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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodge of the Wabash	723 E Ramsey Rd Vincennes, IN 47591

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist (IP) working at least part-time at that facility. The Director of Nursing (DON) acted as the IP, but lacked documentation of hours worked as the IP. Finding includes:During an interview on 3/3/26 at 7:04 A.M., Regional Support indicated the DON was the current IP, and the Clinical Nurse Manager was the backup IP, but lacked certification.During an interview on 3/4/26 at 12:20 P.M., the DON indicated she acted as the current IP, DON, and minimum data set (MDS) nurse. At that time, she indicated she lacked documentation of hours spent on IP duties.On 3/4/26 at 1:31 P.M., the Administrator provided an Infection prevention and Control Officer job description, revised 2/24, 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 .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the Medical Doctor/Nurse Practitioner (MD/NP) about significant changes in a resident's physical and functional ability for 1 of 1 resident reviewed for positioning. (Resident 26) Finding includes:On 2/26/26 at 11:10 A.M., Resident 26 was observed propelling herself in her wheelchair to the dining room. She was leaning so far to the right side, that her right axilla was over the right arm rest, the resident's arm was hanging off the wheelchair over the side, and she was slouched over and down with her head toward her knees. The resident ran into chairs at the nurse's station and then ran her head into the wall and handrail going down the hallway. On 3/3/26 at 7:20 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to bipolar disorder, anxiety, and dementia. The resident's active diagnoses did not include any diseases of the spine. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/11/25, indicated the resident did not use any mobility devices such as a walker or wheelchair, was independent for transfers, and could walk 150 feet independently.The most recent Significant Change MDS assessment, dated 1/27/26, indicated Resident 26's cognition was not able to be assessed, used a manual wheelchair, needed partial to moderate assistance from staff (staff to perform over half the effort) for transfers in the wheelchair, and had physical (PT) and occupational therapy (OT) in the last seven days. A current Self Care Deficit Care Plan, last revised 1/9/26 included, but was not limited to, nursing interventions to assess functional level of the resident and therapy referral.A current Comfort Care Plan, last revised 1/9/26 included, but was not limited to, nursing interventions to assess for physical symptoms, position for comfort, and notify MD as needed.A current Activity Attendance Care Plan, last revised 1/20/26, included, but was not limited to, nursing interventions to continue to assess and monitor resident for changes in physical and mental status. Notify MD with concerns. Progress notes in the clinical record from 11/1/25 to 2/25/26 included nursing documentation of declining physical and functional abilities, but lacked documentation of notification to the MD. During an interview on 3/3/26 at 9:50 A.M., Qualified Medication Aide (QMA) 6 indicated Resident 26 started slouching more recently so they had to put her in a wheelchair because she was not able to ambulate safely. To her knowledge they were not using any positioning devices for her and just tried to encourage Resident 26 to sit up straighter. During an interview on 3/4/26 at 9:22 A.M., Licensed Practical Nurse (LPN) 18 the resident was declining mentally and physically and getting more tired. She was not aware of anything being done for Resident 26's slouching. She indicated she had kyphosis in the past but in last couple months she went from walking to leaning to the right in the wheelchair. She had done therapy recently but the slouching was getting worse. 