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 01/27/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately notify the resident's family, and/or emergency contact when a cognitively intact resident developed new onset altered mental status, vomiting, and physical decline for 1 of 3 residents reviewed for family notification (Residents B). Findings include:A confidential concern during the survey process indicated Resident B had a sudden change in his health status, and the physician ordered the resident to go to the hospital. Despite the resident continuing to get worse, the Executive Director (ED) and Director of Nursing (DON) refused to allow the resident to go. Resident B's clinical record was reviewed on [DATE] at 2:33 p.m. Diagnoses on Resident B's profile included prostate cancer, lung cancer, insulin dependent diabetes mellitus (DM) and gastro-esophageal reflux disease (GERD). A quarterly MDS (Minimum Data Set) assessment completed on [DATE], assessed Resident B as being cognitively intact. He was independent with eating, bed mobility, transfers, ambulation, and did not use mobility devices. The resident routinely ate 75 - 100% of his meals and had gained a significant amount of weight (5% or more in the last month or 10% or more in the last 6 months). A nursing progress note, dated [DATE] at 10:46 a.m., indicated Resident B started coughing and had a small amount of coffee ground emesis. The resident complained of feeling drunk and staggering when he ambulated. A nursing progress note, dated [DATE] at 1:44 p.m., indicated Resident B's physician ordered a complete blood count (CBC) lab for gastrointestinal upset and vertigo, and he ordered medication changes to include discontinue diclofenac (an anti-inflammatory pain reliever) and to start protonix (medication that heals and treats excess stomach acid) 40 milligram (mg) daily for gastrointestinal (GI) upset. The note lacked documentation the family was notified. A nursing progress note, dated [DATE] at 8:06 a.m., indicated Resident B continued to have nausea and vomiting, and was having confusion, dizziness, complainant of abdominal pain, and his pulse was 128 beats per minute. The physician ordered a STAT (immediately) chest x-ray, STAT abdominal x-ray, and a STAT CBC. The STAT CBC was not obtained prior to the resident's death. The note lacked documentation the family was notified. A nursing progress note, dated [DATE] at 6:03 p.m., indicated Resident B continued to have yellow liquid emesis, his confusion remained, and he now had a temperature of 99.1 Fahrenheit (F). The note lacked documentation the family was notified. A nursing progress note, dated [DATE] at 6:44 p.m., indicated the physician gave new orders to include sennosides-docusate sodium (a combination laxative/stool softener) 8.6-50 mg twice daily for constipation, Miralax powder (a bulk laxative) twice daily, and doxycycline (antibiotic) 200 mg twice daily for 10 days for pleural effusion. The note lacked documentation the family was notified. A nursing progress note by the Director of Nursing (DON), dated [DATE] at 9:55 a.m., indicated Certified Nursing Assistants (CNAs) went into Resident B's room around 4:48 a.m. Licensed Practical Nurse (LPN) 5 went into the room to check on the resident as he had not been feeling well. The resident had vomited bile-like emesis into the trash can and on the left side of the (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

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	01/27/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. Resident B went unresponsive while the nurse was in room, with no pulse and no respirations. The code status was verified by a second nurse and Cardiopulmonary Resuscitation (CPR) was started immediately at 4:50 a.m. Two (2) rounds of CPR were completed by staff, and EMS arrived around 4:56 a.m. and took over. EMS stopped CPR at 5:20 a.m. The resident had expired. The daughter, ED, DON, and Regional Director of Clinical Services (RDCS) were notified. At 6:20 a.m., the Coroner was in possession of the body as no funeral arrangements had been made. The clinical record lacked documentation Resident B's emergency contact had been contacted by facility nursing personnel when he had a change in condition on [DATE], with updates on his condition and treatment orders, or that the resident or resident representative were consulted on their preference to be transferred to the hospital for evaluation and treatment. Confidential interviews were conducted during the survey: a. The employee indicated they had been told the resident was ill but was surprised when he died. They did not know details but had been informed he had generally not felt well and had some vomiting. There was an unidentified staff member who had been upset when the resident was not sent to the hospital for evaluation, and they'd been told upper management would not allow him to go. b. The employee indicated on [DATE] the resident started vomiting thick, stringy, coffee ground looking black stuff, that days later turned into just throwing up bile. The attending physician had been notified and gave orders on [DATE] and [DATE]. They could not remember if the physician had given orders to send the resident to the emergency room (ER) for evaluation, but