STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155632	A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LODGE OF THE WABASH	723 E RAMSEY RD VINCENNES, IN 47591

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00450791. This visit included a State Residential Licensure Survey. Complaint IN00450791 - Federal/state deficiencies related to the allegations are cited at F695. Survey dates: January 2, 3, 8, 9, 13, 14, 2025 Facility number: 001138 Provider number: 155632 AIM number: 200157070 Census Bed Type: SNF/NF: 50 Residential: 0 Total: 50 Census Payor Type: Medicare: 5 Medicaid: 38 Other: 7 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 26, 2025.	F 0000		
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure a notice of transfer or discharge	F 0623	Facility does provide written notification required for	01/15/2025

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	was given to residents or resident representatives for 3 of 3 residents reviewed for hospitalizations. The transfer discharge form was not completed. (Resident 27, Resident 37, Resident 13) Findings include: 1. On 1/6/25 at 11:20 A.M., Resident 27's clinical records were reviewed. Diagnoses included, but were not limited to anemia, dementia, neurogenic bladder, and chronic kidney disease, stage 4. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/14/24, indicated Resident 27 had moderate cognitive impairment, required set up or clean up for eating, bed mobility, toilet use and transfer, and had a suprapubic catheter. On 1/6/25 at 11:47 A.M., Resident 27's clinical records indicated he was hospitalized from 12/1/24 to 12/5/24. Clinical records lacked transfer/discharge paperwork. During an interview on 1/9/25 at 1:35 P.M., Licensed Practical Nurse (LPN) 9 indicated she was unable to find the last hospitalization information or discharge paperwork. She indicated when a resident was transferred the paperwork was given to Director of Nursing (DON) and she would ask the Assistant Director of Nursing (ADON) where the paperwork was located. During an interview on 1/13/25 at 2:00 P.M., the Clinical and Quality Consultant indicated the nurse who transferred Resident 27 to the hospital did not keep a copy of the transfer/discharge paperwork.		facility-initiated transfer/discharges. Residents 27, 37 and 13 and representatives were notified by phone or in person prior to or at time of transfer. Residents and representatives were in agreement of transfers that occurred. Residents returned to facility as anticipated. Review of all transfer/discharge in prior 30 days identified no other concerns. Staff provided re-education on Notice Requirements before Transfer/Discharge and applicable documentation-retention of record on 1-15-25. Social Service or designee will review all transfers/discharges daily to ensure applicable documentation-written notification provided for 3 months and report negative finding to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	

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	2. On 1/6/25 at 1:02 P.M., Resident 37's clinical records were reviewed. Diagnoses included, but were not limited to atrial fibrillation, heart failure, dementia, depression, and psychotic disorder. The most current Annual MDS assessment, dated 9/6/24, indicated Resident 37 had severe cognitive impairment, required set up or clean up for eating, bed mobility, toilet use and transfer. Clinical records indicated Resident 37 was hospitalized on 2/24/24 to 2/29/24, 11/1/24 to 11/12/24, and 11/16/24 to 11/30/24. Clinical records lacked transfer/discharge paperwork. During an interview on 1/9/24 at 4:43 P.M., the Clinical and Quality Consultant indicated they were still looking for the transfer/discharge paperwork. 3. On 1/6/25 at 1:08 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, osteomyelitis, end stage renal disease, diabetes mellitus type II, and peripheral vascular disease. On 1/9/25 at 1:40 P.M., all completed transfer and discharge notices from January 2024 to present were requested. During an interview on 1/9/25 at 4:40 P.M., the Clinical and Quality Consultant indicated Resident 13 was transferred and hospitalized on the following dates: 1/17/24, returned 1/20/24 6/7/24, returned 6/9/24 6/17/24, returned 6/19/24 9/23/24, returned 9/25/24			

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	10/18/24, returned 12/3/24 1/2/25, returned 1/6/25 The clinical record lacked documentation of the resident and representative receiving a notice of transfer or discharge at the time of the hospitalizations. During an interview on 1/13/25 at 2:05 P.M., the Clinical and Quality Consultant indicated she could not provide completed transfer and discharge notices for the following dates: 6/7/24 6/17/24 9/23/24 10/18/24 1/2/25 During an interview on 1/13/25 at 2:05 P.M., the Clinical and Quality Consultant indicated when the resident was transferred, the transfer and discharge notices should have been completed, copied, sent with the resident, and the copy should have been placed in the resident's clinical record. On 1/14/25 at 9:00 A.M., a current Transfer and Discharge Policy, revised October 2022, was provided by the Clinical and Quality Consultant and indicated "Purpose: The facility will comply with regulations regarding initiating a transfer or discharge of a resident and the accompanying documentation that must be included in the medical record ... the facility will notify the resident and the resident's representative of the transfer and reasons for the move in writing and in a language the resident understands ... the facility will document in the medical record, before or as close as possible to the actual time of transfer or discharge ... "			

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F 0625 SS=D Bldg. 00	3.1-12(a) 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 3 of 3 residents reviewed for hospitalizations. The bed hold form was not completed. (Resident 27, Resident 37, Resident 13) Findings include: 1. On 1/6/25 at 11:20 A.M., Resident 27's clinical records were reviewed. Diagnoses included, but were not limited to anemia, dementia, neurogenic bladder, and chronic kidney disease, stage 4. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/14/24, indicated Resident 27 had moderate cognitive impairment, required set up or clean up for eating, bed mobility, toilet use and transfer, and had a suprapubic catheter. On 1/6/25 at 11:47 A.M., Resident 27's clinical records indicated he was hospitalized from 12/1/24 to 12/5/24 for sepsis and weakness with a one week history of nausea, vomiting, diarrhea and abdominal pain. Clinical records lacked bed hold paperwork. During an interview on 1/9/25 at 1:35 P.M., Licensed Practical Nurse (LPN) 9 indicated she was unable to find the last hospitalization information or bed hold paperwork. She indicated when a resident was transferred the paperwork	F 0625	Facility does provide notification of Bed Hold Policy for residents that are transferred to hospital. Residents 27,37 and 13 reviewed Bed Hold upon admission and with transfer as occurred. Residents returned as anticipated. Review of all transfer/discharge in prior 30 days identified no other concerns. Staff provided re-education on Bed Hold before/upon transfer with applicable documentation and retention of record on 1-15-25. Social Service or designee will review all transfer/discharges daily to ensure applicable documentation-written notification provided for 3 months and report negative findings to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	01/15/2025

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	was given to Director of Nursing (DON) and she would ask the Assistant Director of Nursing (ADON) where the paperwork was located. During an interview on 1/13/25 at 2:00 P.M., the Clinical and Quality Consultant indicated the nurse who transferred Resident 27 to the hospital did not keep a copy of the bed hold paperwork. 2. On 1/6/25 at 1:02 P.M., Resident 37's clinical records were reviewed. Diagnoses included, but were not limited to atrial fibrillation, heart failure, dementia, depression, and psychotic disorder. The most current Annual MDS assessment, dated 9/6/24, indicated Resident 37 had severe cognitive impairment, required set up or clean up for eating, bed mobility, toilet use and transfer. Clinical records indicated Resident 37 was hospitalized on 2/24/24 to 2/29/24 for sepsis, chronic atrial fibrillation, cellulitus of right lower extremity, Streptococcal bacteremia and chronic right heart failure,11/1/24 to 11/12/24 for major neurocognitive disorder with behaviors, and 11/16/24 to 11/30/24 for cellulitus of the right leg, cellulitus of right little finger, sepsis secondary to cellulitus, fall, delirium and mood disorder with behavior disturbances. Clinical records lacked bed hold paperwork. During an interview on 1/9/24 at 4:43 P.M., the Clinical and Quality Consultant indicated they were still looking for the bed hold paperwork. 3. On 1/6/25 at 1:08 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, osteomyelitis, end stage renal disease, diabetes mellitus type II, and peripheral vascular disease.			