410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was discharged with sufficient preparation for 1 of 3 closed records reviewed. A discharged resident failed to receive appropriate paperwork and assessments prior to being sent to the hospital. (Resident 44)Finding includes:On 3/3/26 at 9:14 A.M., Resident 44's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus.Resident 44 was admitted to the facility on [DATE] and discharged to the hospital on [DATE].An admission minimum data set (MDS), dated [DATE], indicated a moderate cognitive impairment.Progress notes lacked information related to Resident 44's discharge on [DATE].Resident 44's clinical record lacked any discharge assessments prior to or on 12/14/25.Resident 44's clinical record lacked any respiratory assessments prior to the 12/14/25 discharge.Resident 44's clinical record lacked a transfer/discharge and bed-hold form for the 12/14/25 discharge.During an interview on 3/3/26 at 9:35 A.M., the Clinical Nurse Manager indicated Resident 44 lacked any assessments and documentation leading up to the hospitalization on 12/14/25.During an interview on 3/4/26 at 9:09 A.M., the Regional Support indicated Resident 44 lacked any assessments and documentation because they were sent out emergently.During an interview on 3/4/26 at 10:32 A.M., the Regional Support indicated she would expect documentation and assessments leading up to the discharge as well as a completed transfer/discharge and bed-hold form.On 3/4/26 at 1:31 P.M., the Administrator provided a current Transfer and Discharge policy, revised 4/2025 that indicated, The facility will comply with regulations regarding initiating a transfer or discharge of a resident and the accompanying documentation must be included in the medical record. Transfer and Discharge.Bed-Hold: Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.410 IAC 16.2-3.1-12(a)(21)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure that a resident with a decline in positioning was offered an evaluation for adaptive devices or equipment to help her maintain the highest practicable physical and functional well-being for 1 of 1 resident reviewed for positioning. A resident with kyphosis was observed leaning so far to the right seated in her wheelchair that her right axilla (arm pit) rested on the arm rest of the wheelchair and her head was down towards her knees. (Resident 26)Finding includes:On 2/25/26 at 11:40 A.M., Resident 26 was observed sitting in her wheelchair in the dining room. She was leaning so far to the right side, that her right axilla was over the right arm rest, the resident's arm was hanging off the wheelchair over the side, and she was slouched over and down with her head toward her knees. On 2/26/26 at 11:10 A.M., Resident 26 was observed propelling herself in her wheelchair to the dining room. She was leaning so far to the right side, that her right axilla was over the right arm rest, the resident's arm was hanging off the wheelchair over the side, and she was slouched over and down with her head toward her knees. The resident ran into chairs at the nurse's station and then ran her head into the wall and handrail going down the hallway. On 2/26/26 at 12:05 P.M., Resident 26 was observed during lunch sitting in her wheelchair at a table in the dining room leaning to the right with her head resting on her right hand on the table. On 3/3/26 at 9:26 A.M., Resident 26 was observed in the shower room with Qualified Medication Aide (QMA) 6 and Certified Nurse Aide (CNA) 14 getting ready to toilet the resident. She was leaning so far to the right side sitting in her wheelchair, that her right axilla was over the right arm rest, the resident's arm was hanging off the wheelchair over the side, and she was slouched over and down with her head toward her knees. After the resident was seated on the toilet slouching forward with her head toward her knees. While QMA 6 washed her hands, she told the resident to try to sit up straight or she was going to fall off the toilet. On 3/3/26 at 7:20 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to bipolar disorder, anxiety, and dementia. The resident's active diagnoses did not include any diseases of the spine. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/11/25, indicated the resident did not use any mobility devices such as a walker or wheelchair, was independent for transfers, and could walk 150 feet independently.The most recent Significant Change MDS assessment, dated 1/27/26, indicated Resident 26's cognition was not able to be assessed, used a manual wheelchair, needed partial to moderate assistance from staff (staff to perform over half the effort) for transfers in the wheelchair, and had physical (PT) and occupational therapy (OT) in the last seven days. A current Self Care Deficit Care Plan, last revised 1/9/26 included, but was not limited to, nursing interventions to assess