

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LANE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00106904 and Complaint IN00108021.</p> <p>Complaint IN00106904- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00108021- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 1, 2, 3, &amp; 4, 2012.</p> <p>Facility number: 000462 Provider number: 155477 AIM number: 100275380</p> <p>Survey team: Rita Mullen, RN-TC Michelle Carter, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 7 Medicaid: 29 Other: 12 Total: 48</p> <p>Sample: 12</p>	F0000	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers.</p> <p>This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied.</p> <p>The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly.</p> <p>Please accept this plan as our credible allegation of compliance. We respectfully request a desk review and paper compliance determination on all citations. Thank you. Cynthia D. Stevens, Executive Director</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LANE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 14, 2012, by Bev Faulkner, R.N.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0224 SS=A	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to prevent the loss of property for Resident #49. This impacted 1 of 12 residents reviewed for loss of property in a sample of 12. (Resident #49)</p> <p>Findings include:</p> <p>The clinical record for Resident #49 was reviewed on May 2, 2012 at 9:15 A.M.</p> <p>Diagnoses for Resident #49 included, but were not limited to, Alzheimer's disease, depressive disorder, and general muscle weakness.</p> <p>A physician's order, dated 2/25/12, indicated an x-ray for the left ring finger. X-ray results, dated 2/25/12, were negative for fracture. During an interview with the Executive Director (E.D.) on 5/2/12 at 11:40 A.M., the E.D. indicated the resident's daughter reported a missing wedding ring set that belonged to her mother on 2/25/12. The resident's room</p>	F0224	<p>I. Immediate Corrective Action</p> <p>P &amp; P on misappropriation of resident property was followed at the time of the event. ISDH and the Crawfordsville Police were notified at that time. Resident # 49 discharged from the facility on 3/5/12, prior to the survey.</p> <p>II. Identification of others potentially affected.</p> <p>Upon review of comment and concerns log for the last 30 days, no other residents were identified.</p> <p>III. Systemic Changes</p> <p>Administration will continue to follow current P &amp; P by reviewing comments and concerns. In addition, Administration will interview two alert residents weekly x 30 days inquiring if there has been any misappropriation of</p>	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>was searched without successful finding of the ring. The Executive Director stated she wanted to rule out the possibility of someone forcefully removing the ring from the resident's finger. The x-ray was ordered to determine if any harm was done.</p> <p>The missing ring investigation was reviewed on 5/4/12. An investigation of the missing ring was started immediately after the daughter's report on 2/25/12. The police were notified on 2/25/12. The police department asked for the facility to discontinue their investigation because the police department would take over due to the fact the police detective recognized an employee name (Employee #2) that was related to some people involved with other crimes in the area. The investigation was turned over to the police department and the investigation remains open.</p> <p>Employee #2's records were reviewed on 5/4/12 at 2:30 P.M. The employee was hired on 10/25/11. A criminal background search was completed with no results. On 2/27/12, Employee #2 called the Director of Nursing (DON) and quit. No notice or reason was given to the DON.</p> <p>A policy for Protection of Residents:</p>		<p>their property. Administration will interview one responsible party weekly x 30 days inquiring if there has been any misappropriation of property.</p> <p>IV. Quality Assurance</p> <p>After the initial 30 days, administration will continue to interview at minimum one alert resident and one family member monthly inquiring if there has been any misappropriation of property x 5 months. Results will be reviewed through the P.I. committee to determine the need to continue audits. Administration will continue to review concern &amp; comment log M-F.</p> <p>V. Completion Date</p> <p>May 30, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Reducing the Threat of Abuse &amp; Neglect (no date), received from the Executive Director on 5/1/12 at 2:30 P.M., indicated the following:</p> <p>"...Misappropriation of Resident Property Investigation</p> <p>Policy</p> <p>Residents have the right to live at ease without the fear of losing irreplaceable personal property. Reports of misappropriation of resident property shall be promptly and thoroughly investigated...."