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	On 1/9/25 at 1:40 P.M., all completed bed hold notices from January 2024 to present were requested. During an interview on 1/9/25 at 4:40 P.M., the Clinical and Quality Consultant indicated Resident 13 was transferred and hospitalized on the following dates: 1/17/24, returned 1/20/24 6/7/24, returned 6/9/24 6/17/24, returned 6/19/24 9/23/24, returned 9/25/24 10/18/24, returned 12/3/24 1/2/25, returned 1/6/25 The clinical record lacked documentation of the resident and representative receiving a bed hold notice and policy at the time of the hospitalizations. During an interview on 1/13/25 at 2:05 P.M., the Clinical and Quality Consultant indicated she could not provide completed bed hold notices for the following dates: 1/17/24 6/7/24 6/17/24 9/23/24 10/18/24 1/2/25 During an interview on 1/13/25 at 2:05 P.M., the Clinical and Quality Consultant indicated when the resident was transferred, the bed hold notice should have been completed, copied, sent with the resident, and the copy should have been placed in the resident's clinical record. On 1/14/25 at 9:00 A.M., a current Bed Hold			

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	Policy, revised October 2017, was provided by the Clinical and Quality Consultant and indicated "Purpose: To provide notice in writing before transfer or a resident to a hospital ... at the time of transfer for a resident for hospitalization or therapeutic leave, the facility will provide to the resident and the resident representative written notice ... " 3.1-12(a)25 3.1-12(a)26			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview, and record review, the facility failed to provide adequate supervision and prevent falls for 2 of 6 residents reviewed for accidents. Fall assessments and care plans were not updated in a timely manner and family was not notified a fall. (Resident 44, Resident 33) Findings include: 1. On 1/6/25 at 1:23 P.M., Resident 44's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus, hypertension, and dementia. The most recent Significant Change Minimum Data Set (MDS) assessment, dated 11/5/24, indicated Resident 44 had a severe cognitive impairment, and he required substantial or maximal assistance on toileting and transferring. The MDS indicated Resident 44 had 2 or more falls since the last MDS assessment. Resident 44's care plans included, but were not limited to, a potential for falls, dated 11/8/24.	F 0689	Facility does provide environment that remains as free of accident hazards as possible with adequate supervision. Resident 44 and 33 families were notified of fall history and interventions. Assessments and care plans were updated for falls. Review of all resident records for falls in prior 30 days to ensure notifications, updated assessments and care plan completed. Licensed and Management staff provided re-education on Incident/Accident, fall assessment, fall investigation, notification expectations, care plans and applicable documentation on 1-15-25 and 1-17-25. Administrator or designee will review all incident/accident-falls to ensure fall assessments, care plans and notifications are	01/17/2025

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	Resident 44's fall history included, but was not limited to the following: Fall 1--1/12/24 Resident 44's clinical record lacked a care plan update and indicated the fall assessment for the 1/12/24 fall was completed on 2/5/24. Fall 2-- 2/15/24 Resident 44's clinical record lacked a care plan update and a fall assessment. Fall 3-- 11/5/24 Resident 44's clinical record indicated the fall assessment was completed on 11/14/24. Fall 4-- 11/18/24 Resident 44's clinical record indicated the fall assessment was not completed until 11/25/24, and Resident 44's family was not notified of the fall. Fall 5-- 11/29/24 Resident 44's clinical record lacked a care plan update. Fall 6-- 12/2/24 Resident 44's clinical record indicated the fall assessment was not completed until 1/9/25. Fall 7-- 1/2/25 Resident 44's clinical record indicated the fall assessment was not completed until 1/9/25. 2. On 1/6/25 at 1:50 P.M., Resident 33's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 10/10/24 indicated Resident 33 had a severe cognitive impairment and, and she required substantial or maximal		completed timely for 3 months and report negative findings to QAPI.	

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	assistance on toileting and transferring. Resident 33's care plans included, but were not limited to, a potential for falls, dated 11/8/24. Resident 44's fall history included, but was not limited to the following: Fall 1-- 11/5/24 Resident 33's clinical record lacked a fall assessment and notification to the family of the fall. During an interview on 1/14/25 at 10:31 A.M., the Clinical and Quality Consultant indicated family should be notified on same shift as the fall, the care plan should be updated immediately with every fall, and fall assessments should be completed within 4 hours of the fall. On 1/13/25 at 11:05 A.M., the Clinical and Quality Consultant provided a Fall Assessment and Prevention Protocol, revised 5/2024, that indicated, "...A new fall assessment will also be completed after each fall...Notify the POA (power of attorney) or other legal representative...Complete a new fall assessment...and discuss the new intervention that was immediately implemented...Update the resident care plan...with appropriate intervention(s) to keep resident safe..." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure each resident received necessary respiratory care and services	F 0695	Audit of all residents with current respiratory orders conducted to ensure appropriate dating of equipment, items	02/03/2025

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	in accordance with professional standards of practice for 3 of 3 residents reviewed for respiratory care. Oxygen tubing was not changed, portable oxygen tanks were not checked, and oxygen concentrator machine filters were not cleaned. (Resident C, Resident B, Resident D) Findings include: 1. On 1/2/25 at 1:57 P.M., Resident C was observed laying in bed wearing oxygen per nasal cannula at 2 liters per minute (LPM). The tubing was dated 12/8/24. The oxygen concentrator machine filter was soiled with dust and hair. On 1/8/25 at 9:57 A.M., Resident C was observed laying in bed wearing oxygen per nasal cannula at 2 LPM. The oxygen concentrator machine filter was soiled with dust and hair. During an observation of Room 409 on 1/13/25 11:40 A.M., the Maintenance Supervisor came into the room, observed the oxygen concentrator machine filter was soiled with dust and hair, indicated it needed to be cleaned, and took it to the Housekeeping Supervisor to have her clean it. On 1/6/25 at 12:20 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). The most recent Quarterly Minimum Data Set (MDS) assessment, dated 10/27/24, indicated Resident C's cognition was moderately impaired and was receiving oxygen therapy. Current Physician's Orders included, but were not limited to, the following: Change oxygen tubing one time per week on		changed/cleaned and preventative maintenance completed. Education of oxygen management and related expectations including – checking tank supply more frequently if higher liter flow, preventative maintenance of concentrators – filter change/cleaning and process was completed on 2-3-25. All orders updated to ensure applicable equipment changed same day of week as well as shift, Clinical Nurse Manager (ADON) will be verifying completion with progressive disciplinary process for any identified concerns. For 3 months, Clinical Nurse Manager (ADON) or designee will audit oxygen tubing and preventative maintenance of equipment weekly and perform random E-tank supply audit 5 days week with negative findings reported to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	

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	Sunday nights, ordered 5/19/24 Clean oxygen concentrator and filters (to be done by housekeeping and maintenance) one time per week on Monday mornings, ordered 5/19/24 A current COPD Care Plan, dated 7/7/24, included, but was not limited to the following intervention: Change oxygen tubing and clean concentrator weekly, initiated 7/7/24 During an interview on 1/13/25 at 9:43 A.M., Licensed Practical Nurse (LPN) 9 indicated the night nurse is responsible for changing the oxygen tubing weekly on Sunday nights. When the tubing was changed, it should be documented in the TAR and the tubing should have that date on it. 2. On 1/2/25 at 1:30 P.M., Resident D was observed lying in bed with head of the bed (hob) elevated wearing oxygen (O2) at 5 liters per minute (lpm) per nasal cannula. The filter on the back of the concentrator was dusty. On 1/8/25 at 9:44 A.M., Resident D was observed lying in bed with hob elevated with O2 on at 5 lpm per nasal cannula, television on, call light in reach, oxygen tubing was dated 1/5/25 and filter on the back of the oxygen concentrator was dusty. On 1/6/25 at 9:07 A.M., Resident D's clinical records were reviewed. Diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD), hypertension, and anxiety disorder. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/30/24, indicated Resident D had moderate cognitive impairment, required partial/moderate assistance with toilet use and bed mobility, set up or clean up assistance for eating, transfer was not attempted,			

