STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155477	A. BUILDING 00 B. WING	04/07/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00456290. Complaint IN00456290 - No deficiencies related to the allegations are cited. Survey dates: April 1, 2, 3, 4, and 7, 2025 Facility number: 000462 Provider number: 155477 AIM number: 100275380 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 1 Medicaid: 35 Other: 9 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 15, 2025.	F 0000	This Plan of Correction is to serve as The Lane House' credible allegation of compliance. By submitting the enclosed materials, The Lane House nor its management company are not admitting the truth or accuracy of any specific findings or allegations. The Lane House reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective May 2, 2025 to the state findings of the Recertification and Licensure Survey with Complaint conducted on April 7, 2025. The Lane House respectfully requests a desk review.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure falls were documented, interventions implemented, and a call light was within the resident's reach for 1 of 2 residents reviewed for falls (Resident 29).	F 0689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 29 had no negative outcomes. Call light was put in	05/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Stephens	Executive Director	04/25/2025

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

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	Findings include: During an observation, on 4/1/25 at 11:05 a.m., Resident 29 was in his recliner with no call light within his reach. The call light was observed at the end of his bed. At the same time, the resident indicated he used the call light to request assistance when needed, and it was "over there on the bed somewhere." When queried how he used the call light when it was on the bed, the resident indicated, "I don't." The resident requested to lay back down in bed. During an interview, on 4/1/25 at 12:07 p.m., Resident 29's daughter indicated he had fallen "a lot" since being at the facility. He fell often at home too. The resident used the call light to ask for help and knew how to use it, but he sometimes got up without assistance. The resident had fallen earlier in the day on 4/1/25. Resident 29's record was reviewed on 4/3/25 at 2:15 p.m. Census information indicated the resident was admitted to the facility on 1/2/25. Diagnoses on the resident's profile included, but were not limited to, generalized muscle weakness, subsequent encounter for a fracture of the unspecified carpal (bones in wrist) bone of the right wrist, and history of falling. A Progress Note, dated 1/3/25, indicated the resident's roommate turned on the call light and reported the resident rolled out of bed. The resident was lying beside the bed and indicated he was "sleeping." The bed was in the lowest position with a mat placed at bedside. An Interdisciplinary Team (IDT) note, dated 1/6/25, indicated the resident had an unwitnessed		place immediately. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? An in-house audit has been completed by nursing management/designee on residents considered to be high fall risk to ensure interventions are care planned, documented and in place by date of compliance. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing management will educate staff on appropriate interventions for falls to be in place per plan of care by date of compliance. No staff will work past date of compliance without this education completed. Education will be offered upon hire, at least annually and as needed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Nursing Management/designee will observe five residents weekly x 3 months, then 3 residents weekly x 3 months to ensure compliance. ED/designee will observe 3 residents weekly x 6 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need	

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	fall on 1/3/25. The bed was placed in the lowest position. The resident had another unwitnessed fall on 1/4/25 at 4:25 p.m. when he was found on the floor mat next to his bed. The resident had no injuries and was assisted back to bed by staff. New interventions included floor mat next to bed and bed in the lowest position. The IDT Note lacked documentation of new interventions placed after the fall on 1/4/25, as the low bed and mat next to the bed were initiated after the resident's fall on 1/3/25. Progress Notes lacked documentation of the fall on 1/4/25, at the time it occurred, including a post-fall assessment or new interventions put into place. A Progress Note, dated 1/9/25 at 4:35 a.m., indicated the resident fell from a raised bed onto the floor while the Certified Nurse Aide (CNA) provided care to the resident at 4:10 a.m. The note lacked documentation an intervention was initiated immediately to prevent further falls. An IDT Note, dated 1/9/25 at 10:13 a.m., indicated the resident had a witnessed fall at 4:10 a.m. The resident rolled out of his raised bed while the CNA provided care, and landed on his right side. There were two skin tears to the resident's right elbow. A new intervention of two staff to assist with resident care was initiated. An admission Minimum Data Set (MDS) Assessment, dated 1/13/25, indicated the resident had a severe cognitive impairment, required substantial/maximal assistance with transfers, and one fall since the resident's admission. An IDT Note, dated 1/17/25 at 9:22 a.m., indicated the IDT reviewed the resident's fall from 1/16/25 at		for further audits.	

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	9:20 a.m. The resident was found lying beside his bed on the floor mattress with no injuries. The new intervention was to monitor the resident for restlessness and assist the resident into his wheelchair as needed. The Progress Notes lacked documentation of the fall on 1/16/25, at the time it occurred, including a post-fall assessment or new interventions put into place. A Progress Note, dated 3/28/25, indicated another resident reported Resident 29 was sitting on the floor. The staff went to the resident and found he had gotten himself up from the floor and was sitting on the other bed in his room. The resident was assessed and denied pain. The note lacked documentation of an intervention implemented immediately to prevent further falls. A Progress Note, dated 3/29/25 at 11:21 a.m., indicated the resident complained of right wrist pain. The resident's daughter requested evaluation in the emergency room (ER) for x-ray. The resident's daughter reported the resident had a history of a wrist fracture, but she was unable to remember which wrist he previously fractured. The resident was transported to the ER via ambulance. A Progress Note, dated 3/29/25 at 2:17 p.m., indicated the resident returned to the facility. The resident's daughter reported he was to wear the splint for four weeks, and there was no orthopedic treatment recommended. The resident was moved to a room closer to the nurse's station for increased observation. An x-ray report, dated 3/29/25, indicated evidence of a chronic healing fracture to the left wrist.			

