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	06/21/2023

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 a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00409941, IN00407874, and IN00407490. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00409941- Federal/State deficiency related to the allegations are cited at F684 and F584. Complaint IN00407874 - No deficiencies related to the allegations are cited. Complaint IN00407490 - Federal/State deficiency related to the allegations is cited at F565. Survey dates: June 14, 15, 16, 19, 20, and 21, 2023. Facility number: 000166 Provider number: 155265 AIM number: 100267080 Census Bed Type: SNF/NF: 106 Total: 106 Census Payor Type: Medicare: 8 Medicaid: 75 Other: 23 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on July 17-21st 2022. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Jay Nowlin, HFA**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Nowlin	Executive Director	07/13/2023

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.

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	06/21/2023

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
	Quality review completed on June 28, 2023.			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (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 members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (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. (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. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident			

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	06/21/2023

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
	representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on record review and interview, the facility failed to promptly resolve the grievances and recommendations made by the Resident Council during 9 of 12 meetings and 7 of 11 complaint logs reviewed where the same issues were being reported as continuing problems. This deficient practice had the potential to affect all 106 residents residing in the facility. Findings include: On 6/19/23 at 2:00 p.m., the Resident Council minutes for the months of July 2022 through June 2023 were reviewed after permission was obtained by the Resident Council President. The review of the Resident Council minutes indicated on 7/26/22 the residents' had the following concerns: - Staff were not distributing trays in a timely manner. - Staff were not reminding people on their shower days and/or putting them off until too late. - Staff were not offering to change bed linens. No response to these concerns could be located. The review of the Resident Council minutes indicated on 11/22/22 the residents' had the following concerns: - Certified Nurse Aides (CNA) were rude when they answered call lights. - There were no weekly bed changes. - Staff were saying showers were refused when they weren't.	F 0565	**F565** Corrective action for the residents found to have been affected by the deficient practice:Corrective action taken for those residents having the potential to be affected by the same deficient practice:Measures/systemic changes put into place to ensure the deficient practice does not recur:Corrective actions to be monitored to ensure the deficient practice will not recur:	07/17/2023

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	06/21/2023

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
	No response to these concerns could be located. The review of the Resident Council minutes indicated on 12/27/22 the residents' had the following concerns: - CNAs were not emptying the trash. - CNAs and nurses were too loud in the hallways. They were laughing, talking and discussing residents where they can be easily overheard. No responses to these concerns could be located. The review of the Resident Council minutes indicated on 1/31/23 the residents' had the following concerns: - Housekeeping was not sweeping or mopping floors. - Mops were not being changed out. - There were stained or torn bed linens. - Resident's clothes were missing. - CNAs were wearing their name tags backwards and refusing to tell their names when asked. - Residents could not find aides on night shift. They were always at the desk or on their phones with ear buds in. On 2/4/23, the Housekeeping Supervisor did not address all the housekeeping issues identified by the residents. On 2/4/23, the RN Supervisor responded to the concern and indicated staff re-education would be done on the use of name tags and onboarding new staff. The review of the Resident Council minutes indicated on 2/28/23 the residents' had the			

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	06/21/2023

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
	following concerns: - Housekeeping was not mopping the floors. - CNAs were not cleaning out the urinals and commodes. - CNAs were ignoring the residents and sitting at the nurse's station. - Ice water was not being passed out on the halls. - Staff were on their cell phones. - Call lights were not being answered in a timely manner. - Staff were not distributing meal trays in a timely manner. Meal carts sat for 30 minutes or more at times, before they were passed. On 2/28/23, the Housekeeping Supervisor responded to the concern that she would re-train her staff. On 2/28/23 and 3/1/23, RN Supervisor in-serviced the CNAs on emptying the urinals and bedside commodes, passing ice and water every shift and as needed on demand, acknowledging the residents when they approach the nurse's station and med carts, answering call lights, distribution of meal trays, and cell phone usage. The review of the Resident Council minutes indicated on 3/28/23 the residents' had the following concerns: - A housekeeping staff member was only taking the garbage out and did not sweep, dust or mop. - Second shift CNAs and nurses were too noisy and woke the residents up. - CNAs were still not distributing meal trays in a timely manner. - CNAs were still not passing ice water. - Night-time medication was passed too slowly.			

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	06/21/2023

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
	On 3/30/23, the Housekeeping Supervisor had a meeting with all housekeeping staff and went over the 5-step room cleaning process, bathroom cleaning process. She indicated she would be monitoring the staff to ensure every room was cleaned and deep cleaning was done daily. On 3/30/23, the RN Supervisor re-educated the nursing staff on customer service, prioritizing medication pass, and that it was all-hands on deck with team work to pass food trays timely. The review of the Resident Council minutes indicated on 4/25/23 the residents' had the following concerns: - Sinks and toilets were not being cleaned. - Some of the nursing staff gave the appearance of not caring. They were not smiling and resident concerns were brushed off or ignored entirely. - CNAs were still not answering call lights in a timely manner. - Wound care was being neglected. - CNAs were not offering showers. On 4/25/23, the Housekeeping Supervisor indicated she re-trained all her team members. On 4/26/23, the RN Supervisor indicated the nursing staff were re-educated on customer service, answering call lights, prioritizing residents for wound care, and taking the initiative to complete all scheduled showers. All staff would be monitored for compliance. The review of the Resident Council minutes indicated on 5/23/23 the residents' had the following concerns: - Housekeeping was taking too long to clean up			

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	06/21/2023

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
	messes. - Toilet paper holders were broken. - Laundry was not getting clothes back to the residents. - Residents wanted diabetic friendly foods. - CNAs were not emptying bedside commodes. - Nursing staff were taking too long to answer call lights. - There were not enough linens. On 5/23/23, the Housekeeping Supervisor responded to the concerns with resident clothes were not labeled. Residents were not writing down what was missing and nursing was throwing linen away rather than cleaning it. The laundry staff had up to 72 hours to return residents clothing after being cleaned. On 5/24/23, RN Supervisor re-educated the staff on providing showers on scheduled days, emptying commodes when rounding and staff performance would be reviewed regularly by administration. On 5/23/23, the Maintenance Director responded to the concern that he would be changing out all broken toilet paper holders. The review of the Resident Council minutes indicated on 6/20/23 the residents' had the following concerns: - Housekeeping staff were not mopping and garbage was not changed. Residents were being told the floor looked clean and good enough that it didn't need to be swept or mopped. - Medications, including insulins were not being passed on time, especially at night. Medications could be as late as 11:00 p.m. to 1:00 a.m. - Nursing staff were not getting things when			

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	06/21/2023

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
	residents asked. When an aide was asked to help resident or for something, if they were not assigned to that resident, then they would not help and would say they would have to get the resident's assigned aide or nurse, even for something as simple cup of water. Or they would say they would be right back and then never came back. - Wound dressing changes were completed late or not at all. - Bed linens were not being changed. - Residents had to wait for the floor staff to pass trays. Sometimes the food was cold by the time staff would come on the floor and passed them. - Residents could hear staff laughing and talking at the nurse's station when resident call lights were going off. Sometimes the residents would have to go out to nurse's station to get them. Staff would occasionally have an attitude when they came into the room like they didn't want to be there or they treated the resident like a child. On 6/21/23 at 9:30, the Executive Director (ED) presented a copy of the Resident Grievance/Complaint Logs for August 2022 through June 2023. The logs identified the following concerns in August 2022: - Trays on the halls were not getting passed in a timely manner. - Staff were putting off showers. - Staff were not changing bed linens - Call lights were not being answered timely. - Ice water was not being passed. - There was no help on the night shifts. The logs identified the following concerns in September 2022:			

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	06/21/2023

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
	- Ice water was not being passed. - Clothing was not being labeled and labeled clothing was found in the lost and found rather than returned to the residents. The logs identified the following concerns in October 2022: - Residents observed other resident's wearing clothing that did not belong to them. - There was missing clothing and belongings. - Residents were not getting showers. The logs identified the following concerns in November 2022: - Residents were missing clothes. - Residents were not receiving showers. - Bed linens were not being changed with clean linen weekly. The logs identified the following concerns in December 2022: - Residents were missing clothes. - Residents were not being changed on 300 hall. - Staff were too loud. - Floors were not being mopped in resident rooms and trash was not being emptied. The logs identified the following concerns in January 2023: - Resident clothing was missing. The logs identified the following concerns in February 2023: - Residents were not getting showers on 300 hall.			

