

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  03/27/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to ensure power strips were not used to supply power to medical devices for 3 (#17, 21, and #24) of 17 sampled residents reviewed for tracheostomy care.</p> <p>The ADON identified 23 residents had tracheotomies at the facility.</p> <p>Findings:</p> <p>1. On 03/25/25 at 12:25 p.m., Res #17 was observed in bed. Their flowby machine and suctioning machine were observed to be plugged into a gray power strip.</p> <p>Res #17's admission record, dated 09/22/22, showed the resident had diagnosis which included encounter for attention to tracheostomy.</p> <p>On 03/25/25 at 12:26 p.m., the MDS coordinator stated Res #17's flowby and suctioning machine were plugged into the gray power strip.</p> <p>2. On 03/25/25 at 12:29 p.m., Res #21 was observed in bed. Their nebulizer and suctioning machine were plugged into a gray power strip.</p> <p>Res #21's admission record, dated 08/19/22, showed the resident had diagnosis which included encounter for attention to tracheostomy.</p> <p>On 03/25/25 at 12:31 p.m., the MDS coordinator stated Res #21's nebulizer and suctioning machine were plugged into a gray power strip.</p> <p>3. On 03/25/25 at 12:30 p.m., Res #24 was observed in bed. Their ventilator was observed operating and plugged into a black power strip.</p> <p>Res #24's admission record, dated 01/31/25, showed the resident had diagnoses which included muscular dystrophy and acute respiratory failure.</p> <p>On 03/25/25 at 12:31 p.m., the MDS coordinator stated Res #24's ventilator was plugged into a black power strip.</p> <p>(continued on next page)</p>

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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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	On 03/27/25 at 3:20 p.m., the DON stated they did not have a policy for the use of power chords. They stated the medical devices should have been plugged in directly to the outlets on the wall.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34270</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. residents with indwelling medical devices were placed on EBP for 17 (#4, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 21, 26, 28, 29, 30, and #31) of 25 sampled resident reviewed for EBP; and</p> <p>b. required PPE was worn by staff while providing tracheostomy care for 3 (#10, 11, and #12) of 3 sampled residents reviewed for tracheostomy care.</p> <p>The ADON identified 21 residents that had tracheostomy tubes in place at the facility and 19 residents that had PEG tubes in place at the facility.</p> <p>Findings:</p> <p>A.</p> <p>On 03/05/25 at 2:32 p.m., a tour of the facility was conducted and 10 rooms (#23, 28, 29, 30, 31, 32, 33, 40, 41, and #43) that were occupied by residents with either a tracheostomy, and PEG tube or both. None of the 10 rooms had a sign or other indicator that the occupants of the room were on EPB.</p> <p>On 03/06/25 at 10:24 a.m., a tour of the facility was conducted. Ten resident rooms (#23, 28, 29, 30, 31, 32, 33, 40, 41, and #43) previously identified as those whose occupants had indwelling medical devices, but and continued to lack EBP indicators.</p> <p>On 03/11/25 at 1:45 p.m., a tour of the facility was conducted. The same 10 rooms (#23, 28, 29, 30, 31, 32, 33, 40, 41, and #43) were occupied by residents with indwelling medical devices and the rooms did not have any type of indicator the residents were on EBP.</p> <p>A document titled Escalation to LTC [Long Term Care] regarding Candida auris at Lane Nursing and Ventilator Care, showed on 05/30/24 the Oklahoma State Department of Health's Healthcare-associated Infections and Antimicrobial Resistance (HAI/AR) program had contacted the facility's DON/IP and conducted a telephone infection control assessment which identified the facility's lack of use of EBP. The document further showed the HAI/AR team conducted an onsite visit to the facility on [DATE] and the team found EBP had not been initiated.</p> <p>An undated document titled Lane Nursing and Vent Infection Control Program Overview, read in part, The goals of the infection control program are to:</p> <p>a. Decrease the risk of infection to residents and personnel</p> <p>b. Monitor for occurrence of infection and implement appropriate control measures</p> <p>c. Identify and correct problems relating to infection control practices</p> <p>d. Insure compliance with state and federal regulations relating to infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An undated resident room roster showed which residents had tracheostomies and the room where they resided. The roster showed the ADON wrote on the document Res [ the letter c with a slash above it to stand for the word with] trach[tracheostomy], to identify purpose of the document. The roster identified the following room assignments:</p> <ul style="list-style-type: none"> <li>a. room [ROOM NUMBER] was occupied by Res #9 and Res #28;</li> <li>b. room [ROOM NUMBER] was occupied by Res #29 and Res #30;</li> <li>c. room [ROOM NUMBER] was occupied by Res #10 and Res #11;</li> <li>d. room [ROOM NUMBER] was occupied by Res #16 and Res #17;</li> <li>e. room [ROOM NUMBER] was occupied by Res #18 and Res #19;</li> <li>f. room [ROOM NUMBER] was occupied by Res #20 and Res #21;</li> <li>g. room [ROOM NUMBER] was occupied by Res #25;</li> <li>h. room [ROOM NUMBER] was occupied by Res #26; and</li> <li>i. room [ROOM NUMBER] was occupied by Res #13 and Res #14.