STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD HEALTHCARE CENTER	**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)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician was notified of a change in condition for a COVID-19 positive resident. This deficient practice affected 1 of 3 residents reviewed for physician notification. (Resident B) Findings include: The clinical record of Resident B was reviewed on 5/05/20 at 11:00 a.m. Resident B's [DIAGNOSES REDACTED]. The nurse's notes between 4/24/20 and 4/30/20, indicated the resident had tested positive for COVID-19 and had experienced a decline in condition, including labored breathing and O2 saturation levels as low as 65% . The nurse had started high flow oxygen, and eventually discontinued it, after which the resident passed away 7 hours and 45 minutes later. The clinical record lacked documentation of any notification to the physician of the resident's decline in condition or the administration or discontinuation of high flow oxygen. During an interview on 5/04/20 at 4:42 p.m., the Director of Nursing (DON) and the Regional Nurse both indicated they could not locate documentation of notification of the physician regarding the resident's decline in condition. During an interview on 5/05/20 at 10:37 a.m., LPN 6 indicated she had not spoken with the physician about the resident's change in condition because she had been busy and forgot to contact the physician. During an interview on 5/05/20 at 3:23 p.m., the Medical Director indicated he did not recall any discussion about the resident's care. He was not made aware of the resident's decline until 5/4/20. The Physician Notification for Change in Condition Reporting Policy and Procedure, last revised 8/1/16, was provided by the DON as the current policy and included, but was not limited to, . 1. Unless there are documented extenuating circumstances, the nurse will report CICs (change in conditions) based on the following criteria for reporting to the physician/provider .Report immediately .Oxygen Saturation, 90% . Abrupt onset of wheezing, rales or rhonchi .abrupt shortness of breath with pain, fever, or respiratory distress This Federal tag relates to Complaint IN 579. 3.1-5(a)(2)
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident, who was positive for COVID-19 and experiencing an acute decline in condition with labored breathing and decreased oxygenation, was free from abuse. The resident was deprived of necessary care and services, when a facility nurse independently discontinued all supplemental oxygen without any contact with the physician, which was followed by no other care and services provided for the resident through the time of his death 7 hours and 45 minutes later. This deficient practice affected 1 of 3 residents reviewed for abuse. (Resident B) This deficient practice resulted in immediate jeopardy. The immediate jeopardy began on 4/30/20 at 1:00 a.m. when a facility nurse removed all supplemental oxygen from Resident B, and the resident progressively declined to death with no care or monitoring documented during that time. The Health Facility Administrator, Director of Nursing, and Regional Nurse were notified of the immediate jeopardy on 5/08/20 at 2:50 p.m. The immediate jeopardy was removed on 5/12/20, 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 clinical record of Resident B was reviewed on 5/05/20 at 11:00 a.m. Resident B's [DIAGNOSES REDACTED]. A nurse's note, dated 3/13/20 at 3:55 p.m., indicated the resident had been admitted to the facility. The care plan, dated 3/16/20, indicated the resident was a full code. A physician's orders [REDACTED]. The care plans lacked documentation of any changes to advanced directives including, but not limited to, do not resuscitate, palliative care or comfort measures only. The Admission MDS (Minimum Data Set) assessment, dated 3/20/20, indicated the resident was moderately cognitively impaired. A nurse's note, dated 4/24/20 at 5:10 p.m., indicated the resident had new orders for COVID-19 testing. The nurse's note, dated 4/26/20 at 4:28 p.m., indicated the resident was COVID-19 positive. A nurse's note, dated 4/28/20 at 12:00 a.m., documented by LPN 6 on 4/30/20 at 1:36 a.m. as a late entry, indicated the resident had an O2 sat (oxygen saturation) of 64% (normal range is greater than 90%). O2 (oxygen) was started at 2 LPM (liters per minute) via nasal cannula, with no improvement. The resident was displaying diaphragmatic breathing, and had rhonchi (abnormal continuous low pitched, rattling lung sounds) throughout the lungs. The O2 was increased to 5 LPM via a face mask, and the resident's O2 saturation raised to 84%. The resident was then changed to a non-rebreather mask and the oxygen was increased to 10 LPM. The resident's O2 saturation rose to 89%. The nurse's note, dated 4/28/20 at 1:36 a.m., documented by LPN 6 on 4/30/20 at 1:43 a.m. as a late entry, indicated the resident's condition was guarded. O2 continued at 10 LPM via non-rebreather mask, with O2 saturation remaining around 80-85% as the resident continued to display a diaphragmatic breathing pattern. The resident's breathing was labored and had rhonchi throughout the lung fields. There was no documentation in nurses' notes between 4/28/20 at 1:36 