STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgewood Healthcare Center	101 Potters LN Clarksville, IN 47129

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) assessment for 1 of 6 residents reviewed for accuracy of assessments. (Resident 40)Findings include:During an interview with Resident 40, on 9/22/25 at 11:08 a.m., she indicated she wanted to return home to her apartment and was just waiting on a call that one had opened. She had been planning to return home since she came into the facility, but had a few setbacks that initially caused her uncertainty.The clinical record for Resident 40 was reviewed on 9/24/25 at 9:10 a.m. The resident's diagnoses included, but were not limited to, generalized anxiety disorder, emphysema, and chronic obstructive pulmonary disease.A care plan, dated 9/26/22, indicated the resident wished to be discharged to her prior assisted living facility. The interventions included, but were not limited to, establish a pre-discharge plan. Evaluate her progress and revise plan as needed.The Quarterly MDS assessment, dated 4/9/25, indicated the resident was alert and oriented, she had no mood or behavior issues; and was set up or supervision for all Activities of Daily Living (ADLs), bed mobility and transfers.Under the section Discharge, the questions for return to the community and was there an active discharge plan in place were both answered No.The Annual MDS assessment, dated 7/11/25, indicated the resident was alert and oriented, had no mood or behavior issues, and was independent for ADLs, bed mobility and transUnder the section Discharge, the question that asked if there was an active discharge planning already occurring for the resident to return to the community, the answer was NO.The section also asked the resident if she wanted to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community, the answer was unknown or uncertain.During an interview, on 9/26/25 at 10:00 a.m., the Social Services Director indicated when the resident went to the meeting at (Name of Apartments), she decided it was too small to suit her. She also found out she could return to the apartments where she used to live. The resident's anxiety got high whenever she got a call from the person at her former apartments. Each time she spoke to the resident about her plans, the resident indicated she was still thinking about it and was uncertain what she was going to do. The Social Service Assistant, indicated at that time, he only came into this position in March and was playing catch up with the notes and MDS assessments. He assumed that because the resident was on the Rehabilitation Hall but was not getting therapy anymore, she was going to be long term and was why he coded the MDS assessments as No.In an interview, on 9/26/25 at 11:00 a.m., the Director of Nursing (DON) indicated there was no policy which addressed coding the MDS assessment. The Resident Assessment Instrument (RAI) manual was followed.3.1-31(d)(3)

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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	155265	A. Building B. Wing	09/26/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure (ADL) Activities of Daily Living care, related to laundry and bowel and bladder was provided for 1 of 5 residents reviewed for ADL care. (Residents 41) Findings include:During an observation, on 9/22/25 at 2:00 p.m., Resident 41 had a urinal sitting on his bedside dresser three fourths full of straw-colored urine. The resident indicated that the urinal was there from night shift and no one had emptied it. The resident's bed had food debris and brown spots on his sheets. The resident's chair had a pile of clothing laying in it, and he indicated staff were supposed to take his clothes to the laundry, but the clothes had been in the chair for several days. During an observation, on 9/25/25 at 10:30 a.m., the resident's urinal was sitting on his bedside dresser half full of urine. He indicated that it was his urinal he used during the night. His dirty clothes were still in his chair. During an observation, on 9/25/25 at 2:00 p.m., the resident's urinal was still sitting on his bedside dresser half full of urine from the night shift. His dirty clothes had not been taken to laundry by the staff. The resident indicated he was going to gather up his clothes and take them to the laundry himself. His bed had not been changed, and the resident indicated the only time staff changed his bed was when he asked them to. The bed had food debris and stains on the sheets.The record review, on 9/22/25 at 2:29 p.m., indicated Resident 41's diagnoses included, but were not limited to, spinal stenosis, weakness, major depression disorder, and anxiety. The care