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	An x-ray report, dated 3/29/25, indicated a fragment along the dorsum (back or upper side) of the right wrist which was concerning for a possible triquetral (bone on inner side of wrist) fracture. An IDT Note, dated 3/31/25, indicated the IDT reviewed the resident's unwitnessed fall on 3/28/25. The resident was placed on 15-minute checks and moved closer to the nurse's station. A Progress Note, dated 4/1/25 at 9:45 a.m., indicated the resident was found on the floor next to his closet, and his recliner was tipped over on its side. The resident was assisted to his wheelchair. The note lacked documentation of an assessment of the resident after the fall or an intervention implemented immediately to prevent further falls. On 4/4/25 at 11:20 a.m., the Director of Nursing (DON) provided the following Risk Management documents. At the same time, the DON indicated the falls should have been documented in the Progress Notes and Risk Management. The Risk Management was an internal incident report and included information about the falls and interventions. The Risk Management documents were visible to nurses and management. a. An unwitnessed fall occurred on 1/3/25. The resident's roommate reported the resident was on the floor. The resident had rolled out of bed and indicated he was "sleeping." The resident was assessed, and no injuries were noted. Interventions to prevent further falls were bed in lowest position and mat placed at bedside. b. An unwitnessed fall occurred on 1/4/25. The			

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	CNA found the resident sitting on the floor. There were no injuries noted, and the resident was unable to say what happened. The Risk Management document lacked documentation of an intervention put in place to prevent further falls. c. An unwitnessed fall occurred on 1/16/25. The resident was found lying on the mat next to his bed on his left side. An assessment was completed. The Risk Management document lacked documentation of an intervention put in place to prevent further falls. d. An unwitnessed fall occurred on 4/1/25. The resident was found lying on his right side next to his recliner. The recliner was flipped over next to the resident. The resident told his daughter he was trying to get into his chair. No injuries were noted, and the resident was assisted into his wheelchair. The immediate intervention was to "ensure staff provides frequent checks for resident when in recliner." A care plan, target dated 4/21/25, indicated the resident was at risk for falls. The resident rolled out of bed, on 1/3/25, with no injuries, was found sitting on the floor at bedside, on 1/4/25, with no injuries, rolled out of bed while being assisted by staff with incontinence care, on 1/9/25, was found lying on the floor mat, on 1/16/25, and was observed by another resident sitting on the floor and then got himself up, on 3/28/25. Interventions included monitor for restlessness and get resident up into wheelchair as needed, initiated on 1/17/25, bed in lowest position, initiated on 1/6/25, floor mat at bedside, initiated on 1/6/25, two staff assistance with activities of daily living (ADLs), initiated on 1/9/25, anticipate and meet the resident's needs, initiated on 3/29/25, assist with			

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	ADLs as needed, initiated on 1/3/25, call light within reach, initiated on 1/3/25, complete fall risk assessment, initiated on 1/3/25, and resident monitored for safety every 15 minutes, initiated on 3/29/25. During an interview, on 4/4/25 at 10:41 a.m., the DON indicated falls were documented in the Progress Notes and Risk Management documents. Risk Management documents were internal incident reports and were visible to nurses and management. An intervention should have been initiated at the time of each fall. The IDT reviewed falls and ensured care plans were updated. Staff was notified of fall interventions verbally and education was provided as needed. During an interview, on 4/4/25 at 11:20 a.m., the DON indicated she reviewed the resident's record and was unable to find Progress Notes for the falls on 1/4/25 and 1/16/25. During an interview, on 4/4/25 at 11:30 a.m., CNA 13 she was taking care of Resident 29. The resident had fallen a few days ago, but she had not worked in about a week. She should have been notified of any required fall interventions for the resident when she received report. She was not sure what intervention was put in place for the resident's last fall, and she was not aware of any interventions specific to the resident's recliner. The resident's call light should have been kept within his reach, and he was able to use the call light. During an interview, on 4/4/25 at 11:55 a.m., the DON indicated the resident's wrist fracture may have been old, but they were unable to tell for sure. The resident's daughter reported he previously fractured his wrist, but she was unable			

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	to remember which wrist. On 4/4/25 at 1:06 p.m., the DON provided a document titled, "Fall Management," last revised 3/11/25, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The facility will assess the resident upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls...Procedure...4. The interdisciplinary team will review and revise the care plan, if indicated...upon a fall event and as needed thereafter...6. The interventions to reduce the risk of falls should be individualized based on the resident risk factors and fall history...." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to address a significant weight discrepancy for 2 of 4 residents reviewed for nutrition and the facility failed to obtain daily weights for 1 of 4 residents reviewed for weights (Residents 27, 17, and 21). Findings include: 1. Resident 27's record was reviewed on 4/2/25 at 1:45 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic combined systolic (congestive) and diastolic (congestive) heart failure (a long-term condition where the heart's ability to pump blood effectively impairs both systole [contraction] and diastole [relaxation], leading to fluid buildup and	F 0692	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #27, #17 and #21 had no negative outcomes. MD notified of weight variances. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Other residents have the potential to be affected. Therefore, an in house audit will be completed on weights. Any issues identified will have appropriate follow up and	05/02/2025