a.m. and 4/30/20 at 1:00 a.m. The nurse's note, dated 4/30/20 at 1:00 a.m., documented by LPN 6, indicated the resident continued with diaphragmatic breathing. O2 saturation was down to 64% as O2 continued at 10 LPM via non-rebreather mask. The resident appeared to be weak and tired. The nurse asked the resident if he was tired of fighting, and whether he wanted to let go and go to heaven. The resident indicated he did, and the nurse removed all supplemental oxygenation. The clinical record lacked documentation of any notification to the physician of the resident's continual decline or the discontinuation of oxygenation therapy, and any physician's orders [REDACTED]. There was no further documentation by LPN 6 after 1:00 a.m. on 4/30/20. A nurse's note, dated 4/30/20 at 8:45 a.m., documented by the day shift nurse, LPN 7, indicated the resident had passed away. At this time, the physician was notified of the resident's death. Review of a social media post, made by LPN 6 on 5/01/20, indicated, I just want y'all to know the hardest thing I've ever done in [AGE] years start a patient on O2 for 4 days 12 LPM. with a non-rebreather mask and I asked him on day 4 if he's tired he said yes I said do you want me to take all this off for you and let you go and fly with the angels and he said yes I took it all off of him I went in the hallway and I cried and I let him go and he passed away 1 hour and 45 minutes after I left. During an interview on 5/04/20 at 4:42 p.m., the DON and the Regional Nurse both indicated they could not locate documentation of notification of the physician regarding the resident's decline in condition, or any orders to administer or discontinue any oxygenation. During an interview on 5/05/20 at 10:37 a.m., LPN 6 indicated she had started oxygen on the resident when his sats (oxygen saturation) were in the 70's. They had standing orders for up to 5 LPM (liters per minute) of O2. She put him on 5 LPM via a mask, but it only brought the resident's sats up to 77. She then increased it to 10 LPM via a non-rebreather mask. She told the resident's daughter, who was the POA (power of attorney), the oxygen was only .prolonging the inevitable The daughter had told her if it was her father's wishes she could remove the mask. She later removed the oxygenation. She did not speak with the physician because she was taking care of over 40 COVID patients, and the week that I had had was terrible, and that is one thing I forgot to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) do was call the doctor. She indicated they only had standing orders for up to 5 LPM of O2. The physician did not give the order to start the oxygen or to use the non-rebreather mask, she was just trying to keep the resident's sats (oxygen saturation) up. The physician did not give an order to discontinue the oxygenation. On 5/05/20 at 12:10 p.m., interview with LPN 7 indicated LPN 6 had told her the resident wasn't doing good, and he wanted the O2 off and family wanted it off, so she took the oxygen off. LPN 6 did not tell her if she had notified the doctor. LPN 7 assumed LPN 6 had notified the doctor, because LPN 6 had removed the oxygen. LPN 7 said she would not have taken the oxygen off without contacting the doctor first. LPN 7 indicated she was absolutely not aware the doctor wasn't notified. During an interview on 5/05/20 at 2:43 p.m., APRN (Advanced Practice Registered Nurse) 9, who practiced under the direction of the resident's attending physician/facility Medical Director, indicated the last time she had seen the resident was on 4/28/20. She indicated the resident's oxygen saturations were in the low to mid 80's (percent), and she had wanted to send the resident out to the hospital. The resident had told her he wanted to go to the hospital, but the nurse told her she had discussed it with the family and they did not want him to be sent out. She did not believe he was of sound mind. She did not personally speak with the daughter. During an interview on 5/05/20 at 3:23 p.m., the Medical Director, who was also the resident's attending physician, indicated he did not recall any discussion about the resident's care. He was not made aware of the resident's decline or the oxygen administration and removal until 5/04/20. During an interview on 5/05/20 at 4:22 p.m., the Regional Nurse indicated no orders had been transcribed into the resident's medical record to administer or discontinue oxygenation. She could not locate any notification or discussion with the physician regarding the continued decline after the APRN's visit on 4/28/20, or the nurse's decision to discontinue the oxygenation. During an interview on 5/06/20 at 9:43 a.m., the resident's family member indicated on 4/27/20 she started getting calls to let her know the resident was declining around 8:00 p.m. LPN 6 had told her the resident would not keep his mask on. She talked to him on a video call and asked him to keep the mask on, he nodded his head up and down, but she could tell he was tired. It was said to her that he kept taking the oxygen off. She told LPN 6 she could remove it, but try to put it back on him later when he calmed down. On the night of the 28th, they snuck her in the exit door of the 400 hall to see her father. He had the mask in place, and was