STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1				COMPLETED 04/24/2025	
		155477	B. W			04/24/		
NAME OF P	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP COD			
LANE HO	OUSE, THE			1000 LANE AVE CRAWFORDSVILLE, IN 47933				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL				ATE	COMPLETION	
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
□ 0000								
Bldg	An Emergency Preparedness Survey was		E 0	000	This Plan of Correction is to s	erve		
		ndiana Department of Health in		000	as The Lane House' credible	,0,70		
	accordance with 42				allegation of compliance. By			
					submitting the enclosed mate	rials,		
	Survey Date: 04/24	4/25			The Lane House nor its management company are no	ot		
	Facility Number: (admitting the truth or accurac			
	Provider Number:	155477			any specific findings or			
	AIM Number: 100	275380			allegations. The Lane House			
	And T	D 1 70			reserves the right to contest t			
		Preparedness survey, The und in compliance with			findings or allegations as part			
		edness Requirements for			any proceedings and submit to responses pursuant to our	inese		
		icaid Participating Providers			regulatory obligations. The fa	acility		
	and Suppliers, 42 C				requests the plan of correctio	-		
	The facility has 60	certified beds. At the time of			considered our allegation of compliance effective May 16,	2025		
	the survey, the cens				to the state findings of the Life Safety Code Recertification a	е		
	Quality Review con	mpleted on 04/25/25			Emergency Preparedness Su	ırvey		
					conducted on April 24,2025.			
					Lane House respectfully requal a desk review.	esis		
K 0000								
Bldg. 01								
	•	Recertification and State	K 0	000	This Plan of Correction is to s	serve		
	-	vas conducted by the Indiana			as The Lane House' credible			
	-	Ith in accordance with 42 CFR			allegation of compliance. By			
	483.90(a).				submitting the enclosed mate The Lane House nor its	riais,		
	Survey Date: 04/24	4/25			management company are no admitting the truth or accuracy			
	Facility Number: (000462			any specific findings or	y O1		
	Provider Number:				allegations. The Lane House	:		
	AIM Number: 100	275380			reserves the right to contest t			
					Î		I	

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

TITLE (X6) DATE

Michelle Stephens Executive Director 05/09/2025

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155477		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/24/2025
	ROVIDER OR SUPPLIER DUSE, THE	1000 LA	ADDRESS, CITY, STATE, ZIP COD ANE AVE FORDSVILLE, 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 APPROPRIA DEFICIENCY)	DATE
I/ 0300	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 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 any proceedings and submit the responses pursuant to our regulatory obligations. The fair requests the plan of correction considered our allegation of compliance effective May 16, 2 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Sur conducted on April 24,2025. The House respectfully request a desk review.	cility be 2025 d vey The
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 practic. No resident was affected by the deficient practice. The	ce?