often he would instruct nurses to defer to resident or family wishes. The DON had been made aware and kept apprised of the resident's new and deteriorating symptoms and gave instruction to wait for physician's orders before sending the resident to the hospital. They indicated were not sure if the resident had specifically been told he was being sent out to the hospital. c. The employee indicated they had not worked directly with Resident B recently while he was ill. But symptoms to include vomiting that started with coffee ground emesis and persisted for several days with altered mental status and dizziness with inability to safely ambulate would warrant being seen in the ER for more advanced assessment, testing and treatment. To their knowledge, the resident's record did not have documentation to indicate if he or the resident representative had been consulted on Resident B's wishes for treatment. During an interview on [DATE] at 9:58 a.m., Resident B's daughter indicated although she lived out of state, she had been Resident B's emergency contact. She and the resident texted each other often and had kept in contact right up until the day before he died. A few days before the resident passed, he told her he could not walk anymore, was in a wheelchair (WC), and vomiting black stuff. Resident B was confused enough that he could not answer basic questions such as his age. The daughter called an unidentified nurse at the facility, and when she asked if a urinary analysis had been completed to check for an infection as she knew this had caused him to be confused in the past, the nurse replied she was not sure what good it would do to as he was already on an antibiotic for a finger infection and he had not felt well for a few days. The daughter indicated, she understood Resident B had no Power of Attorney, but she was his emergency contact and felt like she should have been notified of his condition once he became confused. The daughter indicated in her opinion, the nurse did not relay a sense of urgency when describing the resident's current state of decline but instead repeated several times that he had an upcoming oncology follow-up appointment scheduled. On [DATE], Resident B had texted her 3 times and stated he was being sent to the hospital. She had reminded him to take his cell phone and charger so she could keep in contact. The daughter indicated, in her opinion, her father's sudden change in mental status and sudden health decline with coffee ground emesis and vomiting that lasted multiple days should have warranted at least a hospital visit for assessment. She continued to have questions that included (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why he was not sent to the hospital, and why the facility staff had not been more concerned. During an interview on [DATE] at 12:42 p.m., Resident B's daughter indicated she had not received a response to her last text on [DATE] at 2:16 p.m. and thought her father might be sleeping. The daughter indicated she assumed Resident B had been sent to the hospital and waited for a hospital follow report that never came. Instead, she got a call that he had died the next morning. During an interview on [DATE] at 11:34 a.m., LPN 5 indicated he had worked the night shifts of [DATE], [DATE], [DATE] and cared for Resident B on those nights. On [DATE], LPN 5 was given report that Resident B had an episode of emesis after dinner and was having some confusion. He did not witness Resident B having confusion, and to him the resident seemed to be himself. On [DATE] around 6:30 p.m., within the first 30 minutes of the shift starting, Resident B reported throwing up, and the nurse observed yellowish bile stomach content partially in the trash can and on the bed. The primary care physician was notified and gave an order for Zofran 4 mg, which LPN administered. LPN 5 indicated, on [DATE] at approximately 4:30 a.m., he had gone into Resident B's rooms to check on him before his shift ended and could hear a CNA speaking with the resident. By the time the nurse cleared the curtain as he entered the room, Resident B went unconscious with no pulse or respirations. LPN 5 indicated he initiated CPR, had one of the CNA's call 911, and another CNA get the crash cart. The ambulance arrived at the facility quickly and EMT's took over CPR. Resident B was coded for 30 minutes without ever getting a response. Resident B's daughter was notified, and when it was determined funeral arrangements had not been made previously, the coroner was called to take the body. Review of Resident B's clinic record with the ED and DON on [DATE] at 4:05 p.m. The clinical record lacked documentation of the emergency contact being notified of the resident's change in condition, there was no documentation to indicate Resident B had been asked for his preference of going to the ER. The DON indicated she had no further information to provide. If documentation was not found in Resident B's electronic medical record, it had not been done. On [DATE] at 9:42 p.m., the Regional [NAME] President provided a Changes in Resident's Condition or Status policy, revised [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, .This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status.A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative[s] when there is.