barely opening his eyes. She asked him to keep the mask on. After she left, the nurse called her and said he was not doing well. The nurse told her if they sent him out to the hospital they would just be doing the same things they were already doing at the facility, so the family member told them to let him stay there and not send him out. LPN 6 called her back and said the resident was not keeping the mask on, and she told the nurse to let him calm down and put it back on. The nurse told her she would try to keep putting it on him, but she could not force him to keep it on. The next time a nurse called her, it was LPN 7 to tell her, her father had passed away at 8:52 a.m. on the morning of 4/30/20. During an interview on 5/08/20 at 9:23 a.m., the DON indicated she found out about the incident regarding LPN 6's actions sometime after 9:00 a.m. on 5/04/20, when the Executive Director (ED) made her aware he had started an investigation. After making appropriate notifications to authorities, the physician, family, and ISDH, she began reviewing the record. She had not been aware of the documentation in the medical record prior, because it had been made as a late entry, and it had not shown up on her 24 hour report she reviewed daily. They knew the resident was sick and not doing well, but she had never been notified of the oxygen. The facility did not have any standing orders for oxygen. The DON indicated adding oxygen was a change in condition, and the physician would have to be notified. She did not question his death because they knew he was COVID positive, and the APRN had said it would most likely take him. The facility had not considered it an unexpected death. During an interview on 5/08/20 at 10:50 a.m., the ED indicated early in the morning on 5/04/20 between 7:30 a.m. and 8:00 a.m., a staff member called and said a social media post had concerned the staff member. The ED had the screenshot of the post sent to him and began his investigation on 5/04/20 between 8:00 and 10:00 a.m. Part of the problem was the nurse made a late entry, so it did not show up on the 24 hour report. The ED indicated late entries were not the facility's goal, and they tried to educate not to do that. During a subsequent interview on 5/08/20 at 11:37 a.m., the DON indicated the nurse's note on 4/30/20 at 1:00 a.m., was not a late entry. It should have shown up on the 24 hour report she reviewed daily. She did not remember seeing it, or discussing it with the clinical team. She had no reason she could provide as to why it was not discussed, and indicated it was definitely something they should have discussed. The INDIANA Abuse & Neglect & Misappropriation of Property policy and procedure, last revised 4/01/19, was provided by the DON as the current policy and included, but was not limited to, .Abuse . In Indiana, the willful infliction of injury , unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful: In Indiana, the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm The policy did not identify the deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being as abuse. The immediate jeopardy that began on 4/30/20 was removed on 5/12/20 when the facility audited all residents for abuse and staff education was completed, but the 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 because continued monitoring was needed of staff who were working more than 40 hours per week, picking up additional shifts, and/or working the COVID unit. This Federal tag relates to Complaint IN 579. 3.1-27(a)(1)
F 0607 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on record review and interview, the facility failed to develop policies to prevent abuse, which comprehensively defined and identified abuse as the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This deficient practice had the potential to affect all 82 residents living in the facility. Findings include: The INDIANA Abuse & Neglect & Misappropriation of Property policy and procedure, last revised 4/01/19, was provided by the Director of Nursing (DON) as the current policy and included, but was not limited to, .Abuse . In Indiana, the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful: In Indiana, the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm The policy did not include in the definition or identification of abuse the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. During an interview on 5/12/20 at 2:23 p.m., both the Regional Nurse and the Executive Director indicated the INDIANA Abuse & Neglect & Misappropriation of Property policy and procedure provided, was the most current abuse policy. They confirmed the policy did not list deprivation of necessary goods and services under abuse, but indicated it was listed under neglect, and neglect was a form of abuse. This Federal tag relates to Complaint IN 579. 