</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LANE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure 3 of 12 residents were immunized during the influenza season in a sample of 12 residents. (Residents # 25, 8 and 18)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #25 was reviewed on, 5/2/12 at 10:00 A.M.</p> <p>Resident was admitted to the facility 2/14/06 and readmitted on 9/14/11</p> <p>Diagnoses included, but were to limited</p>	F0334	<p>I. Immediate Corrective Action There is no immediate correction due to influenza season for administering vaccination has expired (typically stated as Oct 1 through April 30) There were no adverse events- no cases of influenza diagnosed during this past flu season. Residents will receive flu vaccination during the next flu season as ordered. Administration has pre-booked Fluvirin through their supplier on 5-25-12 for the 2012-2013 flu season.</p> <p>II. Identification of others potentially affected 100% audit was completed 5/16/12 by nursing admin to identify others</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>to, congestive heart failure, dementia and chronic obstructive pulmonary disease.</p> <p>A Physician's order summary, dated for the month of April 2012, indicated "May follow pneumovax &amp; influenza vaccines per facility protocol/standing orders." This order was dated 9/14/11.</p> <p>A review of the immunization record for Resident #25 did not indicate the influenza vaccine had been administered for the 2011 - 2012 flu season.</p> <p>During an interview with the corporate nurse, on 5/3/12 at 3:00 P.M., she indicated there were no records to indicate Resident #25 had received the annual influenza vaccine.</p>		<p>potentially affected. Those identified were unable to be given the influenza vaccination at this time due to the season being over. Residents will receive flu vaccination during the next flu season as ordered.</p> <p>Administration has pre-booked Fluvirin through their supplier on 5-25-12 for the 2012-2013 flu season.III. Systemic ChangesThe licensed nursing staff were educated beginning on May 8, 2012 and completing on May 30, 2012 by nursing admin. Any nurse unavailable for training prior to May 30, 2012 will be required to complete the education prior to the next shift worked. Education included the P &amp; P for obtaining consent and orders and administration of and documentation of said administration for the annual flu vaccination.The DON created and implemented a "tickler file" system to facilitate review and completion of annual influenza vaccinations each year for each resident.IV. Quality AssuranceNursing Admin will add each new resident admitted to the newly created tickler file for influenza administration tracking. The file card identifies consent and date of administration. Nursing Admin will review each card weekly during the annual influenza season to determine compliance with the influenza P &amp; P of obtaining consent, orders, and administration of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>2. The clinical record for Resident #8 was reviewed on 5/4/12 at 1:00 P.M. An immunization record was found with no entries related to flu vaccination.</p> <p>3. The clinical record for Resident #18 was reviewed on 5/4/12 at 11:00 A.M. An immunization record was found with the latest flu vaccine administration dated 10/19/09.</p> <p>During an interview with the Director of Nursing, on 5/4/12 at 3:15 P.M., she indicated no records for Resident's #8 and 18 could be found showing they had received the flu immunization for the prior flu season.</p> <p>3.1-13(a)</p>		<p>influenza immunization. This is a new system with no stop date.V. Systemic Change Completion DateMay 30, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to ensure residents were</p>	F0441	I. Immediate Corrective Action Res # 37 - PPD given on	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>tested annually or upon admission for tuberculosis (TB) skin testing. This affected 8 of 12 residents reviewed for tuberculosis skin testing screenings. (Residents #37, 22, 44, 8, 18, 9, 14 &amp; 32)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #37 was reviewed on 5/3/12 at 9:00 A.M.</p> <p>An immunization record was found with the last entry for TB skin testing dated 2/27/11.</p> <p>During an interview with the D.O.N. (Director of Nursing), on 5/4/12 at 1:30 P.M., she indicated the TB test was not administered.</p> <p>2. The clinical record for Resident #22 was reviewed on 5/3/12 at 11:00 A.M.</p> <p>An immunization record was found with the last entry for TB skin testing dated 2/28/11.</p> <p>During an interview with the D.O.N., on 5/4/12 at 1:30 P.M., she indicated the TB test was not administered.