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	other symptoms) and cardiomegaly (an enlarged heart). A quarterly Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident had severe cognitive impairment and indicated the resident had weight loss in the last 6 months and was not on a weight loss regimen. A care plan, dated 1/14/25, indicated the resident had unplanned/unexpected weight gain related to 5% weight gain in 30 days. Interventions included but were not limited to, daily weight, observe and report to medical doctor as needed situations leading to increased food consumption, reasons for weight gain, and significant weight changes. A physician order, dated 2/20/25, indicated to obtain a daily weight in the morning before breakfast every day and report a 3-pound weight gain/day or a 5-pound weight gain/week to medical doctor. A physician order, dated 2/26/25, indicated the resident was to have a regular diet, mechanically altered texture (foods that have been modified to be softer and easier to chew), and nectar/mildly (used for people with swallowing difficulties to reduce the risk of choking) consistency. Review of the resident's weights indicated she weighed 174 pounds on the most recent MDS assessment dated 2/26/25. Subsequent weights included, but were not limited to the following: a. On 2/28/25 at 2:33 p.m., the resident was weighed in her wheelchair. Her weight was 180.9 pounds. b. On 3/4/25 at 6:08 p.m., the resident was weighed		notification. Audit will be completed by date of compliance. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff will be educated by Director of Nursing/designee on the weight policy to include: reweighs, notification of MD/family, care plans updates and appropriate documentation. Education will be offered upon hired, at least annually and as needed. No nursing staff will work without education past date of compliance. Weight scale(s) to be put on schedule for calibration. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly, weekly and daily weights will be reviewed by nursing management. Nursing management will enter monthly/weekly weights after review and ensure MD/family notified of significant weight loss/gain. Floor staff will enter daily weights on eMAR. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	in her wheelchair. Her weight was 185.9 pounds. c. On 3/5/25 at 12:25 p.m., the resident was weighed in her wheelchair. Her weight was 179.3 pounds. d. On 3/9/25 at 11:23 a.m., the resident was weighed in her wheelchair. Her weight was 186.5 pounds. e. On 3/10/25 at 12:37 p.m., the resident was weighed in her wheelchair. Her weight was 191.6 pounds. f. On 3/12/25 at 1:38 p.m., the resident was weighed in her wheelchair. Her weight was 182.3 pounds. h. On 3/15/25 at 5:51 p.m., the resident was weighed in her wheelchair. Her weight was 190.1 pounds. i. On 3/17/25 at 9:23 a.m., the resident was weighed in her wheelchair. Her weight was 181.2 pounds. j. On 3/18/25 at 9:57 a.m., the resident was weighed in her wheelchair. Her weight was 187.7 pounds. k. On 4/2/25 at 6:21 p.m., the resident was weighed in her wheelchair. Her weight was 187.2 pounds. l. On 4/3/25 at 2:45 p.m., the resident was weighed in her wheelchair. Her weight was 199.2 pounds. The record lacked documentation that the significant weight discrepancies in the resident's weights had been addressed by the facility and the record lacked documentation of the weights being conducted before breakfast daily as ordered by the physician.			

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	During an interview, on 4/2/25 at 1:56 p.m., Registered Dietitian (RD) was not concerned about Resident 27's weight but she had been gaining weight recently, she further indicated she usually eats well, and she had edema at times. The RD had questioned rather staff was weighing the resident accurately. During an interview, on 4/4/25 at 1:32 p.m., the Director of Nursing (DON) indicated the facility had noticed some inconsistency with some of the residents' weights back in the fall of 2024 and they felt the scale could have been off and needed recalibrated, but it had not been looked at yet. She indicated there was a systemic issue that the facility needed to work on, and staff should have notified the medical doctor as ordered for weight discrepancies. She was aware Resident 27 was a congestive heart failure resident, and her weights should be monitored more closely. 2. Resident 17's record was reviewed on 4/4/25 at 10:26 a.m. The profile indicated the resident's diagnoses included, but were not limited to, mild protein calorie malnutrition (a condition caused by a deficiency in both protein and calories, leading to poor growth, muscle weakness, and potential neurological complications), dysphasia (swallowing difficulties), and gastrostomy tube (feeding tube-a flexible, hollow tube inserted through the abdominal wall and into the stomach which provides a direct route for administering nutrition and medications into the stomach). An annual Minimum Data Set (MDS) assessment, dated 2/11/25, indicated the resident had no cognitive deficit, had a documented weight loss of 5% in the last month or 10% in past 6 months, and had a feeding tube.			