3.1-28(a)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's (Resident C) plan of care was developed to reflect an elopement risk for 1 of 5 residents reviewed for care plans. Findings include: The clinical record for Resident C was reviewed on 5/04/20 at 11:00 a.m. [DIAGNOSES REDACTED]. The admission MDS (Minimum Data Set) assessment, dated 3/20/20, indicated the resident had severely impaired cognition. The admission observation tool, dated 3/11/20 at 7:22 p.m., indicated the resident had risk factors for elopement and/or unsafe wandering. There were no other elopement assessments completed for the resident. The cognitive assessment completed by the nurse on 3/11/20 indicated the resident was unable to report the correct year, month, or day of the week. The Social Services note, dated 3/20/20 at 8:12 a.m., indicated the resident had difficulty making decisions, keeping focus on what was being said, and jumped from one thing to another. She did not know the day of the week and changed the subject when asked to repeat three words. Review of the skilled documentation notes on 3/13/20, 3/14/20, 3/15/20, 3/16/20, 3/21/20, 3/22/20, 3/23/20, 3/24/20, 3/25/20, 3/26/20, and 3/28/20 indicated Resident C had poor decision making skills and required cues and supervision. Review of the care plan, initiated on 4/7/20, lacked documentation of a plan of care and interventions related the resident's elopement risk. During an interview with the Director of Nursing on 5/04/20 at 2:19 p.m., she indicated the resident was an elopement risk and did not have an elopement care plan in place. On 5/7/20 at 12:23 p.m., the Director of Nursing provided a current copy of the document titled Plan of Care Review dated 7/26/18. It included, but was not limited to, Definitions .for the purpose of this policy the plan of care .is the written treatment provided for a resident that is resident-focused .Policy .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) concerns of the residents. Safety is a primary concern for our residents This Federal tag relates to Complaint IN 579. 3.1-35(a)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely revision of a care plan for advanced directives for 1 of 5 residents whose care plans were reviewed. (Resident B) Findings include: The clinical record of Resident B was reviewed on 5/05/20 at 11:00 a.m. Resident B's [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) assessment, dated 3/20/20, indicated the resident was moderately cognitively impaired. The care plan, dated 3/16/20, indicated the resident was a full code. A physician's orders [REDACTED]. The care plans lacked documentation of any changes to advanced directives including, but not limited to, do not resuscitate. During an interview on 5/11/20 at 10:46 a.m., the Regional Nurse indicated she had not realized the care plan had not been updated. It should have been updated immediately when they got the order to change to a DNR. The Plan of Care Overview Policy and Procedure, last revised on 7/26/18, was provided by the DON as the current policy and included, but was not limited to, . for the purpose of this policy, the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care . d. There facility will . Review care plans .with significant changes in care This Federal tag relates to Complaint IN 579. 3.1-35(b)
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident who was positive for COVID-19 was assessed, monitored and provided necessary care and treatment in accordance with professional standards of practice during a decline in condition with shortness of breath and decreased oxygenation, and failed to ensure the physician was notified of the decline in condition. At the time of the resident's decline, a facility nurse administered oxygen via a non-rebreather mask without physician orders [REDACTED]. The next documentation in nursing notes was two days later, when the same nurse discontinued all oxygen without notifying the physician or receiving orders to do so, which was followed by the resident's death. This deficient practice affected 1 of 3 residents reviewed for quality of care. (Resident B) This deficient practice resulted in immediate jeopardy. The immediate jeopardy began on 4/28/20 at 12:00 a.m. when a resident was experiencing a decline in condition, the nurse did not notify the physician and obtain orders for the resident's care and treatment, and the facility did not monitor and assess the resident for the following two days. On 4/30/20, the nurse acted independently and discontinued all oxygen, again without notifying the physician or obtaining orders for care, and the resident progressively declined to death 7 hours and 45 minutes later, again with no care or monitoring documented during that time. The Health Facility Administrator, Director of Nursing, and Regional Nurse were notified of the immediate jeopardy on 5/04/20 at 4:33 p.m. The immediate jeopardy was removed on 5/12/20, 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 clinical record of Resident B was reviewed on 5/05/20 at 11:00 a.m. Resident B's [DIAGNOSES REDACTED]. A nurse's note, dated 3/13/20 at 3:55 p.m., indicated the resident had been admitted to the facility. The care plan, dated 3/16/20, indicated the resident was a full code. A physician's orders [REDACTED]. The care plans lacked documentation of any changes to advanced directives including, but not limited to, do not resuscitate, palliative care, or comfort measures only. The Admission MDS (Minimum Data Set) assessment, dated 3/20/20, indicated the resident was moderately cognitively impaired. A nurse's note, dated 4/24/20 at 5:10 p.m., indicated the resident had new orders for COVID-19 testing. The nurse's note, dated 4/26/20 