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	06/21/2023

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
	- Mop heads were not being changed. - Residents were missing clothing. On 6/21/23 at 10:00 a.m., the Activities Assistant provided the facility's current policy titled Resident Grievance Indiana, dated 6/19/18 with a review date of 5/30/19. Review of this policy included, but was not limited to, "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. This facility will provide a venue for residents, and others involved in patient care, to voice concerns, complaints, or grievances to the facility leadership and external parties...Procedure:...3. Investigation: a. The Grievance Official shall complete an investigation of the resident's grievance...4. Time Frame: a. The Grievance review will be completed in a reasonable time frame consistent with the type of grievance but not to exceed 30 days...6. Resident Notification: a. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved, if applicable..." This Federal tag relates to Complaint IN00407490. 3.1-3(k) 3.1-3(l) 3.1-7(a)(2) 3.1-3(l) 3.1-7(a)(2)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

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	06/21/2023

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
	her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its			

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	06/21/2023

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
	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of a blood sugar levels over 400 mg/dL for 1 of 3 residents reviewed for Notification of Change. (Resident 79) Findings include: The record for Resident 79 was reviewed on 6/15/23 at 11:44 a.m. The diagnoses included, but were not limited to, type 2 Diabetes Mellitus, chronic kidney disease stage 3, and acute kidney failure. The Quarterly MDS (Minimum Data Set) assessment, dated 3/30/23, indicated the resident was cognitively intact. The care plan, dated 8/8/22 and last revised on 10/10/22, indicated the resident had Diabetes Mellitus and was non-compliant with diet, placing him at risk for complications related to high blood glucose. The interventions included, but were not limited to, administer insulin injections per orders and report any abnormal findings to the medical provider. The physician order, dated 1/19/23, indicated staff were to administer the resident's insulin lispro subcutaneously with meals by pen-injector as per sliding scale: If the resident's blood sugar was 151 to 200 they were to give 5 units; 201 to 250 give 8 units; 251 to 300 give 10 units; 301 to 350 give 12 units; 351 to 400 give 14 units; 401 to 450 give 16 units and Lantus Solostar subcutaneously by	F 0580	**F580** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 79's bloods sugars were reviewed with NP. Resident 79 experienced no negative outcomes related to the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. An audit of all diabetic residents was conducted and blood sugar levels reviewed with NP. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee completed education with all licensed staff regarding physician notification of blood sugar levels. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will	07/17/2023

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	06/21/2023

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
	pen-injector inject 20 units subcutaneously at bedtime for hyperglycemia and inject 30 units subcutaneously in the morning for hyperglycemia. The Blood Sugar Summary indicated the following: - On 9/12/22 at 12:30 p.m., the resident's blood sugar level was 472 mg/dL (milligrams per deciliter). The clinical record lacked documentation indicating the physician was notified. - On 4/7/23 at 12:07 a.m., the resident's blood sugar level registered HI (meaning over 600 mg/dL). The clinical record lacked documentation indicating the physician was notified. - On 5/8/23 the resident's blood sugar level was 450 mg/dL. The clinical record lacked documentation indicating the physician was notified. - On 6/9/23 the resident's blood sugar level was 466 mg/dL. The clinical record lacked documentation indicating the physician was notified. - On 6/10/23 the resident's blood sugar level was 450 mg/dL. The clinical record lacked documentation indicating the physician was notified. During an interview on 6/19/23 at 2:35 p.m., the NP (Nurse Practitioner) indicated when a resident's blood sugar was above 400 mg/dL the NP should be notified. During an interview on 6/20/23 at 10:04 a.m., LPN (Licensed Practical Nurse) 7 indicated if a		review/audit 5 residents for blood sugar notifications per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident x 4 weeks, and ongoing as needed. 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.	

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	06/21/2023

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
	resident's blood sugar was elevated, she would go by the sliding scale for insulin. If the blood sugar was over 400 mg/dL, she would call the physician or NP and give insulin according to what was ordered. During an interview on 6/21/23 at 10:00 a.m., RN 11 indicated if a blood sugar was over 400 mg/dL and according to the sliding scale, she would call the physician. She would give the insulin within 15 minutes of the blood sugar results. During an interview on 6/21/23 at 3:00 p.m., the RDCO (Regional Director of Clinical Operations) indicated the goal for the facility would be to manage the resident's diabetes and ensure he had no adverse effects from the diabetes. The current Notification for Changes in Condition Policy, provided by the Corporate Nurse on 6/21/22 included, but was not limited to, "... The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition..." 3.1-5(a)2 3.1-5(a)3			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-			

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	06/21/2023

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
	§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, record review, and interview, the facility failed to ensure the heating and air units were in good working condition for a comfortable temperature for 2 of 106 resident residing in the facility. (Residents E and D)	F 0584	**F584** **Corrective action for the residents found to have been affected by the deficient practice:** Resident E and D's HVAC unit	07/17/2023

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	06/21/2023

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
	Finding include: During and observation on 6/14/23 at 9:55 p.m., the HVAC (heating, ventilation, and air conditioning) unit was set to the fan only setting, upon entrance into Residents E and D's room. The room was observed to feel warm. During an interview on 6/14/23 at 9:55 a.m., Resident E, indicated the air conditioning unit was not functioning properly. The fan only button was on and was blowing warm air. If the cool setting was on, it would only run for 10 minutes or so and then shut off. The E9 (error) lighted setting would appear in the temperature screen. The HVAC unit didn't work even though it was new. The Maintenance Director informed Resident E that he couldn't do anything about it. During an interview on 6/15/23 at 10:44 a.m., Resident E indicated the HVAC unit was out and had been this way for a few months. Her roommate got hot sometimes or cold sometimes, so Resident E would go by how Resident D felt, as to whether she would have the fan turned on or not. The fan was all that worked on the unit. On 6/16/23 at 1:50 p.m., the ED (Executive Director) provided a copy of the original work order, dated 4/19/23. The work order indicated a medium priority by the Maintenance Director to replace the HVAC unit. During an interview on 6/20/23 at 9:46 a.m., the Maintenance Director indicated the issue with the unit could have been a surge in the plug or electric. The E9 was probably nothing and it could be reset. He indicated the new units were "crap." He had done 5 room per week checks on the units. At that time, Maintenance Staff 10, indicated on		was replaced at the time alleged deficient practice identified. Resident E and D experienced no negative outcomes from alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. An audit of all HVAC units was conducted and any identified concerns addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Designee completed education with all staff regarding comfortable and safe temperatures and facility repairs. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit 5 residents HVAC units per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident x 4 weeks, and ongoing as needed. The Administrator/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	

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	06/21/2023

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
	6/15/23, he had reset the unit and it showed E9 again, so he replaced the unit with a new one. During an interview on 6/21/23 at 3:44 p.m., the RDCO (Regional Director of Clinical Operations) indicated the facility had no policy for environmental repairs. This Federal tag relates to Complaint IN00409941 3.1-19(j)		when 100% compliance is achieved or if ongoing monitoring is required.	
F 0600 SS=D 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 record review and interview, the facility failed to ensure a resident was free of verbal abuse for 1 of 3 residents reviewed for abuse. (Resident 58) Findings include: The record for Resident 58 was reviewed on 6/15/23 at 12:53 p.m. The diagnoses included, but were not limited to, aphasia following cerebral	F 0600	**F600** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 58 was assessed and observed for psychosocial changes from baseline. Resident 58 experienced no adverse outcomes by the alleged deficient	07/17/2023

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	06/21/2023

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
	infarction, dysphasia following cerebral infarction, dementia. The care plan, dated 5/1/22, indicated the resident had a self-care performance deficit and required assistance of 2 staff members with toileting and 1 staff member with personal hygiene. The record for Resident 12 was reviewed on 6/20/23 at 9:24 a.m. The Quarterly MDS (Minimum Data Set) assessment, dated 5/9/23, indicated the resident was cognitively intact. The statement of Resident 12 (Resident 58's roommate), dated 5/25/23, indicated early that morning during care, two aides came in to provide care to his roommate, Resident 58. Resident 58 was resistive to care and the male aide CNA (Certified Nurse Aide) 16 said to the resident "... We aren't putting up with your s*** tonight, you're going to get changed whether you like it or not." They then proceeded to provide care to the resident without any issues. The Executive Director's (ED) statement, dated 5/25/23, indicated he requested a statement from CNA 16 concerning the incident. CNA 16 refused to give a statement and gave his resignation. The ED's statement, dated 5/25/23, indicated he conducted an interview with CNA 15 to take her statement. She indicated during care for Resident 58, CNA 16 stated to the resident that he was done putting up with the resident's s***, rolled the resident to his side, and continued to provide care. CNA 15 was unavailable for interview.		practice. CNA 16 is no longer employed at facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. All residents were interviewed and/or observed for changes from baseline or for concern of abuse. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Designee completed education with all staff regarding abuse and resident rights. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will interview 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident x 4 weeks, and ongoing as needed. The DON/Designee will observe 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident x 4 weeks, and ongoing as needed. The Administrator/Designee will interview 5 staff per week x 4 weeks, then 3 staff per week x 4 weeks, then 1 staff x 4 weeks, and ongoing as needed. The Administrator/Designee will	

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	06/21/2023

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
	During an interview on 6/21/23 at 1:18 p.m., the ED indicated he took CNA 15's statement on the incident. The statement he provided a copy of was her verbatim words. She did confirm that CNA 16 said what he did to Resident 58. Resident 58 was non-interviewable, but they obtained confirmation of the incident from both CNA 15 and Resident 12. He did feel the allegation was substantiated. The most current Resident Rights policy, provided on 6/21/23 at 1:00 p.m. by the RDCO (Regional Director of Clinical Operations), included but was not limited to, "... Residents have the right to ... Be free from abuse and neglect..." The most current Abuse & Neglect & Misappropriation of Property policy, provided on 6/14/23 at 1:00 p.m. by the ED, included but was not limited to, "... Definitions... Verbal Abuse: In Indiana, oral, written, and/or gestured language that includes disparaging and/or derogatory terms to the residents or their families, either directly or within their hearing... Verbal abuse includes any staff to resident episodes..." 3.1-27(b)		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.	
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	06/21/2023

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
	comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure the physician's orders were followed to schedule a paracentesis for a resident with ascites and jaundice which resulted in the unstable hospitalization which was followed by the death of Resident C for 1 of 32 residents reviewed for Quality of Care. (Resident B) The Immediate Jeopardy began on 9/30/22 when facility staff failed to schedule an appointment as ordered for Resident C to have a paracentesis (procedure to remove excess fluid buildup from the abdomen) procedure performed to relieve the resident's ascites (collection of fluid in the abdomen). The Executive Director (ED), Director of Nurses (DON) and Regional Director of Clinical Operations (RDCO) were notified of the immediate jeopardy at 12:51 p.m. on 6/20/23. The immediate jeopardy was removed on 6/21/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The record for Resident B was reviewed on 6/19/23 at 11:00 a.m. The diagnoses included, but were not limited to, cognitive communication deficit, acute kidney failure, and alcoholic cirrhosis of liver with ascites. The hospital report, dated 9/8/22, indicated the resident was treated in the hospital for weakness that had started several months prior and gotten progressively worse. He had a history of multiple falls within the past few months and had a decreased appetite. He had a large amount of	F 0684	**F684** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C admitted to facility on 9-19-2022. Prior to admission resident had paracentesis performed at hospital on 9-12-22. On 9-30-22 NP visit with Resident C were ascites was noted and an order for a paracentesis was initiated. On 10/11/22 Resident C was sent out for evaluation. Resident was admitted and three day's post admission to hospital had a paracentesis procedure completed. The facility was unable to validate that the order written by the NP on 9/30/2022 for paracentesis was completed. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who reside in the facility have the potential to be affected by the alleged deficient practice. DON/Designee have reviewed all orders per MD/NP for the last 30 days to ensure they were initiated and completed per MD order. Upon completion of the audit, no other residents were identified as being affected by the alleged deficient practice. An audit was conducted for all	07/17/2023

