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	01/04/2023

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: 01/04/23 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 01/12/23	E 0000		
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: 01/04/23 Facility Number: 000462 Provider Number: 155477 AIM Number: 100275380 At this Life Safety Code survey, The Lane House was found not in compliance with Requirements	K 0000		

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

Gloria McGowen | Executive Director | 01/27/2023

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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	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 providing storage services one of which includes an oxygen storage and transfilling building, which were each not sprinklered. Quality Review completed on 01/12/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 4 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as many as 8 residents, 10 staff and 2 visitors if needing to exit the facility by the main entrance. Findings include: Based on observations with the Director of Maintenance (D.O.M.) during a tour of the facility at 12:06 p.m. on 01/04/23, the main entry / exit door was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code but the code was not posted at the exit. A small sign that read "The Month and Year that COVID-19 began." was posted near the keypad. When asked if he felt this four-digit code was public knowledge to anyone wanting to enter or exit the building in an emergency situation, the D.O.M. agreed that not everyone might know this information.	K 0222	1. Installed a hinged box at the front exit door that identifies the code by lifting the lid; outer side of hinged lid tells user that code is in the box. 2. Hinged boxes with door codes were installed at all upper level exit doors. 3. The Maintenance Director was in-serviced regarding this regulation by the ED. The Maintenance Director or designee will inspect all exits for proper code provided bi-weekly for 6 months. The results of the audits will be presented to QAPI for 6 months & QAPI will determine the need for further audits.	02/10/2023

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	This deficiency was discussed at the exit conference on 01/04/23 at 2:07 p.m. with the D.O.M. only as the facility Administrator was unavailable at the time of the conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler heads under the facility main entrance canopy were clean, free of foreign materials, and corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in	K 0353	1. The identified sprinkler heads under the facility main entrance canopy will be replaced & inspected for proper function by B&R Fire Protection. 2. All other sprinkler heads have been inspected for dirt, dust & corrosion, no further issues noted. 3. The Maintenance Director was in-serviced by the ED regarding sprinkler inspection	02/10/2023

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	the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all residents, staff, and visitors entering the facility at the main entrance. Findings include: Based on observations with the Director of Maintenance (D.O.M.) during a tour of the facility at 12:02 p.m. on 01/04/23, the main entry / exit canopy was protected by four sprinkler heads. These heads were covered in dust, dirt, and corrosion. During an interview at the time of the observation, the D.O.M. agreed that the sprinkler heads located under the main entrance canopy were dirty and may not function properly or malfunction in the event of a fire emergency in that location. This deficiency was discussed at the exit conference on 01/04/23 at 2:07 p.m. with the D.O.M. only as the facility Administrator was unavailable at the time of the conference. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect as many as 10 staff working in the basement.		based on the regulation. The Maintenance Director or designee will inspect all sprinklers bi-weekly for 6 months. The results of the audits will be presented to QAPI for 6 months & QAPI will determine the need for further audits	

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	Findings include: Based on observations with the Director of Maintenance (D.O.M.) during a tour of the facility at 1:02 p.m. on 01/04/23, two fourteen-foot section of blue data wire was hung onto and supported by the sprinkler pipe in the basement area within the D.O.M.'s office. Based on an interview at the time of the observation, The D.O.M. acknowledged the blue data cables being supported on the sprinkler pipe and supports. He then got up onto a ladder and moved both sections of data wire off the sprinkler piping and supports removing the deficiency prior to my exiting of the facility. This deficiency was discussed at the exit conference on 01/04/23 at 2:07 p.m. with the D.O.M. and was noted as being repaired. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 100% of the 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	K 0521	1. All smoke duct detectors will be inspected & tested by B&R Fire Protection. 2. The smoke duct detector inspection & test will be set up with vendor for every 4 year inspection. 3. The Maintenance Director was in-serviced regarding this	02/10/2023

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	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. The test and inspection frequency shall be every 4 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 all residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance (D.O.M.) on 01/14/23 at 11:16 a.m., the D.O.M. was asked if the facility had fire and smoke dampers. The D.O.M. stated that there were fire and smoke dampers located throughout the facility. When asked if any documentation was available for review on the facilities smoke dampers, none could be located or produced. The D.O.M. contacted his vendor, who stated he would look for any testing documentation. Based on an interview during the exit conference with the D.O.M. it was noted that no documentation was available for review and that the lack of documentation would have to be cited as deficient. This deficiency was discussed at the exit conference on 01/04/23 at 2:07 p.m. with the		regulation by the ED. The Maintenance Director will set up a reminder for the 4 year inspection in the Preventative Maintenance log.	

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	D.O.M. only as the facility Administrator was unavailable at the time of the conference. 3.1-19(b)			