at 4:28 p.m., indicated the resident was COVID-19 positive. The nurse's note, dated 4/28/20 at 12:00 a.m., documented by LPN 6 as a late entry on 4/30/20 at 1:36 a.m., indicated the resident had an O2 sat (oxygen saturation) of 64% (normal range is greater than 90%). O2 (oxygen) was started at 2 LPM (liters per minute) via nasal cannula, with no improvement. The resident was displaying diaphragmatic breathing, and had rhonchi (abnormal continuous low pitched, rattling lung sounds) throughout the lungs. The O2 was increased to 5 LPM via a face mask, and the resident's O2 saturation raised to 84%. The resident was then changed to a non-rebreather mask and the oxygen was increased to 10 LPM. The resident's O2 saturation rose to 89%. The clinical record lacked documentation of notification to the physician of the resident's decline in condition, or the initiation of oxygenation therapy. The nurse's note, dated 4/28/20 at 1:36 a.m., documented by LPN 6 as a late entry on 4/30/20 at 1:43 a.m., indicated the resident's condition was guarded. O2 continued at 10 LPM via non-rebreather mask, with O2 saturation remaining around 80-85% as the resident continued to display a diaphragmatic breathing pattern. The resident's breathing was labored and had rhonchi throughout the lung fields. There was no documentation in nurses' notes between 4/28/20 at 1:36 a.m. and 4/30/20 at 1:00 a.m. The nurse's note, dated 4/30/20 at 1:00 a.m., documented by LPN 6, indicated the resident continued with diaphragmatic breathing. O2 saturation was down to 64% as O2 continued at 10 LPM via non-rebreather mask. The resident appeared to be weak and tired. The nurse asked the resident if he was tired of fighting, and whether he wanted to let go and go to heaven. The resident indicated he did, and the nurse removed all supplemental oxygenation. The clinical record lacked documentation of any notification to the physician of the resident's continual decline or the discontinuation of oxygenation therapy, and any physician's orders [REDACTED]. There was no further documentation by LPN 6 after 1:00 a.m. on 4/30/20. A nurse's note, dated 4/30/20 at 8:45 a.m., documented by the day shift nurse, LPN 7, indicated the resident had passed away. At this time, the physician was notified of the resident's death. The clinical record lacked documentation of any respiratory assessments from the time the oxygen administration was started, to the time of the resident's death. Review of a social media post, made by LPN 6 on 5/01/20, indicated, I just want y'all to know the hardest thing I've ever done in [AGE] years start a patient on O2 for 4 days 12 LPM. with a non-rebreather mask and I asked him on day 4 if he's tired he said yes I said do you want me to take all this off for you and let you go and fly with the angels and he said yes I took it all off of him I went in the hallway and I cried and I let him go and he passed away 1 hour and 45 minutes after I left. During an interview on 5/04/20 at 12:30 p.m., LPN 4 indicated a non-rebreather mask would only be utilized for a resident if a physician ordered it. During an interview on 5/04/20 at 4:42 p.m., the DON and the Regional Nurse both indicated they could not locate documentation of notification of the physician regarding the resident's decline in condition, or any orders to administer or discontinue any oxygenation. During an interview on 5/05/20 at 10:37 a.m., LPN 6 indicated she had started oxygen on the resident when his sats (oxygen saturation) were in the 70's. They had standing orders for up to 5 LPM (liters per minute) of O2. She put him on 5 LPM via a mask, but it only brought the resident's sats up to 77. She then increased it to 10 LPM via a non-rebreather mask. She told the resident's daughter, who was the POA, the oxygen was only .prolonging the inevitable. . The daughter had told her if it was her father's wishes she could remove the mask. She later removed the oxygenation. She did not speak with the physician because she was taking care of over 40 COVID patients and the week that I had had was terrible and that is one thing I forgot to do was call the doctor. She indicated they only had standing orders for up to 5 LPM of O2. The physician did not give the order to start the oxygen or to use the non-rebreather mask, she was just trying to keep the resident's sats (oxygen saturation) up. The physician did not give an order to discontinue the oxygenation. On 5/05/20 at 11:56 a.m. a subsequent interview with LPN 4 indicated she provided the care during day shift on 4/28/20 and 4/29/20 for the resident, and he had been on the non-rebreather mask at 12 LPM when she came on to the shift, but he hadn't been in any distress during her care. She had assumed the other nurse who started the oxygen would have notified the physician and gotten an order to start the oxygen. On 5/05/20 at 12:10 p.m., interview with LPN 7 indicated LPN 6 had told her the resident wasn't doing good, and he wanted the O2 off and family wanted it off, so she took the oxygen off. LPN 6 did not tell her if she had notified the doctor. LPN 7 assumed LPN 6 had notified the doctor, because LPN 6 had removed the oxygen. LPN 7 said she would not have taken the oxygen off without contacting the doctor first. LPN 7 indicated she was absolutely not aware the doctor wasn't notified. During an interview on 5/05/20 at 2:43 p.m., APRN (Advanced Practice Registered Nurse) 9, who practiced under the direction of the resident's attending physician/facility Medical Director, indicated the last time she had seen the resident was on 4/28/20. She indicated the resident's oxygen saturations were in the low to mid 80's (percent), and she had wanted to send the resident out to the hospital. The

