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	12/14/2023

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00415576. This visit included a State Residential Licensure Survey. Complaint IN00415576 - No deficiencies related to the allegations are cited. Survey dates: December 6, 7, 8, 11, 12, 13 &14, 2023 Facility number: 001138 Provider number: 155632 AIM number: 200157070 Census Bed Type: SNF/NF: 51 Residential: 0 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 38 Other: 10 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 22, 2023.	F 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 solely because the provisions of 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 to render adequate care. The statement of decencies has been taken to the facilities Quality Assurance/Assessment Committee. **The Lodge of The Wabash respectfully requests that a 'desk' review be conducted and accepted.**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who			

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

Greg Matheis | HFA | 01/08/2024

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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	needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 residents reviewed for oxygen. A resident's oxygen was not given as ordered and the oxygen concentrator and filter were not cleaned. (Resident 12) Findings include: On 12/6/23 at 2:09 P.M., Resident 12 was observed laying in bed watching TV with oxygen on per nasal cannula at 3 LPM (liters per minute). The oxygen tubing was not dated and the oxygen concentrator machine and filter were dusty. On 12/13/23 at 11:08 A.M., Resident 12 was observed laying in bed with the oxygen concentrator set at 3 LPM oxygen per nasal cannula. The oxygen concentrator machine and filter were dusty. On 12/11/23 at 12:49 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD). The most recent MDS (Minimum Data Set) Assessment, dated 9/15/23, indicated Resident 12's cognition was moderately impaired and he required supervision with setup of 1 staff for bed mobility, transfer, and eating.	F 0695	Lodge of the Wabash does provide clean oxygen concentrators and proper oxygen liter flow for resident receiving oxygen. The oxygen order for resident 12 was immediately clarified with the correct liter flow with the hospice provider. The concentrator was pulled and replaced with a different concentrator. All nursing staff were educated on the Oxygen-Appropriate Use, Management and Storage policy and procedure with emphasis on monitoring the liter flow of oxygen. The oxygen concentrators were checked for cleanliness and proper oxygen liter flow for any resident receiving oxygen with appropriate actions taken as necessary. The Director of Nursing or designee will conduct daily audits for four weeks to verify the oxygen flow rate, and will monitor the concentrators for cleanliness and that the filters are changed per manufacturer guidelines, then weekly for 3 months to ensure compliance. Any negative findings will be reported to the facility QAPI Committee.	01/03/2024

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	Current Physician's Orders included, but were not limited to, the following: administer oxygen at 2 LPM per nasal cannula for COPD, continuous, dated 5/9/22 A current Respiratory Distress Care Plan, dated 12/6/23, included, but was not limited to the following intervention: administer oxygen at 2 LPM per nasal cannula, continuous, 12/6/23 On 12/12/23 at 1:58 P.M., current CNA (Certified Nurse Aide) assignment forms were provided by RN (Registered Nurse) 16 and indicated Resident 12 was on 2 LPM of oxygen. During an interview on 12/12/23 at 10:30 A.M., Hospice RN indicated that the communication was effective between hospice and staff. She indicated Resident 12's oxygen was set at 2 LPM and was verified with order when they visit the resident at least a couple times a week. On 12/13/23 at 11:35 A.M., Corporate Consultant 1 observed Resident 12's oxygen concentrator was set at 3 LPM and dusty. At that time, she indicated the physician's order needed to be clarified with the ordering physician and also should check with hospice to see if it was changed by them and just not updated in the resident's chart. During an interview on 12/13/23 at 11:33 A.M., Corporate Consultant 1 indicated Resident 12's current oxygen order was 2 LPM, she's not sure how often staff should check the LPM and the concentrator filter and machine should be cleaned by staff, but she wasn't sure how often.			