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	06/21/2023

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
	ascites in the abdomen pelvis. The ascites could be due to severe hypothyroidism but additional work-up would need to be done. Gastroenterology was following him, and he was receiving paracentesis. He desired skilled rehabilitation placement at discharge. The nurse's note, dated 9/19/23 at 7:06 p.m., indicated the resident arrived at the facility via his personal vehicle escorted by a family member. His blood pressure was hypotensive at 92/61, but he was asymptomatic. He was in no distress. His orders were verified by the Nurse Practitioner (NP). The nurse's note, dated 9/21/22 at 10:35 a.m., indicated the resident had been assisted up from the floor by therapy where he had gone down on his knees while using his walker. The SBAR (Situation Background Assessment Recommendation) note, dated 9/21/22 at 10:47 a.m., indicated the resident's vitals were within normal limits. He had been walking back from the bathroom with 2 therapists when his knees buckled and hit the floor slightly. The only new intervention was for staff to remind the resident to use the call light for assistance and to alert staff to have hands on assistance was implemented. The nurse's note, dated 9/23/22 at 4:01 a.m., indicated the resident was on an antibiotic therapy for an upper respiratory infection. He had a round, distended abdomen which was nontender with active bowel sounds. He refused his bolus feeding because it made him feel nauseated. The Wound NP's note, dated 9/27/22 at 6:33 p.m., indicated the resident's abdomen was taut and he		orders from September 30th of 2022 to present to ensure that no specialized appointments were missed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee have educated all licensed nurses on the facility's policy identified as, "Physician Orders" with emphasis on ensuring all orders for appointments are completed. DON/Designee will ensure Monday through Friday at each clinical morning meeting an order listing report is reviewed to validate orders from the previous day. DON/Designee will verify order is correct and transcribed in PCC accurately any orders requiring additional follow-up will be tasked to appropriate staff and reviewed in stand down daily for completion. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will audit 5 resident's new orders daily x's 4 weeks and 10 resident's new orders weekly x's 4 weeks then 5 resident new orders weekly x's 4 weeks to ensure that any new MD/NP orders written are initiated and completed per MD order. The DON/Unit Manager/Designee will present the results of these	

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	06/21/2023

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
	had observed ascites. The nurse's note, dated 9/29/22 at 7:15 p.m., indicated the resident refused to eat due to an upset stomach. He asked for assistance to toilet but was unable to urinate. The NP's order, dated 9/30/22 at 1:30 p.m., indicated to set up an appointment for paracentesis for ascites one time only. The NP's note, dated 9/30/22 at 8:30 p.m., indicated the resident was developing ascites. He had diffusely located jaundice which was gradual in onset. The plan indicated to set up paracentesis for ascites and for her to conduct a return NP visit in 1 week. The clinical record lacked documentation of any appointments being scheduled for the resident's paracentesis as ordered by the NP. The nurse's note, dated 10/4/22 at 11:35 a.m., indicated the resident was sitting on the floor with his walker. The nurse had assisted him to the restroom and when he was walking back to his bed he stumbled over his feet and sat down on the floor. He indicated he felt weak and had to go to the floor. The NP was notified and indicated staff were to continue to monitor the resident and report any changes. The physician's note, dated 10/11/22 at 8:20 a.m., indicated the resident had a change in condition. He had altered mental status and labored breathing. His vitals were unstable, and he had blue fingertips and pale skin. His blood pressure was 84/40, his heart rate was 47, his respiratory rate was 24, and his temperature was 96.9 Fahrenheit. He was sent to the emergency		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.	

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	06/21/2023

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
	department for evaluation and management of acute respiratory failure and altered mental status. The nurse's note, dated 10/11/22 at 2:30 p.m., indicated the resident was found on the floor during morning round by the CNA (Certified Nurse Aide). He had an unwitnessed fall. The nurse saw him lying on the floor on his right side. He could not state his name or where he was. The nurse assessed the resident and notified the on-call provider. The resident was sent to the emergency room. The nurse's note, dated 10/11/22 at 7:16 p.m., indicated the resident was admitted to the intensive care unit for a diagnosis of resident found down. The hospital final report, dated 10/14/22, indicated on 10/11/22 the resident had cirrhosis of the liver and hypotension. His GCS (Glasgow Coma Scale) was an 8 (a score of 8 or less being indicative of severe brain injury) on arrival to the emergency department and he was intubated. His initial pressures were in the 60's and he was started on Levophed. He likely had septic shock. His core body temperature was 87.62 degrees Fahrenheit and he was placed on a bearhugger (a forced air warming system to warm the resident's body). His creatinine was 5.9 (indicative of severe kidney damage), his BUN (Blood Urea Nitrogen)was 39 mg/dL (normal value 7 to 20 mg/dl). A catheter for CRRT (a non-stop, 24-hour dialysis therapy) was going to be placed. His upper and lower extremities were cold and mottled. On 10/12/22 the resident remained hemodynamically unstable and he was receiving CCRT. The resident's CT (Computed Tomography) scan showed he had a large collection of ascites. Paracentesis was performed on 10/14/22 with 5.7 liters of output			

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	06/21/2023

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
	obtained. A culture of his ascites fluid was obtained from the resident's abdomen. His diagnoses included altered mental status, renal failure, and sepsis. He had end stage hepatorenal syndrome. On 10/14/22 the family indicated they were ready to move towards comfort measures only. He was not likely to improve clinically. Orders for comfort measure were processed. During an interview on 6/19/23 at 1:37 p.m., the Nurse Practitioner indicated she did vaguely recall the patient, but she would have to review her notes for some information because the patient was there back in September. Usually when they came in on admission, she would see them. Then two weeks after admission and anytime something came up, as well as monthly regulatory visits if they didn't have an acute need. She could not recall the visit on 9/30/22. She did assess him for ascites. Her expectation was for the nurse to set up outpatient paracentesis with a GI (gastrointestinal) doctor. She would have given orders to the nurse to set up the appointment. She did give the orders to the nurse. It would have been done verbally and she would have put the order in the resident's record. She would have wanted it done within 7 days at the minimum if she felt he needed paracentesis. The ideal was to see him in a week. She indicated he should have had the appointment set up. During an interview on 6/19 at 2:24 p.m., the RDCO (Regional Director of Clinical Operations) indicated the order to schedule an appointment for paracentesis was in the resident's record. During an interview on 6/19/23 at 2:30 p.m., the NP indicated the resident had an order for an appointment, but they did not have any documentation of whether or not he went out to			

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	06/21/2023

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
	the appointment. They did not find any documentation that the appointment was scheduled. She did not know if he had any paracentesis until he went out on 10/11/22 when he went out to the hospital. Up until that time he was not symptomatic. He had no shortness of breath or trouble breathing, so she would have been ok with an extended wait period. She did not give any orders for an extended wait period, but she didn't give any orders for seven days either. During an interview on 6/20/23 at 9:44 a.m., LPN 7 indicated she did not recall the resident. She did not recall sending any residents out for paracentesis. They would chart that they went LOA to doctors' appointments. Sometimes they put an order in the system but sometimes they did not. Usually, the nurses were responsible for setting up transportation and appointments. During an interview on 6/20/23 at 10:12 a.m., the RDCO indicated she was still not sure if the resident had ever gone to any appointment for paracentesis. They were still trying to get the information. During an interview on 6/20/23 at 10:16 a.m., the resident's family member indicated prior to coming to the facility the resident had been told he would need to have fluid taken off weekly, however she was not sure if that had been put in his orders. When he went to the facility, he was there for three weeks and they never had any fluid taken off When his stomach filled up with fluid he had no energy, he couldn't move, and he couldn't eat. She kept asking about his paracentesis while he was at the facility, they kept saying they were waiting on an appointment. One night he finally got up and fell, and they sent him to the hospital.			