functional level of the resident and therapy referral.A current Comfort Care Plan, last revised 1/9/26 included, but was not limited to, nursing interventions to assess for physical symptoms, position for comfort, and notify MD as needed.A current Activity Attendance Care Plan, last revised 1/20/26, included, but was not limited to, nursing interventions to continue to assess and monitor resident for changes in physical and mental status. Notify MD with concerns. Progress notes in the clinical record were reviewed from 11/1/25 to present and included, but were not limited, to the following:On 11/5/25, an assessment note indicated the resident had no muscular-skeletal complaints and was up ad-lib (as much or as often as desired). She required no help from staff to transfer, walk, and move about on the unit but had an unsteady gait at times and used the walls, furniture, and handrails. She did not require the use of appliances or devices to assist with locomotion, did not require supportive device to assist in preventing falls, and had not had a decline in functional status in the past 90 days. No referrals were needed at that time. The recommendations were to continue current plan of care, monitor, and notify Medical Doctor/Nurse Practitioner (MD/NP) of change.On 12/20/25, a fall follow-up note indicated the resident was up walking ad-lib with usual gait. Staff continued to monitor.On 1/20/26, a fall risk assessment note indicated Resident 26 was alert and oriented to herself but had poor safety judgement. She now propelled self in her wheelchair (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but had no muscular-skeletal complaints. IDT recommendations indicated to continue current plan of care, monitor, and notify MD/NP of changes.On 2/1/26, a note indicated resident showed decline with Activities of Daily Living (ADLs), ambulating and feeding self. Posture has declined considerably as well. Staff has to help hold her head up to give meds and to eat at times.On 2/5/26, a fall risk assessment note indicated the resident had a decline in functional status in the last 90 days (or since last assessment) and needed more assistance with ADLs, eating, and ambulating.On 2/20/26, an attending physician note indicated the physician examined the client on 2/20/26 and gave no new orders.On 2/21/26, a falls assessment note indicated the resident had increased weakness, leans forward when standing, and was leaning forward in the wheelchair with chest on knees.On 2/25/26, a falls assessment note indicated the resident had a loss of physical coordination that could possibly be related to the history of multiple falls. Resident seemed to be more hunched over recently. Her gait had deteriorated and stooping had increased. The note indicated she had chronic scoliosis of spine. During an interview on 3/3/26 at 9:50 A.M., Qualified Medication Aide (QMA) 6 indicated Resident 26 started slouching more recently so they had to put her in a wheelchair because she was not able to ambulate safely. To her knowledge they were not using any positioning devices for her and just tried to encourage Resident 26 to sit up straighter. During an interview on 3/4/26 at 9:22 A.M., Licensed Practical Nurse (LPN) 18 the resident was declining mentally and physically and getting more tired. She was not aware of anything being done for Resident 26's slouching. She indicated she had kyphosis in the past but in last couple months she went from walking to leaning to the right in the wheelchair. She had done therapy recently but the slouching was getting worse.During an interview on 3/4/26 at 9:33 A.M., Occupational Therapy Assistant (OTA) 20 indicated she was familiar with Resident 26 because she was recently in therapy and they worked on her gait and sitting laterally in her wheelchair but she was discharged for meeting her goals. She indicated therapy had not been notified that she needed any more assistance. The nursing staff should notify the MD/NP and they could evaluate her for positioning and see if they could find anything that may assist Resident 26.During an interview on 3/4/26 at 11:30 A.M., Regional Support indicated she had been notified last night the resident got a skin tear on her right arm and they were going to look into trying a different wheelchair for her now. At that time, she indicated to her knowledge, nothing had been tried for the resident's worsening slouching/positioning in the wheelchair.During an interview on 3/4/26 at 1:46 P.M., the Administrator indicated they did not have a positioning/maintaining highest practical well-being policy but it would be their policy to follow standard practice. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure proper storage of medications in 1 of 1 medication storage room. The temperature log for the refrigerator and room temperature lacked several readings. (Medication Storage Room)Finding includes:On 2/25/26 at 9:49 A.M., the February 2026 temperature log posted on the refrigerator in the medication storage room was observed to be missing refrigerator and room temperatures.The missing temperatures included, but were not limited to the following:2/10/26 Refrigerator temperatures for evening and night shift.2/12/26 Refrigerator and room temperatures for evening and night shift.2/13/26 Refrigerator and room temperatures for evening and night shift.2/16/26 Refrigerator and room temperatures for day shift.2/18/26 Refrigerator and room temperatures for day, evening, and night shift.2/19/26 Refrigerator and room temperatures for evening shift.2/20/26 Refrigerator and room temperatures for night shift.2/21/26 Refrigerator and room temperatures for day shift.2/22/26 Refrigerator and room temperatures for day shift.2/23/26 Refrigerator and room temperatures for night shift.During an interview on 2/25/26 at 10:00 A.M., Registered Nurse (RN) 12 indicated that the refrigerator and room temperatures should be checked every shift and recorded on the log.On 3/4/26 at 9:30 A.M., the Regional Support provided a Storage of Medications and Biologicals policy, dated 5/21/18, which indicated .19. iv. Manual temperature checks should be performed per facility policy. Refrigerator and room temperature log, medication room, reviewed 11/25, indicated Nursing staff to check medication room refrigerator and ambient room temperature of medication room each shift and record temperatures on log.410 IAC 16.2-3.1-25(m)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure accurate information was documented in the clinical record for 1 of 4 residents reviewed for nutrition. Meal intake documentation was missing and meal and snack consumption was recorded in the clinical record before the resident was served. (Resident 26) Finding includes:On 2/26/26 at 12:05 P.M., Resident 26 was observed during lunch sitting in her wheelchair at a table in the dining room with her head resting on her right hand on the table. On 3/3/26 at 7:20 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to bipolar disorder, anxiety, and dementia. The most recent Significant Change Minimum Data Set (MDS) assessment, dated 1/27/26, indicated Resident 26's cognition was not able to be assessed, needed partial to moderate assistance of staff (staff performs over half the effort) for eating, was 64 inches, 135 pounds (lbs), and had not had weight loss. Current Physician's Orders included, but were not limited to, the following:Regular diet, initiated 8/4/22 Monitor weight one week per week on Monday morning, initiated 2/9/26 Med Pass 2.0 supplement upon rising and in the evening, initiated 2/23/26 A current Weight Fluctuation Care Plan, dated and last revised 2/9/26, included, but were not limited to, the following interventions:Monitor and document food intakeResident to sit at feed table for supervision, cueing, and encouragement at meal timeProvide ordered dietOffer replacement foodOffer extra snacksRecord food intake A current Activity Attendance Care Plan, last revised 1/20/26, included, but were not limited to, the following interventions:Things important to Resident 26 are provide snacks between meals, likes just about any snack (allergy to oranges) Resident 26's clinical record included the following documented weights since 1/1/26 which indicated the resident had a 10.34% weight loss from 1/5/26 to 2/4/26:1/5/26 135.42/4/26 121.42/16/26 119.42/23/26 116.8 Resident 26's meal and snack intake and consumption log was reviewed from 2/1/26 to present and the following meals and snacks were missing or consumption was documented before meal and snack times:2/1/26 P.M. snack documented at 4:29 P.M. (missing other snack)2/2/26 P.M. snack documented at 4:32 P.M. (missing other snack)2/3/26 P.M. snack documented at 9:53 P.M. (missing other snack)2/4/26 at 4:12 P.M. 75% dinner consumed; P.M. snack at 4:12 P.M. (missing other snack)2/5/26 missing dinner and both