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	A care plan, dated 5/19/23, indicated the resident had the potential for nutritional problems related to protein calorie malnutrition and dysphasia, and being NPO (nothing by mouth) with a feeding tube. A care plan, dated 7/15/24, indicated the resident required a tube feeding related to diagnoses of dysphasia and history of malignant neoplasm of lip, oral cavity, and pharynx (a cancerous growth in the tissues lining the mouth, lips, and upper throat). A care plan, dated 3/17/25, indicated the resident would refuse his tube feeding if not offered at scheduled times. A physician's order, dated 4/26/24, indicated to weigh the resident weekly on the day shift, every Tuesday, related to his tube feeding. Review of the residents' weights indicated the resident weighed 213.8 lbs. (pounds) on 9/3/24 and dropped to 177.4 lbs. on 1/7/25. This indicated a weight loss of 17.03% in 90 days. A quarterly Registered Dietician (RD) assessment, dated 1/3/25, indicated the resident's weight on 12/24/24 had been 177.6 lbs., which indicated a significant weight loss of 22 lbs. or an 11% weight loss in 1 month or 32 lbs. or an 15.3 % weight loss in 6 months. The RD questioned the accuracy of weight obtained on 12/24/24, (177.6) as inconsistent with the previous month's weights which indicated an upward trend of his weights of 194.2 lbs. to 199.8 lbs. The RD recommended that weights and tolerance to tube feeding continue to be monitored and requested a new weight be obtained.			

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LANE HOUSE, THE	1000 LANE AVE CRAWFORDSVILLE, IN 47933

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	During an interview, on 4/2/25 at 11:17 a.m., the RD indicated she believed the facility had some issues with their scales in the fall and the beginning of the year. She had recommended additional bolus feedings, at that time, but the resident refused because he did not accept the weight that had been indicated by the scales. She also had failed to see any evidence of the resident being malnourished or having any significant weight loss. During an interview, on 4/4/25 at 11:24 a.m., the Director of Nursing (DON) indicated the resident had always been weighed in his wheelchair. He had been care planned for refusal to accept his feedings at times and had failed multiple swallow studies. When she was the Assistant Director of Nursing (ADON), she had recognized many inconsistencies with the facility's scale and had asked to get the scale looked at, but the previous administration never acted on her request. During the period when she had been made aware of the resident's weight loss, she met with him and did not notice any signs that he had any significant weight loss (i.e., clothes fitting more loosely or his watch being loose on his wrist). At the same time, she indicated the expectation would be that when the RD documented a need for a re-weight, it should be done as soon as possible to make sure that the weight loss was an actual loss or a malfunction of the scale. On 4/4/25 at 1:08 p.m., the DON provided a document, with a revision date of 8/19/24, titled, "Weight Measurement," and indicated it was the policy currently being used by the facility. The policy indicated, "...Critical Notes...3. Notify the nurse if the weight obtained is significantly different from the prior weight (greater or equal to 3 lbs. for a weekly weight; greater or equal to 5			

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	lbs. for a monthly weight). Reweigh as needed. 4. The unit manager/designee should review and verify the weights on the day they are obtained to ensure there is no unexplained significant variance from the prior weight by utilizing the weight reports in PCC (Point Click Care-the electronic medical record)...."3. Resident 21's record was reviewed on 4/3/25 at 11:16 a.m. Diagnoses on the resident's profile included, but were not limited to, chronic systolic congestive heart failure (CHF) (a condition in which the heart does not pump blood effectively). An admission Minimum Data Set (MDS) assessment, dated 2/18/25, indicated the resident was cognitively intact. A Physician's Order, dated 3/17/25, indicated daily weight in the morning before breakfast related to CHF. A weight gain of three pounds in a day or five pounds in a week should have been reported to the physician. A Medication Administration Record (MAR), dated March 2025, lacked documentation a daily weight was obtained on 3/20/25, 3/21/25, 3/22/25, 3/25/25, 3/27/25, and 3/28/25. A MAR, dated April 2025, lacked documentation a daily weight was obtained on 4/1/25. The weights vital signs section of the electronic record lacked documentation daily weights were obtained on 3/20/25, 3/21/25, 3/22/25, 3/25/25, 3/27/25, 3/28/25, and 4/1/25. Progress Notes, dated March and April 2025, lacked documentation the resident refused daily weights.			

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	During an interview, on 4/3/25 at 2:52 p.m., the Director of Nursing (DON) indicated the daily weights were ordered because of the resident's CHF diagnosis, but he was not symptomatic. She reviewed the resident's chart but was unable to find additional weights, refusals, or reasons why the daily weights were not obtained. Daily weights should have been completed everyday, and if they were not completed for some reason, the reason should have been documented on the MAR. On 4/3/25 at 2:52 p.m., the DON provided a document titled, "Lippincott Advisor-Diseases and Conditions: Heart failure, long-term care," dated 2025, and indicated it was the facility's policy related to caring for residents with CHF. The policy indicated, "...Monitoring: Daily or weekly weight...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observations, interviews, and record review, the facility failed to ensure proper storage of respiratory equipment for 1 of 2 residents reviewed for respiratory care (Resident 14). Findings include: 1a. On 4/1/25 at 11:21 a.m., Resident 14's unbagged nebulizer (turns liquid medicine into a mist that can be easily inhaled) mouthpiece and tubing were observed laying on top the nebulizer machine. The resident was sitting in her wheelchair next to her bed. 1b. On 4/1/25 at 2:38 p.m., Resident 14 was sitting	F 0695	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #14 had nebulizer placed in appropriate storage equipment immediately and had no negative outcomes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with O2 equipment will be reviewed for appropriate storage	05/02/2025

