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	07/29/2024

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 the Investigation of Complaints IN00438305, IN00438706, IN00438938, and IN00439801. Complaint IN00438305 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00438706 - Federal/state deficiencies related to the allegations are cited at F693. Complaint IN00438938 - No deficiencies related to the allegations are cited. Complaint IN00439801 - No deficiencies related to the allegations are cited. Survey dates: July 26 and 29, 2024 Facility number: 000462 Provider number: 155477 AIM number: 100275380 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 4 Medicaid: 38 Other: 5 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2024.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because The Lane House agrees with the allegations and citations listed. The Lane House maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gloria McGowen	Executive Director	08/20/2024

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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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure a dependent resident had adequate supervision, a safe environment, and was provided care to remain free from injuries of unknown origin for 1 of 3 residents reviewed for accidents (Resident B). Finding includes: On 7/26/24 at 10:45 a.m., a review of an Indiana Department of Health (IDOH) Reportable Incident document, dated 7/6/24 at 6:01 a.m., indicated Resident B was found with bruising to bilateral face and swelling to the nose. She also had a skin tear noted to her left forearm. The type of injury that was noted on the document indicated bruising of unknown etiology. A head-to-toe assessment was completed, and the resident was sent to the emergency room for evaluation and an investigation was initiated. On 7/26/24 at 11:05 a.m., Resident B was observed sitting in a wheelchair outside of her room across from the nurses' station. No bruising was noted to her face at this time, but she did have a foam dressing on her left hand. The resident was unable to communicate about why she had a dressing on her hand. The resident's room was noted to have an end table (with a drawer) next to the bed and was approximately an inch and half away from the mattress. On the other side of the	F 0689	*What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident B had an investigation initiated immediately, Dermatologist appointment on July 15th set up and her MD saw on 7/9 with no new orders. Room was evaluated for any safety issues and none found. Staff interviewed for prior 72 hours with no abnormalities noted. Skin and Pain UDA completed and resident denied pain. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. An in house audit has been completed by nursing management by date of compliance to review any abnormal bruising that meets the ISDH reportable guidelines and none noted. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*	08/23/2024

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	bed was a standard high back chair. There were no side rails noted on the bed. Resident B's record was reviewed on 7/26/24 at 11:15 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 6/29/24, indicated the resident was severely cognitively impaired and required assistance from staff for bed mobility, transfers, and toilet use. A care plan, dated 7/7/24, indicated the resident had a skin tear/potential for skin tear of the left forearm and bilateral facial bruising related to unknown injury. Interventions included, but were not limited to, inform staff of causative factors and measures to prevent skin tears and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. A nurse's note, dated 7/6/24 at 6:06 a.m., indicated Licensed Practical Nurse (LPN) 7 noticed Resident B had multiple bruised areas to her face, her nose appeared swollen, and she had a left hand that was bruised, swollen, and contained a 5 centimeter (cm) skin tear. An Emergency Room note, dated 7/6/24, indicated they were unsure of etiology of the facial purpura (a rash of purple spots due to small blood vessels leaking blood into the joints, intestines, or organs) /petechiae (small red or purple spot that appear on		1. Residents with abnormal bruising that meet the ISDH reportable guidelines will have a through investigation completed per LCCA policy. A root cause analysis will be completed as part of the investigation to determine cause. Staff will be educated by nursing management by date of compliance on the fall policy and protocol including reporting to nurse and not moving until assessed. No staff will work past date of compliance unless education is completed. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. Nursing management will interview nursing staff on the policy and protocol for falls including what is the proper action if resident found on floor - 5 nursing staff weekly x 2 months, then 4 nursing staff weekly x 2 months, then 3 nursing staff weekly x 2 months rotating shifts. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	skin which is caused by hemorrhage of capillaries). This could be from patient scratching at her face or some type of trauma. A Care Management note, dated 7/8/24 at 10:02 a.m., indicated Resident B was found to have bilateral facial bruising on 7/6/24 in the morning with a swollen nose and a skin tear to her left hand. There was no reported fall or injury. The resident was sent to the emergency room and returned with no abnormal lab values or fractures noted. Interviews with staff continued currently. An event note, dated 7/8/24 at 7:05 p.m., indicated Resident B had purple spots on bilateral cheeks and 3 cm bruise on left side of jaw and some splotches to left neck. A follow up note, dated 7/11/24, indicated an investigation had been completed and there were no indications or validation of any type of abuse. Staff interviews did not indicate a fall of any kind. Resident B was a two-person transfer requiring extensive assistance with all transfers. Resident was scheduled to have a follow up appointment with a dermatologist on 7/15/24. A skin integrity note, dated 7/11/24, indicated Resident B had petechiae to bilateral cheeks. These areas appeared to be purple and red in color. She had bruises to her left jaw and neck area and 2 small yellowing bruises to chest area. A dermatology progress note, dated 7/15/24, indicated Resident B had purpura to bilateral cheeks and hands. The purpura was consistent with a traumatic injury. Concurrent laceration on the left dorsal hand spoke to traumatic injury. The note was signed by nurse practitioner of the dermatology office.			