snacks2/6/26 missing dinner and both snacks2/7/26 at 8:49 A.M.,100% of A.M. snack consumed (missing other snack)2/8/26 at 7:57 A.M., 100% A.M. snack consumed; 11:28 A.M., 75% lunch consumed; 11:32 A.M., 100% P.M. snack consumed2/9/26 P.M. snack documented at 8:08 P.M. (missing other snack)2/10/26 missing all meals and both snacks 2/11/26 missing lunch and dinner; P.M. snack documented at 4:38 P.M. (missing other snack)2/12/26 P.M. snack documented at 7:58 P.M. (missing other snack)2/13/26 missing dinner and both snacks2/14/26 missing dinner; P.M. snack documented at 5:01 P.M. (missing other snack)2/15/26 P.M. snack documented at 8:54 P.M. (missing other snack)2/16/26 P.M. snack documented at 3:04 P.M. (missing other snack)2/17/26 P.M. snack documented at 9:23 P.M. (missing other snack)2/18/26 P.M. snack documented at 7:08 P.M. (missing other snack)2/19/26 missing dinner and both snacks 2/20/26 missing dinner and both snacks2/21/26 at 8:20 A.M. snack (missing other snack)2/22/26 at 6:51 A.M. breakfast; 6:51 A.M. snack (missing other snack)2/23/26 missing both snacks2/24/26 missing dinner and both snacks2/25/26 P.M. snack documented at 7:19 P.M. (missing other snack)2/26/26 missing dinner and both snacks2/27/26 missing all meals and both snacks2/28/26 P.M. snack documented at 10:01 P.M. (missing other snack)3/1/26 missing lunch; P.M. snack documented at 9:28 P.M. (missing other snack)3/2/26 missing dinner and both snacks During an interview on 3/3/26 at 9:55 A.M., the Administrator indicated meals were served to residents daily at 7:30 A.M., 11:30 A.M., and 5:30 P.M. During an interview on 3/4/26 at 9:20 A.M., Certified Nurse Aide (CNA) 16 indicated the CNAs or Qualified Medication Aides (QMA) should offer snacks around 2:00 P.M., and between 7:00-8:00 P.M., daily. They do not give A.M. snacks usually because by the time the resident gets up and ready, it's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time for lunch so she was unsure why the A.M. snacks were documented. There should be documentation of refusals or 0% if resident didn't eat the offered snack or meal. Meal and snack consumption should be documented after the resident eats not before. She indicated the log was kept to help determine why the resident was losing weight and should be accurate. During an interview on 3/4/26 at 9:22 A.M., Licensed Practical Nurse (LPN) 18 indicated the resident was declining mentally and physically. She was also getting more fatigued. The staff believed it was due to her dementia progressing and that was the reason the resident was losing weight. On 3/4/26 at 1:31 P.M., a current non dated CNA job description was provided by the Administrator and indicated, . Records accurate, legible information about resident care and condition in appropriate sections of residents' records such as temperature, blood pressure, pulse and respiration rates, and food and fluid intake and output, as directed . On 3/4/26 at 1:31 P.M., a current Documentation Policy was provided by the Administrator and indicated, . Entries should be made as soon as possible after an event . An entry should never be made in advance . make sure entry is complete and contains all significant information . 410 IAC 16.2-3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used proper hand hygiene to help prevent the development and transmission of communicable diseases and infections for 2 of 2 observations of incontinence care. Staff washed their hands with an 8, 10, 15 and 12 second lather. (Resident 26, Resident 22)Findings include: 1. On 3/3/26 at 9:26 A.M., Qualified Medication Aide (QMA) 6 and Certified Nurse Aide (CNA) 14 were observed toileting Resident 26 in the shower room. After the resident was seated on the toilet, QMA 6 washed her hands with an 8 second lather and put on gloves. QMA 6 removed Resident 26's soiled incontinence pad and discarded it into the trashcan. Then she washed her hands with a 10 second lather. QMA 6 applied the gait belt and QMA 6 and CNA 14 lifted Resident 26 from the toilet to stand. 