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) resident had told her he wanted to go to the hospital, but the nurse told her she had discussed it with the family and they did not want him to be sent out. She did not believe he was of sound mind. She did not personally speak with the daughter. During an interview on 5/05/20 at 3:23 p.m., the Medical Director, who was also the resident's attending physician, indicated he did not recall any discussion about the resident's care. He was not made aware of the resident's decline or the oxygen administration and removal until 5/04/20. During an interview on 5/05/20 at 4:22 p.m., the Regional Nurse indicated once the physician sees the resident, the APRN would have to write the orders on a paper order and the nurse would transcribe and place in the electronic record. She did not see any orders for oxygenation in the electronic record for the resident. No orders had ever been transcribed into the resident's medical record to administer or discontinue oxygenation. She could not locate any notification or discussion with the physician regarding the continued decline after the APRN's visit on 4/28/20, or the nurse's decision to discontinue the oxygenation. During an interview on 5/06/20 at 9:43 a.m., the resident's family member indicated on 4/27/20 she started getting calls to let her know the resident was declining around 8:00 p.m. LPN 6 had told her the resident would not keep his mask on. She talked to him on a video call and asked him to keep the mask on, he nodded his head up and down, but she could tell he was tired. It was said to her that he kept taking the oxygen off. She told LPN 6 she could remove it, but try to put it back on him later when he calmed down. On the night of the 28th, they snuck her in the exit door of the 400 hall to see her father. He had the mask in place, and was barely opening his eyes. She asked him to keep the mask on. After she left, the nurse called her and said he was not doing well. The nurse told her if they sent him out to the hospital they would just be doing the same things they were already doing at the facility, so the family member told them to let him stay there and not send him out. LPN 6 called her back and said the resident was not keeping the mask on, and she told the nurse to let him calm down and put it back on. The nurse told her she would try to keep putting it on him, but she could not force him to keep it on. The next time a nurse called her, it was LPN 7 to tell her, her father had passed away at 8:52 a.m. on the morning of 4/30/20. During interview on 5/08/20 at 11:37 a.m., the DON indicated the nurse's notes on 4/28/20 were late entries, but the note on 4/30/20 at 1:00 a.m. was not a late entry. It should have shown up on the 24 hour report she monitors daily. She did not remember seeing it or discussing it with the clinical team. She indicated she had no reason she could provide as to why it was not discussed and it was definitely something they should have discussed, with someone at 64% oxygen saturation on 10 LPM of oxygen. The DON indicated they would have assessed the patient before morning meeting even started, and she would have called the doctor herself. The Oxygen-Medical Gas Use policy and procedure, last revised 12/21/18, was provided by the DON as the current policy and included, but was not limited to, .I. Oxygen Safety . b. Oxygen will be ordered by a physician or other authorized provider . II. Residents Receiving Oxygen a. Will have a physician/provider's order for the oxygen including route of administration, liters per minute, and frequency of use The Physician Notification for Change in Condition Reporting Policy and Procedure, last revised 8/1/16, was provided by the DON as the current policy and included, but was not limited to, . 1. Unless there are documented extenuating circumstances, the nurse will report CICs (change in conditions) based on the following criteria for reporting to the physician/provider .Report immediately .Oxygen Saturation, 90% . Abrupt onset of wheezing, rales or rhonchi .abrupt shortness of breath with pain, fever, or respiratory distress Review of the Indiana Administrative Code, Title 848, Indiana State Board of Nursing Article 2 Standards for the Competent Practice of Registered and Licensed Practical Nursing included the following: 848 IAC 2-3-2 Responsibility as a member of the health team Sec. 2. The licensed practical nurse shall do the following: (1) Function within the legal boundaries of practical nursing practice based on the knowledge of statutes and rules governing nursing. (2) Accept responsibility for individual nursing actions and continued competence. (3) Communicate, collaborate, and function with other members of the health care team to provide safe and effective care . 848 IAC 2-3-3 Unprofessional conduct Sec. 