plan, dated 3/21/25, indicated the resident had ADL deficit related to weakness. The interventions include, but were not limited to, the resident would improve his current level of function. The Quarterly Data Set (MDS), dated [DATE], indicated the resident was cognitively intact. The resident was dependent on staff to maintain personal and toileting hygiene. During an interview, on 9/26/25 at 9:00 a.m., RN 6 indicated the Certified Nursing Aide (CNAs) or nurses should empty the urinals and take the resident's clothes to the laundry. The urinal should not be sitting on the bedside dresser with urine in it.During an interview, on 9/26/25 at 9:30 a.m., CNA 7 indicated the CNAs should empty the residents' urinals and take their clothes to the laundry.The position description of the Certified Nursing Aide, dated 6/2019, indicated the job duties and responsibilities included but were not limited to, . provide personal care functions to residents, Monitor and respond to resident request and needs in a dignified and respectful manner. Maintain a clean and pleasant environment for residents. Maintain physical environment in a clean, safe, and pleasant manner.3.1-38(a)(3)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident was provided proper management of the urinary catheter drainage system related to lack of catheter care orders, tubing and bag on floor, and lack of securement device for 1 of 7 residents reviewed for bowel and bladder. (Resident 4)Findings include:During an observation, on 9/22/25 at 1:00 p.m., the resident was sitting in his recliner. The urinary catheter drainage system had a dignity bag covering the drainage bag, but the tubing was lying on the floor.During an observation, on 9/23/25 at 9:02 a.m., Resident 4 was in his room asleep in his recliner. The urinary tubing of the drainage system was compressed between the resident's legs. The tubing had backed up with dark yellow urine and sediment. A securement device was not secured to either of the resident's legsDuring an observation of catheter care, on 9/25/25 at 10:15 a.m., the resident's catheter care was completed and a securement device was not secured to either of the residents' legs.The record for Resident 4 was reviewed on 9/22/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, obstructive and reflux uropathy, muscle weakness, type 2 diabetes mellitus without complications, the need for assistance with personal care, primary osteoarthritis, and benign prostatic hyperplasia without lower urinary tract symptoms.The care plan, dated 8/6/24 and revised on 6/4/25, indicated the resident required an indwelling urinary catheter due to obstructive uropathy. The interventions included, but were not limited to, dated 3/29/25, provide catheter care every shift and PRN (as needed); change the catheter per medical provider order, and PRN; staff to use enhanced barrier precautions when providing personal hygiene, toileting and perineum care, and providing care to a urinary catheter; ensuring a securement device is in place; observe for signs of pain due to the catheter, and for signs and symptoms of a urinary tract infection (UTI).The laboratory recusation, collected on 7/3/25 and results dated 7/5/2025, indicated the resident had a high level of Candida Glabrata.The Annual Minimum Data Set assessment (MDS), dated [DATE], indicated the resident's cognition was moderately impaired.The nurse's note, dated 7/16/25 at 1:52 p.m., indicated the resident's catheter was leaking. The urinary catheter was replaced using sterile technique.The laboratory results, collected on 7/17/25 and results dated 7/19/2025, indicated the resident had Klebsiella pneumoniae with Gram Negative Growth, > (grater) 100,000 colony-forming units per milliliter (cfu/ml). The resident had a history of the multidrug-resistant organism (MDRO) called Extended-spectrum beta-lactamases (ESBL).The clinical record lacked documentation of orders for the resident's catheter care. During an interview, on 9/23/25 at 1:00 p.m., Resident 4 indicated that he had not been on antibiotics for urinary infections recently but had chronic infections with antibiotics needed twice in July. The resident reported that catheter care wasn't done daily but was unable to verbalize how many times a day or a week that the catheter care was completed. The resident indicated that he would always have the catheter because of obstructions in his urinary system.During an interview, on 9/25/25 at 10:12 a.m., the DON indicated that she had identified the lack of physician's orders for catheter care on Resident 4. A new physician's order, dated 9/25/25, was entered into the resident's clinical record by the Director of Nursing (DON).During an interview, on 9/25/25 at 