STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155632	A. BUILDING -- B. WING	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/15/25 Facility Number: 001138 Provider Number: 155632 AIM Number: 200157070 At this Emergency Preparedness survey, Lodge of the Wabash was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a total capacity of 117 with 70 certified beds and had a census of 51 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation. Quality Review completed on 01/17/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the provisions of Federal and State Law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care. Completion Date 02/28/2025	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This	E 0025	The facility has developed and implemented emergency preparedness policies and procedures, based on the facility emergency plan. The facility did secure new agreements with new ownership of local LTC facilities to accept residents in the event the	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KHUSHALI SHAH	ADMINISTRATOR	02/08/2025

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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	deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director and Administrator present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, the dates on the LTC facilities and other provider was listed 2014, 2017, and 2018 for the various facilities, furthermore, the names and ownerships of two of the facilities had changed since the previous dates mentioned. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		facility had need. The facility had and has an agreement for transfer with the local hospital in the event short term emergency need arises. The Administrator has been educated to review the emergency transfer agreements and any arrangements with other facilities or providers in the event of limitation or cessation of operations to maintain continuity of services to LTC residents is needed. The Regional Director of operations will review the agreement on an annual basis to ensure continued compliance and report any negative findings to the facility QAPI Committee.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/15/25 Facility Number: 001138 Provider Number: 155632 AIM Number: 200157070	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the provisions of Federal and State Law require it. The facility	

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	155632	A. BUILDING 01 B. WING	01/15/2025

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	At this Life Safety Code survey, Lodge of the Wabash was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, areas open to the corridors, and all resident sleeping rooms. The facility has a total capacity of 117 with 70 certified beds and had a census of 51 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a garage used as a maintenance shop and for facility storage. Quality Review completed on 01/17/25		maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care. Completion Date 02/28/2025	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review and interview, the facility failed to ensure documentation was provided for the testing of 1 of 1 battery powered emergency light unit that was tested monthly for 30 seconds during 12 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires	K 0291	The exterior lights have been tested and are tied to the emergency generator. Maintenance Director was educated on completing and documenting details of monthly functional and visual tests of Emergency Lighting for 30 seconds and annual testing of 90	02/04/2025

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	functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, the facility did have a line item on the emergency generator monthly load testing form indicating "Emergency Lighting", "Comes On", with answer "Yes" each time, however, there was no indication on the form that it was a 30 second test each month. Furthermore, there was no documentation available to show the battery powered emergency light unit was tested annually for 90 minutes during the past 12 month period. Based on interview at the time of record review, the Maintenance Director said he does test the battery powered emergency light unit at the generator during each monthly load test, but it is not a full 30 second test. He further said there is no documentation of a 90 minute test of the battery powered emergency light unit available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		minutes. The 90 minute test was conducted on 02/04/2025. The Administrator will review all testing logs monthly for 6 months to ensure continued compliance. Any negative finding will be reported to the facility QAPI Committee. Date Completed 02/04/2025	

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K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure there was documentation available to show 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff and all residents, staff, and visitors while in the dining room. Findings include:	K 0324	Maintenance Director has been educated on 2-4-25 to ensure that semiannual and annual inspections are completed on kitchen range hood cleaning and inspection as per the requirement by NFPA. Contracted vendor has been contacted for the semi-annual for the current period. The Administrator will review records of completion of inspections quarterly for 12 months to ensure compliance. Any negative findings will be reported to the facility QAPI Committee	02/04/2025

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	Based on record review on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there were no current semi annual inspection reports available to review for the range hood exhaust system. There was a sticker on the range hood from the vendor indicating an inspection was performed on 04/16/24, however, there was no report of the inspection available to review. Based on interview at the time of record review, the Maintenance Director confirmed there were no semi annual kitchen range hood cleaning inspections available to review for the past 12 month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances	K 0345	Maintenance Director has been educated to make sure semiannual visual inspection of the Facility fire alarm is done for smoke detectors and heat detector and have recorded the inspection. The facility fire and alarm system inspection and monitoring company completed visual semiannual inspection of the smoke detectors and heat detectors on 2-5-25. The company will provide the required listing of each inspected or tested device and provide in their reports to the facility. The	02/05/2025

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	e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 10/21/24 by the facility's fire alarm inspection vendor, furthermore, there were quarterly inspections available dated 01/16/24, 04/18/24, and 08/02/24 by the facility's fire alarm inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors and heat detectors. For each device listed on each of the quarterly reports it said "Not Tested". The facility's pull stations were tested during each quarterly inspection. Based on interview at the time of record review, the Maintenance Director agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors and heat detectors. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		administrator will review all reports quarterly for 12 months to ensure continued compliance. Any negative finding will be reported to the facility QAPI Committee.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure the ceiling in 1 of 5 sprinklered	K 0353	The identified hole in the ceiling in the laundry room and has been	01/30/2025

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	smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 01/15/25 between 1:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there was a 4 inch by 3 inch hole in the ceiling in the laundry dryer enclosure. Based on interview at the time of observation, the Maintenance Director acknowledged the 4 inch by 3 inch hole in the ceiling within the laundry dryer enclosure. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		patched and sealed. on 01/30/2025. The Maintenance Director was re-educated on rounding in all areas where outside vendors may have completed work to ensure there are no gaps that would affect the functioning of any sprinkler head. The Administrator and Maintenance director will complete quarterly safety rounds to ensure compliance and will report any negative findings to the QAPI Committee.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, there was no fire drill documentation available for the third shift (night) of the third quarter (July, August, and September) of 2024. Based on interview at the	K 0712	Maintenance Director has been re-educated on 1/29/25 to provide quarterly fire drills at varied times for each shift and to ensure documentation is completed . The Administrator will review all fire drill reports monthly to ensure continued compliance. Any negative findings will be reported to the facility QAPI Committee.	01/29/2025

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	time of record review, the Maintenance Director acknowledged there was no fire drill report available to review for the third shift of the third quarter of 2024. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 01/15/25 between 10:00 a.m. and 1:45 p.m. with the Maintenance Director present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 10:15 a.m. and 10:40 a.m. b. 3 of 4 second shift (evening) fire drills were performed between 2:51 p.m. and 3:15 p.m. c. 3 of 3 third shift (night) fire drills were performed between 4:15 a.m. and 5:15 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times all three shifts fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			

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K 0921 SS=F Bldg. 01	3.1-51(c) NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 01/15/25 between 10:00	K 0921	Maintenance Director has been educated for testing Patient care related electrical equipment before being put into service and after any repair or modification to the equipment on 1-28-25. The Maintenance Director will complete labeling and testing of current PCREE on or before 2-28-25. The administrator will audit 5 PCREE items per day for one month and then 5 per week for 60 days to ensure compliance. Any negative findings will be reported to the facility QAPI Committee.	02/28/2025

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	a.m. and 1:45 p.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility was not aware PCREE items had to be tested and documented. Based on observation between 1:45 p.m. to 3:00 p.m. during a tour of the facility with the Maintenance Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			