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate interpersonal behaviors in providing nursing care. The immediate jeopardy that began on 4/28/20 was removed on 5/12/20 when the facility completed staff education, an audit of all residents in the building to ensure physician notification had been completed if needed, all residents were assessed for change of condition, and extended the 24 hour review to 72 hours to ensure late entries would be monitored. 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 because continued monitoring was needed. This Federal tag relates to Complaint IN 579. 3.1-37(a)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision and interventions were in place to prevent a severely cognitively impaired resident (Resident C), who was assessed by the facility as an elopement risk, fall risk and COVID-19 positive, from exiting the facility unsupervised. She was missing for more than three hours when she was found 2.8 miles away from the facility. Although the facility assessed the resident as at risk for elopement, no interventions and/or increased supervision had been implemented to attempt to protect the resident from elopement. The facility also failed to ensure staff responded promptly to the 200 hall door alarm when the resident exited. This affected 1 of 2 residents reviewed for elopement. This deficient practice resulted in immediate jeopardy. The immediate jeopardy began on 5/02/20 when a cognitively impaired resident with dementia, who was also a fall risk, exited the facility unsupervised and was missing for more than three hours when she was found 2.8 miles from the facility. The resident exited the 200 hall fire door which alarmed for 8 minutes before a staff member responded. The Health Facility Administrator, Director of Nursing, and Regional Nurse were notified of the Immediate Jeopardy on 5/04/20 at 4:33 p.m. The immediate jeopardy was removed on 5/11/20, 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 clinical record for Resident C was reviewed on 5/04/20 at 11:00 a.m. [DIAGNOSES REDACTED]. The hospital discharge note, dated 3/11/20 at 3:37 p.m., indicated Resident C had fallen, and had been brought to the hospital and admitted for further evaluation. The patient had been confused as well as a poor historian with an underlying history of [MEDICAL CONDITION] and behavioral issues. The cognitive assessment completed by the nurse on 3/11/20 indicated the resident was unable to report the correct year, month, or day of the week. The admission observation tool, dated 3/11/20 at 7:22 p.m., indicated the resident had risk factors for elopement and/or unsafe wandering. There were no other elopement assessments completed for the resident. Fall observation tools indicated the resident had fallen on 3/18/20. The admission MDS (Minimum Data Set) assessment, dated 3/20/20, indicated the resident had severely impaired cognition, had a history of [REDACTED]. The Social Services note, dated 3/20/20 at 8:12 a.m., indicated the resident had [DIAGNOSES REDACTED]. She had difficulty making decisions and keeping focus on what was being said. She jumped from one thing to another, such as could she have chicken, could she have soup, she needed shoes, and so on. She was alert and able to answer some questions. When asked what year it was, she said March 20, however did not know the day of the week. When asked to repeat three words, she changed the subject and never did repeat the three words. The clinical record lacked documentation of a plan of care and interventions related the resident's elopement risk. The skilled documentation notes, dated 3/13/20, 3/14/20, 3/15/20, 3/16/20, 3/21/20, 3/22/20, 3/23/20, 3/24/20, 3/25/20, 3/26/20, and 3/28/20 indicated Resident C had poor decision making skills and required cues and supervision. The nurse's note, dated 4/26/20 at 2:54 p.m., indicated Resident C had been educated to stay in her room to prevent spread of infection and to wear a mask if out in hall. The resident continued to come out in hallways with her mask not on appropriately. The resident had been educated on the proper way to wear the mask. The resident continued to wear her mask over her mouth with her nose not covered. Education had been provided throughout shift. A progress note, dated 4/30/20 at 12:32 p.m., indicated the resident tested positive for COVID-19. The nurse's note, dated 5/02/20 at 10:24 a.m., recorded as a late entry on 5/03/20 at 10:39 a.m., indicated at 6:58 p.m., RN 5 walked to the nurse's station area from the 300 hall and heard an alarm sounding. RN 5 assessed the situation to find the door at the end of the 200 hall sounding. He went out the 200 hall door and made a visual sweep of the area, entered back into the facility, and began a head count of the residents on the hall. CNA (Certified Nursing Assistant) 8 entered the hall through the zippered barrier wall and was informed of the situation. They continued with room searches and head counts. It was quickly determined that Resident C was absent from her room. CNA 8 had interacted and assisted the resident back to her room and shut the door at approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD HEALTHCARE CENTER	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.

