STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00401557, IN00403032, IN00404879 and IN00405388. Complaint IN00401557 - No deficiencies related to the allegations are cited. Complaint IN00403032 - Federal/State deficiencies related to the allegations are cited at F656 and F757. Complaint IN00404879 - Federal/State deficiencies related to the allegations are cited at F600 and F609. Complaint IN00405388 - No deficiencies related to the allegations are cited. Survey dates: April 3, 4 and 5, 2023 Facility number: 000166 Provider number: 155265 AIM number: 100267080 Census Bed Type: SNF/NF: 112 Total: 112 Census Payor Type: Medicare: 9 Medicaid: 77 Other: 26 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	/b> ="" span="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Nowlin	Executive Director	04/21/2023

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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	Quality review completed on April 10, 2023.			
F 0600 SS=E Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure Resident to Resident abuse did not occur for 4 of 8 resident to resident altercations reviewed for abuse. (Residents E, D and G) Findings include: 1. The clinical record for Resident E was reviewed on 4/3/23 at 11:20 a.m. The diagnoses included, but were not limited to, bipolar, affective mood disorder and dementia with anxiety. On 4/3/23 at 3:25 p.m., the resident was observed resting in his bed with his eyes closed. There was 1:1 (one staff member to on resident) supervision in place. The incident report, dated 3/20/23, indicated on 3/17/23 Resident E made contact with Resident D's	F 0600	**F-600** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents E, D, G could not be identified as they were part of a complaint survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other residents have the	04/21/2023

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	face. The alleged incident was not witnessed by staff. There were no documented interventions. The indicated report, dated 3/20/23, indicated on 3/18/23 Resident G entered his room at which time Resident E made contact with him. There were no documented interventions The incident report, dated 3/24/23, indicated Resident D was standing near Resident E when Resident E made contact with Resident D. The incident report, dated 3/30/23, indicated Resident E and Resident G were passing in the hallway when Resident E made contact with Resident G for no apparent reason. The care plan, dated 3/6/23, indicated the resident had a behavior problem such as hitting staff. The interventions indicated staff were to intervene as necessary to protect the rights and safety of others and to maintain as much independence and control/decision making as possible. On 3/20/23, the care plan was revised to include the resident had a behavior problem such as hitting others and to monitor behavioral episodes, attempt to determine underlying causes, and to anticipate the residents' needs. The progress note, dated 3/1/23 at 2:42 p.m., indicated while a staff member was kneeling to assist the resident to change, Resident E struck the staff member on the top of the head. The resident was noted with baseline aggressive behaviors. The resident was sent to the hospital for evaluation.		potential to be affected by this alleged deficient practice. All residents with BIMS score of 8 or higher were interviewed regarding any concerns with abuse. Those residents who were not able to be interviewed had skin assessments complete. No concerning findings were noted as a result of audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DON/ADON or Designee educated staff on facilities policy "Indiana Abuse and Neglect & Misappropriation of Property" with emphasis on resident to resident abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 8 weeks, to ensure no concerns are noted with resident to resident abuse, these audit will consist of interviews for residents with BIMS scores of 8 or higher or skin assessments for those noted with BIMS lower than 8.	

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	The progress note, dated 3/1/23 at 8:57 p.m., indicated the resident returned from the hospital. The social worker note, dated 3/20/23 at 12:18 p.m., indicated the resident was going to be sent to the hospital for evaluation due to his behaviors. The progress note, dated 3/20/23 at 3:15 p.m., indicated the resident left via EMS (emergency medical services) for transfer to the hospital. The progress note, dated 3/20/23 at 8:16 p.m., indicated the resident returned from the hospital with a diagnosis of dementia with behavioral disturbance. There were no new orders or medication changes made. The progress note, dated 3/24/23 at 10:53 p.m., indicated Resident E hit another resident in the face with his fist. The nurse intervened immediately and separated the residents. Resident E was placed 1:1 supervision. The progress noted, dated 3/24/23 at 9:29 p.m., the resident was sent to the hospital for a psychiatric evaluation. The progress note, dated 3/25/23 at 12:32 p.m., indicated the resident returned from the hospital. There were no medication adjustments or changes. Upon return from the hospital on 3/25/23, Resident E was placed on 1:1 supervision. During an interview on 4/3/23 at 1:50 p.m., the Executive Director indicated staff did not report the incidents to him on 3/17/23 and 3/18/23. He		The DON and/or 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. The results of the audit will be reviewed at the monthly QAPI meeting. Changes may be established to the auditing process, based upon the results of the audits. Date of compliance 4/21/23	