[B] A significant change in the resident's physical, mental, or psychosocial status [this is, a deterioration in health.2. The facility will utilize the following INTERACT tools per policy: Stop and Watch Early Warning Tool, SBAR [situation, background, assessment, recommendation. Cross reference F684. This citation relates to Intake 2718798. 3.1-5(a)(2)3.1-5(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a cognitively intact resident with new onset altered mental status and vomiting was monitored and treated timely resulting in the resident having a delay in treatment and death for 1 of 3 residents reviewed for quality of care (Resident B). The immediate jeopardy began on [DATE] at 10:46 a.m. when a cognitively intact resident had new onset symptoms of coughing, coffee ground emesis, complaints of feeling drunk, and staggering while ambulating. The physician ordered a Complete Blood Count (CBC) that was not obtained. The record lacked documentation of the resident's condition on [DATE]. On [DATE] the resident had altered mental status, dizziness, abdominal pain, and his pulse was 128. The physician ordered a STAT (immediately) chest x-ray, a STAT abdominal x-ray, and STAT CBC with differential for cough, nausea, vomiting, abdominal pain, altered mental status, weakness, and dizziness. The STAT CBC was not obtained prior to the resident's death. On [DATE] at 6:03 p.m. the resident continued vomiting yellow liquid emesis, continued with altered mental status, and had a temperature of 99.1 degrees Fahrenheit (F). The physician ordered Zofran 4 milligrams (mg). The x-ray results, dated [DATE] at 4:35 p.m., indicated a colonic ileus (blockage) and small right pleural effusion (accumulation of excess fluid between lung and chest wall). The physician was notified and ordered stool softeners and MiraLAX. On [DATE] at 9:55 am, the DON documented that the CNA went into the resident's room at 4:48 am and found the resident had bile like emesis. The resident became unresponsive, CPR was initiated, and the resident died at the facility. The resident's family indicated they thought the resident had been sent to the hospital. The record lacked documentation of assessments, follow-up vital signs, or nursing interventions on [DATE], [DATE], [DATE], or [DATE]. The Executive Director (ED), and Regional [NAME] President (RVP) were notified of the immediate jeopardy at [DATE] at 11:28 a.m. The immediate jeopardy was removed on [DATE], but noncompliance remained at a lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy. Findings include:A confidential concern during the survey process indicated Resident B had a sudden change in his health status, and the physician ordered the resident to go to the hospital. Despite the resident continuing to get worse, the Executive Director (ED) and Director of Nursing (DON) refused to allow the resident to go, and the resident subsequently died. Resident B's clinical record was reviewed on [DATE] at 2:33 p.m. Diagnoses on Resident B's profile included prostate cancer, lung cancer, insulin dependent diabetes mellitus (DM), gastro-esophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD). A care plan, dated [DATE], indicated Resident B was at risk for rehospitalization due to current health status, COPD, repeated falls, age-related physical debility and delirium. Interventions included discuss with the resident/family his history of hospitalization, complete labs as ordered, and staff would provide timely communication to the physician regarding any change in the resident's condition. An Indiana Physician Orders For Scope Of Treatment (POST), dated [DATE], included if the resident had no pulse and was not breathing, then attempt CPR. If the resident had a pulse and was breathing or had a pulse and was not breathing, then attempt limited additional interventions: stabilization of medical condition. In addition to care described in Comfort Measures and use of medication treatment for stabilization, the following was allowed IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition, may use basic airway management techniques and non-invasive positive-airway pressure, do not intubate, transfer to hospital if indicated to manage medical needs and comfort, and avoid intensive care if possible. The resident approved the use of antibiotics consistent with his treatment goals. The resident allowed defined trial period of artificial nutrition by tube. A (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician's order, dated [DATE], ordered ondansetron (Zofran) (a medication to treat nausea and vomiting) 8 milligrams (mg), 1 tablet by mouth every 8 hours as needed for nausea and vomiting. The active physician's order was not documented as administered on [DATE], [DATE], [DATE], or [DATE]. A physician's order, dated on [DATE], ordered Meclizine HCI (antihistamine and anticholinergic medication used to treat vertigo and prevent nausea, vomiting, and dizziness) 12.5 mg, 1 tablet by mouth three times daily as needed. The active physician's order was not documented as administered on [DATE], [DATE], [DATE], or [DATE]. A quarterly Minimum Data Set (MDS) assessment, completed on [DATE], assessed Resident B as being cognitively intact. He was independent with eating, bed