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	up in her wheelchair watching T.V. and her unbagged nebulizer mouthpiece and tubing were observed laying on top of the nebulizer machine on her bedside table. 1c. On 4/2/25 at 9:50 a.m., Resident 14 was resting in bed and her nebulizer mouthpiece and tubing was observed sitting on top of her nebulizer machine in a clear plastic trash bag. The trash bag was not labeled with the resident's name or date. 1d. On 4/3/25 at 10:28 a.m., Resident 14's unbagged nebulizer mouthpiece and tubing were observed to be sitting on top of her nebulizer machine. The resident indicated that she knew the mouthpiece and tubing should be bagged when not in use, but she doesn't have good dexterity of her fingers to put it in the bag herself. Resident 14's record was reviewed on 4/3/25 at 10:34 a.m. The profile indicated the resident diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). An admission Minimum Data Set (MDS) assessment, dated 3/14/25, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 3/7/25, indicated the resident had altered respiratory status/ difficulty breathing related to anxiety (intense, excessive, and persistent worry and fear about every situation), COPD, and asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe). Interventions included, but were not limited to, administer medications/puffers		by nursing management by date of compliance. Any issues identified will be corrected immediately. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Education will be provided to licensed and certified nursing staff on the appropriate storage of O2 equipment per LCCA policy by date of compliance. Education will be offered upon hired, at least annually and as needed. No staff will work without education past date of compliance. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Nursing management/designee will observe 5 residents weekly x3 months, then 3 resident weekly x3 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	as ordered. A physician's order, dated 3/7/25, indicated albuterol sulfate solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier) 2.5 milligrams (mg)/3 milliliters (ml) inhale 3ml orally via nebulizer every 6 hours for shortness of breath. During an interview on 4/3/25 at 1:45 p.m., Licensed Practical Nurse (LPN) 10 indicated the nebulizer mouthpiece and medication chamber was to be rinsed out after use and once dried it should be placed in a bag with the resident's name and date on it. The nebulizer mouthpiece and tubing should not be left out unbagged when not in use. During an interview on 4/3/25 at 2:12 p.m., Director of Nursing (DON) indicated the nebulizer mouthpiece, and tubing should be bagged when not in use. On 4/3/25 at 2:52 p.m., the DON provided a document with a revised date of 10/11/24, titled, "Oxygen Administration (Safety, Storage, Maintenance)," and indicated it was the currently policy currently being used by the facility. The policy indicated, " ...3. Storage oxygen and respiratory supplies in bag labeled with resident's name when not in use ...." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure accurate	F 0732	1. What corrective action(s) will be accomplished for those residents	05/02/2025

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	staffing sheets were posted daily for 3 of 5 days during the recertification survey. Findings include: During an observation, on 4/01/25 at 12:19 p.m., the staffing sheet posted on the wall outside of the nurses' station was dated correctly, but the posting lacked documentation of the total number of the facility census and the name of the facility. During an observation, on 4/2/25 at 9:27 a.m., the staffing sheet posted on the wall outside of the nurses' station, was dated on the top half of the sheet for 4/2/25 and the bottom half for 4/3/25, but the posting lacked documentation of the total number of the facility census and the name of the facility. During an interview, on 4/2/25 at 9:30 a.m., the Director of Nursing (DON) indicated she was not aware the staffing sheet posted was not completed accurately. She indicated the scheduler was responsible for making sure the posting was completed accurately. The DON indicated she would post the staffing sheet in the morning if the scheduler wasn't there. On 4/2/25 at 1:14 p.m., the DON provided a document with a revised of 6/12/24, titled, "Staffing," and indicated it was the policy currently being used by the facility. The policy indicated, " ...3. The daily posting must include: a. Facility name b. Current date ...d. Resident census ...."		found to have been affected by the deficient practice? Nurse staff information was posted, however, lacked census and facility name. The form being utilized was updated immediately by the Director of Nurses adding the census and facility name. No resident was identified as being affected in this statement of deficiencies. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents have the potential to be affected. The Director of Nurses implemented a form that includes actual census and facility name. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing, nurse scheduler and Executive Director were educated by the Regional Vice President on the posted nurse staff hours requirement and have been designated with the responsibility of ensuring posted information includes census and facility name is posted 7 days a week. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Nurses/designee will	