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	on hospice and uses oxygen. Physician orders included, but were not limited to the following: RESPIRATORY TREATMENT: Administer oxygen 2.0 liter/min - 5 (per nasal cannula) continuous, dated 4/8/2024 RESPIRATORY TREATMENT: Clean O2 concentrator and filters to be done by housekeeping and maintenance 1 x wk, Monday A.M. , dated 05/19/2024 RESPIRATORY TREATMENT: Change oxygen tubing 1 x wk. Sunday night, dated 05/19/2024 During an interview on 1/9/25 at 10:28 A.M., Registered Nurse (RN) 3 indicated oxygen tubing was dated and changed weekly on Sunday, and the maintenance man cleaned oxygen concentrator filters on Monday. 3. On 1/9/25 at 10:25 A.M., Resident B was sitting in wheelchair at resident council meeting, O2 on per nasal cannula with portable tank, arrow on tank just above red. On 1/9/25 at 11:12 A.M. RN 3 went to activity room and indicated the portable oxygen tank was set at 4 lpm (liters per minute). The arrow on the portable tank was in the red area, and RN 3 indicated the tank was empty. RN 3 wheeled Resident B out of the activity room to replace portable O2 tank. On 1/9/25 at 11:14 A.M., RN 3 was observed checking Resident B's O2 saturation level. Oxygen saturation level was 92-97. At that time, Certified Nurse Aide (CNA) 37 replaced the portable O2			

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	tank with a new one and attached the nasal cannula. On 1/13/25 at 2:53 P.M., Resident B was observed sitting in wheelchair in activity room with O2 on at 4 lpm (liters per minute) per nasal cannula using the oxygen concentrator instead of a portable tank. On 1/9/25 at 3:20 P.M., Resident B's clinical records were reviewed. Diagnoses included, but were not limited to advanced dementia, atrial fibrillation, coronary artery disease, heart failure, chronic kidney disease, stage 3, and pneumonia. The Admission MDS assessment had not been completed. Resident B was admitted on 1/3/25. Physician orders included, but were not limited to the following: RESPIRATORY TREATMENT: Change oxygen tubing 1 x week. Sunday night, dated 1/3/2025 RESPIRATORY TREATMENT: Administer oxygen 4.0 liter/min (minute) (per nasal cannula) continuous, dated 1/3/2025 During an interview on 1/13/25 at 11:30 A.M., RN 3 indicated the portable O2 tanks were checked about 2 hours after they were changed since they only lasted about 2 hours. On 1/14/25 at 11:20 A.M., the Clinical and Quality Consultant provided an Oxygen-Appropriate Use, Management, and Storage policy, revised 9/2021, which indicated " Purpose was to follow current standards of practice with regard to oxygen supply changes, infection control practices, and safe storage...2. Oxygen Management: a...The skill			

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	of applying a nasal cannula or oxygen mask (not adjusting oxygen flow rate) can be delegated to Certified Nurse Aides (C.N.A.s)[sic]. The nurse is responsible for assessing the resident's respiratory system, response to oxygen therapy and setup of the oxygen therapy and liter flow, including the adjustment of oxygen flow rate...e. For oxygen supply changes, please ensure that in addition to the provider order for a 7-day (weekly) supply change, that you also document the weekly supply change in the Electronic Treatment Administration Record (eTAR) and date/initial the supply change on the product when put into use..." This citation relates to Complaint IN00450791. 3.1-47(a)(6)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on observation, interview, and record review, the facility failed to ensure competent nurse staffing necessary to provide services to meet resident rights and well-being for 1 of 3 residents reviewed for respiratory care and 1 random observation. A resident's order for an expectorant was not administered, a wound dressing was initiated without an order or notification to the physician, and a bandage was left on a resident for six days. (Resident 43, Resident 46) Findings include: 1. On 1/6/25 at 10:42 A.M., Resident 43's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and allergic rhinitis.	F 0726	Licensed nurses and Nurses aides are able to demonstrate competency and provide services to meet resident rights and wellbeing. LPN was counseled for not following expected protocol related to respiratory care and wound dressing. Resident 43 MD and family updated on medication not being administered. No other residents affected. Resident 46 MD and family updated with investigation that included resident records, notes/orders as well as interviews with staff and resident with an	01/15/2025

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	The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/24/24, indicated cognition status could not be assessed, and resident required substantial to maximal assistance with bed mobility and transfers, and was dependent on staff for toileting and bathing. Physician orders included, but were not limited to: guaifenesin ER (extended release) (an expectorant) 600 mg (milligrams) twice a day through 1/4/25, ordered 12/28/24. Medication was discontinued 1/2/25. Resident 43's Medication Administration Record (MAR) for December 2024 through January 2025 indicated guaifenesin had not been administered. Progress notes included, but were not limited to, the following: 12/28/24 at 1:37 P.M. Resident was lethargic, sinus congestion and cough. New order was placed for (guaifenesin). 12/29/24 at 7:04 P.M. guaifenesin held - medication unavailable. 12/30/24 at 6:44 A.M. guaifenesin held - medication unavailable. 12/30/24 at 7:26 P.M. guaifenesin held - medication unavailable. 12/31/24 at 6:53 A.M. guaifenesin held - medication unavailable. 12/31/24 at 6:58 P.M. guaifenesin held - medication unavailable.		in-house skin sweep completed to ensure no other residents affected. Nursing staff re-educated on 1-15-25 on services and skills to ensure resident care provided to meet individual resident needs including: Skin treatment guidelines, notification of DON if med /supplies not available, resident hygiene and personal cares. Weekly skin assessment added to TAR. Daily review 5 days week for 3 months of NN, EMAR/ETAR, 24-hour board and physician orders along with walking rounds by Director of Nursing or designee to identify medication unavailable, dressings appropriately signed/dated with documentation, lab draws documented with dressing removed and resident hygiene and personal care needs are met. Negative findings will be reported to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	

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	1/1/25 at 11:25 A.M. guaifenesin held - medication unavailable. 1/1/25 at 8:24 P.M. guaifenesin held - medication unavailable. On 1/8/25 at 9:33 A.M., Resident 43 was observed sitting in a recliner in the activity room coughing several times. On 1/9/25 at 10:16 A.M., Resident 43 was observed sitting in a recliner in the activity room coughing. On 1/9/25 at 8:50 A.M., the Clinical and Quality Consultant indicated when an over the counter medication was ordered, the nurse would let the Director of Nursing (DON) know. The DON would then order the medication through (pharmacy name). She indicated the medication was not ordered for Resident 43, and because the resident was not having symptoms that warranted the medication anymore, it was discontinued before it was given. On 1/14/25 at 9:30 A.M., the Regional Director indicated the nurse was supposed to check and see if there was a facility stock of the medication Resident 43 had been ordered, and then notify the DON if the facility did not have it. The nurse failed to notify the DON so it was not ordered. 2. On 1/8/25 at 9:41 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression. The most recent Annual Minimum Data Set (MDS) Assessment, dated 12/6/24, indicated a severe cognitive impairment and no behaviors.			