mobility, transfers, ambulation, did not use mobility devices, required substantial/maximum assistance with toileting hygiene, and had no recent falls since his admission. The resident had no skin breakdown. The resident routinely ate 75 - 100% of his meals and had gained a significant amount of weight (5% or more in the last month or 10% or more in the last 6 months). Review of Resident B's clinical record, dated [DATE] - 31, 2025, lacked documentation of resident complainants related to dizziness, confusion, signs of altered mental status, abdominal pain, constipation, or gastrointestinal distress to include nausea or vomiting. A nursing progress note, dated [DATE] at 10:46 a.m., indicated Resident B started coughing and had a small amount of coffee ground emesis. The resident complained of feeling drunk and staggering when he ambulated. A nursing progress note, dated [DATE] at 1:44 p.m., indicated Resident B's physician ordered a complete blood count (CBC) lab for gastrointestinal (GI) upset and vertigo, and he ordered medication changes to include discontinue diclofenac an anti-inflammatory pain reliever and to start protonix (medication to treat and heal stomach acid) 40 milligrams (mg) daily for gastrointestinal (GI) upset. The resident's record lacked documentation the CBC was obtained. Vital Signs, dated [DATE] at 2:37 a.m., indicated the resident's blood pressure (BP) was 100/65, pulse (P) was 98 beats per minute, respirations (R) was 14, and temperature (T) 96.3 degrees Fahrenheit (F). The record lacked documentation of the resident's condition on [DATE]. A nursing progress note, dated [DATE] at 8:06 a.m., indicated Resident B continued to have nausea and vomiting, and was having confusion, dizziness, complained of abdominal pain, and his pulse was 128 beats per minute. The physician ordered a STAT (immediately) chest x-ray, STAT abdominal x-ray, and a STAT CBC. The resident's record lacked documentation the STAT CBC obtained prior to the resident's death. Vital Signs, dated [DATE] at 8:06 a.m., indicated BP was 132/82, P was 128, R was 20, T was 98.9 degrees F. The clinical record lacked documentation of a Change in Resident Condition assessment or Stop and Watch Early Warning tool had been completed per the facility protocol. A contracted laboratory request daily log, dated [DATE] at 8:00 a.m., indicated an order for Resident B was input into the electronic system for a CBC. The DON indicated the order lacked documentation to specify it was a STAT order. A mobile x-ray report, date of service [DATE], included:a. Results for the abdomen X-ray for unspecified nausea and vomiting and altered mental status indicated mild to moderate colonic stool burden contributing at least in part to a mild ascending and transverse colonic ileus [implies a temporary, functional interruption of bowel motility or paralytic ileus where the intestinal muscles become temporarily paralyzed and stop moving].b. Results for the chest X-ray for cough, nausea and vomiting, and altered mental status indicated the resident had a small pleural effusion (buildup of excess fluid in the pleural place between the lungs and chest wall). A nursing progress note, dated [DATE] at 6:03 p.m., indicated Resident B continued to have yellow liquid emesis, his confusion remained, and he had a temperature of 99.1 degrees F. A nursing progress note, dated [DATE] at 6:44 p.m., indicated the physician gave new orders to include sennosides-docusate sodium (a combination laxative/stool softener) 8.6-50 mg twice daily for constipation, Miralax powder (a bulk laxative) twice daily, and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	doxycycline (antibiotic) 200 mg twice daily for 10 days for pleural effusion. Vital Signs, dated [DATE] at 8:03 p.m., indicated temperature of 99.1 degrees F. A nursing progress note by the Director of Nursing (DON), dated [DATE] at 9:55 a.m., indicated Certified Nursing Aides (CNAs) went into Resident B's room around 4:48 a.m. Licensed Practical Nurse (LPN) 5 went into the room to check on the resident as he had not been feeling well. The resident had vomited bile-like emesis into the trash can and on the left side of the bed. Resident B went unresponsive while the nurse was in room, with no pulse and no respirations. The code status was verified by a second nurse and Cardiopulmonary Resuscitation (CPR) was started immediately at 4:50 a.m. Two rounds of CPR were completed by staff, and EMS arrived around 4:56 a.m. and took over. EMS stopped CPR at 5:20 a.m. The resident had expired. The daughter, ED, DON and Regional Director of Clinical Services (RDCS) were notified. At 6:20 a.m., the Coroner was in possession of the body as no funeral arrangements had been made. The clinical record lacked documentation Resident B had been assessed by a nurse after 7:10 p.m. on [DATE] when a new order for Zofran 4 mg was administered. The clinical record, dated [DATE], [DATE], or [DATE], lacked documentation Resident B had been administered Zofran 8 mg or Meclizine 12.5 mg. The clinical record lacked documentation Resident B's emergency contact had been contacted by facility nursing personnel when he had a change in condition on [DATE], with updates on his condition and treatment orders, or that the resident or resident representative were consulted