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155477	(X2) MULTIPLE A. BUILDING B. WING	Onstruction 01	(X3) DATE SURVEY COMPLETED 04/24/2025
	PROVIDER OR SUPPLIER		1000	ET ADDRESS, CITY, STATE, ZIP COD LANE AVE WFORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
PREFIX	tested in accordance published instruction of Chapter 14. Sect testing, and maintent the requirements of equipment manufact Section 14.4.8.1 starecommended by the instructions, single-alarms shall be replied to operability tests belonger than 10 year. This deficient pract. Based on observation facility with the Exemple Maintenance Direct resident room #2 has alarm in it. When it ceiling for inspectic over 10 years old as of January 2014. Based Maintenance Direct was unaware of the smoke alarms and it battery-operated smooth for the manufic for inspection of the manufic for the manufic for the manufic for the manufic for the section of the manufic for the section of the manufic for the manufactor of the	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULDID CROSS-REFERENCED TO THE APPROPRICE PROVIDER CORRECTIVE ACTION SHOULDID CROSS-REFERENCED TO THE APPROPRICE PROVIDER CORRECTIVE ACTION SHOULDID CROSS-REFERENCED TO THE APPROPRICE PROVIDER CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE CROSS-REFERENCED TO THE APPROPRICE CORRECTIVE ACTION SHOULD SHOULD CROSS-REFERENCED TO THE APPROPRICE CORRECTIVE ACTION SHOULD SHOULD CROSS-REFERENCED TO THE APPROPRICE CORRECTIVE ACTION SHOULD SHOULD CROSS-REFERENCED SHOULD	COMPLETION DATE Cod the sector aving by the be //e ad ne leted lity and a years ated e put ic sure bes not was I NFPA tion(s) the
	conference with the	Executive Director and the or held on 04/24/25.		i.e., what quality assurance program will be put into place. The Maintenance Director/designee will comp monthly visual inspection of	ce? lete a
				manufacturer date of battery-operated smoke det for 6 months and provide th	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155477	B. WI		<u>01 </u>	04/24/	
	PROVIDER OR SUPPLIE	R	<u>I </u>	1000 L	ADDRESS, CITY, STATE, ZIP COD ANE AVE FORDSVILLE, IN 47933	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				Executive Director with the resof these audits. The Executive Director will present a report of the findings at the monthly QA meeting. Any negative trends be addressed with an action provided the This criteria for determining the monitoring is no longer necess will be 100% accuracy. If audit do not meet this criterion, audit shall continue at the same schedule for an additional 6 months. At that time, analysis data will be done to ensure the deficient practice does not recand/or adapt audit schedules. 5 Date of Compliance: Mail 16, 2025	e AQI will blan. eat sary its its of e	
	facility failed to en systems was inspected 2011 Edition, Stan Fire Protection of Operations, Section system shall be insproperly trained, quacceptable to the anand in accordance Schedule for Insperequires systems so cooking operations semiannually. NFF inspection, if the econtaminated with	review and interview; the sure 1 of 1 kitchen exhaust eted semiannually. NFPA 96, dard for Ventilation Control and Commercial Cooking in 11.4 states the entire exhaust pected for grease buildup by a sualified, and certified person(s) authority having jurisdiction with Table 11.4. Table 11.4, etion for Grease Buildup, erving moderate volume a shall be inspected PA 96, 11.6.1 states, upon whaust system is found to be deposits from grease laden inated portions of the exhaust	K 0	324	1 What corrective action(s will be accomplished for those residents found to have been affected by the deficient practic. No residents were affected by deficient practice. Upon further review with the contracted ver exhaust cleaning was completed August 1, 2023, February 6, 2 and August 28, 2024. The Maintenance Director also mather floor under the kitchen hose extinguishing equipment to enthe cooking appliance is returned.	ice? this er ndor, ted 2024, arked od ssure	05/16/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/24/2025 155477 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 LANE AVE LANE HOUSE, THE CRAWFORDSVILLE, IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE system shall be cleaned by a properly trained, to the correct position if moved. qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease How other residents having removal devices, fans, ducts, and other the potential to be affected by the appurtenances shall be cleaned to remove same deficient practice will be combustible contaminants prior to surfaces identified and what corrective becoming heavily contaminated with grease or action(s) will be taken? oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other All residents have the potential to substance. When an exhaust cleaning service is be affected by the deficient used, a certificate showing the name of the practice. Documentation of the servicing company, the name of the person semi-annual exhaust cleaning has performing the work, and the date of inspection or been provided to the facility from cleaning shall be maintained on the premises. This the contracted vendor. The deficient practice could affect at least 18 residents, Maintenance marked the floor 6 staff and 2 visitors. under the kitchen hood extinguishing equipment to ensure Findings include: the cooking appliance is returned to the correct position if moved. Based on record review on 04/24/25 at 10:49 a.m. with the Maintenance Director, the contracted What measures will be put vender's exhaust cleaning documentation was into place and what systemic dated 01/10/23 and was the most recent exhaust changes will be made to ensure cleaning documentation available. Based on that the deficient practice does not interview on 04/24/25 at 10:50 a.m., the Maintenance Director stated that he would have The contracted vendor is to provide to contact his vendor and have them send the the Executive Director and the most recent inspection documents to him as he Maintenance Director with could not locate either of the two semi-annual documentation of any services inspections. Based on an interview at the exit rendered. The Maintenance conference held on 04/24/25 at 1:54 p.m., the Director was educated on NFPA Maintenance Director was asked if he had 96. received any correspondence from his vendor in How the corrective action(s) reference to the two inspections, and he stated will be monitored to ensure the that he had not. At that time, it was stated that the deficient practice will not recur, deficiency would have to be sited and if the i.e., what quality assurance records were received after the survey had program will be put into place? concluded, the documents should be submitted to The Maintenance Quality Review with the plan of correction. Director/designee will complete a monthly audit of contracted