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	06/21/2023

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
	They took him out on 10/11/23 and he passed away at the hospital on 10/14/22. They took off over five liters of fluid at the hospital. He never did regain consciousness at the hospital. She came in and saw him three times weekly while he was there. They never scheduled an appointment for him to have his fluid taken off. In fact, she ran into the NP on 10/10/23 before he went to the hospital and asked her why she still hadn't made the appointment. The NP asked her who his GI doctor was, and she told them. The NP told her she had tried to reach them, but the GI doctor wouldn't return her calls. His feet and legs were swelling, his stomach was swollen, and he got weaker and weaker. To her knowledge they did not do anything to help with his ascites. She had a copy of his death certificate, and it said his cause of death was multiple organ failures. If he had an appointment he would have had to have gone by ambulance because he was so weak they couldn't have transported him. He was so weak she couldn't even get him in the car. During an interview on 6/20/23 at 12:29 p.m., the RDCO indicated she had contacted three local hospitals and she could locate no documentation or record of Resident C being at any of their facilities for a paracentesis between the dates of 9/30/22 and 10/10/22. She had looked at all their documentation and the only thing they had was the order to schedule the paracentesis. She did not have any documentation of an appointment date or time, or anything to show that he went out between those dates. The most current, but undated, Physician Orders policy, provided on 6/20/23 at 12:44 p.m. by the RDCO, included but was not limited to, " ... It is the policy of this facility to provide resident centered care that meets the psychosocial,			

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	06/21/2023

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
	physical and emotional needs and concerns of the residents ... III. Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide safe hand-off to the next nurse ... i. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order ..." The immediate jeopardy, that began on 9/30/22, was removed on 6/21/23, when the facility conducted the following: The DON/Designee reviewed all orders given by physicians for the last 30 days to ensure they were initiated and completed per physician's order. An audit was conducted for all orders from 9/30/22 to 6/21/23 to ensure that no specialized appointments were missed. The DON/Designee educated all licensed nurses on the facility's policy identified as, "Physician Orders" with emphasis on ensuring all orders for appointments were completed. All nurses were educated in person or on phone as well as via app, on scheduling appointments and physician's orders. This Federal Tag relates to Complaint IN00409941. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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	06/21/2023

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
	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure reducing boots were in place as ordered for 1 of 6 residents reviewed for Pressure Ulcers. (Resident 22) Findings include: The record for Resident 22 was reviewed on 6/19/23 at 8:58 a.m. The diagnoses included, but were not limited to, contracture of unspecified joint, left hip, and left knee, osteomyelitis of vertebra, sacral, and sacrococcygeal region, cerebral infarction affecting right dominant side, pressure ulcer of the hip, and contracture of multiple sites both upper and lower extremities. The physician's order, dated 10/28/22, indicated the resident was to wear heel boots to his bilateral feet while in bed every shift for prevention. The physician's order, dated 10/28/22, indicated staff were to encourage the resident to float heels while in bed as tolerated every shift for preventative measure. The care plan, initiated on 10/18/22, indicated the resident had impaired skin integrity and was admitted with stage 3 pressure wound to his left hip and was at risk for altered skin integrity. The interventions included, but were not limited to, apply appropriate pressure reducing appliances.	F 0686	**F686** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 22 received a full skin assessment with no new concerns noted. Resident 22's care plans and orders were reviewed and updated as appropriate. Resident 22 did not experience adverse outcome as a result of alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with potential to be affected will have their wound prevention care plans and physician orders reviewed and updated as appropriate. All residents with potential to be affected were observed for appropriate preventative interventions. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee completed education all direct care staff	07/17/2023

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	06/21/2023

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
	The Wound NP's (Nurse Practitioner) note, dated 10/28/22, indicated the resident was seen by the Wound NP for the pressure ulcer to his left hip which was present on the resident's admission to the facility. The wound was improving with delayed wound closure. Recommendations included for heel lift boots or pillows to be placed to offload the heels and both sides of the feet. The resident was at high risk for skin breakdown related to contractures, decreased mobility, and chronic medical conditions. During an observation on 6/15/23 at 10:04 a.m., Resident 22 was lying abed. He did not have pressure relief boots on, and both heels were lying directly on the bed. There was a blue pressure relief boot lying in a chair in the corner of the resident's room. During an observation on 6/16/23 at 10:56 a.m., Resident 22 was laying abed. He had no pressure relief boots in place and his heels were lying directly on the bed. There was one blue pressure relief boot lying in a chair in the corner of his room. No other boot was observed in the room. During an interview on 6/16/23 at 10:57 a.m., Resident 22 indicated he was supposed to wear boots on his heels and he didn't know why they were not on. During an interview, on 6/16/23 at 11:06 a.m., CNA 19 indicated they put a pressure relief boot on him in the afternoons. He did wear the boot sometimes, but only to the right heel. She didn't know if he could wear one on his left due to his contractures. She looked in the room and indicated she could only locate one pressure relief boot.		regarding wound prevention interventions. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe 5 resident interventions per day x 4 weeks, then 3 residents per day x 4 weeks, then 1 resident per day x 4 weeks, and ongoing as needed. 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.	

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	06/21/2023

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

During an observation, on 6/16/23 at 1:04 p.m., Resident 22 was lying on his back in bed. He had no boots to his heels.

During an observation on 6/19/23 at 8:51 a.m., Resident 22 was lying abed. He had no pressure boots in place. One blue pressure relief boot was observed lying in a chair in the corner of the room.

During an observation on 6/20/23 at 10:00 a.m., CNA 21 indicated she did not believe the resident was supposed to wear any boots.

During an observation on 6/21/23 at 12:46 p.m., LPN (Licensed Practical Nurse) 7 provided wound care to the resident's left hip. The resident had a shallow wound to the left hip which was fully granulating with minimal bloody drainage. LPN 7 indicated the wound had greatly improved and was healing well.

During an interview on 6/21/23 at 12:47 p.m., OT 22 (Occupational Therapist) indicated the resident's pressure relief boot was dirty and needed washed, but he had pressure relief donuts that they could apply to elevate the resident's heels.

During an interview on 6/21/23 at 1:04 p.m., LPN 7 indicated she had never seen him refuse his pressure relief boots. He was usually compliant. If staff worked with him they could get him to do stuff for them, they just had to be gentle with him.

The Pressure Ulcer Prevention policy, last revised on 5/31/22, provided on 6/21/23 at 1:00 p.m. by the RDCO (Regional Director of Clinical Operations) included, but was not limited to, "... Individualized interventions are implemented as indicated for a

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	06/21/2023

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
	resident... Procedure... 2. Monitor for consistent implementation of interventions..." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 1 of 4 residents reviewed for accidents. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 6/19/23 at 8:58 a.m. The diagnoses included, but were not limited to, contracture of unspecified joint, left hip, and left knee, osteomyelitis of vertebra, sacral, and sacrococcygeal region, cerebral infarction affecting right dominant side, pressure ulcer of hip, and contracture of multiple sites both upper and lower extremities. The care plan, dated 10/18/22, indicated the resident was at risk for falls related to gait and balance problems, impaired cognition, incontinence, medication, weakness, hemiplegia, and schizophrenia. The interventions, initiated on 10/18/22, indicated staff were to place the resident's call bell within reach, remind the	F 0689	**F689** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 22 received a full assessment with no new concerns noted. Resident 22's care plans and orders were reviewed and updated as appropriate. Resident 22 did not experience adverse outcome as a result of alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with potential to be affected will have fall interventions reviewed and updated as appropriate. All residents with potential to be affected were observed to ensure fall	07/17/2023

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	06/21/2023

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
	resident to call for assistance, and personal items within reach. The nurse's note, dated 1/28/23 at 3:43 p.m., indicated the resident fell out of bed. He was moving around a lot and trying to fall out of bed. He hit his head and had two small cuts by his eyebrow that looked as if they might cause bruising. The nurse contacted the physician and they indicated to monitor the resident and call back if there were any significant changes. The nurse's note, dated 5/29/23 at 2:33 p.m., indicated the resident was trying to get up and he fell and landed on his feet and legs and hit his right outer ankle. He did not hit his head. The fall was witnessed by a CNA. During an observation on 6/15/23 at 10:04 a.m., Resident 22 was lying abed. Both upper and lower extremities were contracted. The resident's call light was lying across the resident's roommate's bed, tucked into the footboard where he could not reach it. His left hand was fully contracted with no palm protector or splint in place. During an observation on 6/19/23 at 8:51 a.m., Resident 22 was lying abed. His call light was dangling over the headboard of his bed, dangling approximately 2 to 4 inches above the ground where the resident could not touch it to activate the light. During an observation on 6/20/23 at 10:00 a.m., CNA 21 indicated the resident was able to use his call light, it was a touch pad and he could nudge it with his elbow. It had to be near his elbow. If it was over the bed or across the room he couldn't get to it. He would use it sometimes, or he would scream for help.		interventions in place. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee completed education all direct care staff regarding fall prevention interventions. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe 5 resident interventions per day x 4 weeks, then 3 residents per day x 4 weeks, then 1 resident per day x 4 weeks, and ongoing as needed. 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.	

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	06/21/2023

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
	During an interview on 6/21/23 at 1:04 p.m., LPN 7 indicated the resident did sometimes use his call light and they needed to try and keep it within his reach. The most current Resident Rights policy, provided on 6/21/23 at 1:00 p.m. by the RDCO (Regional Director of Clinical Operations), included but was not limited to, "... i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff..." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	06/21/2023

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
	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure proper maintenance of a catheter and drainage system off the floor for 1 of 2 residents reviewed for bowel and bladder. (Resident 57) Findings include: The record for Resident 57 was reviewed on 6/16/23 at 8:16 a.m. The diagnoses included, but were not limited to, urinary tract infection, ESBL (Extended Spectrum Beta Lactamase) resistance, acute cystitis, obstructive uropathy, acute kidney failure, and benign prostatic hyperplasia with lower urinary tract symptoms. The nurse's note, dated 6/21/22 at 3:20 p.m., indicated the resident was on an antibiotic for ESBL of his urine. The nurse's note, dated 9/19/22 at 7:33 p.m., indicated the resident was sent to the hospital and returned three days later with a diagnosis of a UTI (urinary tract infection) and was on IV (intravenous) antibiotics. He had a urinary catheter in place draining clear yellow urine. The Nurse Practitioner's (NP) note, dated 10/21/22	F 0690	**F690** **CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:** Residents 57 received catheter care and full nursing assessment. Resident 57's care plan and physician orders were reviewed and updated as appropriate. Resident 57 did not experience adverse outcomes related to alleged deficient practice. **IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND CORRECTIVE ACTION TAKE:** Residents identified of having the potential to be affected by the same deficient practice are those with indwelling catheters. The DON reviewed these residents for	07/17/2023