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	Resident 46 required substantial to maximal assistance with toileting, partial to moderate assistance with bed mobility and transfers, and was dependent on staff with bathing. Resident 46 had no skin conditions. Resident 46's clinical record lacked an order for skin treatments. A potential for tissue integrity impairment care plan, dated 9/3/24, indicated to assess skin status and keep the physician informed. Skin assessments included the following from September 2024 through January 2025: 9/30/24 pale and dry with no skin problems or lesions. 11/11/24 warm and dry. 12/13/24 pale, warm, and dry with no skin problems or lesions. On 1/8/25 at 1:32 P.M., Resident 46 was observed in her room sitting in a wheelchair. The resident's family member was observed sitting in front of her. At that time, a bandage was observed on the resident's left wrist/forearm and was dated 1/4/24. A dark area was observed seeping through the middle of the bandage. The family member indicated he had noticed the bandage when he got there, and had asked two staff members (did not remember who), and the staff members were unaware of why she had the bandage. On 1/9/25 at 10:01 A.M., Resident 46 was observed with Certified Nurse Aide (CNA) 45 and CNA 15 in her bathroom getting dressed. At that time, a bandage was observed on the resident's left wrist/forearm dated 1/8/25. A bandage was			

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	also observed in the crease of the left arm above the forearm (gauze type material with tape holding it on). CNA 45 and CNA 15 were unaware why the resident had the bandage on her wrist/forearm, and CNA 45 attempted to remove the tape from the inside of the elbow. The tape was stuck on the skin and the CNA was unable to remove it. She indicated at that time that she would notify the nurse to remove. On 1/9/25 at 10:51 A.M., Resident 46 was observed sitting in a wheelchair at the nurses station. Licensed Practical Nurse (LPN) 9 indicated Resident 46 had a skin tear on the left wrist, and she had changed the dressing the day before because she noticed the would was seeping through the dressing that was on. She indicated at that time she was unaware how or when the skin tear occurred, and there was not a physician's order for the dressing. She indicated she was unaware of the tape on the resident's arm, and was from a blood draw that was done on 1/3/25 (6 days prior). At that time, she rolled the resident's left sleeve up and removed the tape which was stuck tightly to the resident's skin. On 1/9/25 at 2:10 P.M., Registered Nurse (RN) 3 indicated all dressings required a physician's order to change. If there was no order, the nurse should call the physician to get the order. She further indicated bandages left from a blood draw should be removed by the nurse within 24 hours. On 1/9/25 at 2:50 P.M., the Clinical and Quality Consultant indicated when a resident experienced a skin tear, it was facility protocol to cover the area and notify the physician. If not that day, then by the next business day. She indicated Resident 46 did not have an order for the treatment given to her left arm.			

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	On 1/13/25 at 10:14 A.M., RN 3 indicated not all residents received a skin assessment weekly. Only if they have a treatment they would have an order for a weekly skin assessment. On 1/13/25 at 2:12 P.M. the Clinical and Quality Consultant indicated skin assessments should be performed on every residents weekly. She further indicated nurses should obtain a treatment order after doing any first aid for residents. On 1/9/25 at 2:00 P.M., the Clinical and Quality Consultant provided a current Physician Order Summary policy, dated 6/2022, that indicated "It is the policy of this facility to ensure medication and treatment accuracy by a review of each resident's monthly Physician Order Summary (POS), Medication Administration Records (MAR), and Treatment Administration Records (TAR) by a licensed nurse" On 1/9/25 at 2:00 P.M., the Clinical and Quality Consultant provided a current House Supplied (Floor Stock) Medications policy, dated 5/21/18, that indicated "The facility maintains a supply of commonly used over-the-counter medications considered as floor stock or house medications as permitted by state regulation" On 1/14/25 at 9:00 A.M., the Clinical and Quality Consultant provided a current Skin Care Management policy, dated 9/2024, that indicated "Skin integrity will be monitored at least weekly on the resident's bath day for all residents that are identified at risk ... Initial wound documentation will be entered into the Pressure-Injury Assessment folder (for any pressure-injuries) or Non-Pressure Wounds folder (for all other wound types) ... The treatment protocol will be initiated			

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	using the Skin Treatment Management Protocol and the attending physician orders ... The nurse will notify the resident's responsible party of any skin integrity issues and/or changes in treatment and document this in the nursing progress notes" On 1/14/25 at 9:00 A.M., the Regional Director provided a current Notification of Director of Nursing policy, dated 11/2023, that indicated "It is the policy of this facility to ensure timely notification by the charge nurse to the Director of Nursing or designee, regardless of time of day, of emergency situations ... Any situation of ordered but unavailable supplies, medications or equipment" 3.1-14(a)(1) 3.1-25(l)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted and contained the correct information daily for 6 of 6 days reviewed. (January 2, 3, 8, 9, 13, 14, 2025) Findings include: On 1/2/25 at 10:24 A.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly with the Day Shift section filled out. Under the column Shift and Schedule-Day- 6:00-2:00, 6:30-2:30, 7:00-3:00. Under the Registered Nurse (RN) Nursing Staff-Actual Hours Worked 8, Staffing Total 1. Under the Licensed Practical Nurse (LPN) Nursing Staff-Actual Hours Worked 8, Staffing Total 1. Under the Non Licensed Nursing Staff-Actual	F 0732	Facility does post daily staffing form at nurses' desk that is prominent and accessible to residents and visitors. No residents were affected by this alleged deficiency and facility does have policy with guidance on completion of posted information. Licensed Staff provided education on entering correct information to ensure accurately reflects with current staffing pattern on 1-17-25. Clinical Nurse Manager (ADON) or designee will verify posted nurse staffing information daily for 3 months. Negative findings will be reported to QAPI. Monitoring will	01/17/2025

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	Hours worked 30, Staffing Total 4. It did not differentiate what hours the staff worked. On 1/3/25 at 1:06 P.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly with the Day Shift section filled out. Under the column Shift and Schedule-Day- 6:00-2:00, 6:30-2:30, 7:00-3:00. Under the RN Nursing Staff-Actual Hours Worked 16, Staffing Total 2. Under the LPN Nursing Staff-Actual Hours Worked 0, Staffing Total 0. Under the Non Licensed Nursing Staff-Actual Hours worked 40, Staffing Total 5. It did not differentiate what hours the staff worked. On 1/8/25 at 9:48 A.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly with the Day Shift section filled out. Under the column Shift and Schedule-Day- 6:00-2:00, 6:30-2:30, 7:00-3:00. Under the RN Nursing Staff-Actual Hours Worked 8, Staffing Total 1. Under the LPN Nursing Staff-Actual Hours Worked 8, Staffing Total 1. Under the Non Licensed Nursing Staff-Actual Hours worked 37.5, Staffing Total 5. It did not differentiate what hours the staff worked. On 1/8/25 at 3:05 P.M., Posted Nurse Staffing Evening-2:30-10:45, 2:30-11:00, RN had been filled out with Actual Hours Worked 16, Staffing Total 1.5, LPN 0, and nothing under Non Licensed Staff. It did not differentiate what hours the staff worked. On 1/9/25 at 11:00 A.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly. Under the column Shift and Schedule-Day- 6:00-2:00, 6:30-2:30, 7:00-3:00. Under the RN Nursing Staff-Actual		continue until 4 consecutive weeks with 100% compliance is achieved.	

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	Hours Worked 8, Staffing Total 1. Under the LPN Nursing Staff-Actual Hours Worked 8, Staffing Total 1. Under the Non Licensed Nursing Staff-Actual Hours worked 38, Staffing Total 5. It did not differentiate what hours the staff worked. On 1/9/25 at 3:34 P.M., Posted Nurse Staffing was observed to only have the Day Shift portion filled out. No additional information had been added for the evening shift. On 1/13/25 at 10:15 A.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly with the Day Shift section filled out. It did not differentiate what hours the staff worked. On 1/13/25 at 3:00 P.M., Posted Nurse Staffing still only had the Day Shift portion filled out. No additional information had been added for the evening shift. On 1/14/25 at 9:25 A.M., Posted Nurse Staffing was observed hanging on the wall behind the nurse's desk dated correctly with all sections filled out. It did not differentiate what hours the staff worked. During an interview on 1/14/25 at 9:33 A.M., the Assistant Director of Nursing (ADON) indicated the shift nurse filled out Posted Nurse Staffing when they arrived for their shift. She indicated the hours they worked should be filled out under Shift and Schedule to differentiate who was working which hours. If two staff members worked 1/2 shift each, they only counted that as one staff member. She indicated the nurses worked from 6 A.M. to 2:00 P.M. On 1/14/25 at 1:42 P.M. the Clinical and Quality			