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155477	l í	UILDING	onstruction 01	(X3) DATE COMPL 04/24 /	ETED
	PROVIDER OR SUPPLIEF	·	•	1000 LA	ADDRESS, CITY, STATE, ZIP COD ANE AVE FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	This item was again conference with the Maintenance Direct 3.1-19(c) 2) Based on observe failed to provide an returning cooking a when the kitchen he was designed and in extinguishing syste. Ventilation Control Commercial Cookin Edition Section 12. requiring protection or rearranged without fire-extinguishing sor servicing agent, the design of the fir Section 12.1.2.3 sta system shall not recooking appliances maintenance and clappliances are return location prior to cooking appliances are returned to the appliance with the manual. Section 12 method shall be proappliance is returned location. The deficing many as 18 resident facility.	a discussed at the exit e Executive Director and the for held on 04/25/25. ation and interview, the facility approved method for ppliances to where they were ood extinguishing equipment installed for 1 of 1 kitchen hood in. NFPA 96, Standard for and Fire Protection of ing Operations Section 2011 1.2.2, states cooking appliances in shall not be moved, modified, but prior re-evaluation of the system by the system installer unless otherwise allowed by the extinguishing system. Ites the fire-extinguishing puire reevaluation where the are moved for the purposes of the eaning, provided the med to approved design oking operations, and any extinguishing system nozzles iances are reconnected in the manufacturer's listed design 1.2.3.1 states an approved ovided that will ensure that the dot on approved design ient practice could affect as ts, 6 staff, and 2 visitors in the		IAU	exhaust cleaning x 6 months. Maintenance Director/designe will also complete a visual inspection of the stove placem weekly x 4 weeks, then month 5 months and provide the Executive Director with the res of these audits. The Executive Director will present a report of the findings at the monthly QA meeting. Any negative trends be addressed with an action p This criteria for determining th monitoring is no longer necess will be 100% accuracy. If audi do not meet this criterion, aud shall continue at the same schedule for an additional 6 months. At that time, analysis data will be done to ensure the deficient practice does not rec and/or adapt audit schedules. 5 Date of Compliance: Ma 16, 2025	The e nent lly x sults n QI will lan. at sary ts its of	DATE
	Findings include:						
		ons made during a tour of the ecutive Director and the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155477		A. BUILDING B. WING	COMPLETED 04/24/2025		
	ROVIDER OR SUPPLIER		1000 L	ADDRESS, CITY, STATE, ZIP COD ANE AVE FORDSVILLE, IN 47933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	the six (6) burner stricted to burner stricted on the cooking kitchen was not promethed that would be returned to an appropriate that the appropriate that the appropriate aware an approved design loc cleaning and that he to the kitchen stove compliance as soon. This item was again conference with the Maintenance Direct 3.1-19(b) NFPA 101 Sprinkler System - Based on record reversaled to provide were vidence the sprinkle been inspected and 4.6.12.1 requires an required for compliant maintained in according the record of the Inspection, The Water-Based Fire Pater 1.3.1 requires recording the recording proposed to the stricted and stricted to the sprinkle that the sprinkle of t	discussed at the exit Executive Director and the	K 0353	K353 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practic. No residents were affected by deficient practice. Upon further review with the contracted ven a sprinkler system inspection of completed April 8, 2024, December 11, 2024 and April 2025. 2 How other residents have	ce? this er idor, was 14,