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	06/21/2023

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
	at 1:24 p.m., indicated the resident presented with dysuria. It was described as aching and burning. The symptom was sudden in onset. He had a UTI with Providencia startii which was sensitive to Bactrim. He was started on Bactrim-DS (Bactrim Double Strength) twice daily for ten days. The nurse's note, dated 11/1/22 at 5:42 p.m., indicated the resident returned from an appointment with his urologist and an order was received for the resident to have a 20 Fr (French) catheter which was placed at the urologist's office. The medication administration note, dated 12/20/22 at 4:45 a.m., indicated the resident was started on Sulfamethoxazole-Trimethoprim Tablet 800-160 mg (milligram) one tablet every 12 hours for a urinary tract infection for 10 days. The care plan, dated 1/1/23 and last revised on 1/5/23, indicated the resident had an indwelling catheter related to obstructive reflux uropathy. The resident's goals included to show no signs or symptoms of urinary infections through the next review date. The nurse's note, dated 2/6/23 at 6:22 p.m., indicated the resident had returned from the emergency room with a diagnosis of a UTI and new orders for cefdinir 300 mg twice daily for 7 days. The nurse's note, dated 2/15/23 at 12:23 p.m., indicated the resident had completed his antibiotic however continued with pain and discomfort at his catheter site. His catheter had dark, yellow urine and his family requested he be seen at the hospital. The resident was sent to the hospital. The nurse's note, dated 2/16/23 at 12:03 a.m.,		concerns and addressed any concerns as appropriate. **MEASURES PUT INTO PLACE AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEDGED DEFICIENT PRACTICE DOES NOT RECUR:** The DON/Designee educated all direct care staff on proper maintenance of catheter and draining system off the floor. **HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:** DON or designee will conduct random observations for catheter bag placement of residents with catheters five times per week for four weeks, three times per week for four weeks, then twice weekly for four weeks, then weekly for four weeks. 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	

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	06/21/2023

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
	indicated the resident was admitted to the hospital with altered mental status and a urinary tract infection. The nurse's note, dated 2/18/23 at 3:30 p.m., indicated the resident was admitted back to the facility from the hospital. He had a catheter with amber urine to bedside drainage. He would continue on antibiotics per order. The physician's order, dated 4/7/23, indicated the resident had a 16 Fr urinary catheter to drainage for neurogenic bladder. During an observation on 6/15/23 at 9:55 a.m., Resident 57's catheter bag was hanging on the frame of his bed. The tubing of the bag was lying directly on the floor. There was no urine in the tubing at the time. During an observation on 6/16/23 at 11:23 a.m., Resident 57's catheter was hanging on the bed frame with the tubing of the catheter lying directly on the floor. The catheter had light, orange tinged urine in the tubing. During an observation on 6/16/23 at 1:03 p.m., the resident's catheter remained on the floor with light orange-tinged urine observed in the catheter. During an observation and interview on 6/20/23 at 9:51 a.m., CNA (Certified Nurse Aide) 21 provided catheter care for Resident 57. During the care she retracted the skin around the resident's insertion site, and a moderate amount of greenish-brown drainage was observed. CNA 21 indicated the resident had the drainage for quite some time now, at least a week or two. She had told the nurses but she did not know if anything had been done about it yet. She wiped the drainage with a wet		100% compliance is achieved or if ongoing monitoring is required.	

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	06/21/2023

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
	wipe and a moderate amount of drainage was observed on the wipe before she discarded it. She indicated the resident had a history of UTIs. They should provide good perineal care, encourage fluids, and ensure his catheter tubing was up off the floor. The catheter tubing being on the floor would put the resident at risk for infection. The most current Catheter Care policy, provided on 6/21/23 at 1:00 p.m. by the RDCO (Regional Director of Clinical Operations, included but was not limited to, "... V. Check that collection bag is not on the floor and is draining properly... 3.1-41(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure the oxygen concentrator filters were maintained for 9 of 20 residents reviewed for respiratory care. (Residents 18, 15, D, 99, 78, 66, 65, 6, and 40) Findings include: 1. During the initial tour on 6/14/23 at 9:32 a.m., Resident 18's oxygen concentrator filter was completely coated with a white powdery	F 0695	**F695** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 18, 15, D, 99, 78, 66, 65, 6, and 40 were not harmed by	07/17/2023

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	06/21/2023

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
	substance. The record for Resident 18 was reviewed on 6/21/23 at 3:12 p.m. The diagnoses included but were not limited to COPD (chronic obstructive pulmonary disease), chronic congestive heart failure, and automatic cardiac defibrillator. The Admission MDS (Minimum Data Set) assessment, dated 5/19/23, indicated the resident was cognitively intact. The care plan, dated 5/17/23 and last revised on 6/15/23, indicated the resident had COPD with shortness of breath while lying flat. She required oxygen at 2 L related to her disease process. The interventions, dated 6/15/23, included, but was not limited to, provide oxygen therapy as ordered. Change tubing per facility policy. The physician's orders, dated 6/15/23, indicated to administer oxygen at 2 L (liters) per minute by nasal cannula. 2. During the initial tour on 6/14/23 at 9:42 a.m., both of Resident 15's oxygen concentrator filters were coated with a white powdery substance. The oxygen was running at 2 liters per minute. During a second observation with the DON (Director of Nursing) on 6/15/23 at 8:30 a.m., both of Resident 15's oxygen concentrator filters were completely coated with a white powdery substance. The record for Resident 15 was reviewed on 6/21/23 at 2:15 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypercapnia, pneumonia, COPD, and anxiety disorder.		the alleged deficient practice and had their oxygen filter changed immediately upon notification of concern from surveyor. **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 receiving oxygen therapy have the potential to be affected by this alleged deficient practice. The DON/designee completed an audit of all oxygen concentrators and replaced all oxygen concentrator filters. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Oxygen Supply Company was educated on contractual agreement to maintain and replace filters. Central supply and maintenance staff was educated on maintenance of oxygen concentrators and filter replacement.	

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	06/21/2023

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
	The nurse's note, dated 4/18/23 at 7:30 p.m., indicated the resident admitted from a local hospital. The resident received oxygen at 3 L per minute. The care plan, dated 4/19/23, indicated the resident had chronic obstructive pulmonary disease with shortness of breath while lying flat and she required the use of supplemental oxygen. The interventions, dated 4/19/23, included, but was not limited to provide oxygen therapy as ordered. Change the tubing per facility policy. The Admission MDS assessment, dated 4/25/23, indicated the resident was cognitively intact. The physician's order, dated 6/15/23, indicated to administer oxygen at 2 L per minute by nasal cannula to keep her oxygen saturation greater than 90% as needed and every shift for shortness of breath. 3. During the initial tour on 6/14/23 at 9:55 a.m., Resident D's oxygen concentrator filter was completely coated with a white powdery substance. The oxygen was running at 3 L per minute. During a second observation with the DON on 6/15/23 at 8:35 a.m., Resident D's oxygen concentrator filter was coated with a white powdery substance. The record for Resident D was reviewed on 6/15/23 at 3:11 a.m. The diagnoses included, but were not limited to, COPD, hypoxemia, dementia, and cognitive communication deficit. The physician's order, dated 3/9/23, indicated 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 DON/designee will conduct audits on 5 concentrators daily for 4 weeks, then weekly for 8 weeks to ensure the oxygen concentrator filter is being maintained and changed per facility contract expectations. The DON/Unit Manager/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.	

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	06/21/2023

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
	apply oxygen at 2 liters per minute every shift for shortness of breath. The physician's order, dated 3/13/23, indicated to clean the oxygen concentrator filter with soap and water weekly and as needed one time a day every Monday for O2 (oxygen) care. The Quarterly MDS assessment, dated 5/3/23, indicated the resident was moderately cognitively impaired. The Convergence Consultation diagnosis note, dated 3/22/23 at 1:20 a.m., indicated the resident complained of shortness of breath. The nurse report indicated the resident complained of shortness of breath this afternoon, however vitals were completely stable and the resident did not appear SOB. The resident's oxygen saturation prior to receiving her scheduled nebulizer treatment was 95% on 2 L and now post scheduled nebulizer treatment was at 97% on 2L. The resident's vitals indicated a blood pressure of 132/89, heart rate of 86 beats per minute, respirations at 18, a temperature of 97.8 degrees Fahrenheit, and oxygen saturation of 96% on 2L. The resident initially indicated she felt fine, but when asked if anything was bothering her, the resident indicated it was hard to breathe. The resident was able to speak in full sentences but was hard of hearing. Her respirations appeared even and unlabored via video. The resident indicated she had chest pain, a racing heart, and shortness of breath. The resident's family was at the bedside and reported the resident had severe dementia and was hard of hearing, so it was unclear what could really be bothering her and she may just be answering just to answer. The nurse indicated the resident was normally dependent on supplemental 02 at 2L per minute,			

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	06/21/2023

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
	so no increased oxygen demands were warranted at this time. The resident's family came up to the desk to report that the resident just told her that when she took a deep breath if she felt pain under her breast. An order to administer prednisone 20 mg (milligrams) 2 tablets now with food or snack. a stat (urgent) CXR (chest x-ray) 2 view, a stat CBC (complete blood count) with differential, BMP (basic metabolic panel), D-Dimer (protein fragment made when a blood clot dissolves) test, obtain vitals every 8 hours was ordered. Report outliers to the providers promptly, report any laboratory results of diagnostic results received to providers for review upon receipt, and monitor the resident and report any acute changes in condition to providers promptly especially any further respiratory decline observed or changes in vitals. 4. During an observation with the DON on 6/15/23 at 8:32 a.m., Resident 99's oxygen concentrator filter was completely covered with a white powdery substance. The record for Resident 99 was reviewed on 6/15/23 at 3:00 p.m. The diagnoses included, but was not limited to, COPD, anxiety disorder, atrial fibrillation, heart failure, and pneumonia. The care plan, dated 4/5/23, indicated the resident had COPD with shortness of breath while lying flat. The interventions, dated 6/15/23, included, but was not limited to, provide oxygen therapy as ordered. Change tubing per facility policy. The Admission MDS assessment, dated 4/6/23, indicated the resident was severely cognitively impaired. The nurse's note, dated 5/25/23 at 2:16 a.m., the resident began to experience shortness of breath.			