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	Consultant indicated they didn't have a specific policy for Posted Nurse Staffing, but they followed the federal guidelines.			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to ensure person-centered dementia treatment and services were provided for 2 of 4 residents reviewed for dementia care. (Resident 46, Resident 47) Findings include: 1. On 1/2/25 at 11:14 A.M., Resident 46 was observed sitting in a wheelchair in front of the nurses station with her head drooped down and eyes closed. Staff were observed walking by the resident without engaging. On 1/8/25 at 9:12 A.M., Resident 46 was observed sitting in a wheelchair by the nurses station with her eyes closed. Staff were observed walking by the resident without engaging. On 1/8/25 at 9:34 A.M., Resident 46 was assisted to the activities room and transferred from a wheelchair to a recliner facing a television. On 1/8/25 at 1:32 P.M., Resident 46 was observed sitting in her room in a wheelchair with a family member. The family member indicated when he got to the facility that day, Resident 46 was sitting at the nurses station weeping. On 1/9/25 at 10:51 A.M., Resident 46 was observed sitting in a wheelchair at the nurses station. Staff were observed walking by the resident without engaging.	F 0744	Facility provides appropriate treatment and services to attain or maintain resident highest practicable physical, mental and psychosocial well-being. Resident 46 and 47 individual care plans were reviewed and revised with input from family to ensure staff are providing appropriate services while encouraging meaningful resident centered physical activity and stimulation. Other residents with dementia diagnosis reviewed as potentially affected, if indicated care plan revisions completed. Activity room rearranged to promote more individual -interactive opportunities. Staff dementia training to be completed by 2-12-25 Administrator or designee will conduct random observations at varied times across all shifts 5 days week for 30 days then 3 days a week for 30 days then weekly for 3 months to ensure ongoing compliance. Negative findings will be reported to QAPI.	02/12/2025

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	On 1/9/25 at 2:03 P.M., Resident 46 was observed sitting in a recliner in the activity room facing a television. Her left sock and shoe were both off and the resident was grimacing while moving around in the recliner, leaving forward and pulling knees up. During a continuous observation on 1/13/25 from 10:03 A.M. until 11:00 A.M., Resident 46 was observed sitting in a recliner in the activity room facing a television with an activity going on behind her. At 10:49 A.M., the resident was brought to the nurses station in a wheelchair. Nothing was given to the resident for stimulation, and the resident was observed fidgeting. Staff was not engaging with the resident. On 1/8/25 at 9:41 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression. The most recent Annual Minimum Data Set (MDS) assessment, dated 12/6/24, indicated a severe cognitive impairment and no behaviors. Resident 46 required substantial to maximal assistance with toileting, partial to moderate assistance with bed mobility and transfers, and was dependent on staff with bathing. A dementia care plan, dated 9/4/24, indicated nurses should engage in conversation and encourage participation. Nurse's aides should encourage attendance and participation in scheduled activities, and offer conversation, snacks and other interventions as needed. Resident 46 experienced 5 falls from 2/2024 through 12/2024, all unwitnessed and resident was			

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	found on the floor. On 1/9/25 at 2:20 P.M., Registered Nurse (RN) 3 indicated Resident 46 enjoyed taking walks, liked candy, and getting her nails and hair done. She indicated at that time that dementia care consisted of an individualized plan of care for each resident. 2. On 1/2/25 at 11:12 A.M., Resident 47 was observed sitting in a wheelchair at the nurses station. The resident was talking nonsensical to herself and Licensed Practical Nurse (LPN) 9. The resident was observed to attempt to get up out of the wheelchair several times and LPN 9 attempted to redirect. LPN 9 was observed indicating to the resident "what are you doing?", "huh?", "stay right there, stay right there", and "you can't get up, you have to sit down and get ready for lunch. After each interaction with the resident, LPN 9 turned to work on the computer, and Resident 47 continued to fidget and move around. On 1/2/25 at 1:11 P.M., Resident 47 was observed sitting in a wheelchair at the nurses station with no supervision. The kitchen manager came by the nurses station, as well as the Clinical and Quality Consultant, and staff did not engage with the resident. The resident was observed with nothing in her lap or hands. On 1/8/25 at 9:18 A.M., Resident 47 was observed sitting in a wheelchair in the activity room closing her eyes off and on. At that time, there was music being played from the television. On 1/8/25 at 1:28 P.M., Resident 47 was observed sitting in a wheelchair by the nurses station with nothing in her hands or lap. She was not talking with one hand on her forehead. Staff was not engaging with the resident.			

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	On 1/9/25 at 9:12 A.M., Resident 47 was observed sitting in a recliner in the activity room facing a television. On 1/9/25 at 11:01 A.M., Resident 47 was observed still sitting in the recliner in the activity room facing a television. At that time there was a blanket over her and she was holding the blanket. On 1/9/25 at 2:21 P.M., Resident 47 was observed sitting in a wheelchair at the nurses station. At that time, Licensed Practical Nurse (RN) 3 indicated staff sat the resident at the nurses station because she likes to get up. She indicated Resident 47 was not easily directed and could "get feisty". Talking to her would worked sometimes. She indicated the activity room had activity boards for the residents to use to keep busy, but there were none at the nurses station. During a continuous observation on 1/13/25 from 10:03 A.M. until 10:53 A.M., Resident 47 was observed sitting in a wheelchair at the nurses station with nothing to do, fidgeting with the wheelchair, seat, handles, her pants, socks, hands, hair, and arms. Staff walking by and at the nurses station did not acknowledge the resident or attempt to engage with her. At 10:28 A.M., the Assistant Director of Nursing (ADON) sat at the nurses station and asked the resident how she was, then turned away from the resident. At 10:53 A.M., Certified Nurse Aide (CNA) 45 pushed the resident away from the nurses station and down the hall. On 1/6/25 at 10:29 A.M., Resident 47's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and depression.			

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	The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/29/24, indicated a severe cognitive impairment and no behaviors. Resident 47 required partial to moderate assistance with bed mobility and transfers, and was dependent on staff for toileting and bathing. An alteration in thought processes related to dementia care plan, dated 11/6/24, indicated to ask the resident to play ball toss/balloon toss, sing-along activity, and include resident in reminiscing activities. On 1/13/25 at 2:12 P.M., the Clinical and Quality Consultant indicated dementia care consisted of individualized plans for each resident. On 1/14/25 at 9:00 A.M., the Clinical and Quality Consultant provided a current Dementia Management policy, dated 9/2022, that indicated "To ensure that facility staff members understand the needs of residents who display or are diagnosed with dementia and provide appropriate treatment and services to meet the highest practicable physical, mental, and psychosocial well-being of these individuals ... Encouraging meaningful resident-centered physical activity ... Providing meaningful stimulation (to avoid boredom) ... Ensuring an adequate number and type of activities on all shifts" 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review the facility failed to ensure proper storage of medications in 2 of 3 medication carts. Narcotic boxes were not double locked in the medication	F 0761	Facility storage of drugs and biologicals are in accordance with state and federal laws. There are separately locked compartments	01/16/2025