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			review the nurse staff posting daily x 6 months. Friday of each week nurse staff postings will be reviewed for the weekends ongoing x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure behaviors were documented to support the declination of a medication gradual dose reduction (GDR) for 1 of 5 residents reviewed for unnecessary medications (Resident 36). Findings include: Resident 36's record was reviewed on 4/2/25 at 10:55 a.m. Diagnoses on the resident's profile included, but were not limited to, major depressive disorder single episode and unspecified mild anxiety disorder. Progress Notes, dated December 2024, lacked documentation of behaviors, including restlessness. A physician's order, dated 12/31/24, indicated administer Ativan (antianxiety medication) 0.25 milligrams (mg) via gastrostomy tube (g-tube) twice daily for anxiety. A physician's order, dated 12/31/24, indicated administer sertraline (antidepressant medication) 25 mg via g-tube once daily for depression.	F 0758	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #36 had orders corrected immediately and had no negative outcomes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? SSD will audit residents on psychotropic meds to ensure appropriate documentation is in place to decline/accept GDR recommendations by date of compliance. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? SSD will educate in house psych services on not recommending GDRs without reviewing appropriate supporting documentation from staff by date of compliance.	05/02/2025

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	Progress Notes, dated January 2025, lacked documentation of behaviors, including restlessness. A Medication Administration Record (MAR), dated February 2025, indicated monitor and document behaviors of yelling out and disturbing others every shift related to unspecified anxiety disorder. The documentation included interventions and their efficacy. The resident had one episode of behaviors on 2/2/25, day shift. The MAR lacked documentation of other behaviors during February 2025. A quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident had a severe cognitive impairment and received antidepressant and antianxiety medications during the look-back period. Progress Notes, dated February 2025, lacked documentation of behaviors, including restlessness. A MAR, dated March 2025 indicated monitor and document behaviors of yelling out and disturbing others every shift related to unspecified anxiety disorder. The documentation included interventions and their efficacy. The resident had one episode of behaviors on 3/8/25, day shift. The MAR lacked documentation of other behaviors during March 2025. Progress Notes, dated March 2025, indicated the resident yelled out several times throughout the night shift on 3/24/25. The Progress Notes lacked documentation of other behaviors during March 2025. A Psychiatry Progress Note, dated 3/20/25,		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? SSD will review recommended GDRs for appropriate supporting documentation to ensure compliance for 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	indicated, "Per staff, [Resident 36] has remained psychiatrically stable at baseline with no new concerns or behaviors since last visit. Seen in her room, alert and calm. Is mostly nonverbal but indicated her mood has been okay. Does endorse some anxiety. Denies changes with sleep or appetite...." The note lacked documentation of persistent restlessness. A Pharmacy Consultation Report, dated 3/24/25, indicated the resident had received sertraline 25 mg daily for the management of major depressive disorder since 9/27/24. The pharmacist recommended an initial GDR attempt of a trial off of the sertraline. The Nurse Practitioner (NP) declined the GDR and documented, "will increase at next visit d/t [due to] persistent restlessness and then GDR Ativan." The NP signed the form on 4/1/25. A Pharmacy Consultation Report, dated 3/24/25, indicated the resident had received Ativan 0.25 mg twice daily for anxiety since 9/7/24. The pharmacist recommended a GDR to lorazepam 0.25 mg once daily. The NP declined the GDR and documented, "more alert and restless. Will likely increase Zoloft [sertraline] and then GDR Ativan." The NP signed the form on 4/1/25. A care plan, target dated 5/15/25, indicated the resident exhibited behaviors of yelling out and disturbing others and had the potential to be verbally aggressive towards staff related to poor impulse control. Interventions included, but were not limited to, observe and document behaviors and attempted interventions each shift and analyze key times, places, circumstances, triggers, and what de-escalates behaviors and document. A MAR, dated April 2025 indicated monitor and			

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	document behaviors of yelling out and disturbing others every shift related to unspecified anxiety disorder. The documentation included interventions and their efficacy. The MAR lacked documentation of any behaviors. Progress Notes, dated April 2025, lacked documentation of behaviors, including restlessness. During an interview, on 4/3/25 at 10:26 a.m., the Director of Nursing (DON) indicated she reviewed the resident's medical record and was unable to find additional documentation the resident had behaviors. Behaviors and the interventions attempted should have been documented by the nursing staff. During an interview, on 4/3/25 at 10:36 a.m., the Social Services Director (SSD) indicated behaviors and interventions attempted were documented on the MAR. There was no additional documentation of Resident 36's behaviors. On 4/3/25 at 10:45 a.m., the DON provided a document titled, "Psychotropic Medication Use," dated 2025, and indicated it was the policy currently being used by the facility. The policy indicated, "...10. If physician/prescriber orders a psychotropic medication in the absence of a diagnosis, facility should ensure that the ordering physician/prescriber reviews the medication plan and considers a gradual dose reduction...of psychotropic medications for the purpose of finding the lowest effective dose unless a GDR is clinically contraindicated. 10.1 physician/prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed			