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) 6:42 p.m. All the rooms and floors were searched, and a silver alert was called. The nurse's note, dated 5/02/20 at 8:32 p.m., recorded as late entry on 5/3/20 at 8:30 p.m., indicated staff had alerted RN 5 of the code silver (missing resident) due to the resident unable to be accounted for. RN 5 had been on the 500 hall and exited through the 500 hall door with other staff at which time staff split up to complete a visual sweep of the facility grounds. The staff were unable to find the resident. Staff were informed to, once again, complete a head count and were instructed to look at each resident's face in bed to ensure the resident was not lying in another resident's bed due to the resident may have been confused due to all the room changes and the placement of the zipper wall barrier. The local police were notified of possible elopement, and the resident's medical condition of COVID-19 positive had been provided. The Executive Director was also informed and all policy and procedures were currently being followed. An organized search was implemented and the maintenance director contacted to view the video footage to help establish the whereabouts of the resident along with a detailed time frame. A progress note, dated 5/02/20 at 10:14 p.m., indicated the facility was notified by the police that the resident was found at her home, and the resident refused to return to the facility. On 5/04/20 at 1:45 p.m., during an observation of the video footage of the 200 hall on 5/02/20, Resident C was observed to exit her room and ambulate to the end of the 200 hall. She pressed the egress bar of the fire door at 6:50 p.m., which initiated the alarm. After 15 seconds, the door opened and the resident exited the facility. The resident walked around the building and at 6:56 p.m., ambulated to the right on the sidewalk, off the facility premises. At 6:58 p.m., RN 5 was observed to walk to the end of the hall and turn the alarm off and then exited the door. During an interview on 5/04/20 at 2:19 p.m., the Director of Nursing indicated the resident was an elopement risk, did not have an elopement care plan in place, did not have a Wander guard bracelet on and should have, and staff should have responded immediately to the 200 hall alarm. During a telephone interview on 5/06/20 at 10:35 a.m., Resident C's sister indicated the resident had arrived at her home around 8:00 p.m. on 5/02/20. She had not spoken with her sister for several days but had attempted multiple times, over the course of several days, to reach the facility so she could talk with her. She was aware her sister tested positive for COVID-19. Resident C informed her sister she had left the facility and had been walking when someone had stopped and given her a ride to her sister's office. When Resident C realized her sister was not at the office, she received another ride from someone who dropped her off at her sister's house. Resident C and her sister visited out on the porch and then Resident C walked to her home which was 4 blocks away. Resident C's sister had decided to go check on her sister and found the police at Resident C's home. She informed the police that Resident C was inside. On 5/04/20 at 1:17 p.m., the Director of Nursing provided a current copy of the document titled Elopement Prevention, dated 4/20/17. It included, but was not limited to, Definition .Elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury .Policy .The facility strives to prevent resident/patient elopement .Procedure . (a) All new admissions that are at risk for elopement will have interventions put into place immediately until further assessment is complete. Interventions may include, but are not limited to .Environmental modifications to prevent undetected exit such as wander alerts, door alarms .Increased frequency of resident observation rounds . (b) Any resident/patient admitted who is cognitively impaired and can self-ambulate is considered an elopement risk until determined otherwise On 5/04/20 at 1:17 p.m., the Director of Nursing provided a current copy of the document titled Elopement Prevention and Management Overview, dated 5/30/19. It included, but was not limited to, Definition .Elopement is defined as when a resident/patient leaves the premises or safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury. Unsafe wandering is defined when a resident/patient enters an area that is physically hazardous .Policy .The interdisciplinary team plans the least restrictive interventions to promote mobility and safety and to meet the individualized needs and goals of the resident .Procedure .Identify resident/patients who are at a risk for elopement .Determine elopement risk factors .Develop and document individualized interventions to manage risk factors .Communicate risk factors and interventions to the caregiving staff The immediate jeopardy that began on 5/02/20 was removed on 5/11/20 when the facility completed staff education on elopement prevention/management and risk factors that put residents at risk for elopement, wander/elopement assessments on all residents, and elopement drills with staff response. 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, because not all staff had participated in the elopement drills and continued monitoring was needed. This Federal tag relates to Complaint IN 579. 3.1-45(a)(2)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure respiratory assessments and monitoring were provided for a resident who was COVID-19 positive, for 1 of 8 residents reviewed for respiratory assessments. (Resident B) Findings include: 1. The clinical record of Resident B was reviewed on 5/05/20 at 11:00 a.m. Resident B's [DIAGNOSES REDACTED]. The nurse's note, dated 4/26/20 at 4:28 p.m., indicated the resident was COVID-19 positive. The Physicians order, dated 4/30/20 at 6:00 a.m., indicated to evaluate for COVID-19 symptoms every shift, including but not limited to, temperature, oxygen saturation, and respiratory signs and symptoms. The clinical record lacked documentation of any respiratory assessments under the assessments tab, or on the medication and treatment administration records. The only documented assessments were on 4/28/20 at 12:00 a.m. and 1:36 a.m., and on 4/30/20 at 1:43 a.m., when the nurse documented the resident's decline in condition in the nurses' notes. During an interview on 5/11/20 at 10:10 a.m., the Regional Nurse indicated the facility did not have a policy specific to COVID-19 respiratory assessments; however they expected nurses to do daily temperatures and O2 sats (oxygen saturation), and a daily assessment. Prior to 4/30/20, they were only required to do a temperature. It was not a policy, but a standard clinical practice. She would expect staff to be monitoring respiratory effort, lung sounds and respirations every shift. This Federal tag relates to Complaint IN 579. 3.1-47(a)(6)