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	carts. (200 Hall medication cart, 400 Hall medication cart) Findings include: 1. On 1/2/25 at 9:58 A.M., the narcotic box was observed unlocked in the 200 Hall medication cart. On 1/9/25 at 11:23 A.M., the narcotic box was observed unlocked in the 200 Hall medication cart. 2. On 1/2/25 at 10:00 A.M., the narcotic box was observed unlocked in the 400 Hall medication cart. During an interview on 1/2/25 at 10:03 A.M., Registered Nurse (RN) 21 indicated the narcotic boxes in the medication carts should be locked when not in use. On 1/14/25 at 11:20 A.M., a current Controlled Substances Policy, revised April 2021, was provided by the Clinical and Quality Consultant and indicated "Purpose: To ensure appropriate and consistent procedures for safeguarding controlled substances are followed from deliver through the actual administration and/or destruction of the medications ... all schedule 2 [two] controlled substances must be stored in double locked areas ... " 3.1-25(m)		for storage of controlled medications. Carts were checked to ensure locking mechanisms functioning. Re-education was provided to licensed staff on medication storage, double locking of controlled substances and medication carts on 1-16-25. Clinical Nurse Manager (ADON) or designee will randomly check all med carts across all shifts 10 times weekly for 1 month, then 5 times weekly for 1 month then weekly for 3 months to ensure ongoing compliance. Negative Findings will be reported to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 4 residents during observation of incontinence care and 7 of	F 0880	Facility does have infection prevention and control program designed to provide safe, sanitary and comfortable environment for residents and to help prevent the	02/12/2025

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	16 observations of medication administration. Gloves were not changed and hand hygiene was not performed between dirty and clean tasks during peri care, hand hygiene was not performed prior to administering medications, and staff performed a 2 second hand lather. (Resident B, Resident F, Resident 37, Resident 12, Resident 14, Resident 39, Resident 46, Resident 2, Resident 41). Findings include: 1. On 1/13/25 at 11:04 A.M., Resident B transferred from the wheelchair to the toilet by Certified Nurse Aide (CNA) 37 and CNA 41. CNA 37 used both gloved hands to remove the foot pedals on Resident B's wheelchair. CNA 37 failed to change gloves and perform hand hygiene before she removed Resident B's incontinence pad. CNA 37 removed the soiled brief and failed to change gloves or perform hand hygiene before she put the clean incontinence pad on Resident B. CNA 37 then wrapped toilet paper around her gloved hands and gave the toilet paper to CNA 41. CNA 41 wiped the resident, removed her gloves, and failed to perform hand hygiene prior to putting the gait belt on Resident B. 2. During an observation on 1/9/25 at 11:23 A.M., Registered Nurse (RN) 3 passed medications to Resident 37. After the medications were given, RN 3 performed an 8 second hand lather. 3. During an observation on 1/9/25 at 11:34 A.M., RN 3 passed medications to Resident 13. After the medications were given, RN 3 performed a 2 second hand lather. 4. During a medication pass on 1/9/25 at 11:10 A.M., staff was observed not washing hands or using antibacterial hand rub (ABHR) before or after administering medications to the following		development of transmission of communicable disease and infections. All staff review of WHO Hand Hygiene protocols including glove use, hand washing and hand rub with demonstration and competency will be completed by 2-12-25 Re-education with nurse aides on perineal hygiene including return competencies will be completed by 2-12-25 Re-education with licensed staff on hand hygiene with medication pass with return competencies completed by 2-12-25 Clinical Nurse Manager (ADON) or designee will conduct 30 random HH opportunities across all shifts, with medication passes and perineal cares weekly x 4 weeks then monthly to ensure ongoing compliance. Negative Findings will be reported to QAPI. Auditing is a facility best practice and is ongoing.	

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	residents: Resident 14 Resident 39 Resident 46 Resident 2 Resident 41 5. On 1/9/25 at 3:55 P.M., incontinence care performed on Resident F by Certified Nurse Aides (CNA)45 and CNA 41 was observed. Both CNAs put gloves on, attached hoyer straps, CNA 45 operated the mechanical lift controls while CNA 41 moved the vacated wheelchair out of the way. Once Resident F was laid in her bed, both CNAs unhooked the lift pad from the lift. CNA 45 performed perineal care while CNA 41 held the resident on her left side. CNA 45 removed Resident F's pants and CNA 41 unfastened the soiled incontinence pad. CNA 45 took off the soiled incontinence pad and discarded it in the trash can. CNA 45 grabbed a wipe and wiped the resident's backside from front to back, folded the wipe, and wiped again from front to back. CNA 45 removed her gloves and put a new pair of gloves on without sanitizing her hands. Resident 41 was rolled onto her back and CNA 45 grabbed a new wipe, wiped the resident's vaginal area, from top to bottom, folded the wipe, and wiped again. CNA 45 and CNA 41 assisted the resident back to her left side, placed a clean incontinence pad under Resident F, rolled her back onto her back, fastened the new incontinence pad, and put resident F's pants back on. Both CNAs removed their gloves. After transferring the resident with the mechanical lift back into the wheelchair, CNA 45 removed the mechanical lift from the room and wiped the lift down with a disinfectant wipe. CNA 41 pushed Resident F up the hallway to the nurse's station. Neither CNAs were observed			

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	sanitizing their hands after leaving Resident F's room. During an interview on 1/14/25 at 10:56 A.M., the Assistant Director of Nursing (ADON) indicated prior to providing incontinence care, staff should remove gloves and perform hand hygiene after touching random items, she would expect staff to perform hand hygiene and change gloves between dirty to clean tasks, and perform hand hygiene prior to and after providing care and medication passes. When washing hands, staff should lather with soap 45-60 seconds. When performing perineal or incontinence care, staff should clean the front side and then the back side. On 1/14/25 at 11:20 A.M., a current Medication Administration General Guidelines Policy, reviewed 5/21/18, was provided by the Clinical and Quality Consultant and indicated " ... hand hygiene is completed before and after every medication preparation or administration ... " On 1/14/25 at 1:40 P.M., a current Hand Hygiene handout used as the policy, revised August 2009, was provided by the Clinical and Quality Consultant and indicated " ... Duration of the entire procedure for hand washing (if hands are visibly soiled): 40-60 seconds ... Duration of the entire procedure for using hand rub: 20-30 seconds ... [should be performed] before touching a patient ... before clean/aseptic procedure ... after body fluid exposure risk ... after touching a patient ... after touching patient surroundings ... the use of gloves does not replace the need for cleaning your hands ... " On 1/14/25 at 1:40 P.M., a current non dated Perineal Care handout used as the policy, was provided by the Clinical and Quality Consultant			

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	and indicated " ... wash and dry patient's upper thighs. washed labia majora, retract labia from thigh with nondominant hand, use dominant hand to wash skinfolds, wiped front to back, repeated on opposite side with separate section of wash cloth, rinse and dry area thoroughly. Separate labia wash urethral meatus and vaginal orifice front to back use separate section of cloth for each stroke, rinse and dry area thoroughly ... " 3.1-18(l)			
F 0882 SS=E Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist (IP) worked at least part-time at that facility, and the interim IP lacked an infection control certification. Finding includes: During an interview on 1/13/25 at 1:47 P.M., the Clinical and Quality Consultant indicated the Director of Nursing (DON) is the IP, but she was currently out on leave, and the interim IP was the Assistant Director of Nursing (ADON) . At that time, she indicated the ADON lacked a certification related to infection control. During an interview on 1/14/25 at 9:24 A.M., the Clinical and Quality Consultant indicated the facility lacked documentation on how many hours were dedicated to IP. At that time, she indicated the DON had a weekly schedule that she followed. During an interview on 1/14/25 at 10:56 A.M., the ADON indicated the DON was the IP. At that time, she further indicated that she was the interim	F 0882	Facility does have designated infection preventionist (IP) that has completed professional training and works full time. The Clinical Nurse Manager is completing the approved course. In any absence or the Facility ICP, IP duties are assigned to the Clinical Nurse Manager with assistance from the Clinical and Quality Consultant who is IP certified. The Clinical and Quality Consultant will be on site weekly to confer and assure surveillance is being conducted. There are multiple corporate Clinical Infection Professional certified support persons she can consult with as needed. Clinical and Quality Consultant will provide support and off-site remote review of all resident records as well to ensure identification of potential outbreaks. Frequent walking rounds are	01/15/2025