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	behavior. 11. Facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication...Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure keys to the medication room were kept in an area only accessible to nursing staff, food was not kept in the medication room, multi-use medication containers were dated when opened, and insulin was disposed of once it was past the use by date for 1 of 1 medication rooms reviewed and 1 of 2 medication carts reviewed (Residents 33 and 12). Findings include: 1. During an observation, on 4/7/25 at 10:19 a.m., the Director of Nursing (DON) removed keys from an unsecured drawer at the nurse's station and unlocked the medication room. The nurse's station was not locked or secured and was accessible to staff and visitors. The keys obtained from the unsecured drawer unlocked the narcotic and refrigerated emergency drug kits (EDKs) in the medication room. A container of peanut butter bars was observed on the counter in the medication room. A medication bottle contained three vials of Aplisol (tuberculosis testing solution) and was stored in the refrigerator. One	F 0761	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #33 and #12 had no negative outcomes. The insulin pen was removed immediately off med cart. The food was removed from the medication room, multiuse medications were dated, and the med room keys are now on the key rings for the med carts therefore only licensed nurses have access to the medication room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? An in house audit was completed by nursing management on med and treatment carts to ensure appropriate medication and treatment storage regulations are	05/02/2025

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	of the vials of Aplisol was opened. There was no opened date on the Aplisol vial or the medication bottle. At the same time, the DON indicated the nurses were not supposed to have food at the nurse's station so it was in the medication room. 2. During an observation, on 4/7/25 at 10:24 a.m., Registered Nurse (RN) 14 opened the "wing medication cart." A Humalog (fast-acting insulin) pen for Resident 33 had an opened date of 2/21/25 and a pharmacy filled date of 2/19/25. A stock bottle of Prosource Plus Liquid Protein was opened and undated. A bottle of Milk of Magnesia (MOM) for Resident 12 was opened and undated. At the same time, RN 14 indicated she thought insulin could be used for 30 days after it was opened, and the liquid protein and MOM should have been dated when opened. 2a. Resident 33's record was reviewed on 4/7/25 at 10:40 a.m. Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus (a chronic condition where the body either does not produce enough insulin, or the body's cells do not respond normally to insulin, leading to high blood sugar levels). A Physician's Order, dated 8/26/22, indicated Humalog Kwikpen 100 units (u)/milliliters (ml), inject per sliding scale before meals. 2b. Resident 12's record was reviewed on 4/7/25 at 10:44 a.m. A Physician's Order, dated 1/10/25, indicated MOM 30 ml by mouth daily as needed for constipation. During an interview, on 4/7/25 at 10:34 a.m., the Assistant Director of Nursing (ADON) indicated insulin should have been discarded 28 days past the opened date. The Aplisol, liquid protein, and		in place. Any issues identified will be corrected immediately by date of compliance. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Education will be provided to licensed nursing staff on medication and treatment storage policy. No staff will work past date of compliance without this education completed. Education will be offered upon hired, at least annually and as needed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Nursing management will audit one med/treatment cart weekly x6 months to ensure compliance. Med carts will be rotated per audit. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	155477	A. BUILDING 00 B. WING	04/07/2025

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	MOM should have been dated when they were opened. During an interview, on 4/7/25 at 10:59 a.m., the Nurse Consultant indicated the medication room keys should not have been stored where they were accessible to anyone other than nursing staff. At the same time, the DON indicated they kept the medication and EDK keys in the drawer at the nurse's station. On 4/7/25 at 10:53 a.m., the DON provided a document titled, "Storage Recommendations for Injectable Diabetes Medications," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Humalog...Opened...Room Temperature...28 days...." On 4/7/25 at 10:53 a.m., the DON provided a document titled, "...Storage and Expiration Dating of Medications, Biologicals," dated January 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...This Policy...sets forth the procedures relating to the storage and expiration dates of medications...PROCEDURE: 1. Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable law...3.6 Facility should ensure that food is not stored in the...general storage areas where medications and biologicals are stored...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier			

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	guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container...when the medication has a shortened expiration date once opened...5.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial...." 3.1-25(m)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary A. Based on observation, interview, and record review, the facility failed to ensure the low temperature dish machine (a commercial dishwashing machine that relies on chemical sanitizers, rather than high temperatures, to sanitize dishes, typically operating at temperatures between 120° Fahrenheit [F] and 140 F) wash and rinse temperatures met minimum standards and the March 2025 logs for the dish machine temperatures were completed for 1 of 2 kitchen observations. This had the potential to affect all residents who consumed food or liquids from the kitchen. B. Based on observation, interview, and record review, the facility failed to ensure the March 2025 logs for the sanitizer solution bucket (a container filled with a sanitizer solution [like bleach or a similar chemical] used to reduce germs on surfaces, often wiping cloths or equipment, to safe levels), freezer, refrigerator, and dinner meal food temperatures were completed for 1 of 2 kitchen observations. This had the potential to	F 0812	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no negative outcomes for residents on alleged deficient practice. Temperatures for the freezer, refrigerator and dishwasher in the kitchen was corrected immediately. The ice scoop was stored in a sanitary manner, and the sanitation bucket logs were completed for the current shift. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Other residents have the potential to be affected. Therefore, above cited areas were corrected immediately. 3. What measures will be put into	05/02/2025