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	was unaware until 3/20/23, while in morning meeting. He had been sent to the hospital for psychiatric evaluation and the hospital would keep him a few hours and then send him back. He had been 1:1 since his return on 3/25/23. They had discontinued the 1:1 supervision on 3/30/23 per the psychiatric physician and 3 hours later Resident E struck another resident. The resident had been 1:1 supervision ever since. 2. The clinical record for Resident D was reviewed on 4/3/23 at 3:02 p.m.., the diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 3/20/23, indicated on 3/17/23 Resident E made contact with Resident D's face. The alleged incident was not witnessed by staff. The incident report, dated 3/24/23, indicated Resident D was standing near Resident E when Resident E made contact with Resident D. 3. The clinical record for Resident G was reviewed on 4/4/23 at 1:55 p.m. The diagnoses included, but were not limited to, dementia, insomnia and anxiety. The indicated report, dated 3/20/23, indicated on 3/18/23 Resident G entered his room at which time Resident E made contact with him. The incident report, dated 3/30/23, indicated Resident E and Resident G were passing in the hallway when Resident E made contact with Resident G for no apparent reason. On 4/3/23 at 11:41 a.m., the Executive Director provided a current copy of the document titled			

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	"INDIANA Abuse & Neglect & Misappropriation of Property" date 9/1/2017. It included, but was not limited to, "Physical Abuse...defined as a willful act against a resident by another resident...hitting...Policy...It is the policy of this facility to provide resident centered care...It is the intent of this facility to prevent the abuse...of residents...." This Federal tag relates to Complaint IN00404879 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all			

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	investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure staff reported resident to resident abuse to the Administrator, in a timely manner, for 3 of 8 incidents reviewed for abuse. (Residents D, E, G and L) Findings include: 1. The clinical record for Resident D was reviewed on 4/3/23 at 3:02 p.m.., the diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 3/20/23, indicated on 3/17/23 Resident E made contact with Resident D's face. The alleged incident was not witnessed by staff. The incident report, dated 3/20/23, indicated on 3/18/23 Resident L struck Resident D when Resident D walked by the table and knocked Resident L's bottle of water off the table. During an interview on 4/3/23 at 1:50 p.m., the Executive Director (ED) indicated he was unaware of the incidents on 3/17/23 and 3/18/23 until 3/20/23. LPN (Licensed Practical Nurse) 3 told the ED she was unaware that she needed to notify him. During an interview on 4/5/23 at 11:35 a.m., LPN (Licensed Practical Nurse) 5 indicated the Administrator should be notified immediately of	F 0609	**F-609** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents E, D, G, and L could not be identified as they were part of a compliant survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this alleged deficient practice. An audit has been conducted to review progress notes for the last 14 days to ensure all noted resident abuse has been reported per regulations to Indiana State Department of Health. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	04/21/2023

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	any type of abuse. 2. The clinical record for Resident E was reviewed on 4/3/23 at 11:20 a.m. The diagnoses included, but were not limited to, bipolar, affective mood disorder and dementia with anxiety. The incident report, dated 3/20/23 indicated on 3/17/23, Resident E made contact with Resident D's face. The alleged incident was not witnessed by staff. The indicated report, dated 3/20/23, indicated on 3/18/23 Resident G entered his room at which time Resident E made contact with him. 3. The clinical record for Resident G was reviewed on 4/4/23 at 1:55 p.m. The diagnoses included, but was not limited to, dementia, insomnia and anxiety. The indicated report, dated 3/20/23, indicated on 3/18/23, Resident G entered his room at which time Resident E made contact with him. 4. The clinical record for Resident L was reviewed on 4/4/23 at 2:31 p.m. The diagnoses included, but were not limited to, Huntington's disease and anxiety. The incident report, dated 3/20/23, indicated on 3/18/23 Resident L made contact with Resident D when Resident D walked by the table and knocked off Resident L's bottle of water. On 4/3/23 at 11:41 a.m., the Executive Director provided a current copy of the document titled "INDIANA Abuse & Neglect & Misappropriation of Property" dated 9/1/2017. It included, but was not limited to, "Policy...It is the policy of the		**practice does not recur;** ED/DON/and or Designee educated staff on facilities policy "Indiana Abuse and Neglect & Misappropriation of Property" with emphasis on requirements for reporting abuse in a timely manner and who it should be reported to. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The ED/DON/ and or Designee will review all resident to resident abuse occurrences to ensure they are reported in a timely manner and to appropriate personnel weekly for 4 weeks, then bi-weekly for 8 weeks. The DON and/or 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. Date of compliance 4/21/23	