on a preference to be transferred to the hospital for evaluation and treatment. Confidential interviews were conducted during the survey: a. The employee indicated, they had been told the resident was ill but was surprised when he died. They did not know details but had been informed he had generally not felt well and had some vomiting. There was an unidentified staff member who had been upset when the resident was not sent to the hospital for evaluation, and they'd been told upper management would not allow him to go. When a resident became ill, nurses had critical system pathways for guidance on managing the resident in the facility. The corporate nursing consultant then had to be called for approval before any resident could be sent to the hospital for evaluation and treatment. The employee indicated corporate staff had the ability to stop any physician's order they did not feel necessary to include orders for sending a resident to the hospital for evaluation or an antibiotic. b. The employee indicated on [DATE] the resident started vomiting thick, stringy, coffee ground looking black stuff, that days later turned into just throwing up bile. The attending physician had been notified and gave orders on [DATE] and [DATE]. They could not remember if the physician had given orders to send the resident to the emergency room (ER) for evaluation, but often he would instruct nurses to defer to resident or family wishes. The DON had been made aware and kept appraised of the resident's new and deteriorating symptoms. The DON gave instruction to wait for physician's orders before sending the resident to the hospital. They indicated they were not sure if the resident had specifically been told he was being sent out to the hospital. On [DATE] at 8:00 a.m., STAT labs had been ordered for Resident B that were supposed to be completed within 8 hours, but a lab technician did not present to the facility to draw the labs until [DATE] around 9:00 a.m. after Resident B had died.c. The employee indicated they had not worked directly with Resident B recently while he was ill. But symptoms to include vomiting that started with coffee ground emesis and persisted for several days with altered mental status and dizziness with inability to safely ambulate would warrant being seen in the ER for more advanced assessment, testing, and treatment. To their knowledge, the resident's record did not have documentation to indicate if he or the resident representative had been consulted on Resident B's wishes for treatment. STAT labs meant urgent and were supposed to be completed as soon as possible. During an interview on [DATE] at 9:58 a.m., Resident B's daughter indicated although she lived out of state, she had (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	been Resident B's emergency contact. She and the resident texted each other often and had kept in contact right up until the day before he died. A few days before the resident passed, he told her he could not walk anymore, was in a wheelchair (WC), and vomiting black stuff. Resident B was confused enough that he could not answer basic questions such as his age. The daughter called an unidentified nurse at the facility, and when she asked if a urinary analysis had been completed to check for an infection as she knew this had caused him to be confused in the past, the nurse replied she was not sure what good it would do to as he was already on an antibiotic for a finger infection and he had not felt well for a few days. The daughter indicated she understood Resident B had no Power of Attorney, but she was his emergency contact and felt like she should have been notified of his condition once he became confused. The daughter indicated, in her opinion, the nurse did not relay a sense of urgency when describing the resident's current state of decline but instead repeated several times that he had an upcoming oncology follow-up appointment scheduled. On [DATE], Resident B had texted her 3 times and stated he was being sent to the hospital. She had reminded him to take his cell phone and charger so she could keep in contact. The daughter indicated, in her opinion, her father's sudden change in mental status and sudden health decline with coffee ground emesis and vomiting that lasted multiple days should have warranted at least a hospital visit for assessment. She continued to have questions that included why he was not sent to the hospital, and why the facility staff had not been more concerned. Screen shots of text message correspondence between Resident B and his daughter, dated and timestamped included,On Friday [DATE] at 10:34 a.m.:Resident: I got to be in a wheelchair for awhile.Daughter: Why? On Friday [DATE] at 11:51 a.m.:Daughter: I talked to your nurse she said you go back to cancer doctor soon. You need to tell them or have them write something about you vomiting black s--- .that would be your cancer. And I requested a urine sample. But she said you just got off antibiotics for infection in your fingers and you were sick.Resident: I;m sorry freaking okDaughter: Dad don't be sorry I just want you to be ok.Resident: noDaughter: no whatResident: ok I don't sDaughter: your not making sense dad. Maybe you need to take a nap On Friday [DATE] at 3:26 p.m.:Resident: ok nite. I hope. I