	is provided within the cooking			Director on requirements for L	SC	
	facility that deactiv	rates the cooktop or range.			19.3.2.5.4.		
	(b) The switch is us	sed to deactivate the cooktop			Corrective actions to be		
	or range whenever	the kitchen is not under staff			monitored to ensure the		
	supervision.				deficient practice will not		
	This deficient pract	tice could affect up to 15			recur:		
	residents, staff and	visitors in the therapy room			The Administrator/Designee w	/ill	
	and conference roo	m.			observe stoves/ovens 5 x per		
					x 4 weeks, then 3 x per week		
	Findings include:				weeks, then 1 time weekly x 4		
					weeks to ensure switch off wh	en	
	Based on observati	on on 08/19/2024 between 1:15			not in use and secured within		
	PM and 3:45 PM w	vith the Director of Plant			room where stove/oven are		
	Operations and For	mer Director of Plant			located. The results of these		
	_	ve/oven disconnect for the			audits monthly to the QAPI		
		conference room and the			committee for no less than 3		
	therapy room were	both located in the hallway in a			months. Any patterns that are	)	
		tove/oven display on the			identified will have an Action F		
		onference room was flashing			initiated. The QAPI committee		
		stove/oven had power			determine when 100% compli		
		at the time of observation, the			is achieved or is ongoing		

Director of Plant Operations and Former Director

monitoring is required.

	NT OF DEFICIENCIES OF CORRECTION			ETED			
	PROVIDER OR SUPPLIER			101 PO	DDRESS, CITY, STATE, ZIP COD TTERS LN SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0331 SS=D Bldg. 01	appliances was in the This finding was re Director in Training	stated the disconnect for both he hallway breaker box.  viewed with the Executive g, Director of Plant Operations, of Plant Operations at the exit					
Blag. 01	review; the facility as an interior finish office had a flame s Class B. LSC 101 to be tested in according Standard Method of Characteristics of B grouped in the followith their flame spr (a) Class A Interior spread 0-25; smoke any material classif spread test scale and scale. Any element not continue to prop (b) Class B Interior spread 26-75; smoke any material classif more than 75 on the 450 or less on the si (c) Class C Interior spread 76-200; smo Includes any material but not more than 2 scale and 450 or less cale and 450 or	Wall and Ceiling Finish. Flame e development 0-450. Includes ited at more than 25 but not a flame spread test scale and	K 03	31	K 331 Corrective action for the residents found to have been affected by the deficient practice: No residents were affected by 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 into place to ensure the deficient practice does not recur: ED educated Maintenance Director on requirements for National Maintenance Corrective actions to be monitored to ensure the deficient practice will not	the  e  he	09/23/2024

