Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2024
NAME OF PROVIDER OR SUPPLIER: Lane Nursing & Ventilator Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 North Broadway Inola, OK 74036	

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. 46703 Based on record review and interview, the facility failed to ensure the required number of staff were present when the mechanical lifts were operated for one (#1) of one resident reviewed for mechanical lifts. Findings: Resident #1 had diagnoses which included chronic pain, anxiety, and pulmonary edema A care plan, dated 08/11/23, documented the resident required two person assist with transfers using a Hoyer lift. An Incident Report, dated 03/05/24, read in part, .Staff attempted to put resident in his wheel chair using the Hoyer Lift. While trying to put resident back in .chair resident slid off the chair into the floor. Staff was educated on Hoyer use and the importance of two staff members when using lifts. On 03/11/24 at 2:00 p.m., CNA #4 was asked if they had received an in-service regarding the use of a mechanical lift. They stated, No. On 03/11/24 at 2:05 p.m., CNA #1 and CNA #2 were asked if they had received an in service regarding the use of a mechanical lift. They stated no. On 03/11/24 at 2:10 p.m., CNA #3 and CNA #5 were asked if they had received an in service regarding the use of a mechanical lift. They stated no. On 03/11/24 at 2:15 p.m., CNA #6 was asked if they had received an in service regarding the use of a mechanical lift. They stated no. ON 03/11/24 at 3:15 p.m., the DON stated two people were required to utilize a mechanical lift.

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