too. A two hour On Saturday [DATE] at 6:41 a.m.:Resident: Nurse said I'm not going anywhere she taking me h hospitalDaughter: So your going to hospitalResident: yesDaughter: goodResident: coohwDaughter: WhatResident: Ganmherehome hereDaughter: your not making any senseResident: Please come hereDaughter: Dad I can't its alright. They will figure out what is going on. Why are they sending you to hospitalResident: shakeypDaughter: I guarantee you have a UTIResident: he will get itDaughter: Make sure you take your phone and charger. They will find out what is going on with you and why your puking black stuffResident: okDaughter: Are they sending you by ambulanceResident: Yy. YesDaughter: Ok let me know when you get thereResident: okayDaughter: I love you. Am I still on your paperwork.Resident: love you. On Saturday [DATE] at 10:12 a.m.:Daughter: R you at the hospitalResident: am. Sed g the time lijj. HuuDaughter: whatResident: did as ask from no On Saturday [DATE] at 2:16 p.m.:Daughter: what are you doing During an interview on [DATE] at 12:42 p.m., Resident B's daughter indicated she had not received a response to her last text on [DATE] at 2:16 p.m. and thought her father might be sleeping. The daughter indicated she assumed Resident B had been sent to the hospital and waited for a hospital follow report that never came. Instead, she got a call that he had died the next morning. During an interview on [DATE] at 3:30 p.m., the DON indicated a STAT CBC with differential (a comprehensive blood test to help diagnose infections, anemia, inflammation, leukemia, and monitor overall health) ordered on [DATE] at 8:15 a.m., was not completed before Resident B died on [DATE] at approx. 4:48 a.m. She was unsure why the labs had not been completed. The resident's clinical record lacked documentation the laboratory had been called by nursing staff (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	regarding the STAT lab when they had not shown up on [DATE]. During an interview on [DATE] at 10:37 a.m., Licensed Practical Nurse (LPN) 6 indicated all medical records and correspondence with a physician's office were scanned into a resident's electronic medical record, the facility did not retain hard paper charts or files of resident documents. A nurse could contact a physician's office by phone call, but faxed documents were all scanned. LPN 6 indicated she had looked for faxed correspondence regarding Resident B to his primary physician, and there were no further documents available that could not already be seen in the residents electronic clinical record. During an interview on [DATE] at 10:50 a.m., a representative for the primary care physician indicated routine non-urgent correspondence between the nursing facility and physician usually happened via fax, and a copy of the fax was kept in the resident's medical file at the physician's office. Urgent matters or a resident change in condition correspondence usually happened by phone. The last documentation for Resident B was dated [DATE] when the resident was seen by the physician at the nursing facility. During an interview on [DATE] at 11:34 a.m., LPN 5 indicated he had worked the night shifts of [DATE], [DATE], [DATE] and cared for Resident B on those nights. On [DATE], LPN 5 was given report that Resident B had an episode of emesis after dinner and was having some confusion. He did not witness Resident B having confusion, and to him the resident seemed to be himself. On [DATE] around 6:30 p.m., within the first 30 minutes of the shift starting, Resident B reported throwing up, and the nurse observed yellowish bile stomach content partially in the trash can and on the bed. The primary care physician was notified and gave an order for Zofran 4 mg, which LPN administered. LPN 5 indicated, on [DATE] at approximately 4:30 a.m., he had gone into Resident B's rooms to check on him before his shift ended and could hear a CNA speaking with the resident. By the time the nurse cleared the curtain as he entered the room, Resident B went unconscious with no pulse or respirations. LPN 5 indicated he initiated CPR, had one of the CNA's call 911, and another CNA get the crash cart. The ambulance arrived at the facility quickly and EMT's took over CPR. The EMTs applied a [NAME] machine (an automated, portable device that delivers chest compressions for patients in cardiac arrest), administered 3 rounds of epinephrine (used to stimulate the heart and help restore a heartbeat), intravenous (IV) fluids, and intraosseous access (IO - where the EMT drills into the chin bone to deliver fluids) was obtained. Resident B was coded for 30 minutes without ever getting a response. Resident B's daughter was notified, and when it was determined funeral arrangements had not been made previously, the coroner was called to take the body. LPN 5 indicated it was his routine to document resident information towards the end of his shift. He had checked on Resident B during the night but had not yet documented in the clinical record when the resident passed away around 4:35 a.m. During an interview on [DATE] at 2:18 p.m., a representative for the primary care physician indicated there was no fax documentation from the nursing facility in Resident B's medical file from [DATE], [DATE], [DATE], or [DATE]. The primary