

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Wedgewood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Potters LN Clarksville, IN 47129	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34231</p> <p>Based on observation, interview and record review, the facility failed to ensure indwelling urethral catheter orders were in place for a resident with an indwelling urethral catheter for 1 of 3 residents reviewed for bowel and bladder. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 11/13/24 at 2:20 p.m. The resident's diagnoses included, but were not limited to, indwelling urethral catheter; and obstructive and reflux uropathy. The quarterly Minimum Data Set (MDS) assessment, dated 10/10/24, indicated the resident had an indwelling catheter.</p> <p>Review of the census record for Resident D indicated he was readmitted to the facility on [DATE] with an indwelling urethral catheter.</p> <p>On 11/13/24 at 2:05 p.m., Resident D was observed in his room with an indwelling urethral catheter in place.</p> <p>The care plan, dated 8/6/24, indicated the resident had an indwelling catheter related to obstructive uropathy. The interventions included, but were not limited to, change the catheter per the medical provider orders, provide catheter care every shift and as needed, enhanced barrier precautions, observe and document for pain and discomfort related to the catheter.</p> <p>Review of Resident D's physician's orders indicated the following:</p> <p>A physician's order, dated 11/13/24, indicated staff were to provide catheter care for Resident D every shift and as needed with soap and water, secure straps if applicable, and document output every shift.</p> <p>A physician's order, dated 11/13/24, for Resident D's indwelling urinary catheter care: cleanse with soap and water every shift.</p> <p>A physician's order, dated 11/13/24, indicated staff were to change the resident's indwelling catheter and drainage bag as needed unless specified by physician order for specified medical reasons.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order, dated 11/13/24, indicated staff were to change the resident's indwelling catheter leg bag and accessories every two weeks and as needed.</p> <p>A physician's order, dated 11/13/24, indicated staff were to change catheter as needed as per MD (medical doctor) order.</p> <p>A physician's order, dated 11/13/24, indicated staff were to ensure Resident D's indwelling urinary catheter was in a privacy bag and catheter leg strap on at all times.</p> <p>A physician's order, dated 11/13/24, indicated staff were to secure the resident's indwelling catheter tubing using anchoring device to prevent movement and urethral traction.</p> <p>A physician's order, dated 11/13/24, indicated staff were to measure and record output every shift of the resident's indwelling urinary catheter.</p> <p>A physician's order, dated 11/14/24, indicated staff were to change the resident's catheter as needed as per MD order</p> <p>The clinical record lacked documentation of any indwelling catheter orders for Resident D from 7/26/24 until 11/13/24.</p> <p>During an interview on 11/15/24 at 3:02 p.m., the Director of Nursing indicated due to the transition of staff, the orders were missed when the resident was readmitted .</p> <p>On 11/15/24 at 1:30 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Catheter Care. It included, but was not limited to, It is the policy of this facility to provide resident centered care that meets the .physical .needs .of the residents</p> <p>3.1-41(a)(2)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure a resident's medication administration record accurately reflected the administration on pain medication for 1 of 3 residents reviewed for medical records. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 11/13/24 at 10:47 a.m. The resident's diagnoses included, but were not limited to, osteomyelitis and stage 4 (wound that extends to muscle, tendon or bone) pressure ulcer to the sacrum.</p> <p>The physician's order, dated 8/21/24, indicated the resident was to receive Oxycodone (narcotic pain medication) HCl (hydrochloride) 10 mg (milligrams) every 4 hour as needed for pain.</p> <p>Review of the September 2024 controlled drug administration record indicated the pain medication was signed as given 90 times during the month.</p> <p>Review of the September 2024 medication administration record indicated the pain medication was documented as administered 13 times during the month.</p> <p>Review of the October 2024 controlled drug administration record indicated the pain medication was signed as given 38 times to the resident.</p> <p>Review of the October 2024 medication administration record indicated the pain medication was documented as administered 19 times.</p> <p>During an interview on 11/15/24 at 2:51 p.m., Licensed Practical Nurse (LPN) 5 indicated when an as needed narcotic pain medication was administered, the narcotic should be signed out on the controlled drug administration record. Once administered, the medication should be signed off on the medication administration record as administered.</p> <p>On 11/15/24 at 1:30 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Medication Administration. It included, but was not limited to, Medication Administration Record - the legal documentation for medication administration .Policy .It is the policy of this facility to provide resident centered care .Procedure .Medications will be charted when given</p> <p>This Citation relates to Complaint IN00446311</p> <p>3.1-50(a)(2)</p>		