</p> <p>3. The clinical record for Resident #44 was reviewed on 5/3/12 at 2:15 P.M. An immunization record was found with the</p>		<p>5-11-12 and was read on 5-14-12. Res # 22- PPD given on 5-11-12 and was read on 5-14-12. Res # 44- PPD given on 5-11-12 and was read on 5-14-12. Res # 8- PPD given on 5-11-12 and was read on 5-14-12. Res # 18- PPD given on 5-11-12 and was read on 5-14-12. Res # 9- PPD given on 5-11-12 and was read on 5-14-12. Res # 14- PPD given on 5-11-12 and was read on 5-14-12. Res # 32- PPD given on 5-11-12 and was read on 5-14-12. There were no positive ppd results/ no adverse affects. II. IDENTIFICATION OF OTHERS POTENTIALLY AFFECTED A chart audit was completed on 5-10-12 by nursing admin on current residents to determine the need for ppd administration. Those identified were administered PPD and read on day 3. The audit and administration of annual PPDs was completed on 5/11/12. They were read on 5-14-12. There were no positive ppd readings. III. SYSTEMIC CHANGES Education was provided by nursing administration to licensed staff on infection control, including administration of first and second step PPD and annual PPD. Inservices began on 5-8-12 and will continue through May 30, 2012. Any nurse unavailable for training by May 30, 2012 will be required to complete the education prior to the next shift</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>last entry for TB skin testing dated 2/27/11.</p> <p>During an interview with the D.O.N. on 5/4/12 at 1:30 P.M., she indicated the TB test was not administered.</p> <p>4. The clinical record for Resident #8 was reviewed on 5/4/12 at 1:00 P.M.</p> <p>Resident #8 was admitted to the facility 7/10/08.</p> <p>An immunization record was found with no entry for TB skin testing for 2012.</p> <p>During an interview with the D.O.N., on 5/4/12 at 1:30 P.M., she indicated the TB test was not administered.</p> <p>5. The clinical record for Resident #18 was reviewed on 5/4/12 at 11:00 A.M.</p> <p>An immunization record was found with the last entry for TB skin testing dated 3/18/11.</p> <p>During an interview with the D.O.N., on 5/4/12 at 1:30 P.M., she indicated the TB test was not administered.</p> <p>6. The clinical record of Resident #9 was reviewed on 5/4/12 at 1:30 P.M.</p> <p>Diagnoses included, but were not limited</p>		<p>worked. The DON created and implemented a "tickler file" card system to facilitate review and completion of initial first &amp; second step, and annual ppd administration for each resident. IV. QUALITY ASSURANCE New residents will be reviewed by the DON and/or nursing management, M-F during clinical Change of Condition, to determine that the first and/or second step PPD has been administered and read. This will be an ongoing system with no stop date. The tickler file cards will be filed by month due. The DON and/or nursing admin will pull the cards monthly and update as the annual ppd is given. Education will continue to be provided upon hire and annually to licensed staff on first and second step PPD administration. V. SYSTEMIC CHANGE COMPLETION DATE May 30, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>to, dementia and high blood pressure.</p> <p>Resident #9 was admitted to the facility 12/9/11.</p> <p>A review of the immunization record indicate Resident #9 had not received a TB skin test upon admission to the facility.</p> <p>During an interview with the Director of Nursing, on 5/4/12 at 3:00 P.M., she indicated the resident had a chest x-ray done prior to being admitted but the TB skin test was not done.</p> <p>7. The clinical record of Resident #14 was reviewed on 5/4/12 at 9:15 A.M.</p> <p>Diagnoses included, but were not limited to dementia, high blood pressure and osteoporosis.</p> <p>A review of the immunization record sheet indicated an annual TB skin test was due in March 2012. The record indicated the last TB skin test was done on 3/18/11.</p> <p>During an interview with the Corporate Nurse, on 5/4/12 at 3:00 P.M., she indicated the TB skin test was not done.</p> <p>8. The clinical record of Resident #32 was reviewed on 5/3/12 at 12:50 P.M.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Diagnoses included, but were not limited to, anxiety, depression and osteoarthritis.</p> <p>Resident #32 was admitted to the facility on 12/28/09.</p> <p>There was no record of Resident #32 receiving the annual TB skin test.</p> <p>During an interview with the Corporate Nurse on 5/3/12 at 2:50 P.M., she indicated there was no immunization record of the resident receiving his annual TB skin test.</p> <p>During an interview with the Director of Nursing, on 5/3/12 at 1:40 P.M., she indicated the residents receive an annual TB skin test in February and it's documented on an immunization record that is kept in the resident's chart.