</li> </ul> <p>An undated resident room roster showed which residents had PEG tubes and the room where they resided. The roster showed the ADON wrote on the document, Res [ the letter c with a slash above it to stand for the word with] PEG, to identify the purpose of the document. The roster identified the following room assignments:</p> <ul style="list-style-type: none"> <li>a. room [ROOM NUMBER] was occupied by Res #31;</li> <li>b. room [ROOM NUMBER] was occupied by Res #4;</li> <li>c. room [ROOM NUMBER] was occupied by Res #10 and Res #11;</li> <li>d. room [ROOM NUMBER] was occupied by Res #12;</li> <li>e. room [ROOM NUMBER] was occupied by Res #16 and Res #17;</li> <li>f. room [ROOM NUMBER] was occupied by Res #18 and Res #19;</li> <li>g. room [ROOM NUMBER] was occupied by Res #20 and Res #21;</li> <li>h. room [ROOM NUMBER] was occupied by Res #25; and</li> <li>i. room [ROOM NUMBER] was occupied by Res #26.</li> </ul> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 03/11/25 at 2:05 p.m., LPN #1 stated residents on EBP all had a sign on their door and a container of the required PPE outside their door. LPN #1 stated residents were placed on EBP because they had certain types of infections. LPN #1 stated they were unaware of any other reason a person would be on EBP. They stated they had not used EBP PPE for any resident other than those with the EBP signs.</p> <p>On 03/11/25 at 2:08 p.m., LPN #2 stated they can identify residents on EBP by the sign and PPE outside their door. LPN #2 stated they had used standard precautions for the residents without the EBP signs.</p> <p>On 03/11/25 at 2:10 p.m., CMA #1 stated they had used the EBP required PPE for residents with the EBP signs and standard precautions for the other residents.</p> <p>On 03/11/25 at 2:12 p.m., CMA #2 stated they had used EBP PPE only for the residents with the EBP signs. CMA #2 stated they use standard precautions for the other residents.</p> <p>On 03/11/25 at 2:15 p.m., CNA #1 stated residents with certain types of infections were placed on EBP and that required extra PPE. CNA #1 stated they had used standard precautions on the other residents. CNA #1 stated Res #10, 11, and #12 were not on EBP so they had been using standard precautions with them.</p> <p>B.</p> <p>1. On 03/12/25 at 7:45 a.m., RRT #1 was observed providing tracheostomy care to Res #10. Res #10's assigned room did not have an EBP sign or container of PPE outside of the door. RRT #1 was observed providing the care which included suctioning the resident and replacing the inner cannula. They performed the care with only the use of treatment gloves and cleaning of their hands as infection control measures.</p> <p>Res #10 had diagnoses which included encounter for attention to tracheostomy and encounter for attention to gastrostomy.</p> <p>A document titled Doctor's Orders V2 3 Hole, dated March 2025, showed Res #10 was to receive PEG tube care daily and tracheostomy care twice daily.</p> <p>A document titled Routine/PRN Treatments, dated March 2025, showed Res #10 had received PEG tube care daily on 03/01/25 and 03/11/25.</p> <p>A document titled Respiratory Report, dated March 2025, showed Res #10 had received tracheostomy care on 03/01/25 and 03/11/25.</p> <p>2. On 03/12/25 at 7:50 a.m., RRT #1 was observed providing tracheostomy care to Res #11. The resident's assigned room did not have an EBP sign or a container of PPE outside of the door. During the care RRT #1 suctioned the resident and replaced the inner cannula. The only infection prevention methods used during the care was the use of treatment gloves and hand washing.</p> <p>Res #11 had diagnoses which included encounter for attention to tracheostomy and encounter for attention to gastrostomy.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A document titled Doctor's Orders V2 3 Hole, dated March 2025, showed Res #11 was to receive PEG tube care daily, and tracheostomy care twice daily.</p> <p>A document titled Routine/PRN Treatments, dated March 2025, showed Res #11 had received PEG tube care daily on 03/01/25 through 03/11/25.</p> <p>A document titled Respiratory Report, dated March 2025, showed Res #11 had received tracheostomy care on 03/01/25 through 03/11/25.</p> <p>3. Res. #12 had diagnoses which included encounter for attention to tracheostomy and encounter for attention to gastrostomy.</p> <p>A document titled Doctor's Orders V2 3 Hole, dated March 2025, showed Res #12 was to receive PEG tube care daily, and tracheostomy care twice daily.</p> <p>A document titled Routine/PRN Treatments, dated March 2025, showed Res #12 had received PEG tube care daily and tracheostomy care twice daily on 03/01/25 through 03/11/25.</p> <p>On 03/12/25 at 7:56 a.m., RRT #1 was observed providing tracheostomy care to Res #12. The resident's assigned room did not have an EBP sign or a container of PPE outside the door. RRT #1 was observed providing the care which included replacing the resident's inner cannula and suctioning. RRT #1 was observed providing the care using only treatment gloves and hand washing as their only protective measures.</p> <p>On 03/12/25 at 8:00 a.m., RRT #1 stated they provide tracheostomy care to residents using gloves and hand washing unless they are on EBP and then they add the use of masks and gowns. RRT #1 stated they had never used gowns and masks unless a resident was on EBP or another type of precaution that would require it. RRT #1 stated they know if a resident was on EBP because of the signs. RRT #1 stated Res #10, 11, and #12 did not have the EBP signs because they did not have the infections that would require them. RRT #1 stated they did know any other reason a person would be put on EBP.</p> <p>On 03/12/25 at 12:45 p.m., the ADON stated Res #10, 11, and #12 had required PEG tube and tracheostomy care at the facility since their admission.</p> <p>On 03/12/25 at 1:15 p.m., the ADON stated they were the infection preventionist at the facility. They stated they understood that EBP was used for residents with certain types of infections and that the use of EBP for residents with PEG tubes and tracheostomies was recommended but not required. They stated they had not used EBP for residents just because they had thracheostomy tubes or PEG tubes. They stated they thought EBP use for those residents was not mandatory.</p>		