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	IP when the DON was not in the building, but she was not certified. On 1/14/25 at 1:40 P.M., the Director of Nursing weekly routine provided by the Clinical and Quality Consultant was provided. The DON weekly routine had Thursday's dedicated to infection control, and lacked any other infection control days for the rest of the week. On 1/13/25 at 2:00 P.M., the Administrator provided an Infection prevention and Control Officer job description, revised 1/2017, that indicated, "At least a part time clinical who is responsible for supporting the facilities systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents and others in the facility...will have specialized training and education in infection prevention and control beyond their initial professional degree..."		completed daily to observe residents for any onset of symptoms as component of daily surveillance with IDT in addition to reviews in stand-up meeting with NN, 24-hour report, assignment sheets and staff attendance to identify any potential symptom to ensure immediate mitigation. Infection control entries in electronic record and employee log are maintained. The administrator or designee will review these daily for any issues for 4 weeks and then 2 times weekly for an additional 2 months and in any extended absence of the facility ICP . Negative results will be reported to the QAPI committee. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure a sanitary and home-like environment for 3 of 3 halls, 1 of 1 shower rooms reviewed for environment, and 19 of 19 resident personal refrigerator temperature logs reviewed. Personal items and linens were not labeled and uncovered, vent fans were caked with dust, toilets were soiled, paint was missing, baseboards were falling off or missing, and a toilet seat riser was uncovered on the floor under the sink in the shower rooms. (200 Hall, 300 Hall, 400 Hall, Shower Room, Room 212, Room 208-1, Room 317, Room 208-2, Room 216-1, Room 306, Room 302,	F 0921	Facility provides safe, functional sanitary and comfortable environment for residents, staff and the public. All areas identified were corrected with deep cleaning or repairs. Rounds were conducted to ensure or correct any other areas requiring deep cleaning or repairs. Housekeeper was counseled for documentation of resident fridge temperatures. Environmental Services and	01/28/2025

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	Room 416, Room 415, Room 414, Room 409-1, Room 406, Room 408-2, Room 404-1, Room 407-1, Room 407-2, Room 303, Room 216-2, Room 409-2) Findings include: 1. On 1/2/25 at 10:49 A.M., the following was observed in the shower room: blinds were dusty and broken, towels and wash cloths were stored uncovered on top of a storage bin, a pair of blue checked socks were laying on the floor, two pairs of pants and shirts were laying on a cabinet uncovered, an unlabeled comb and brush were laying on cabinet, missing tiles along baseboard of shower, paint chipping off wall corners, piece of baseboard tile laying in the very back corner, cobweb hanging from the ceiling in shower, bugs in light covers by shower, unlabeled bottle of shampoo/conditioner combo, exfoliating scrub, two bottles of body wash on handrails in shower not labeled, a dent in the wall by cabinet in toilet area, a pair of pants and a shirt were hanging uncovered on the handrail by the toilet, a brown substance on back of the toilet seat and side of lid closest to the sink, yellow water in the toilet, caulk around toilet soiled with brown substance and coming off, toilet seat riser behind trash can on the floor under sink uncovered, unlabeled hair brush laying on top of sharps container, fan inside door is coming down from ceiling, cobweb hanging from ceiling behind the door, sink water temperature was 56.6 degrees Fahrenheit On 1/13/25 at 11:16 A.M., the following was observed in the shower room: blinds were dusty and broken, towels and wash cloths were stored uncovered on top of a storage bin, a drawer of storage bin open and full of miscellaneous large bottles lotions, body washes,		Maintenance received education on the Facility Maintenance Requests Policy and Cleaning policies All Housekeeping Staff received education on the housekeeping job description 1-28-25 All staff educated on the use of the Maintenance (environmental) request policy, linen management and personal items requiring label /bagging. To ensure continued compliance, the maintenance request book will be brought to the daily Stand-up meeting for review. The Administrator or designee shall complete environmental observations of resident rooms one time per week for 3 months and report negative findings to QAPI. Monitoring will continue until 4 consecutive weeks with 100% compliance is achieved, however, ongoing monitoring of the facility environment will continue per facility policy.	

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	and shampoos, bottles of bathing soaps on handrails in shower unlabeled, cobweb hanging from the ceiling in the shower, bugs in the light covers by the shower, a dent in the wall by cabinet in toilet area, two pairs of pants and a shirt were hanging uncovered on the handrail by the toilet, toilet seat riser on floor uncovered under sink, cobweb hanging from the ceiling behind the door. At that time, Certified Nurse Aide (CNA) 15 indicated staff put the resident's clothing in the shower room to change some of the residents and she was not sure how long they had been in there. She also indicated staff use the bottles of bathing soaps in shower on multiple residents if they don't have their own. 2. During an observation of Room 409 (shared by two residents) on 1/2/25 at 2:02 P.M., the following was observed: vent on wall over bed has blackened on the cover and on the ceiling near it, the portable fan in the room was caked with dust, paint missing and scrapes by both beds, individual refrigerator temperature in room 409-2 was observed to be 44 degrees Fahrenheit, log sheet on the front of the refrigerator was dated for December 2024 and the last temperature completed for it was 12/20/24 During an observation of Room 409 (shared by two residents) on 1/13/25 at 11:38 A.M., the same was observed. The individual refrigerator temperature in room 409-2 was observed to be 44 degrees Fahrenheit, log sheet on the front of the refrigerator was dated for January 2025 and the last temperature completed for it was 1/8/25. During an observation of Room 409 on 1/13/25 11:40 A.M., the Maintenance Supervisor came into the room, observed the same refrigerator (409-2), filled in the 8th, 9th, and 13th of January			

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LODGE OF THE WABASH	723 E RAMSEY RD VINCENNES, IN 47591

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	2025 with a temperature of 40 degrees Fahrenheit. At that time, he indicated the Housekeeping Supervisor usually took temperatures once a day but she was out this weekend so it wasn't done. 3. During an observation of Room 414 (shared by two residents) on 1/2/25 at 1:28 P.M., the following was observed: baseboard coming off by bathroom door, uncovered incontinence pad on back of the toilet, vent on wall above bed was blackened, coming away from the ceiling, and the ceiling and wall near the vent was blackened, 3 toothbrushes uncovered and unlabeled by sink in bathroom During an observation of Room 414 (shared by two residents) on 1/8/25 at 10:12 A.M., the same was observed except an uncovered incontinence pad was laying on the shower chair in the bathtub and not on the back of the toilet. 4. During an observation of Room 416 (only one resident) on 1/2/25 at 1:22 P.M., the following was observed: brown substance was on the wall close to the television near the bedside commode, towels laying in the bathtub uncovered, cobwebs in corner of bathroom hanging from ceiling, red substance splattered on and in sink, baseboard missing by entrance to bathroom door During an observation of Room 416 (only one resident) on 1/8/25 at 9:55 A.M., the baseboard was still missing by entrance to bathroom door. 5. On 1/2/25 at 1:16 P.M., the entire 400 Hall was observed with a strong bowel movement odor. On 1/8/24 at 9:55 A.M., the same was observed.			