2. On 3/2/26 at 2:02 P.M., QMA 6 and CNA 8 took Resident 22 into the shower room to void. QMA 6 washed her hands with a 15 second lather and CNA 8 washed his hands with a 12 second lather. After putting gloves on, QMA 6 placed the gait belt around Resident 22's waist. After putting gloves on, CNA 8 pushed the wheelchair closer to the toilet and locked the wheelchair. QMA 6 and CNA 8 assisted Resident 22 to stand using the gait belt. They walked Resident 22 a couple of steps, helped her turn and sit on the toilet. During an interview on 3/4/26 at 12:20 P.M., the Director of Nursing (DON) indicated when washing hands lather with soap for 30-40 seconds. On 3/4/26 at 1:31 P.M. the Administrator provided an undated Hand Hygiene policy which indicated .Any health-care worker, caregiver or person involved in direct or indirect patient care needs to be concerned about hand hygiene and should be able to perform it correctly and at the right time.Wash hands when visibly soiled. Duration of the entire procedure: 40-60 seconds. 410 IAC 16.2-3.1-18(l)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on observation, interview, and record review, the facility failed to follow antibiotic use protocol for 1 of 1 resident reviewed for urinary tract infection. An antibiotic was ordered and given prior to culture results that was resistant to the bacteria. (Resident 22)Findings include:On 3/2/26 at 9:15 A.M., Resident 22's clinical records were reviewed. Diagnoses included, but were not limited to, dementia and depression. The most current quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated Resident 22 was unable to complete the Brief Interview for Mental Status (BIMS) assessment due to the resident being rarely/never understood. Resident 22 was dependent on staff for toileting and was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding).Physician orders included, but were not limited to the following:Keflex (an antibiotic) 500 mg (milligrams) bid (two times a day) x 7 days for UTI (urinary tract infection), dated 1/7/26 and discontinued on 1/12/26Bactrim (an antibiotic) 800mg-160 mg 1 bid through 1/19/26 for UTI, dated 1/12/26 and completed 1/19/26A nurse's note dated 1/7/26 indicated urine was amber, cloudy. No other symptoms were indicated.A urinalysis dated 1/7/26 indicated Resident 22 had a UTI. A urine culture was completed and resulted out on 1/9/26 which showed the bacteria was not sensitive to Cephalexin.Resident 22's Medication Administration Record (MAR) indicated Cephalexin was given from 1/7/26 P.M. through 1/12/26 A.M. until culture results were received and Bactrim was ordered on 1/12/26.During an interview on 3/3/26 at 9:40 A.M., Registered Nurse (RN) 4 indicated the providers normally order an antibiotic for UTI based on resident's symptoms before getting culture results back. On 3/3/26 at 12:16 P.M., the Regional Support provided the Infection Prevention and Control Program policy, revised 1/26, which indicated, .9. Antibiotic Stewardship b. Additional antibiotic use protocols and systems to monitor antibiotic use: .x. Antibiotics will not be utilized in residents with asymptomatic bacteriuria by following the Urinary Tract Infection Protocol. xi. Efforts will be made to reduce antibiotic prophylaxis for the prevention of UTI .410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)1

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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodge of the Wabash	723 E Ramsey Rd Vincennes, IN 47591

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the past state survey results were readily available to visitors, residents, and other individuals without them having to ask to review them for 2 of 2 days reviewed for the survey period. Finding includes:On 3/3/26 at 12:34 P.M., during the resident council meeting, residents indicated there was a sign on the wall at the nurse's station and the state survey results should be in a binder under it. On 3/3/26 at 7:00 A.M., a sign was observed on the wall by the nurse's station that indicated the state survey results were in a slot below it, but the slot only contained a blue emergency preparedness binder. The survey results were not there. On 3/4/26 at 9:10 A.M., the same was observed. During an interview on 3/4/26 at 9:30 A.M., the Administrator indicated that the sign by the nurse's station should have been taken down because they no longer kept the past state survey results there. She went into the front business office and obtained a binder labeled survey history from the top of the filing cabinet with other binders. There was no indication that's where it was kept. On 3/4/26 at 12:00 P.M., Regional Support indicated they did not have a policy for keeping the past survey results readily available, but they would follow regulations. 410 IAC 16.2-3.1-3(b)(1)