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	06/21/2023

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
	Her oxygen saturation was at 94% on room air. The oxygen was placed on the resident at 2 L and the prn (as needed) diltiazem was administered. The resident was now feeling a bit cold and hot with continued shortness of breath. The nurse's note, dated 5/25/23 at 2:30 a.m., the resident indicated the shortness of air was better, however it still continued some. Her pulse was 100 beats per minute and her oxygen saturation was at 99% on oxygen. The MD was notified and ordered as needed diltiazem a little more time to work and to check back in after 30 minutes. The physician's orders, dated 5/25/23, indicated to provide oxygen at 2 L to keep the oxygen saturations greater than 90%. 5. During an observation with the DON on 6/15/23 at 8:35 a.m., Resident 78's oxygen concentrator filter was completely covered with a light layer of a white powdery substance. The record for Resident 78 was reviewed on 3/21/23 at 3:28 p.m. The diagnoses included, but were not limited to, COPD, traumatic subarachnoid hemorrhage, and brain cancer. The Admission MDS assessment, dated 12/14/22, indicated the resident was moderately cognitively impaired. The care plan, dated 12/14/22 and last revised on 12/21/22, indicated the resident had chronic obstructive pulmonary disease with shortness of breath while lying flat. The interventions, dated 6/13/23, included, but were not limited to, provide oxygen as ordered, and change tubing per facility policy.			

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	06/21/2023

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
	6. During an observation with the DON on 6/15/23 at 8:37 a.m., Resident 66's oxygen concentrator filter had chunks of white particles over the surface. The record for Resident 66 was reviewed on 6/21/23. The diagnoses included, but were not limited to respiratory failure with hypoxia, COPD, cardiac arrest, anxiety disorder, and anoxic brain damage. The 5 Day MDS assessment, dated 4/24/23, indicated the resident was cognitively intact. The care plan, dated 12/14/22, indicated the resident had chronic obstructive pulmonary disease with shortness of breath while lying flat. The interventions, dated 6/13/23, included, but was not limited to, oxygen therapy as ordered and change tubing per facility policy. The care plan, dated 6/13/23, indicated the resident had oxygen therapy related to COPD. The intervention, dated 6/13/23, included, but was not limited to, provide oxygen as ordered. The physician's order, dated 6/6/23, indicated to administer oxygen at 2-4 L by way of nasal cannula to keep the oxygen saturation < (less than) 90% every shift for shortness of breath. 7. During an observation with the DON on 6/15/23 at 8:37 a.m., Resident 65's oxygen concentrator was completely covered with a white powdery substance. The record for Resident 65 was reviewed on 6/21/23. The diagnoses included, but were not limited to, COPD and anxiety disorder.			

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	06/21/2023

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
	The care plan, dated 3/31/23 and last revised on 6/15/23, indicated the resident had chronic obstructive pulmonary disease with shortness of breath while lying flat and required oxygen at 3.5 L per minute by nasal cannula. The interventions, dated 3/31/23, included, but was not limited to, observe for signs and symptoms of COPD. The Admission MDS assessment, dated 4/12/23, indicated the resident was cognitively intact. The physician's order, dated 6/15/23, indicated to administer oxygen at 3.5 L per minute by nasal cannula. 8. During an observation with the DON on 6/15/23 at 8:38 a.m., Resident 6's oxygen concentrator filter had the plastic bag covering the filter. The filter was coated with a white powdery substance. The record for Resident 66 was reviewed on 6/15/23 at 2:20 p.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease and atrial fibrillation. The care plan, dated 11/15/21 and last revised on 12/12/21, indicated the resident had COPD with shortness of breath while lying flat. The interventions, dated 11/15/21, indicated to administer oxygen therapy as ordered. Change the tubing per facility policy. The physician's order, dated 11/4/21, indicated to administer oxygen at 3 L by way of nasal cannula continuously. May titrate to keep oxygen saturations at greater than 90%. The Quarterly MDS assessment, dated 2/10/22, indicated the resident was severely cognitively impaired.			

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	06/21/2023

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
	9. During an observation with the DON on 6/15/23 at 8:45 a.m., Resident 40's oxygen concentrator filters were both coated with a white powdery substance. He indicated he had not needed the oxygen for a week. The record for Resident 40 was reviewed on 3/21/23 at 3:37 p.m. The diagnoses included but were not limited to, chronic congestive heart failure, atrial fibrillation, and obstructive sleep apnea. The Admission MDS assessment, dated 4/18/23, indicated the resident was cognitively intact. The physician's orders, dated 6/14/23, indicated to place the resident on oxygen at 2 L and titrate to keep his oxygen saturations above 92% (percent). The care plan, dated 6/15/23, indicated the resident had oxygen therapy related to CHF. The interventions, dated 6/15/23, included, but were not limited to, give medications as order by physician, for residents who should be ambulatory, provide extension tubing or portable oxygen apparatus, to provide oxygen at 2 L by way of nasal cannula and titrate to keep saturations above 92% as needed every shift for hypoxia. The physician's order, dated 6/21/23, indicated to change the cannula initial and date the tubing every night shift on Wednesday for 02 mask and tubing care. The physician's order, dated 6/28/23, indicated, to clean oxygen concentrator filter with soap and water weekly and as needed every night shift every Wednesday for O2 care.			

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	06/21/2023

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
	During an interview on 6/15/23 at 10:01 a.m., the DON indicated the filters should be cleaned weekly. If the filters were covered in the white powdery dust, the resident could develop respiratory infections or respiratory issues. The current Oxygen Therapy Using Concentrators policy was provided by the DON on 6/15/23 at 10:01 a.m. The policy included, but was not limited to, " ... A physician order is required for residents on oxygen concentrators ... v. The tubing cannula (with prongs) will not touch the floor for sanitary conditions and fall prevention ... III. Care and Maintenance a. Filters and machines are to be cleaned once a week ..." 3.1-47(a)(6)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure Social Services followed up on a resident's psychosocial well-being and care planned the behavior after an allegation of sexual inappropriateness was made. This deficient practice affected 1 of 3 residents reviewed for Social Services. (Resident 99) Finding includes: The Reportable to State Incident, dated 4/27/23 at 3:01 a.m., indicated the resident alleged that a man came into her room and was sexually inappropriate with her. The resident was sent to the hospital for	F 0745	**Corrective action for the residents found to have been affected by the deficient practice:** Resident 99 was interviewed and observed for psychosocial changes from baseline. Resident 99 was not affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with potential to be	07/17/2023

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	06/21/2023

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
	evaluation and an investigation was started. The Executive Director (ED), Director of Nursing (DON), the physician and the police were notified. No injury was observed. The type of preventative measures to be put into place after the resident returned to the facility were: care plans and interventions would be updated, and the resident's well-being will be followed. The Hospitalist's progress note, dated 4/28/23, indicated that during the conversation between the resident and the Hospitalist about the possible sexual assault, the resident indicated she really did not know if she was raped and thought maybe she imagined it. The record for Resident 99 was reviewed on 6/19/23 at 1:30 p.m., The diagnoses included, but were not limited to, cognitive communication deficit and anxiety disorder. The care plan, initiated on 3/31/23 and revised on 6/5/23, indicated the resident had an order for anti-anxiety medication for anxiety. The goal was for the resident to be without complications of anti-anxiety medication side effects. The approaches included, but were not limited to, observe for side-effects of anti-anxiety medications, such as anxiety, agitation, depression, hallucinations, and aggressive behaviors. The Admission 5 day Minimum Data Set (MDS) assessment, dated 4/6/23, indicated the resident had moderate cognitive impairment; had occasional, little interest in doing things, trouble with sleep, felt tired, and had a poor appetite. The resident had no behavior issues, hallucinations or delusions were observed.		affected were interviewed/observed for alleged deficient practice with any concerns addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDCO completed education with Administrator, DON, and Social Services Director. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will review 3 resident records per week for psychosocial follow-up x 4 weeks, then 2 resident records per week for psychosocial follow-up x 4 weeks, then 1 resident record per week for psychosocial follow-up x 4 weeks and ongoing as needed. The Administrator/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.	

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	06/21/2023

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
	The care plan, initiated on 4/6/23, indicated the resident had impaired cognitive function related to memory issues. The goal was for the resident to be able to communicate basic needs daily. The approaches included, but were not limited to, encourage the resident to be involved in daily decision making and activities as able; keep her routine as consistent as possible to decrease confusion, and offer 2-3 step instructions when competing basic tasks. A nurse's note, dated 4/27/23 at 11:05 a.m., indicated that while the resident was resting in her room, she reported to the staff that she was raped on the night of 4/26/23. She was unable to recall who it was or any physical features to identify the person. The resident denied pain or distress and a skin assessment indicated no bruises or abrasions were observed to the perineal area. The resident then requested to be sent to the Emergency Room for evaluation and treatment. The ED, DON, family, and Nurse Practitioner were notified of the accusations. The Nurse Practitioner's note, dated 5/5/23 at 1:00 a.m., indicated the resident was sent to the hospital after making a generalized allegation of rape and she could not substantiate any details. The resident had a past medical history of dementia. Her mood was stable with no reported behaviors. The Admission 5 Day MDS assessment, dated 5/11/23, was completed after the resident returned from the hospital on 5/4/23. The assessment indicated the resident had moderate cognitive impairment; had frequent feelings of little interest in doing things, felt tired, trouble with sleep, poor appetite, and had trouble concentrating. The resident had no behavior issues, hallucinations or			