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CE.TERO I OF	THE CONTENTS OF THE PARTY	THE CERTIFICATION OF THE CERTI			32 1.3.0,00 00,			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED				
		155265	B. WING	B. WING 08/19/2024				
				A DED DEGG COMMA CITATION CONTROL CONT				
NAME OF F	PROVIDER OR SUPPLIEF	t		ADDRESS, CITY, STATE, ZIP COD				
\A/E5 0='	NOOD HEATTHS:	DE CENTED		OTTERS LN				
WEDGE\	WOOD HEALTHCA	RE CENTER	CLARK	(SVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	business manager's			recur:				
				The Administrator/Designee w	vill			
	Findings include:			audit life safety book monthly				
				ensure flame spread informati				
	Based on observation	on on 08/19/2024 between 1:15		maintained on record. The re				
		ith the Director of Plant		of these audits monthly to the				
		mer Director of Plant		QAPI committee for no less th				
		iness manager's office had		months. Any patterns that are	-			
		wall. Based on interview at the		identified will have an Action F				
		, the Director of Plant		initiated. The QAPI committee				
		mer Director of Plant		determine when 100% compli				
	Operations stated th			is achieved or is ongoing	ance			
		arding the flame spread rating						
	_	it had not been treated to their		monitoring is required.				
	knowledge.	it had not been treated to then						
	knowledge.							
	This finding was ro	viewed with the Executive						
	_	g, Director of Plant Operations,						
	1	r of Plant Operations at the exit						
	conference.	of 1 fant Operations at the exit						
	conference.							
	3.1-19(b)							
K 0345	NFPA 101							
SS=F	Fire Alarm Systen	n - Testing and						
Bldg. 01	Maintenance							
		ation and interview, the facility	K 0345	K 345	09/23/2024			
		ne fire alarm system to assure		Corrective action for the				
		time information in accordance		residents found to have been	n			
		nts of NFPA 101- 2012 edition,		affected by the deficient				
		9.6 and NFPA 72 - 2010		practice:				
		.1, 14.1.1. This deficient		No residents were affected by	the			
	practice could affect	t all residents, staff and		alleged deficient practice.				
	visitors.			Corrective action taken for				
				those residents having the				
	Findings include:			potential to be affected by the	ne			
				same deficient practice:				
	Based on observation	on on 08/19/2024 at 1:44 PM		Time corrected on fire panel a	ind			
	with the Director of	Plant Operations and Former		annunciator.				
		perations, the 500 hall fire		Measures/systemic changes	put			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155265	B. W			08/19/	
		100200		_		00, 10,	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SETTELET			101 PO	TTERS LN		
WEDGE	WOOD HEALTHCA	RE CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	panel, the fire panel	l indicated the time was 12:53			into place to ensure the		
	PM. Based on inter	view at the time of			deficient practice does not		
	observation, the Di	rector of Plant Operations and			recur:		
		Plant Operations agreed the			ED educated Maintenance		
	time on the fire pan				Director on requirements for		
					NFPA, 19.3.4 and 9.6 and NF	ΡΔ	
	Based on observation	on during a tour of the facility			72	1 / \	
		1:20 AM with the Executive			Corrective actions to be		
		g Hills Maintenance Director,					
		nciator located in the 400 hall			monitored to ensure the		
		as 10:25 AM and at 10:43 AM			deficient practice will not		
					recur:		
		ol panel in the central circular			The Administrator/Designee w		
		AM. Based on interview at the			audit time display on fire pane	I	
		, the Rolling Hills Maintenance			and annunciator weekly X 4		
	_	time displayed on the fire			weeks, then monthly thereafte	r.	
	panel and annuncia	tor was incorrect.			The results of these audits		
					monthly to the QAPI committe	е	
	This finding was re	viewed with the Executive			for no less than 3 months. An	у	
	Director in Training	g, Director of Plant Operations,			patterns that are identified will		
	and Former Directo	or of Plant Operations at the exit			have an Action Plan initiated.	The	
	conference.				QAPI committee will determine	е	
					when 100% compliance is		
	3.1-19(b)				achieved or is ongoing monito	rina	
	. ,				is required.	J	
	2. Based on observa	ation and interview, the facility			· '		
		f 1 fire alarm systems was					
		per operating condition.					
		Fire Alarm and Signaling Code,					
		on 14.2.1.2.2 states system					
	· ·	ctions shall be corrected. This					
		ould affect all residents, staff					
	and visitors.	ouid affect all festdellis, staff					
	and visitors.						
	Findings include:						
	-						
		on on 08/19/2024 between 1:15					
		rith the Director of Plant					
	Operations and For	mer Director of Plant					
	Operations, the 500	hall fire panel was in a trouble					
	-	erview at the time of					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPI 155265 B. WING 08/19		ETED				
	NAME OF PROVIDER OR SUPPLIER WEDGEWOOD HEALTHCARE CENTER			101 PO	ADDRESS, CITY, STATE, ZIP COD TTERS LN SVILLE, IN 47129	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0353 SS=D Bldg. 01	stated 2 modules are and the contractor is the modules and res This finding was red Director in Training and Former Director conference.  3.1-19(b)  NFPA 101  Sprinkler System - Based on observation failed to ensure 1 of sprinkler heads and were replaced. NFF sprinklers shall not be free of corrosion physical damage; at correct orientation (sidewall). Furtherm that shows signs of replaced: (1) Leaka Damage (4) Loss of responsive element unless painted by the This deficient practice.  Findings include:  Based on observation for particular propertions, the 500 head was corroded. Of observation, the 1 and Former Director in the particular propertions and Former Director in the particular propertions.	ector of Plant Operations e causing the trouble mode s coming this week to replace et the fire panel. viewed with the Executive g, Director of Plant Operations, r of Plant Operations at the exit  Maintenance and Testing on and interview; the facility for 1500 hall janitor's closest covered with rust/corrosion on 25, 2011 edition, at 5.2.1.1.1 show signs of leakage; shall g, foreign materials, paint, and and shall be installed in the e.g., up-right, pendent, or hore, at 5.2.1.1.2 any sprinkler hany of the following shall be ege (2) Corrosion (3) Physical foliuld in the glass bulb heat (5) Loading (6) Painting e sprinkler manufacturer. Here could affect up to 2 staff.  on on 08/19/2024 between 1:15 with the Director of Plant hall janitor's closest sprinkler Based on interview at the time Director of Plant Operations or of Plant Operations or of Plant Operations agreed on the sprinkler head in the	K 03	353	K 353 Corrective action for the residents found to have been affected by the deficient practice: No residents were affected by 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 replace sprinkler head in janite closet on 8/21/24. Measures/systemic changes into place to ensure the deficient practice does not recur: ED educated Maintenance Director on requirements for kas it relates to maintenance of sprinkler heads. Corrective actions to be monitored to ensure the deficient practice will not recur:	the  e  and or's  put	09/23/2024

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155265	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE : COMPL 08/19/	ETED
NAME OF PROVIDER OR SUPPLIER WEDGEWOOD HEALTHCARE CENTER			101 PC	ADDRESS, CITY, STATE, ZIP COD DTTERS LN (SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Director in Training	viewed with the Executive s, Director of Plant Operations, r of Plant Operations at the exit		The Administrator/Designee wand audit 5 areas in the facility for sprinkler head corrosion week 4 weeks, then monthly thereaf. The results of these audits monthly to the QAPI committe for no less than 3 months. An patterns that are identified will have an Action Plan initiated. QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.	ly X fter. e y The e	

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