STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155477	A. BUILDING -- B. WING	04/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/24/25 Facility Number: 000462 Provider Number: 155477 AIM Number: 100275380 At this Emergency Preparedness survey, The Lane House was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 39. Quality Review completed on 04/25/25	E 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 16, 2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on April 24,2025. The Lane House respectfully requests a desk review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/24/25 Facility Number: 000462 Provider Number: 155477 AIM Number: 100275380	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Stephens	Executive Director	05/09/2025

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	At this Life Safety Code survey, Lane House was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with two partial basements was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery-operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 39 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings: one providing facility storage and one which is used as an oxygen storage and transfilling building, which were not sprinklered. Quality Review completed on 04/25/25		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 16, 2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on April 24,2025. The Lane House respectfully requests a desk review.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on observation and interview; the facility failed to ensure all battery-operated smoke alarms in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and	K 0300	**K300** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the deficient practice. The	05/16/2025

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	tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents. Findings include: Based on observations made during a tour of the facility with the Executive Director and the Maintenance Director on 04/24/25 at 12:08 p.m., resident room #2 had a battery-operated smoke alarm in it. When it was taken down from the ceiling for inspection, the manufacture date was over 10 years old as it was stamped with the date of January 2014. Based on interview with the Maintenance Director on 04/25/25 at 12:10 p.m., he was unaware of the manufactured date of the smoke alarms and indicated he would check every battery-operated smoke alarm in all residents' rooms for the manufacture date and replace them if necessary. This item was again discussed at the exit conference with the Executive Director and the Maintenance Director held on 04/24/25. 3.1-19(b)		Maintenance Director replaced the battery-operated smoke detector in resident room #2. 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? All residents in the facility had potential to be affected by the deficient practice. The Maintenance Director completed an audit of battery-operated smoke detectors in the facility and replaced any of these with a manufactured date over 10 years old with a new battery-operated smoke detectors. 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 Maintenance Director was educated on NFPA 101 and NFPA 72 Section 29.10. 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? The Maintenance Director/designee will complete a monthly visual inspection of the manufacturer date of battery-operated smoke detectors for 6 months and provide the	

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			Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules. 5 Date of Compliance: May 16, 2025	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1) Based on record review and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust	K 0324	**K324** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. Upon further review with the contracted vendor, exhaust cleaning was completed August 1, 2023, February 6, 2024, and August 28, 2024. The Maintenance Director also marked the floor under the kitchen hood extinguishing equipment to ensure the cooking appliance is returned	05/16/2025

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	system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect at least 18 residents, 6 staff and 2 visitors. Findings include: Based on record review on 04/24/25 at 10:49 a.m. with the Maintenance Director, the contracted vender's exhaust cleaning documentation was dated 01/10/23 and was the most recent exhaust cleaning documentation available. Based on interview on 04/24/25 at 10:50 a.m., the Maintenance Director stated that he would have to contact his vendor and have them send the most recent inspection documents to him as he could not locate either of the two semi-annual inspections. Based on an interview at the exit conference held on 04/24/25 at 1:54 p.m., the Maintenance Director was asked if he had received any correspondence from his vendor in reference to the two inspections, and he stated that he had not. At that time, it was stated that the deficiency would have to be sited and if the records were received after the survey had concluded, the documents should be submitted to Quality Review with the plan of correction.		to the correct position if moved. 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? All residents have the potential to be affected by the deficient practice. Documentation of the semi-annual exhaust cleaning has been provided to the facility from the contracted vendor. The Maintenance marked the floor under the kitchen hood extinguishing equipment to ensure the cooking appliance is returned to the correct position if moved. 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 contracted vendor is to provide the Executive Director and the Maintenance Director with documentation of any services rendered. The Maintenance Director was educated on NFPA 96. 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? The Maintenance Director/designee will complete a monthly audit of contracted	

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	This item was again discussed at the exit conference with the Executive Director and the Maintenance Director held on 04/25/25. 3.1-19(c) 2) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 18 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Executive Director and the		exhaust cleaning x 6 months. The Maintenance Director/designee will also complete a visual inspection of the stove placement weekly x 4 weeks, then monthly x 5 months and provide the Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules. 5 Date of Compliance: May 16, 2025	

