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	05/29/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00459224. Complaint IN00459224: Federal/State deficiencies related to the allegations are cited at F602. Survey date: May 29, 2025 Facility number: 001138 Provider number: 155632 AIM number: 200157070 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 1 Medicaid: 38 Other: 7 Total: 46 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 2, 2025.	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.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on observation, interview, and record review, the facility failed to ensure residents were free from misappropriation for 2 of 3 residents reviewed pharmaceutical services. Resident's narcotic medications went missing after being delivered from the pharmacy which caused	F 0602	Resident D and Resident G's medications were promptly replaced by the facility. All records of resident receiving controlled medication were reviewed to ensure no other residents were effected.	06/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KHUSHALI SHAH	ADMINISTRATOR	06/13/2025

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.

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	05/29/2025

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
	residents to miss physician ordered routine medications. (Resident D, Resident G) Findings include: 1. During record review on 5/29/25 at 10:30 A.M., Resident D's diagnoses included, but were not limited to; osteoarthritis, chronic kidney disease, and diabetes. Resident D's most recent annual Minimum Data Set (MDS) assessment dated 5/11/25, indicated the resident had severe cognitive impairment, had occasional pain rated two (2) on a scale of zero (0) - ten (10) (zero being no pain and ten being the most pain), and received opiod medication. Resident D's physician orders included, but were not limited to; oxycodone hydrochloride (HCL) 5 milligrams (mg), one tablet by mouth twice a day for pain (started 10/9/23), and Tylenol 325 mg, two tablets by mouth every six hours as needed (PRN) for pain. Resident D's Medication Administration Record (MAR) included: 4/7/25 at 10:22 A.M. - PRN medication given - Tylenol 325 mg - 2 tablets "given (due to) out of oxycodone until new script obtained." for pain. 4/8/25 at 2:17 P.M. - PRN medication given - Tylenol 325 mg - 2 tablets for pain 4/9/25 at 7:38 A.M. - PRN medication given - Tylenol 325 mg - 2 tablets for pain 4/9/25 at 3:56 P.M. - PRN medication given - Tylenol 325 mg - 2 tablets for pain 4/10/25 at 7:00 A.M. - PRN medication given - Tylenol 325 mg - 2 tablets for pain Resident D's Controlled Drug Record for medication oxycodone hydrochloride (HCL) 5		To prevent recurrence All nursing management, licensed nursing staff and Qualified Medication Aides have received comprehensive re-education on the facility's policy and procedures regarding the handling and documentation of controlled substances. Re-education focused on accurate and timely documentation of all controlled substances. To ensure continued compliance, the Director of Nursing (DON) or designee will conduct audits of all controlled substance count sheets to verify the presence of two nurse signatures daily, or on the next business day if applicable, for a period of 90 days. Following this, audits will be conducted three times per month for three additional months, then monthly for another three months. In addition, the DON or designee will conduct random medication count observations between nurses to assess ongoing compliance. Any discrepancies or negative findings will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) Committee.	

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	05/29/2025

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
	milligrams (mg), one tablet by mouth twice a day, was dated as received from the pharmacy on 3/20/25 with a total of 28 doses received. The last dose was signed out on 4/5/25 at 4:00 P.M. A pharmacy delivery sheet, dated 3/20/25, indicated Resident D received a total of 58 doses of the medication oxycodone hydrochloride (HCL) 5 milligrams (mg), one tablet by mouth twice a day (one 28 dose sheet, and one 30 dose sheet). The delivery sheet was signed by facility staff as received at 10:30 P.M. on 3/20/25. 2. During record review on 5/29/25 at 11:30 A.M., Resident G's diagnoses included, but were not limited to; malignant neoplasm of left breast, diabetes, left sided hemiplegia, and cirrhosis of liver. Resident G's most recent quarterly Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident had severe cognitive impairment, had frequent pain rated at a five (5) on a scale zero (0) - ten (10), and received an opiod medication. Resident G's physician orders included, but were not limited to; Norco (hydrocodone-acetaminophen 5 mg - 325 mg 1 tablet by mouth three times a day for pain (ordered 3/25/25), and Tylenol Extra Strength 500 mg 2 tablets by mouth twice a day as needed (PRN) for pain (ordered 6/18/22). Resident G's Medication Administration Record (MAR) included: 4/3/25 at 12:45 P.M. - PRN medication given: Tylenol Extra Strength 500 mg 2 tablets due to "Norco no available at this time." Resident G's Controlled Drug Record for			