10:30 a.m., CNA 8 indicated that she would report any changes in the resident to the nurse working that day and CNA 9 indicated that changes to watch in the resident was abdominal or back pain, any discharge from the penis, or blockage. CNA 8 indicated that there was no way to document the resident's output, so they would inform the nurse after emptying the resident's catheter and CNA 9 indicated that catheter care was performed every two hours. A current facility policy, titled Catheter Care, undated and provided by the Director of Nursing on 9/25/25 at 11:00 a.m., included but was not limited to, It is the policy of this facility to provide resident care that meets the physiological, physical and emotional needs and concerns of the residents.Catheter care is performed at least twice daily on residents that have (continued on next page)

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	155265	A. Building B. Wing	09/26/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indwelling catheters.The risk of bacteremia in residents with indwelling catheters is 3-36 times more likely.Catheter care: check physician orders.secure catheter to leg with a device or tape.Check that collection bag is not on the floor and is draining properly and securing allowing for no reflux of urine back to the bladder.Document and report any adverse findings to the nurse. 3.1-41(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interview, the facility failed to ensure narcotics were administered and documented within the appropriate timeframe for the review of 1 of 32 residents reviewed for pharmacy procedures. (Resident 6) Findings include: During an observation on 9/24/25 at 10:17 a.m., of the 500 Hall Medication Cart, the following concerns were identified: Resident 6's Controlled Drug Administration Record sheet indicated the 0.5 milligram (mg) lorazepam tablet had 13 tablets left on sheet. The medication card had 12 tablets left. The lorazepam was last signed out on 9/24/25 at 4:00 a.m., by Licensed Practical Nurse (LPN) 10. The record for Resident 6 was reviewed on 9/25/25 at 1:25 p.m. The diagnoses included, but were not limited to, atrial fibrillation, upper abdominal pain, heart failure, alcohol use, depression, and anxiety. The care plan, dated 9/10/25, indicated Resident 6 used anti-anxiety medication for anxiety disorder. The interventions included, but were not limited to, consult with the pharmacy or medical provider to consider a dosage reduction when clinically appropriate, observe for side effects of anti-anxiety medications, and provide anti-anxiety medication per the medical provider's orders. The physician's order, dated 9/11/25 at 2:30 p.m., indicated the nurse was to administer 0.5 mg Ativan (lorazepam) to the resident every 8 hours as needed (prn) for anxiety for 14 days. The 5-Day Minimum Data Set (MDS) assessment, dated 9/12/25, indicated the resident was cognitively intact. During an interview on 9/26/25 at 9:54 a.m., RN 6 indicated 9/24/25 was crazy and she checked on the last administration time of the Lorazepam, and it was too early. The RN administered the lorazepam to Resident 6 anyway and thought she would go back later to document it on the Medication Administration Record (MAR), when it was time for the medication, but did not do that and didn't click on the administration in the MAR. The September 2025 MAR indicated the resident received the 0.5 mg Lorazepam tablet prn on 9/24/25 at 4:00 a.m., by LPN 10. The physician's order indicated the next dose of lorazepam could be administered 8 hours later at 12:00 p.m. The September 2025 MAR lacked documentation of the administration of the lorazepam on 9/24/25 by RN 6. During an interview on 9/26/25 at 11:12 a.m., the Director of Nursing (DON) indicated the nurse should follow the five rights when administering medications. The nurse should pull the narcotic at the appropriate time and sign the narcotic out on the Controlled Drug Administration Record sheet and the MAR. She should check the MAR to make sure it was at the appropriate time. If the resident needed the medication early, the nurse should contact the Nurse Practitioner. The current Medication Controlled Drugs and Security policy, included, but was not limited to, . Narcotics, scheduled or controlled drugs are medications that pose a high risk for addiction when improperly taken, and are known to depress the respiratory system which, if taken inappropriately could lead to overdose up to and including death. V. a. In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded. 3.1-25(b)(3)3.1-25(b)(9)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure narcotics were disposed of in a timely manner and document the administration of the narcotic