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i '		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>			COMPLETED	
		155477	B. WING 04/24/2025			2025		
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	L.			ANE AVE			
LANE HO	DUSE, THE				FORDSVILLE, IN 47933			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	s shall indicate the procedure			the potential to be affected by			
		pection, test, or maintenance),			same deficient practice will be			
	_	t performed the work, the			identified and what corrective			
		NFPA 25, 5.2.5 requires that			action(s) will be taken?			
		vices shall be inspected			l			
		hey are free of physical			All residents have the potentia	ıl to		
	_	5.3.3.1 requires the mechanical			be affected by the deficient			
		vices including, but not limited			practice. Documentation of th	е		
	_	gs, shall be tested quarterly.			quarterly sprinkler system			
		e-type and pressure			inspections have been provide			
		ow alarm devices shall be			the facility from the contracted			
		This deficient practice could			vendor.			
		staff, and visitors in the						
	facility.				3 What measures will be p	out		
	F' 1' ' 1 1		into place and what systemic					
	Findings include:				changes will be made to ensu			
	Dagad on magand nor	iov. on 04/24/25 at 10:00 a m			that the deficient practice does	s not		
		riew on 04/24/25 at 10:00 a.m. ce Director, the quarterly			recur?	ما المان د		
		spection records were dated as			The contracted vendor is to prethe Executive Director and the			
		08/04/24, and 12/11/24. There				•		
		ion available for a sprinkler			Maintenance Director with			
		or the first quarter (January,			documentation of any services rendered. The Maintenance	•		
		h) of 2025. Based on an			Director was educated on LSC			
		25 at 10:12 a.m. with the			4.6.12.1 and NFPA 25.	,		
		or, he acknowledged there			4.0.12.1 and NFFA 25. 4 How the corrective actio	n(s)		
		ion available to show the			will be monitored to ensure the			
		d been inspected during the			deficient practice will not recu			
	1 *	adding that he would contact		i.e., what quality assurance		,		
		time later the vendor returned			program will be put into place	>		
		rectors phone call and stated			The Maintenance	•		
		spection was supposed to be			Director/designee will complet	e a		
		of 2025. It was then explained			monthly audit of contracted			
		Director that the inspections			sprinkler system inspection x	3		
		the quarters they are			months and provide the Execu			
		the schedule needs to be			Director with the results of the			
	followed for safety				audits. The Executive Director			
		,			present a report on the finding			
	This item was agair	discussed at the exit			the monthly QAQI meeting. Ar			
	I -	Executive Director and the			negative trends will be addres	-		
			- 1		I			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ILDING	01	COMPL 04/24/	ETED		
	PROVIDER OR SUPPLIER			1000 LA	DDRESS, CITY, STATE, ZIP COD NNE AVE FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Maintenance Direct 3.1-19(b)	or held on 04/24/25.			with an action plan. This criterifor determining that monitoring no longer necessary will be 10 accuracy. If audits do not meet this criterion, audits shall continuat the same schedule for an additional 6 months. At that time analysis of data will be done to ensure the deficient practice do not recur and/or adapt audit schedules. 5 Date of Compliance: May 16, 2025	is 0% inue ne, opes	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors						
	failed to ensure 1 of doors to the corridor latch into the door ficuld affect approximand 2 visitors. Findings include: Based on observation facility with the Exemple Maintenance Direct resident room #19 control the doorframe when occasions. Based on Maintenance Direct agreed that the corrifailed to latch into the three separate occase. This item was again	n and interview, the facility 29 sets of resident room would close completely and rame. This deficient practice mately 12 residents, 2 staff, ans made during a tour of the cutive Director and the for on 04/24/25 at 12:38 p.m., forridor door failed to latch into tested on three separate an interview with the for on 04/24/25 at 12:40 a.m., he dor door to resident room #1 are doorframe when tested on ions. discussed at the exit Executive Director and the	K 03	363	Nata What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practic No residents were affected by deficient practice. The Maintenance Director adjusted door hinge in resident room #1 ensure the resident room door closed completely and latched 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken? All residents have potential to affected by the deficient practic The Maintenance Director completed an audit of all residents.	ce? this the 9 to ng the	05/16/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155477		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/24/2025	
	PROVIDER OR SUPPLIEF		1000 L	ADDRESS, CITY, STATE, ZIP COD LANE AVE /FORDSVILLE, IN 47933	
				1	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LY GO DEPOTE TO BE A TOOM ATTOOM	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		or held on 04/24/25.	TAG	room doors to ensure doors closed completely and latched immediately adjusting any as needed. 3 What measures will be into place and what systemic changes will be made to ensuthat the deficient practice does recur? The Maintenance Director was educated on facility policy. 4 How the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place The Maintenance Director/designee will comple monthly audit of resident room doors x 6 months and provide Executive Director with the resofthese audits. The Executive Director will present a report of these audits. The Executive Director will present a report of the findings at the monthly Quimeeting. Any negative trends be addressed with an action provided by the second will be accuracy. If audid not meet this criterion, audishall continue at the same schedule for an additional 6 months. At that time, analysis data will be done to ensure the deficient practice does not recand/or adapt audit schedules. Date of Compliance: May 16,	put are as not as an(s) ae ar, ? te a an as the sults ae an AQI will blan. at assary ats dits as of ae cur