care physician indicated to her, he had been informed when Resident B died but thought someone told him the resident passed at the hospital. Reviewed Resident B's clinic record with the ED and DON on [DATE] at 4:05 p.m. The clinical record lacked documentation for abdominal assessments, nursing interventions for nausea and vomiting, consistent monitoring of vital signs, neurological assessments related to the sudden altered mental status, documentation of the emergency contact being notified of the resident's change in condition, there was no documentation to indicate Resident B had been asked for his preference of going to the ER, and a STAT CBC was not completed. The DON indicated she had been aware of Resident B's change in condition, she knew he was having emesis, but it was small amounts and she had not observed him to be confused as he answered basic questions appropriately. The primary care physician had not given orders and therefore Resident B was not sent to the ER. The (continued on next page)

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 01/27/2026
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff ordered, obtained, and tracked STAT (immediately) laboratory orders for 1 of 3 residents reviewed for completion of laboratory orders (Resident B). Findings include: A confidential concern during the survey process indicated Resident B had a sudden change in his health status, and the physician ordered the resident to go to the hospital. Despite the resident continuing to get worse, the Executive Director (ED) and Director of Nursing (DON) refused to allow the resident to go, and the resident subsequently died. Resident B's clinical record was reviewed on [DATE] at 2:33 p.m. Diagnoses on Resident B's profile included prostate cancer, lung cancer, insulin dependent diabetes mellitus (DM) and gastro-esophageal reflux disease (GERD). A nursing progress note, dated [DATE] at 10:46 a.m., indicated Resident B started coughing and had a small amount of coffee ground emesis. The resident complained of feeling drunk and staggering when he ambulated. A nursing progress note, dated [DATE] at 1:44 p.m., indicted Resident B's physician ordered a complete blood count (CBC) lab for gastrointestinal upset and vertigo. The CBC was not obtained. A nursing progress note, dated [DATE] at 8:06 a.m., indicated Resident B continued to have nausea and vomiting, and was having confusion, dizziness, complainant of abdominal pain, and his pulse was 128 beats per minute. The physician ordered a STAT (immediately) chest x-ray, STAT abdominal x-ray, and a STAT CBC. The STAT CBC was not obtained prior to the resident's death. A contracted laboratory request daily log, dated [DATE] at 8:00 a.m., indicated an order for Resident B was input into the electronic system for CBC. The DON indicated the order lacked documentation to specify it was a STAT order. Confidential interviews were conducted during the survey: a. The employee indicated they had been told the resident was ill but was surprised when he died. They did not know details but had been informed he had generally not felt well and had some vomiting. When a resident became ill, nurses had critical system pathways for guidance on managing the resident in the facility. b. The employee indicated on [DATE] the resident started vomiting thick, stringy, coffee ground looking black stuff, that days later turned into just throwing up bile. The attending physician had been notified and gave orders on [DATE] and [DATE]. On [DATE] at 8:00 a.m., STAT labs had been ordered for Resident B. that were supposed to be completed within 8 hours, but a lab technician did not present to the facility to draw the labs until [DATE] around 9:00 a.m. after Resident B had died.c. The employee indicated they had not worked directly with Resident B recently while he was ill. STAT labs meant urgent and were supposed to be completed as soon as possible. During an interview on [DATE] at 3:30 p.m., the DON indicated a STAT CBC with differential (a comprehensive blood test to help diagnose infections, anemia, inflammation, leukemia, and monitor overall health) ordered on [DATE] at 8:15 a.m., was not completed before Resident B died on [DATE] at approx. 4:48 a.m. She was unsure why the labs had not been completed. The resident's clinical record lacked documentation the laboratory had been called by nursing staff regarding the STAT lab when they had not shown up on [DATE]. Review of Resident B's clinic record with the ED and DON on [DATE] at 4:05 p.m. The clinical record lacked documentation a STAT CBC was completed. The DON indicated she had been aware of Resident B's change in condition, she knew he was having emesis, but it was small amounts and she had not observed him to be confused as he answered basic questions appropriately. The DON indicated she had no further information to provide. On [DATE] at 3:05pm the Administration provided a Laboratory Services policy, reviewed on [DATE]. The policy indicated, .The facility must provide or obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services. The policy did not define STAT or the expectation for timeline of the blood draw. Cross (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reference F684. This citation relates to Intake 2718798. 3.1-49(f)(1)