

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Lane House, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately complete an elopement risk assessment for a vulnerable resident who was found outside the facility, on the grass after falling out of his wheelchair, without the knowledge of staff for 1 of 3 residents reviewed for neglect (Resident C). The deficient practice was corrected by 9/8/25 prior to the start of the survey and was therefore past noncompliance. Findings include: A nursing progress note, dated 9/7/25 at 3:35 p.m., indicated that emergency medical services (EMS) were at the facility. A resident had gotten outside without being seen and had fallen from his wheelchair. EMS had arrived to the facility at 3:32 p.m. and indicated they had gotten a call around 3:28 p.m. that a person was crawling in the grass on the side of the facility. Nursing staff reported last seeing Resident C around 3:00 p.m. A different resident had indicated she saw a visitor coming or going who had left the door open for Resident C to go outside. The resident had no injuries from the elopement/fall. The physician, Director of Nursing, Administrator and family were notified. The resident's care plan was updated, and he was placed on 1:1 supervision of staff until further notice. A Wander Guard [ankle bracelet that would set off an alarm if exiting the facility] was placed on Resident C. The clinical record review for Resident C was completed on 9/9/25 at 10:12 a.m. Diagnoses included alcohol-induced amnesic disorder, metabolic encephalopathy, and major depressive disorder. The resident had admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 8/22/25, indicated the resident had severe cognitive impairment, used a wheelchair for mobility and required assistance for toileting, bathing, and transferring. The resident was able to wheel himself short distances without staff assistance. An Elopement Risk Evaluation, dated 7/2/25, included an answer of no to the following questions: Is the resident cognitively impaired with poor decision-making skills?; Does the resident ambulate independently with or without the use of an assistive device (including a wheelchair)?; Does the resident have a history of Substance Use Disorder? A health care plan, dated 6/22/25, indicated the resident had pulled the facility fire alarm intentionally related to wanting to go home. Interventions included, to anticipate and meet the resident's needs, and to help minimize potential for the resident's disruptive behaviors by offering tasks which divert his attention such as reminiscing, snacks, or magazines. The resident's clinical record lacked a care plan for elopement. A document titled, [Resident C] Elopement Timeline, was provided by the Administrator on 9/9/25 at 10:40 a.m. The timeline indicated the resident was last seen by a staff member on 9/7/25 at 3:15 p.m. around the nurses' station. The Emergency Medical Service run report indicated a unit was dispatched on 9/7/25 at 3:30 p.m. They arrived to the facility at 3:32 p.m. They observed Resident C outside the facility sitting upright next to his wheelchair. A bystander, who had been driving by, observed a male laying in the grass outside the facility next to his wheelchair. The resident indicated he had made his way outside and was on his way home. The resident had indicated he was let out of the facility by an unknown person prior to slipping out of his wheelchair to the ground. The resident was assisted to his wheelchair by the rescue crew and refused any further care or evaluation and complained of no pain. The resident was wheeled back into the facility and care was transferred back to the facility staff. During an interview on 9/9/25 at 2:23 p.m., the Director of Nursing (DON) indicated Resident C had metabolic encephalopathy and struggled to form new memories. He continually asked about his car and when it would be returned from the shop so he could go home. She had not known him to attempt to exit the facility in the past. The July assessment for risk of elopement was not accurate because he had a cognitive deficit and a history of substance abuse, and was able to move around independently in his wheelchair. She, however, felt he was not an elopement risk. Resident C had not been observed pushing on doors to exit the facility. A current facility policy, reviewed 11/19/24, titled, Area of Focus: Elopement, provided by the DON on 9/9/25 at 2:53 p.m., included the following: What Elopement occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so How Upon completion of the other interdisciplinary team's admission and readmission assessments, the interdisciplinary team will review any additional unsafe wandering and/or elopement risk indicators and revise the resident's care plan as indicated. The deficient practice was corrected by 9/8/25 prior to the start of the survey and was therefore past noncompliance. The facility implemented a systemic plan that included re-assessment of residents in regard to elopement, staff education, visitor education, signs regarding not allowing residents to exit the building, and ongoing monitoring. This citation relates to Intake 2611338 3 1.45(a)(2)</p>		