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155477	(X2) MULT A. BUILE B. WING	DING	nstruction 01	COMP	E SURVEY PLETED 4/2025
	ROVIDER OR SUPPLIER DUSE, THE		1	000 LA	DDRESS, CITY, STATE, ZIP COD INE AVE ORDSVILLE, IN 47933	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
K 0521 SS=E Bldg. 01	NFPA 101 HVAC						
Bidg. UT	interview; the facilit dampers in the facilit dampers in the facilit provided necessary four years in accord 9.2.1 requires heatin conditioning (HVA equipment shall be Standard for the Ins and Ventilating Sys Section 5.4.8.1 state maintained in accord for Fire Doors and ONFPA 80, 2010 Edid damper shall be test installation. Section inspection frequence except for hospitals 6 years. If the damplink, the link shall be full closure and lock damper shall not be way. All inspection documented, indicated damper, date of inspectioning deficiencies discover have a space to indicate damper shall not be way. Findings include: Based on record reward the Maintenant facility had any fire	tiew, observation and ty failed to ensure 1 of 1 fire ity were inspected and maintenance at least every ance with NFPA 90A. LSC ng, ventilating and air C) ductwork and related in accordance with NFPA 90A, tallation of Air-Conditioning tems. NFPA 90A, 2012 Edition, as fire dampers shall be dance with NFPA 80, Standard Other Opening Protectives. tion, Section 19.4.1 states each red and inspected 1 year after 19.4.1.1 states the test and y shall then be every 4 years where the frequency is every were is equipped with a fusible re removed for testing to ensure cain-place if so equipped. The blocked from closure in any as and testing shall be ting the location of the fire prection, name of inspector and ered. The documentation shall cate when and how the orrected. This deficient it as many as 7 staff in the	K 052		What corrective action will be accomplished for the residents found to have be affected by the deficient process. The convendor completed an inspet the fire damper May 13, 20.2. How other residents the potential to be affected same deficient practice will identified and what correct action(s) will be taken? All residents have the potential to be affected by the deficient practice. The contracted we completed an inspection of damper May 13, 2025 and provided documentation of inspection to the Executive Director and the Maintenan Director. What measures will be made to entart the deficient practice of the deficient practice will be monitored to ensure deficient practice will not reduce the deficient practice.	pose pen ractice? by the intracted pection of 025. having the by the libe pential to be pential to be perfect to the fire ince the pential to be put mic insure does not was ction(s) be the pential to be the pential to be put mic insure does not was ction(s) be the pential to be pential to be put mic insure does not was ction(s) be the pential to be pential to be put mic insure does not was ction(s) be the pential to be pential to be put mic insure does not was ction(s) be the pential to be pential t	05/16/2025

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P1JU21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/24/2025			ETED	
		155477	B. WING		04/24/2020	
NAME OF PROVIDER OR SUPPLIER LANE HOUSE, THE		1000 L	ADDRESS, CITY, STATE, ZIP COD ANE AVE FORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	damper located in t interview on 04/24/ he could provide th testing requirement Maintenance Direc documentation at a maintenance condu was verified by the stated that he would service the damper This item was again conference with the	he kitchen. Based on an /25 at 10:35 a.m., when asked if e four-year maintenance documentation, the tor could not locate any ll. The lack of four-year cted on the kitchen fire damper Maintenance Director who d have someone come and as soon as possible. In discussed at the exit to be Executive Director and the tor held on 04/24/25.	iad	i.e., what quality assurance program will be put into place The Maintenance Director/designee will comple monthly audit of contracted damper inspection x 6 months will present the Executive Director will present a report on the findings at the monthly QAQI meeting. Any negative trends be addressed with an action provided the transfer of the trends o	te a s and ector will blan. eat sary its its of e	DAIL

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