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	During an interview on 12/13/23 at 1:56 P.M., Corporate Consultant 1 indicated Resident 12's oxygen order was clarified and changed to 3 LPM and the filter and concentrator were cleaned. A current Oxygen Management policy, dated September 2021, was provided by Corporate Consultant 1 and indicated " ... a. Treat oxygen as a medication. As with any drug, continuously monitor the dosage or concentration of oxygen and routinely check the provider's orders to verify that the patient is receiving the prescribed oxygen concentration ... " 3.1-47(a)(6)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview the facility failed to provide hot food for 1 of 1 lunch trays sampled on 1 of 2 halls. Food that was supposed to be served hot was served cold. (300 hall and 400 hall) Finding includes: During an interview on 12/12/23 at 10:08 A.M., two anonymous residents indicated the food that	F 0804	This was an isolated occurrence by one employee and not usual practice. The cook was immediately educated on proper practices for providing palatable food at the appropriate temperature.The Dietary Manager/designee and Dietary Staff have been educated on the facility's policy and procedure on	12/20/2023

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	should be hot was served cold. During an observation on 12/13/23 at 11:15 A.M., the 300 hall and 400 hall trays were being distributed on an open cart. The individual trays were covered with an insulated dome without the use of a base. At 11:22 A.M., a hall tray was sampled. The Bar-B-Que Chicken temperature was 102.6 degrees Fahrenheit, felt cold, and tasted cold. During an interview on 12/14/23 at 9:43 A.M., the Dietary Manager indicated she would expect the chicken to be 160 degrees Fahrenheit when the residents received a tray. On 12/13/23 at 2:45 P.M., Corporate Consultant 1 provided a current Food Temperatures policy, reviewed 4/21, that indicated, "...typical serving temperature standards: Solids (meats/vegetables): 160 degrees Fahrenheit..." 3.1-21(a)(2)		dining services and appropriate temperatures.The Dietary Manager/designee will monitor and document food temperatures on trays on the hall daily x 30 days, then weekly x 90 days. Any negative findings will be reported to the facility QAPI Committee.	
F 9999 Bldg. 00	3.1-13 Administration and management (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. This State rule was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Alzheimer's/Dementia Special Care Unit disclosure was prepared or submitted to the state survey	F 9999	The memory care area is not locked, nor does it require the door to be held to engage an emergency release. The door has an audible alarm when exited without a code, which alerts staff in the building creating a safe environment. Residents can and do freely walk out of the area at any time. Based on this finding the facility has elected to discontinue the memory care area. The hallway doors will no	12/15/2023

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	agency for one of one closed locked unit. Findings include: On 12/6/23 at 11:10 A.M., the Director of Nursing (DON) indicated the facility had a memory care unit within the building. The DON indicated they did not have a dementia disclosure agreement because they did not consider the unit a true dementia unit, just a hall with residents who have a dementia diagnosis. During an observation on 12/6/23 at 2:31 P.M., a code was needed to enter the locked unit where 14 residents resided. On 12/12/23 at 2:04 P.M., The Memory Care Unit Guiding Principles, dated 6/19 revised 3/23, was provided by Corporate Consultant 1 and indicated "Memory care is our secured area...". "Guidelines for admission: Individual must have diagnosis of Alzheimer's or dementia from physician. Must be ambulatory or need limited assistance with ambulation. Must be physically able to participate consistently in the programming of the unit." On 12/13/23 at 2:49 P.M., RN 23 indicated the activities on the memory care unit do differ from the activities of the residents on the other units, and showed an activities calendar on the wall for the memory care unit. During an interview on 12/14/23 at 09:37 A.M., A dementia disclosure policy was requested and not provided. Corporate Consultant 1 indicated they do not have a policy for the dementia disclosure agreement because even though there was a code required to get in and out of the memory care unit, the doors would open after holding the		longer be alarmed and the facility will no longer utilize the memory care guiding principles for admission criteria. Existing residents/responsible parties will be given a 30-day notice regarding the change in practice.	

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	emergency release. In review of the Indiana Code 12-10-5.5 section 3 of the code referred to disclosure form; contents. "Sec. 3. A health facility and a housing with services establishment that provides or offers Alzheimer's and dementia special care or programing shall prepare a written disclosure in a form provided by the division that has been developed in conjunction with the long term care ombudsman's office."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00415576. Complaint IN00415576 - No deficiencies related to the allegations are cited. Survey dates: December 6, 7, 8, 11, 12, 13 & 14, 2023 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	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 solely because the provisions of 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 to render adequate care. The statement of decencies has been taken to the facilities Quality Assurance/Assessment Committee. **The Lodge of The Wabash respectfully requests that a 'desk' review be conducted and accepted.**	

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