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	06/21/2023

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
	delusions observed. The record lacked documentation of any Social Services follow-up on the resident's psychosocial well-being after the allegation, or addition and updates to the care plan to address the resident's accusations. During an interview with the Social Worker on 6/20/23 at 10:15 a.m., she indicated she was out with COVID when the incident with Resident 99 happened and the ED was supposed to be covering for her. She indicated when she came back from medical leave, she was told the issue was resolved, but guessed she still should have followed up on it. All documentation of a resident's psychosocial well-being should be documented in the Social Services notes and a care plan should have been developed to address the resident's allegation. Upon looking through the record, the Social Worker was unable to locate any follow-up documentation or care plan to address the allegation and behavior. During a second interview with the Social Worker on 6/20/23 at 10:30 a.m., she indicated psychosocial well-being follow-up was usually 3 days after the incident. She had spoken with everyone who was involved with the incident and because the resident was sent to the hospital and admitted for a week, there was no need to do a follow-up when she returned because she had been cleared in the hospital about the incident. During an interview with the Regional Director of Clinical Operations (RDCO) on 6/20/23 at 10:55 a.m., she indicated the resident was sent out to the hospital the day she made the allegation because she indicated penetration. The hospital evaluated her, and nothing was confirmed. An			

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	06/21/2023

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
	order was obtained when she came back to monitor for behaviors and there were none. On 6/20/23 at 2:20 p.m., the RDCO (Regional Director of Clinical Operations) presented a copy of the physician's order for behavior monitoring. The order was dated for 5/25/23, three weeks after the resident had been re-admitted to the facility. On 6/20/23 at 12:00 p.m., the RDCO presented a copy of the Social Worker's signed Job Description, dated 9/3/19. The Job Description included, but was not limited to, "Purpose/Belief Statement: The position of Social Services Assistant provides coordination and implementation of services to enhance each resident's social and psychosocial well-being and assure care standards are met and the highest degree of quality resident care is provided...Job Duties & Responsibilities: Perform all duties involved in resident advocacy. Reports all grievances and complaints and makes necessary oral/written reports. Serves as the resident's advocate at all times working in harmony with all direct care giving staff to assure that the resident's needs are being met at all times...Is aware of any changes in a resident's condition... Provides information to the Director of Social Services/designee that would: helps resolve the problems of the residents to better meet their needs. Determines the proper approach to an issue in question. Assist in identifying and correcting problem areas..." 3.1-34(a)(1) 3.1-34(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	06/21/2023

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
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure insulin flexpens were labeled for 1 of 3 medication carts reviewed. (500 Hall medication cart) Findings include: During an observation of the 500 Hall medication cart on 6/20/23 at 10:32 a.m., the label was missing from a Humalog flexpen, a glargine flexpen and a Lantus flexpen. Three labeled flexpens were out of their bags with instructions and the LPN (Licensed Practical Nurse) placed them back into the correct bags. LPN 13 indicated she was not	F 0761	**F761** **Corrective action for the residents found to have been affected by the deficient practice:** The insulin flex pens identified during survey were removed from 500 Hall Medicare Cart. 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:**	07/17/2023

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	06/21/2023

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
	sure who the insulin flexpens with the missing labels belonged to. She was also not sure how the residents labels came off. During an interview on 6/21/23 at 11:04 a.m., LPN 12 indicated there was a problem in April with the insulin pens not having labels, but nothing recently. Nursing should make sure there was a label on the insulin. During an interview on 6/21/23 at 1:39 p.m., the RDCO (Regional Director of Clinical Operations) indicated the nurses should monitor the medications for an expiration date. Insulin pens should be labeled and bagged. If the nurse obtained the insulin out of the EDK (emergency drug kit), they should place a sticker on the pen and it should be placed in a bag, indicating who it was to be administered to. The current Medication Administration policy was provided by the RDCO on 6/20/23 at 3:30 p.m. The policy included, but was not limited to, " ... Procedure ... b. A resident-centered, individualized approach to medication administration will be used for administering medications as possible I. Safety and avoiding adverse effects is considered a high priority for medication administration and may preclude some preferences ... l. Read medication label three times before administering medication ... ii. Second, when comparing label to MAR [Medication Administration Record] ... z. Do not administer medications if the label is not legible or missing. aa. For medication that expire, label the date opened on the label (insulin, irrigation solutions etc.) ..." 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3)		All residents with orders for insulin flex pens were reviewed to ensure appropriate medication available. All medication carts were audited to ensure compliance with labeling and storage. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee educated all licensed staff on insulin flex pen labeling and storage. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe 3 medication carts per week x 4 weeks, then 2 medication carts per week, then 1 medication cart per week x 4 weeks and ongoing as needed to ensure compliance with labeling and storage of insulin flex pens. 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	

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	06/21/2023

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
	3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7) 3.1-25(o)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on observation, record review, and interview, the facility failed to ensure a drainage culture was obtained as ordered for 1 of 3 residents reviewed for laboratory services. (Resident 57) Findings include: The record for Resident 57 was reviewed on 6/16/23 at 8:16 a.m. The diagnoses included, but were not limited to, urinary tract infection, ESBL (Extended Spectrum Beta Lactamase) resistance, acute cystitis, obstructive uropathy, acute kidney failure, and benign prostatic hyperplasia with lower urinary tract symptoms. The care plan, dated 6/1/22 and last revised on 2/7/23, indicated the resident had a history of infections related to ESBL in his urine. Interventions included, but were not limited to, report abnormal findings to the medical provider, and obtain and monitor laboratory and diagnostic studies as ordered.	F 0770	**F770** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 57 received a full assessment with no new concerns noted. Resident 57's orders were reviewed and any uncollected labs were obtained if appropriate per NP order. Resident 57 did not experience adverse outcome as a result of alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with potential to be affected had their lab orders reviewed to ensure completion of laboratory service orders per physician order. **Measures/systemic changes put**	07/17/2023

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	06/21/2023

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
	The NP (Nurse Practitioner) note, dated 6/12/23 at 1:00 a.m., indicated the resident had abnormal non-bloody drainage from his penis. A new order was written to obtain a culture of the drainage. The Medication Administration Note, dated 6/13/23 at 4:08 p.m., indicated the resident's culture of his penile discharge was not obtained because no culture tubes were available. The clinical record lacked any documentation of the culture being obtained as ordered or any results or follow-up on the testing. During an observation and interview on 6/20/23 at 9:51 a.m., CNA (Certified Nurse Aide) 21 provided catheter care for Resident 57. During the care she retracted the skin around the resident's insertion site, and a moderate amount of greenish-brown drainage was observed. CNA 21 indicated the resident had the drainage for quite some time now, at least a week or two. She had told the nurses but she did not know if anything had been done about it yet. She wiped the drainage with a wet wipe and a moderate amount of drainage was observed on the wipe before she discarded it. She indicated the resident had a history of UTIs. They should provide good perineal care, encourage fluids, and ensure his catheter tubing was up off the floor. The catheter tubing being on the floor would put the resident at risk for infection. The nurse's note, written by the MDS (Minimum Data Set) Coordinator, dated 6/20/23 at 6:55 p.m., indicated the culture ordered on 6/13/23 was not completed. The resident had no further drainage, no elevated temperatures, and no complaints. The NP was notified and recommended no further orders.		**into place to ensure the deficient practice does not recur:** The DON/Designee completed education all licensed staff regarding laboratory services to meet the needs of the residents. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will review 5 resident laboratory orders per day x 4 weeks, then 3 resident laboratory orders per day x 4 weeks, then 1 resident laboratory order per day x 4 weeks, and ongoing as needed to ensure completion of all labratory orders. 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.	

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	06/21/2023

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
	During an interview on 6/21/23 at 1:04 p.m., LPN (Licensed Practical Nurse) 7 indicated she thought the lab culture had been obtained. She knew he had the drainage now for quite some time and had personally observed it. The culture should have been obtained when the doctor ordered it. If there were not enough supplies she would order the supplies and it would only take a day or two to get them. During an interview on 6/21/23 at 1:08 p.m., the RN (Registered Nurse) Supervisor indicated if the result posted it would be sent from the company and downloaded to the system. The culture absolutely should have been conducted, and the NP should have followed up on it. She had a responsibility to come back and ask about the results. It was a combined effort. He would expect himself to check on it, to see if the order was carried out if he gave an order. During an interview on 6/21/23 at 1:45 p.m., the MDS Coordinator indicated she had authored the note on 6/20/23. They were going through orders to make sure they were followed and they found there was no results of the penile culture. It had been long enough he had not had any symptoms, so they called the NP and asked if she wished to repeat the culture. She said there was no need. She did not look at the resident herself. She did not talk to the nurses. She did not talk to the aides. She did not ask anyone if he was having any drainage, but it was not reported by the wound nurse, and the wound nurse saw him on the 6/16/23. She looked at his buttocks so she assumed she would see his penis as well. She was not aware he had continued drainage. The nurses should be documenting on the drainage. She did not know who was supposed to follow up to			

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	06/21/2023

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
	ensure the orders were done. She would expect the nurse practitioner to follow up on the orders. It should have been reported. She did not know how long it took to get lab supplies. The most current, but undated, Physician Orders policy, provided on 6/20/23 at 12:44 p.m. by the RDCO (Regional Director of Operations), included, but was not limited to, " ... It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents ... III. Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide safe hand-off to the next nurse ... i. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order ..." 3.1-49(a)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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.			

