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	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lane House, The	1000 Lane Ave Crawfordsville, IN 47933

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35317 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 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. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34525 Based on record review and interview, the facility failed to ensure a resident's gastrostomy tube (g-tube-a tube inserted through the belly that brings nutrition directly to the stomach) was maintained in a clean and sanitary condition, for 1 of 2 residents reviewed for g-tube (Resident C). The deficient practice was corrected on 7/17/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: A complaint intake document, dated 7/12/24, indicated Resident C had been seen in the emergency room (ER) of the local hospital. During the physical assessment, live maggots (fly larvae) were found crawling around his g-tube site. Resident C'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, history of malignant neoplasm (a cancerous tumor) of the lip, oral cavity and pharynx (a hollow, muscular tube inside the neck that starts behind the nose and opens into the larynx [the area of the throat containing the vocal cords and used for breathing, swallowing, and talking] and esophagus), and history of g-tube placement. A quarterly Minimum Data Set (MDS) assessment, dated 6/27/24, indicated the resident had no cognitive deficit, required physical assistance of 2 with activities of daily living (ADLs-basic care tasks of everyday life), and had a g-tube. A care plan, dated 5/19/23, indicated the resident was non-compliant with care related to refusal of additional g-tube feedings. The care plan interventions lacked documentation of assessments to any dressings applied to the g-tube site. A nurse progress note, documented as a late entry, on 7/12/24 at 2:15 p.m., indicated the g-tube site had been assessed and no parasites (maggots) were noted, and a clean dry dressing was in place. Review of the record lacked documentation that any assessment had been completed. A nurse progress note, dated 7/12/24 at 4:27 p.m., indicated while cleaning the residents g-tube site, maggots were noted around the stoma (a surgical connection between an internal organ and the skin on the outside of your body). The resident was sent to the ER for evaluation. An ER report, dated 7/12/24, indicated the resident had presented to the ER for evaluation of maggots found at his g-tube site. The ER course summary indicated upon examination the resident some mild surrounding inflammation. Multiple maggots had been removed by the physician and nursing staff. The report indicated the patient appeared to have been receiving substandard care to his g-tube, at the nursing home. A nurse progress note, dated 7/13/24 at 6:05 p.m., indicated during a g-tube dressing change 2 maggots were observed on the g-tube site. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's physician's orders lacked documentation of an order to assess the g-tube site dressing being intact and/or in place, prior to 7/15/24. The resident's Treatment Administration Record (TAR) and Medication Administration Record (MAR), from 1/1/24 to 7/15/24, lacked documentation of an order to assess the g-tube site dressing being intact and/or in place, prior to 7/15/24. A physician order, dated 7/15/24, indicated to validate the g-tube dressing was in place, dry, and intact, when resident returned from being outdoors, four times a day. A physician's order, dated 7/15/24, indicated to assess the g-tube exit site every shift. The resident's care plan was updated on 7/17/24, to indicate the resident preferred to remain outside for extended periods of time during the daytime hours in the elevated temperatures and humidity and often refused to come indoors. Interventions, dated 7/17/24, included, but were not limited to, staff will clean g-tube site and covers with drain sponge, per physician's orders. A care plan, dated 7/15/24, indicated the resident required a tube feeding. Interventions included, but were not limited to, dressing change to g-tube site every shift. On 7/29/24 at 10:30 a.m., the Director of Nursing (DON) provided documentation of the facility's investigation of the incident. At the same time, she indicated the documentation included the correction plan and events that had been put into place to ensure the situation does not occur again. The documents included, but were not limited to, the following: a. An invoice, dated 7/16/24, from a pest control service, which indicated the facility had been treated with fly bait to minimize the presence of flies in the facility. b. Hand hygiene education had been provided to the resident to ensure his hands were cleaned when he re-entered the facility after being outside. c. Statements from staff as to the lack of presence of flies in the resident's room during assessment of the g-tube site. d. Audit documentation of the facility's 2 residents' g-tube site assessments. e. Education to nursing staff on g-tube site care and observance for flies in the building. The education included skills check sign-off sheets for the g-tube assessment and care. During an interview, on 7/26/24 at 10:58 a.m., Resident C indicated he had gone to the hospital a little while back to get his G-tube looked at. It did not hurt but felt like someone was trying to pull it out. When they looked at it at the hospital, they said they found maggots around it. He acknowledged that he had seen flies in his room on multiple occasions. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/29/24 at 10:01 a.m., the Administrator (ADM) indicated they had completed an investigation related to the maggots which were found on the Resident C's g-tube site. A State Reportable incident was completed and sent. They re-educated all staff on the care and assessment of g-tube sites and were auditing the two residents with g-tubes. The audits would be reviewed by the quality assurance and improvement (QAPI) committee. They also had a pest control service come in and treat the facility in hopes of decreasing the number of flies in the building. This would be an on-going service. During an interview, on 7/29/24 at 11:35 a.m., Certified Nursing Assistant (CNA) 15 indicated the resident has had a dressing on his g-tube for as long as she could remember. She was aware that they had found maggots around his g-tube. She had participated in education on g-tube care and assessment recently. On 7/29/24 at 11:09 a.m., the DON provided a document, dated 8/25/23, titled, Enteral Access Device (EAD) Site Care and Management, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .Critical Notes .2. The nurse will observe for any change .and will inspect the tube . Because .tubes exit through the abdominal wall they require careful skin care .to prevent infection .Caring for gastrostomy .Assess the tube exit site .apply a sterile gauze dressing and external stabilization .around the site .Complications associated with enteral feeding tube exit site care may include .infection This deficient practice was corrected by 7/17/24, after the facility implemented a systemic plan that included the following actions: education provided to all nursing staff on the care and proper assessment of g-tube sites, audits of the resident's with g-tubes were being conducted and results reviewed by the facility QAPI committee, obtained new physician orders for the assessment and care of the resident's g-tube sites, and updated the care plans for the resident's with g-tubes. This citation relates to Complaint IN00438706. 3.1-44(a)(2)