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	6. On 1/2/25 at 10:35 A.M., the 400 Hall carpet in the hallway was observed with debris and the baseboard was falling off the wall by the kitchen door. On 1/13/25 at 11:26 A.M., the baseboard was still falling off the wall by the kitchen door in the 400 Hall. 7. On 1/13/25 at 12:00 P.M., copies of the resident refrigerator temperature logs for December 2024 were requested for Rooms 208, Room 409-2. On 1/13/25 at 12:11 P.M., the following mirror image copies of 19 resident refrigerator temperatures were provided by the Maintenance Supervisor and indicated each refrigerator temperature was 40 degrees Fahrenheit every day of December 2024 and initialed by the Housekeeping Supervisor: Room 212, Room 208-1, Room 317, Room 208-2, Room 216-1, Room 306, Room 302, Room 416, Room 415, Room 414, Room 409-1, Room 406, Room 408-2, Room 404-1, Room 407-1, Room 407-2, Room 303, Room 216-2, Room 409-2. During an interview on 1/8/25 at 9:59 A.M., Housekeeper 31 indicated housekeeping should clean around the bed, floors, and vents above bed when resident's were not in the room, usually at lunch. She indicated she did not clean resident's fan in room 409-2 and was not sure who should clean fans. She indicated there really was no checklist to follow when she was cleaning, but when she worked, she started cleaning in the activity room, emptied trash, and swept and mopped floors. Then she did the same thing in the break room, clean utility, and went down the halls to clean the rooms and indicated the cleaning should be done daily. There were usually two housekeepers and one cleaned the 400 and 200 Halls and the other does 100 and 300 Halls but			

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	sometimes only one housekeeper which made it hard to get to everything completed. She indicated the 400 Hall was the worst with odors usually because a lot of the residents on that hall have accidents (incontinence). Sometimes resident incontinence pads sit in the trash and housekeepers just find soiled toilets instead of notifying housekeeping that something needs cleaned. She indicated the Housekeeping Supervisor checked the temperatures of the resident's refrigerators. During an interview on 1/13/25 at 11:40 A.M., the Maintenance Supervisor indicated when staff noticed things of concern, they were supposed to fill out a work order in the work order book behind the nurse's station for non urgent things and he checked it every morning. If it was an urgent concern, staff should call him day or night. He indicated there was a shortage of housekeeping and maintenance staff so they were trying to catch up. He indicated the blackened vents of 400 Hall rooms were dirty and he did have a calendar for deep cleaning rooms and those should be part of that cleaning, but staff do not document anywhere that it was done. Resident rooms, bathrooms, hallways, and shower rooms should be cleaned daily. The Housekeeping Supervisor was mostly responsible for taking the resident refrigerator temperatures daily and should write it on the log on the front of the refrigerator. The portable fans should be cleaned by staff when dust appeared otherwise it just got blown all over. He indicated there were checklists filled out after each cleaning daily and filed in the maintenance office. During an interview on 1/13/25 at 1:56 P.M., the Housekeeping Supervisor indicated she was responsible for taking the temperatures of the			

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	resident refrigerators daily and filling out the resident refrigerator logs. When she was off work, she told the housekeeping staff to check the temperatures for her, write the temperatures down, and she would put them on the log when she returned to work. All the temperatures and initials match exactly because she was the one who filled them out. At that time, she indicated the refrigerator temperatures usually hang around 40 degrees Fahrenheit. During an interview on 1/14/25 at 10:56 A.M., the Assistant Director of Nursing (ADON) indicated clothing should be stored in resident's closets and brought into the shower room in a bag when they shower and should go in the soiled linens if they were brought in and not used and linens such as wash cloths and towels should be covered. Personal items should be labeled and covered.8. On 1/2/25 at 10:40 A.M., Resident 44's room was observed with debris scattered throughout the room and spiderwebs on the ceiling in the bathroom. On 1/13/25 at 11:18 A.M., the same was observed in Resident 44's room and bathroom. 9. On 1/2/25 at 10:43 A.M., Resident 32's door to enter the room had a loose circular piece behind the doorknob. On 1/13/25 at 11:21 A.M., Resident 32's piece behind the doorknob was still loose. During an observation on 1/2/25 at 1:22 P.M., Resident 32's refrigerator in his room had a refrigerator log on it that lacked a refrigerator temperature from December 15, 2024 through December 31, 2024. At that time, Resident 32 indicated he used the refrigerator.			

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	During an observation on 1/13/25 at 12:02 P.M., Resident 32's refrigerator had a January temperature log that lacked a recorded temperature on the following dates: 1/1, 1/4, 1/5, 1/6, 1/7, 1/9/, 1/10, 1/11, 1/12. 10. During an observation on 1/2/25 at 1:53 P.M., Resident 26's refrigerator in her room had a refrigerator log on it that lacked a refrigerator temperature from December 15, 2024 through December 31, 2024. At that time, Resident 26 indicated she used the refrigerator. 11. During an interview on 1/2/25 at 02:11 P.M., a family member of one of the residents in Room 401 indicated he didn't feel like the place was clean, and the room spelled like urine during his last visit. On 1/13/25 at 10:13 A.M., Room 401 was observed to have multiple brown spots on floor next to bed A and in front of the bedside cabinet. There was no smell of urine in the room. On 1/14/25 at 11:22 A.M., Room 401 was observed to have multiple brown spots on floor next to bed A and in front of bedside cabinet. 12. On 1/3/25 at 1:33 P.M., in Room 402's bathroom, a bar of soap was observed on the sink, white with brown edges and the call light chain was wrapped around the grab bar two times and was rusty. On 1/13/25 at 10:06 A.M., in Room 402's bathroom, a small bar of white soap with brown edges was observed laying on a wire shelf, call light chain was wrapped around the grab bar twice and rusty, and trash can was overflowing with paper towels laying on the floor.			

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	13. On 1/3/25 at 1:37 P.M., in Room 406's bathroom, the toilet paper holder (bar/tube that holds the toilet paper) was observed to be missing, toilet paper was sitting on the grab bar above the holder, call light chain was too long, resting on the floor behind and underneath the trash can and chain was dark and rusty. On 1/13/25 at 10:25 A.M., in Room 406's bathroom, toilet paper holder was observed to be missing, toilet paper was sitting on the grab bar above the holder, call light chain was still hanging down to floor and rusty, and there was brown water in toilet. During an interview on 1/13/25 at 2:01 P.M., the housekeeping supervisor indicated rooms were cleaned daily, the floors were cleaned, the bathrooms were cleaned, and the trash emptied.14. On 1/2/25 at 10:31 A.M., the bathroom in Room 307 was observed with the rings at both ends of the grab bar above the toilet paper roll not attached. The pull cord chain was rusted, the edge of the floor in front of the tub was brown, the sink faucet was loose and moving around, and the vent over the sink was caked with dust. On 1/14/25 at 11:11 A.M., the same was observed. 15. On 1/2/25 at 10:54 A.M., the bathroom in Room 306 was observed with an area on the back of the shower wall with a brown substance that was halfway sticking to the shower and hanging off on the other end. The vent over the sink was caked with dust, and rust was observed on the call light chain. On 1/14/25 at 11:10 A.M., the same was observed. During on interview on 1/13/25 at 2:29 P.M., the			

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	Regional Director indicated there was no policy on checking the residents' fridges. It would be their policy to check the the temperatures daily on resident fridges. During an interview on 1/14/25 at 11:25 A.M., the Clinical and Quality Consultant indicated they did not have an environment policy, but providing a homelike environment would be their policy. On 1/14/25 at 9:00 A.M., a current Food from Outside Sources For Resident Consumption policy, dated 2/2021, was provided and indicated "Nursing staff will monitor resident's room and facility refrigeration units for food and beverage disposal ... All refrigeration units will have internal thermometers to monitor temperatures. All units must be maintained at internal temperatures that are deemed safe for food storage according to state and federal standards ... The Refrigerator Temperature Log will be utilized for logging this information" On 1/14/25 at 11:20 A.M., a current Housekeeping policy, dated 9/2020, was provided and indicated "To maintain rooms in a clean and sanitary manner ... Routine room dusting, vacuuming and wipe down of touch surfaces should occur daily ... Report any defective equipment or repairs needed to your supervisor ... Check walls and doors. Wipe clean of dirt and spots and clean walls ..." On 1/14/25 at 1:40 P.M., a current Infection Prevention and Control Program Policy, revised February 2024, was provided by the Clinical and Quality Consultant and indicated "Purpose: To establish and maintain facility guidelines for the effective prevention ... Facility staff will handle, store, process and transport all linens in a manner to prevent the spread of infection ... Routine			

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	(occupied) and terminal (discharge) room cleaning policies will be followed to ensure appropriate cleaning and disinfection of resident rooms ... " 3.1-19(f) 3.1-19(f)(5) 3.1-19(g)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00450791. Survey dates: January 2, 3, 8,9,13,14, 2025 Facility number: 001138 Residential Census: 0 Lodge of the Wabash was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		