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	affect all residents who consumed food or liquids from the kitchen. C. Based on observation, interview, and record review, the facility failed to ensure the scoop to the ice container used for the resident's lunch drinks, was maintained in a sanitary manner for 1 of 2 dining observations. Findings include: A. During the initial kitchen tour, on 4/1/25 at 9:51 a.m., the facility's low temperature dish machine wash temperatures measured at 115 F and the rinse temperature was measured at 118 F. Observation of the March 2025 dish machine temperature logs lacked documentation of the temperatures being monitored after 3/17/25. During an interview, on 4/1/25 at 11:41 a.m., the Dietary Manager indicated he had re-checked the temperatures on their low temp machine and it had never got above 118 F. At the same time, he indicated he had new dietary staff, and they were still being trained. He felt that this was the reason the temperature logs had not been completed. On 4/1/25 at 12:20 p.m., the Dietary Manager provided a document, dated 4/1/25, titled, "Low Temp Dishwasher Temperature," and indicated it was the policy currently being used by the facility. The policy indicated, "Low-temperature dishwashers operate with wash and rinse cycles between 120 F and 140 F...." B. During the initial kitchen tour, on 4/1/25 at 9:51 a.m., the temperature logs for the kitchen were reviewed, and indicated the following:		place and what systemic changes will be made to ensure that the deficient practice does not recur? Education will be completed to dietary staff by Dietary Manager with E.D. present on logging temperatures per LCCA policy by date of compliance. This education will be offered upon hired, at least annually and as needed. No dietary staff will work without education past date of compliance. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Dietary manager will validate temps being logged per LCCA policy and federal/state regulations 5x weekly for 6 months. E.D. will validate 3x weekly for 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	a. The March 2025 sanitizing bucket daily log lacked documentation of the sanitizer measurements, after 3/18/25. b. The March 2025 refrigerator and freezer temperature logs (logs documenting the temperatures to ensure foods stored were maintained at a safe temperature) lacked documentation that the temperatures had been monitored after 3/19/25. c. The March 2025 Food Temperature logs (logs that measured the holding temperatures of foods to be served for each meal) lacked documentation that the temperatures of the dinner meals had been monitored 3/18/25, and that the breakfast and lunch meals had been monitored on 3/29/25, 3/30/25, and 3/31/25. During an interview, on 4/1/25 at 11:41 a.m., the Dietary Manager (DM) indicated he had new dietary staff, and they were still being trained. He felt that this was the reason the temperature logs had not been completed. On 4/1/25 at 11:40 a.m., the Dietary Manager provided a document, with a revision date of 6/28/24, titled, "Food Temperature Control," and indicated it was the policy currently being used by the facility. The policy indicated, "...Guidelines: 1. Food temperatures are checked at the completion of the cooking process and before being placed in the serving line...." On 4/1/25 at 12:00 p.m., the Dietary Manager provided an undated document titled, "Closing List for PM Cook," and indicated it was the policy currently being used by the facility. The policy indicated, "...All logs are filled out...."			

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	C. On 4/1/25 at 11:48 a.m., an observation of the lunch meal in the main dining room was initiated. On 4/1/25 at 12:02 p.m., Registered Nurse (RN) 15 was observed to open the lid to the ice cooler, pick up the ice scoop, fill ice into a resident's glass, and placed the ice scoop back into the cooler directly on top of the ice, and close the lid. During an interview, on 4/1/25 at 12:32 p.m., the Dietary Manager indicated the ice scoop should be maintained in a container outside of the ice chest and should never be placed into the ice when used. On 4/1/25 at 1:48 p.m., the Dietary Manager provided a document, with a revision date of 6/3/24, titled, "Ice Chests," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...5. Ice scoops used should be...kept on an uncovered stainless steel, impervious plastic, or fiberglass tray on top of the chest or in a mounted holder when not in use...." 3.1-21(a)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observations, interview, and record review the facility failed to ensure a sanitary environment was maintained for residents during meal service for 2 of 2 random observations. This had the potential to affect all residents on the West Hall consuming food during the use of cleaning supplies. Findings include:	F 0921	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were directly affected by alleged deficient practice. Housekeeping carts were removed from hallways immediately during meal service. 2. How other residents having the	05/02/2025

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	On 4/01/25 at 12:10 p.m., during observation of the noon meal service on the West Hall, observed Employees 8 and 3 cleaning rooms and mopping floors while drinks and food trays were being passed to residents. On 4/01/25 at 12:30 p.m., observed Employee 3 cleaning handrails outside of the residents rooms while residents were eating. On 4/01/25 at 12:18 p.m., during interview with Housekeeping Supervisor she indicated she had instructed the staff to remove carts when meals were being served. She indicated the housekeepers were not permitted to clean residents rooms or hall area when meals were being served. On 4/1/2025 at 1:48 p.m., the Administrator provided a document, titled, "Housekeeping Services," dated 6/29/21, and indicated it was the policy currently being used by the facility. The policy indicated, "...Routine Cleaning ...18. Resident rooms should not be cleaned during meal services. 19. Cleaning carts should be removed from resident halls while meal trays are being passed ...." 3.1-19(e)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Other residents have the potential to be affected. Therefore, housekeeping manager educated housekeepers on duty on date of notification. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Education will be provided to all environmental staff by housekeeping manager on infection control practices related to housekeeping carts in the hallway during meal service by date of compliance. Education will be provided upon hired, at least annually and as needed. No environmental staff will work past date of compliance without education. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Housekeeping manager/designee will observe 1 meal daily x6 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	