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	06/21/2023

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
	(iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 3 of 3 kitchen observations. This deficient practice had the potential to affect all 106 residents currently residing at the facility. Findings include: During the initial tour of the kitchen on 6/14/23 at 9:12 a.m., the following concerns were observed: - There was heavy black grime under the dishwasher, on the pipes and going up the walls. There were also two dirty cups and two forks on the floor under the dishwasher. - There was grime under the floor beneath the deep fryer and the steam and hold oven. - There was heavy grease build up to the wall and floor behind and under the deep-fryer and oven as well as on the sides of the grill. - There was a broken white dish and copious amounts of food debris under the stove and deep fryer, including several French fries, tater tots, and scraps of aluminum foil. - There was a heavy black buildup of residue on the splatter guard of the stove. - There was a heavy accumulation of grease, approximately 1 half inch thick to the grease drain on the flat top stove. - There was a heavy accumulation of food particles in the deep fryer, many of the particles were blackened. The oil in the deep fryer was a	F 0812	**F812** **The corrective actions to be accomplished for those residents found to have been affected by the practice.** Current residents have had no actual harm from this alleged deficient practice. Kitchen received full deep clean. Broken dishes removed from kitchen. Ice removal completed on walk-in freezer. Kitchen ceiling scheduled for repair by contractor. **The facility will identify other residents that may potentially be affected by this practice.** Full kitchen observation to include cleanliness, equipment condition, and staff compliance with processes completed with any noted concerns addressed. **The facility will put into place the following systemic changes to ensure that the practice does not recur.** The Administrator/Designee completed education with dietary and maintenance staff on	07/10/2023

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	06/21/2023

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
	very dark brown. - Under the prep table there was a very heavy accumulation of food debris, black grime, paper and foil scraps. - In the dry storage the floors were sticky and there was a moderate amount of brown grime under the metal food racks, as well as 5 loose potato chips. - In the walk in freezer there was an ice formation which was approximately 3 inches thick and 12 inches tall rising up from the floor by the first rack on the left. The floor was sticky and there was a heavy amount of brown grime on the floors. - In the walk in fridge there was a heavy amount of brown grime on the floor as well as butter packets and onion peels. -The ceilings were observed throughout the kitchen to be buckling and cracking in places, with large visible cracks above food preparation areas. -The light fixture over the dirty dish area was secured to wooden boards where the ceiling had to be reinforced. During a follow-up observation on 6/14/23 at 11:54 a.m., the following concerns were observed: - Dietary Cook 26 was observed utilizing oven mitts that had several holes in the material. The insulated padding could be seen showing through and the staff members exposed skin on thumb and forearm could be seen through the holes. - Dietary Aide 27 was observed preparing lemonade in the three compartment sink. The sink was observed to have several dirty dishes in the pan. - Dietary Aide 28 brought a pitcher of red Kool-Aid over to the sink and filled it in the same sink with the dirty dishes. During a follow-up visit to the kitchen on 6/16/23		requirements for Food Procurement in Safe and Sanitary Environment. **The facility will monitor the corrective action by implementing the following measure.** Administrator/designee will observe dietary staff during food preparation 5 x per week x 4 weeks, then 3 x per week x 4 weeks, then 1 x per week x 4 weeks, and ongoing as needed. Administrator/designee will observe the kitchen for safe and sanitary environment for food procurement 5 x per week x 4 weeks, then 3 x per week x 4 weeks, then 1 x per week x 4 weeks, and ongoing as needed. The Executive Director/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.	

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	06/21/2023

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
	at 11:57 a.m., the following concerns were observed: - There was grime under the floor beneath the deep fryer and the steam and hold oven. - There was heavy grease build up to the wall and floor behind and under the deep-fryer and oven as well as on the sides of the grill. - There was a broken white dish and copious amounts of food debris under the stove and deep fryer, including several French fries, tater tots, and scraps of aluminum foil. - There was a heavy black buildup of residue on the splatter guard of the stove. - Under the prep table there was a very heavy accumulation of food debris, black grime, paper and foil scraps. - In the dry storage the floors were sticky and there was a moderate amount of brown grime under the metal food racks, as well as 5 loose potato chips and white powder on the floor under the thickener bin. - In the walk in freezer there was an ice formation which was approximately 3 inches thick and 12 inches tall rising up from the floor by the first rack on the left. The floor was sticky and there was a heavy amount of brown grime on the floors. Ice formation on condenser hoses, dripping formation approximately four inches hanging off the pipes. - In the walk in fridge there was a heavy amount of brown grime on the floor as well as butter packets and onion peels. During a follow-up visit to the kitchen on 6/21/23 at 10:03 a.m. with the Dietary Manager, the following concerns were observed: the same concerns identified on 6/16/23 remained. The Dietary Manager indicated she was not sure what the black debris under the dishwasher was,			

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	06/21/2023

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
	they have had issues with it leaking. Usually they filled beverages at the prep sink not the 3 compartment sink. If it had dirty dishes in it, staff should not be using the sink for drinks. Preparation of food and drinks were always conducted at the prep station. Floors and under equipment was supposed to be swept daily and staff should degrease any time the fryer is cleaned. They should also clean behind and under it. She could see the grease trap was full of garbage. It needed to be cleaned out any time it was used. The back splash on stove was to be cleaned weekly. Floors were to be mopped daily. Usually it was sticky in the dry storage, they needed a scrub machine, like a deep cleaning machine. If spilled products were on floor staff should clean it up. The walk in fridge and freezer were also to be swept daily and deep cleaned weekly. She had replaced the oven mitts five months prior, but she should replace them if they were visibly damaged. The Main Cook Cleaning log, provided on 6/21/23 at 2:00 p.m. by the Dietary Manager, indicated staff were to, on a daily basis sweep the floor from plate holder to sink, remove all food and liquids that are visible, wipe down steam table, stove, prep table, and clean the sink area. On a weekly basis staff were to pull the steam table, tray holder, and bottom warmer away from the wall and clean, wipe the walls down, wipe everything down before moving it back into place, deep clean the stove and fryer, and deep clean the steam table and steamer. The Prep cook cleaning log, provided on 6/21/23 at 2:00 p.m., by the Dietary Manager, indicated on a daily basis staff were to sweep and mop the dry stock room, wipe down the prep tables. On a weekly basis staff were to sweep and organize the			

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	06/21/2023

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
	walk in, deep clean the prep tables, and pull the small prep table away from the wall sweep, mop, and wipe the wall down. The Cleaning log for the Dishwasher, provided on 6/21/23 at 2:00 p.m., by the Dietary Manager, indicated on a daily basis staff were to wipe down the dishwasher from top to bottom, and sweep and mop the floor from double doors to the back door and around dish areas. 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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 based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	06/21/2023

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
	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	06/21/2023

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
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure PPE (Personal Protective Equipment) was donned and doffed per CDC (Centers for Disease Control and Prevention) guidelines upon exit from isolation rooms during 3 of 4 observations on the 300 and 500 halls. (LPN 16, LPN 17, and CNA 15) Findings include: 1. Upon entrance to the facility on 6/14/23 at 9:00 a.m., the ED (Executive Director) indicated surgical masks had to be worn at all times and an N-95 mask and full PPE was required in two rooms due to Residents 71 and 74 testing positive for COVID-19 on 6/13/23. During an observation and interview on 6/14/23 at 12:10 p.m., Licensed Practical Nurse (LPN) 16, entered Resident 74's room donned in a gown, gloves, surgical mask, and face shield. She did not don an N-95 mask. Upon exiting the room, she removed her PPE and disposed of it in the trash can just inside the resident's room and went back to her medication cart. She failed to change her surgical mask or sanitize her hands before working on the computer on the cart. She indicated she forgot the N-95 mask. 2. During an observation on 6/15/23 at 1:05 p.m., LPN 17 entered Resident 71's room, donned in a gown, gloves, and an N-95 mask. Her surgical mask was around her neck and no face shield or goggles were used. She removed her PPE and discarded it in the trash can just inside the door.	F 0880	**F880** **The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 71 and Resident 74 were not harmed by the alleged deficient practice. No other residents were affected by the alleged deficient practice. **The facility will identify other residents that may potentially be affected by this practice.** All residents have the potential to be affected by the deficient practice. **The facility will put into place the following systemic changes to ensure that the practice does not recur.** The Director of Nursing/Designee educated all staff on the facilities policy identified as, “PPE while in the facility” with emphasis on how and when to don and doff PPE.	07/17/2023

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	06/21/2023

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
	She disposed of her surgical mask in her medication cart trash can, down the hall by the nursing station, sanitized her hands and donned a new surgical mask. 3. During an observation on 6/15/23 at 1:36 p.m., Certified Nurse Aide (CNA) 15, entered Resident 71's room, donned a gown, gloves, N-95 over her surgical mask, and a pair of goggles out of the rack, which hung on the outside of the resident's room. She then removed her PPE into the trash can just inside the resident's room. She put the goggles she had just used back into the rack without sanitizing them and threw away her surgical mask to obtain a new one after sanitizing her hands. During an interview on 6/15/23 after CNA 15 sanitized her hands, she indicated she usually had her own goggles for her exclusive use in the isolation rooms but forgot them and had to use the ones in the rack. She also indicated she did not normally sanitize her goggles because they were for her exclusive use only and didn't think to sanitize the ones she just used. She then returned to the nurse's station. On 6/14/23 at 10:00 a.m., the Executive Director (ED) presented a copy of the facility's current policy titled, Standard Precautions and Transmission Based Precautions with a revision date of 6/25/21. The policy included, but was not limited to, "... II. Tier II Precautions: a. Tier 2 Precautions Transmission-Based Precautions: 1. Transmission-Based Precautions are designed for residents documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission of disease		**The facility will monitor the corrective action by implementing the following measure.** The Director of Nursing/Designee will complete visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices, ensuring staff execute proper donning and doffing of PPE and when to wear PPE daily for six weeks. All variances will be corrected upon discovery, and additional training/follow-up will be provided as deemed necessary. The DON/Clinical Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	06/21/2023

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
	causing microorganisms...c. Residents with confirmed or suspected COVID-19 (SARS-CoV2) are placed in transmission based precautions. The following PPE is required when caring for a resident confirmed or suspected to have COVID-19: N-95 mask, face shield, gown, gloves. 2. Tier II Droplet Precautions:.. b. Staff will utilize the proper PPE's upon entering the room or cubical area including gloves, mask, and eye protection before contacting the resident or the environment. c. Discard PPE's before leaving room..." 3.1-18(b)(i)			