</p> <p>3.1-18(e) 3.1-18(f)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0514 SS=A	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure an inventory sheet was included in a closed clinical record (Resident #49) and failed to ensure an assessment tool was accurately documented (Resident #39). This effected 2 of 12 residents in a sample of 12 resident records reviewed for complete and accurate information. (Residents #39 &amp; #49)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #49 was reviewed on 5/2/12 at 9:15 A.M. This review was a closed record review. An inventory sheet was not located in the record.</p> <p>During an interview with the Executive Director on 5/3/12 at 9:00 A.M., she</p>	F0514	<p>I. Immediate Correction Resident # 39 has discharged to home from the facility 5-18-12. Resident # 49 discharged from the facility on 3-5-12, prior to the survey . II. Identification of others affected Skin records at time of transfer: An audit of transfer records of current residents were compared to the admission nursing tri-fold assessment for discrepancies by nursing admin on 5-18-12. One additional record was identified, however, the admitting nurse states there was no redness upon admission so she did not place it on the tri-fold (appropriately so). Resident Inventory Records: An audit of current resident records was completed by nursing admin on May 22, 2012. Inventory lists were updated on any record found to be without.</p> <p>III. Systemic Changes Education was provided by nursing admin to</p>	05/30/2012			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>to, chronic obstructive pulmonary disease and high blood pressure.</p> <p>A Patient Transfer Record, dated 3/10/12, indicated Resident #39 had a red coccyx that blanches. The resident was transferred from the hospital back to the facility.</p> <p>A Nursing "Initial Data Collection Tool," dated 3/10/12 at 4:20 P.M., did not indicate Resident #39 had a reddened area on the coccyx.</p> <p>During an interview with the Wound Nurse, on 5/4/12 at 3:00 P.M., she indicated Resident #39's coccyx was red when she returned from the hospital on 3/10/12. The Patient Transfer Record indicated it was red before she left the hospital.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F9999	<p>STATE FINDINGS</p> <p>3.1-14 PERSONNEL</p> <p>(t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non-paid personnel of facilities shall be screened for tuberculosis.</p> <p>(t)(4) An employee with symptoms or signs of active disease (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure a newly hired employee was provided the second step TB test when the employee failed to provide documentation of a previous TB test administered within the past 12 months. This affected 1 of 13 employee files reviewed. (CNA #1)</p> <p>Findings include:</p>			F9999	<p>I. Immediate Corrective Action The CNA has been given a second step ppd on 5-23-12 and was read on 5-25-12. The reading was negative. II. Identification of others There was a 100% review by nursing admin on 5-24-12 of staff hired in the last 30 days by. There are no other staff members identified with the deficient practice. III. Systemic Changes Newly hired staff will be required to go through the 2 step ppd process upon hire, unless they are able to physically produce by their start date proof of a previous negative ppd within the last 12 months, at which point they will have only one ppd required per state regulation. Nursing Admin received education on this process on 5-24-12.IV. Quality Assurance All newly hired staff members ppd records will be audited by nursing admin at the end of week one from date of hire and the end of week 3 from date of hire to ensure administration of first and second step ppd for six months. Results will be reviewed through the P.I. committee to determine the need to continue audits after six months. V. Completion Date May 30, 2012</p>		05/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012	
NAME OF PROVIDER OR SUPPLIER  LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>During an interview with the Staff Development (SDC) on 5/4/12 at 10:30 A.M., she indicated CNA #1 stated upon hire that she had a TB skin test earlier within the year. The facility administered a TB skin test on 1/6/12 and the results were negative. CNA #1 began working on 1/16/12. CNA #1 told the SDC she would provide the facility the documentation of prior TB skin results. As of 5/4/12, this documentation was not in the facility's possession.</p> <p>A policy for "Prospective Associates" under "Tuberculosis Control Program" submitted by the Executive Director on 5/4/12 at 4:00 P.M. was reviewed. The policy indicated "Skin testing will employ the two-step procedure."</p> <p>3.1-14(t)(1) 3.1-14(t)(4)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155477	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  LANE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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