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	During an interview, on 7/26/24 at 12:04 p.m., the Assistant Director of Nursing (ADON) indicated the facility did a thorough investigation into Resident B's injuries and was unable to determine the cause. The facility interviewed staff taking care of the resident leading up to the morning of July 6th. She indicated their investigation gave them no answers to what had happened. A signed statement, dated 7/6/24, LPN 11 indicated she was asked by a Certified Nurse's Aide (CNA) to enter Resident B's room at around 5:30 a.m. LPN 11 indicated the resident was lying on her left side and her left side had been noted to have appeared purple and had a 5 cm split on the top of her hand. The LPN then noticed multiple bruises on both hands and face. She noted all the bruises were deep purple in color. At 6:00 a.m., she notified the charge nurse. A signed statement, dated 7/6/24 at 2:14 p.m., indicated CNA 12 laid Resident B down for bed around 8 p.m. the night of July 5th, and she did not see any marks on her skin when she went to bed. During an interview, on 7/26/24 at 2:35 p.m., the Director of Nursing (DON) indicated they had their theories on what happened to Resident B but were not able to prove anything. They were unable to determine the cause of her injuries. The DON indicated the resident was not combative with care and was cognitively impaired. She was not aware of any staff having previous disciplinary actions against them. During an interview, on 7/29/24 at 9:45 a.m., CNA 8 indicated she arrived to work on the morning of July 6th and saw Resident B's bruising. She			

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	indicated the night shift was unaware of what happened. CNA 8 indicated the facility did an in-service on reporting accidents and abuse and how long they have to report it to management. During a phone interview, on 7/29/24 at 10:29 a.m., LPN 7 indicated she was working the morning that the injuries to Resident B were noted. Resident B was sitting up in the hallway in her wheelchair across from the nurse's station when she arrived at 6:00 a.m. She questioned the night shift CNA about what happened and was told the resident was found that way. LPN 7 indicated she thought the resident had gotten her head caught between the mattress and her bedside table, but she was unable to prove that was what happened. LPN 7 indicated the resident had bruising to bilateral sides of her face and it was swollen, she also had a skin tear to her left hand. The LPN indicated the bruising eventually moved down jaw and neck. During an interview, on 7/29/24 at 1:15 p.m., CNA 17 indicated she was not working the day that Resident B's bruising was noted but she did work on the following Monday. She indicated the resident was pretty bruised up and something had to have happened to her, but no one came forward with anything. During an interview, on 7/29/24 at 1:30 p.m., DON indicated there had been no allegations against staff regarding abuse or being rough with residents. During an interview, on 7/29/24 at 1:37 p.m., Social Service Director (SSD) indicated Resident B had no behaviors, was not combative with care, and didn't thrash around in her bed. She further indicated something had happened to Resident B, but they were unable to determine the cause. SSD			

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	indicated she had some theories as to what may have happened but was unable to prove them. The SSD interviewed 11 residents, and no one had complaints about staff being rough during care. On 7/29/24 at 11:09 a.m., the DON provided a document with a revised date of 9/24/23, titled, "Incident and Reportable Event Management," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents ...." This citation relates to Complaint IN00438305. 3.1-45(a)			