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	facility to provide resident centered care...Allegations must be reported to the ED immediately...." This Federal tag relates to Complaint IN00404879 3.1-28(c)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a plan of care was implemented for a resident (Resident C) with a diagnosis of anxiety for 1 of 4 residents reviewed for comprehensive care plans. Findings include: The clinical record for Resident C was reviewed on 4/3/23 at 2:21 p.m. The diagnosis included, but was not limited to, anxiety. The physician's order, dated 2/3/23, indicated the resident was to start Clonazepam (anti-anxiety medication), 0.25 mg (milligrams) twice a day for anxiety. The clinical record lacked documentation of a plan of care for the resident's anxiety diagnosis. During an interview on 4/5/23 at 11:35 a.m., LPN (Licensed Practical Nurse) 5 indicated if a resident	F 0656	**F-656** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C could not be identified as they were part of the compliant survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** **All residents with the diagnosis of anxiety** have the potential to be affected by this alleged	04/21/2023

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	had a diagnosis of anxiety and received medication for the anxiety, there should be a care plan in place. On 4/4/23 at 12:45 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled "Plan of Care Overview". It included, but was not limited to, "Definitions...for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care...It is the policy of this facility to provide resident centered care...The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident...in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals...related to...their daily routines...." This Federal tag relates to Complaint IN00403032 3.1-35(a)		deficient practice, an audit was complete to ensure all residents with the diagnosis of anxiety have the appropriate care plan in place to reflect that diagnosis. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON or Designee educated staff on facilities policy “Plan of Care Overview” with emphasis on implementing care plan for resident’s current diagnosis or condition including anxiety. staff on implementing care plans for residents with diagnosis of anxiety. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON or Designee will review 10 residents with an anxiety diagnosis weekly for 4 weeks, then bi-weekly for 8 weeks to ensure care plan is in place. The DON and/or 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	

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			have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. Date of compliance 4/21/23	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure staff monitored a resident (Resident C) for adverse side effects after the resident was started on an anti-anxiety medication and anti-depressant/sedative for 1 of 3 residents reviewed for unnecessary medications.	F 0757	**F-757** **The facility failed to ensure staff monitored a resident (Resident C) for adverse side effects after the resident was started on an anti-anxiety**	04/21/2023

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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
	Findings include: The clinical record for Resident C was reviewed on 4/3/23 at 2:21 p.m. The diagnoses included, but were not limited to, anxiety and insomnia. The physician's order, dated 2/3/23, indicated the resident was start Clonazepam (anit-anxiety medication) 0.25 mg (milligrams) twice daily for anxiety at 9:00 a.m. and 9:00 p.m. The physician's order, dated 2/6/23, indicated the resident was to start Trazodone (Sedative) 25 mg at bedtime for insomnia. Review of the March 2023 medication administration record indicated the resident started the Trazodone on 2/7/23 and the Clonazepam on 2/3/23 at 9:00 p.m. The clinical record lacked documentation of the staff monitoring the resident for any side effects of the medications. On 4/4/23 at 11:02 a.m., the Nurse Practitioner indicated the monitoring of the Trazadone and Clonazepam should be in the chart and staff are supposed to document behaviors of insomnia and anxiety. During an interview on 4/5/23 at 11:35 a.m., LPN (Licensed Practical Nurse) 5 indicated if a resident was on Clonazepam or Trazodone, monitoring of side effects should be completed every shift. On 4/4/23 at 12:45 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled "Behavior Management General". It included, but was not		**medication and anti-depressant sedative for 1 of 3 residents for unnecessary medications.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C could not be identified as they were part of a compliant survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other residents who have new orders for anti-anxiety and anti-depressant medications have the potential to be affected by this alleged deficient practice. A 14-day look back audit was conducted to review all new orders and those found to have new orders for anti-anxiety and anti-depressant medications were reviewed to ensure they were monitored for adverse side effects. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DON/and or designee educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	04/05/2023

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	limited to, "Policy...It is the policy of this facility to...safely manage resident who are exhibiting behaviors...Review pharmacologic...interventions...Include resident specific interventions This Federal tag relates to Complaint IN00403032 3.1-48(a)(3)		staff on facilities policy “Behavior Management General” with emphasis on monitoring for adverse side effects with the start of a new medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON or Designee will review 10 residents with anti-anxiety or anti-depressant medication weekly for 4 weeks, then bi-weekly for 8 weeks to ensure adverse side effect monitoring is occurring. The DON and/or 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. Date of compliance 4/21/23	