in the Controlled Drug Administration Record sheet for 2 of 32 residents reviewed for narcotic medication storage. (Residents 52 and 6) Findings include:1.During an observation, on [DATE] at 10:17 a.m., of the 500 Hall Medication Cart the following concerns were identified: Resident 52's lorazepam tablet was last administered on [DATE]. The medication was still in the narcotic drawer of the medication cart. Resident 52's lorazepam liquid was last administered on [DATE]. The medication was still in the narcotic drawer of the medication cart. Resident 52's morphine tablet was last administered on [DATE]. The medication was still in the narcotic drawer of the medication cart. The record for Resident 52 was reviewed on [DATE] at 2:00 p.m. The resident's diagnoses included, but were not limited to, bronchus or lung cancer, chronic obstructive pulmonary disease, altered mental status, and bone disorders. The Significant Change in Condition Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was severely cognitively impaired. The care plan, dated [DATE] and revised [DATE], indicated the resident received hospice services. The interventions, dated [DATE] and revised [DATE], included, but were not limited to, administering medications per the medical provider's orders, observe for side effects and effectiveness, report abnormal findings to the medical provider, resident, resident representative, or hospice company. Complete a pain evaluation as needed, and report breakthrough pain to the medical provider.The resident was found without respirations or pulse on [DATE] at 9:20 p.m. The [DATE] Medication Administration Record (MAR) indicated the following: -On [DATE] at 9:00 a.m., the resident's 0.5 mg lorazepam tablet was last administered. -On [DATE] at 2:00 p.m., the resident's 0.5 milliliters (mL) lorazepam liquid was last administered.-On [DATE] at 2:00 p.m., the resident's 0.25 mL morphine was last administered. During an interview, on [DATE] 10:31 a.m., the Director of Nursing (DON) indicated she conducted a weekly removal of narcotics for residents who had expired or discharged . She indicated she must have missed the resident's unused narcotics when she last removed the discontinued medications. 2. Resident 6's 0.5 mg lorazepam tablet had 13 tablets left on the Controlled Drug Administration Record sheet. The medication card had 12 tablets left. The lorazepam was last administered on [DATE] at 4:00 a.m., by Licensed Practical (LPN) 10. The record for Resident 6 was reviewed on [DATE] at 1:25 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, upper abdominal pain, heart failure, alcohol use, depression, and anxiety. The care plan, dated [DATE], indicated Resident 6 used anti-anxiety medication for anxiety disorder. The interventions included, but were not limited to, consult with the pharmacy or medical provider to consider a dosage reduction when clinically appropriate, observe for side effects of anti-anxiety medications, and provide anti-anxiety medication per the medical provider's orders. The physician's order, dated [DATE] at 2:30 p.m., indicated staff were to administer the resident's 0.5 mg Ativan (lorazepam) every 8 hours as needed (PRN) for anxiety for 14 days. The 5-Day MDS assessment, dated [DATE], indicated the resident was cognitively intact. The [DATE] MAR indicated the resident received 0.5 mg Lorazepam prn on [DATE] at 4:00 a.m., by LPN 10. During an interview, on [DATE] at 10:28 a.m., RN 6 indicated she should have signed out the narcotic at the time she pulled it. She was rushing and didn't sign the lorazepam out on the Controlled Drug Administration sheet. She had given the lorazepam to Resident 6 prior to administering the breathing treatment to an unknown resident. During an interview, on [DATE] at 11:12 a.m., the DON indicated the nurse should pull the narcotic and sign the narcotic out at that time. The current Medication Controlled Drugs and Security policy, included, but was not limited to, . Narcotics, scheduled or controlled drugs are medications that pose a high risk for addiction when improperly taken, and are known to depress the respiratory (continued on next page)

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	155265	A. Building B. Wing	09/26/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system which, if taken inappropriately could lead to overdose up to and including death. 1. b. A record is retained for all drugs destroyed by licensed personnel and by individual state guidelines. V. a. In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded. VII. a. When the prescribed drug is discontinued, or the resident discharged , the container and control sheet must be removed for drug destruction. 3.1-25(b)(3)3.1-25(o)