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	Maintenance Director on 04/24/25 at 12:00 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview on 04/24/25 at 12:03 p.m., the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was again discussed at the exit conference with the Executive Director and the Maintenance Director held on 04/24/25. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2	K 0353	**K353** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. Upon further review with the contracted vendor, a sprinkler system inspection was completed April 8, 2024, December 11, 2024 and April 14, 2025. 2 How other residents having	05/16/2025

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	requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 04/24/25 at 10:00 a.m. with the Maintenance Director, the quarterly sprinkler system inspection records were dated as follows: 04/08/24, 08/04/24, and 12/11/24. There was no documentation available for a sprinkler system inspection for the first quarter (January, February, and March) of 2025. Based on an interview on 04/24/25 at 10:12 a.m. with the Maintenance Director, he acknowledged there was no documentation available to show the sprinkler system had been inspected during the first quarter of 2025 adding that he would contact his vendor. A short time later the vendor returned the Maintenance Directors phone call and stated that the 12/11/24 inspection was supposed to be for the first quarter of 2025. It was then explained to the Maintenance Director that the inspections must be done within the quarters they are scheduled and that the schedule needs to be followed for safety and consistency. This item was again discussed at the exit conference with the Executive Director and the		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the deficient practice. Documentation of the quarterly sprinkler system inspections have been provided to the facility from the contracted vendor. 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 contracted vendor is to provide the Executive Director and the Maintenance Director with documentation of any services rendered. The Maintenance Director was educated on LSC 4.6.12.1 and NFPA 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? The Maintenance Director/designee will complete a monthly audit of contracted sprinkler system inspection x 6 months and provide the Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends will be addressed	

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	Maintenance Director held on 04/24/25. 3.1-19(b)		with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules. 5 Date of Compliance: May 16, 2025	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 29 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 12 residents, 2 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Executive Director and the Maintenance Director on 04/24/25 at 12:38 p.m., resident room #19 corridor door failed to latch into the doorframe when tested on three separate occasions. Based on an interview with the Maintenance Director on 04/24/25 at 12:40 a.m., he agreed that the corridor door to resident room #1 failed to latch into the doorframe when tested on three separate occasions. This item was again discussed at the exit conference with the Executive Director and the	K 0363	**K363** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. The Maintenance Director adjusted the door hinge in resident room #19 to ensure the resident room door closed completely and latched. 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? All residents have potential to be affected by the deficient practice. The Maintenance Director completed an audit of all resident	05/16/2025

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	Maintenance Director held on 04/24/25. 3.1-19(b)		room doors to ensure doors closed completely and latched immediately adjusting any as needed. 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 Maintenance Director was educated on facility policy. 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? The Maintenance Director/designee will complete a monthly audit of resident room doors x 6 months and provide the Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules. Date of Compliance: May 16, 2025	

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K 0521 SS=E Bldg. 01	NFPA 101 HVAC Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect as many as 7 staff in the kitchen. Findings include: Based on record review on 04/24/25 at 10:34 a.m. with the Maintenance Director, when asked if the facility had any fire or smoke dampers, the Maintenance Director stated that there was a fire	K 0521	**K521** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the deficient practice. The contracted vendor completed an inspection of the fire damper May 13, 2025. 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? All residents have the potential to be affected by the deficient practice. The contracted vendor completed an inspection of the fire damper May 13, 2025 and vendor provided documentation of inspection to the Executive Director and the Maintenance Director. 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 Maintenance Director was educated on NFPA 101. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	05/16/2025

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LANE HOUSE, THE	1000 LANE AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	damper located in the kitchen. Based on an interview on 04/24/25 at 10:35 a.m., when asked if he could provide the four-year maintenance testing requirement documentation, the Maintenance Director could not locate any documentation at all. The lack of four-year maintenance conducted on the kitchen fire damper was verified by the Maintenance Director who stated that he would have someone come and service the damper as soon as possible. This item was again discussed at the exit conference with the Executive Director and the Maintenance Director held on 04/24/25. 3.1-19(b)		i.e., what quality assurance program will be put into place? The Maintenance Director/designee will complete a monthly audit of contracted damper inspection x 6 months and will present the Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules. 5 Date of Compliance: May 16, 2025	