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	05/29/2025

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
	medication Norco (hydrocodone-acetaminophen 5 mg - 325 mg 1 tablet by mouth three times a day was dated as received from the pharmacy on 3/25/25 with a total of 12 doses received. The last dose given was signed out on 4/1/25 at 7:00 A.M. Two more doses were available and not signed out on the count sheet. A pharmacy delivery sheet, dated 3/25/25, indicated Resident G received a total of 42 doses of the medication Norco (hydrocodone-acetaminophen 5 mg - 325 mg 1 tablet by mouth three times a day (one 12 dose sheet, and one 30 dose sheet). The delivery sheet was signed by facility staff as received at 10:20 P.M. on 3/25/25. During an interview on 5/29/25 at 12:15 P.M., RN 2 indicated that full sheets of narcotic medications had recently went missing from the medication cart. RN 2 indicated nursing staff should count all narcotic medications, fill out the narcotic count sheet, and sign the narcotic count sheet at each shift change. On 5/29/25 at 12:30 P.M. an Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form, dated 4/1/25 at 10:30 A.M., indicated (added 5/9/25) the Facility Administrator was notified of a potential concern with medications missing on 4/1/25 and 4/9/25 realized as nursing staff was attempting to refill medications from the pharmacy. The facility investigation into missing medications included an unsigned, typed note that indicated on 4/1/25 at 10:30 A.M., RN 4 reported to the Director of Nursing (DON) that 30 Norco medications for Resident G were missing. After an unsuccessful search for the medications,			

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	05/29/2025

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
	pharmacy was contacted to ensure delivery of the medications. RN 7 had received the medication from the pharmacy on 3/25/25. RN 7 left the medications for LPN 9 to secure in the locked medication cart. LPN 9 documented that 2 cards of 42 medications of Resident G's Norco medication was added to the medication cart. All controlled medication cards were counted in the cart on the morning of 3/26/25 for a total of 34 medication cards. The medications cards were counted again that afternoon at 2:00 P.M. for a total of 34. No night shift medication card count was completed on the night of 3/26/25. The medications card sheets were not counted again on 3/27/25 morning shift at 6:00 A.M., or the afternoon shift at 2:00 P.M.. When the medications cards were counted again on the night of 3/27/25, 32 cards were counted. When RN 4 attempted to reorder Resident G's Norco medication on 3/29/25, the pharmacy responded that the medications were delivered on 3/25/25. The facility investigation also included that Resident G had missed routine doses of narcotic medications on the night of 4/2/25 and the morning of 4/3/25. Resident D had missed routine doses of narcotic medications on the mornings and nights of 4/7/25, 4/8/25, 4/9/25, and 4/10/25. During an interview on 5/29/25 at 1:55 P.M., the Facility Administrator and DON indicated Resident D and Resident G were each missing a sheet of narcotic medications along with the controlled substance count sheet that correlated with the medications cards. Due to nursing staff not completing counts every shift and due to count sheets missing, an exact total of missing medications was unable to be determined. Resident D and Resident G received PRN pain medication while the facility obtained new orders			

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	05/29/2025

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
	and waited on the pharmacy to refill the lost medications. On 5/29/25 at 2:55 P.M., the Facility Administrator supplied a facility policy titled, Controlled Substance Policy, dated 07/2024. The policy included, "Purpose: To ensure appropriate and consistent procedures for safeguarding controlled substances are followed from delivery through the actual administration and/or destruction of the medications... 2. Controlled Substances Count a. All controlled substances will be counted by 2 nurses at each shift change..." This citation relates to complaint IN00459224. 3.1-28(a)			