STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	11430 COLDWATER ROAD, FORT WAYNE, , 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: November 5, 6, and 7, 2025 Facility number: 014419 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 12, 2025	R 0000	Please accept this as our credible allegation of compliance for our recent IDOH Annual Recertification and State Licensure Survey that was completed on November 7, 2025. Submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. Please also consider this Plan of Correction for paper compliance. Please see the attachments under each individual deficiency.	
R 0054	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(x) (x) Residents have the right to confidentiality of all personal and clinical records. Information from	R 0054	**R054– Resident Rights-Confidentiality of Personal and Clinical Records** 1 ADON audited staff on resident	11/21/2025

	these sources shall not be released without the resident ' s consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment contract. The resident ' s records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident ' s expense. Based on observation, interview, and record review the facility failed to ensure protected health information was secured for 3 of 5 residents reviewed (Resident 2, Resident 10 and Resident 11). Findings include: During an observation on 11/6/25 at 11:36 AM, Qualified Medicine Aide (QMA) 2 prepared medicine for Resident 10 in the common area adjacent to the main hallway. QMA 2 walked over to Resident 10 and presented her medication. QMA 2 had her back turned to the medication cart during the process. The computer screen on the medicine cart was open to a page with Resident 10's picture, medication list and other private health information. QMA 2 returned to the cart and prepared medication for Resident 2. She walked away from the cart to administer the medication to Resident 2 with		neighborhoods at various times on 11/19/2025 to ensure privacy and confidentiality was maintained. No concerns were identified. 2 Education: EMR Physical Safeguards and Privacy and Confidentiality policies were reviewed on 11/19/2025 and no changes were necessary. ADON and ED provided in-service education to nursing staff on 11/19/25 regarding proper computer screen locking, safeguarding resident protected health information both printed and electronic, and physically placing medication carts, computer screens, and printed documentation/worksheets out of the view of passersby. (See attached In-Service Agenda & Sign-In Sheets) 3 Quality: Audit tool was developed by RCA to monitor staff to ensure proper precautions are taken to protect resident privacy and confidentiality. Audit will be completed by the ADON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will	

	her back turned to the medicine cart. The medicine cart computer screen was open to a page with Resident 2's picture, medication list and other private health information. A worksheet with a list of the residents residing on the unit with vital signs and other care related notes was lying uncovered on top of the cart. QMA 2 opened the computer screen to a page displaying Resident 11's picture, medication list and other private health information. She then picked up a thermometer and left the cart with the screen open to take Resident 11's temperature. Other residents were in the vicinity of the cart. 1) Resident 10's record was reviewed on 11/6/25 at 2:14 PM. Diagnoses included Alzheimer's disease, and mild protein-calorie malnutrition. A review of physician orders, dated 10/23/2024, indicated Resident 10 should be given Buspirone three times a day for anxiety. 2) Resident 2's record was reviewed on 11/5/25 at 11:22 AM. Diagnoses included unspecified dementia. A review of physician orders included an order, dated 12/26/24, for ibuprofen 600 mg three times a day for pain. A physician order, dated 8/13/24,		be reported monthly during the QAA meeting by the ADON/designee. (See attached audit tool)	

indicated Resident 2 should receive tramadol 50 mg four times daily for pain.

3) Resident 11's record was reviewed on 11/6/25 at 2:17 PM. Diagnoses included Alzheimer's disease and cellulitis right second toe.

A review of physician orders, dated 11/3/25, indicated levaquin 500 mg should be given one time a day for infection/cellulitis right 2nd toe for 7 days.

In an interview, on 11/6/25 at 11:49 AM, QMA 2 indicated she should have closed her computer screen and turned her resident worksheet over each time she walked away from the medicine cart.

In an interview, on 11/6/25 at 11:52 AM, the Director of Nursing indicated the computer screen containing resident information should be locked and worksheets containing resident information should be turned over to protect privacy.

A current policy titled Electronic Medical Safeguards, dated 12/21/16 provided by the Administrator on 11/7/25 at 11:16 AM indicated computer display screens should be arranged in a way that access was only available to those needing to know.

	Based on observation, interview, and record review the facility failed to ensure protected health information was secured for 3 of 5 residents reviewed (Resident 2, Resident 10 and Resident 11). Findings include: During an observation on 11/6/25 at 11:36 AM, Qualified Medicine Aide (QMA) 2 prepared medicine for Resident 10 in the common area adjacent to the main hallway. QMA 2 walked over to Resident 10 and presented her medication. QMA 2 had her back turned to the medication cart during the process. The computer screen on the medicine cart was open to a page with Resident 10's picture, medication list and other private health information. QMA 2 returned to the cart and prepared medication for Resident 2. She walked away from the cart to administer the medication to Resident 2 with her back turned to the medicine cart. The medicine cart computer screen was open to a page with Resident 2's picture, medication list and other private health information. A worksheet with a list of the residents residing on the unit with vital signs and other care related notes was lying uncovered on top of the cart. QMA 2 opened the computer screen to a page displaying Resident 11's picture,			

medication list and other private health information. She then picked up a thermometer and left the cart with the screen open to take Resident 11's temperature. Other residents were in the vicinity of the cart.

1) Resident 10's record was reviewed on 11/6/25 at 2:14 PM. Diagnoses included Alzheimer's disease, and mild protein-calorie malnutrition.

A review of physician orders, dated 10/23/2024, indicated Resident 10 should be given Buspirone three times a day for anxiety.

2) Resident 2's record was reviewed on 11/5/25 at 11:22 AM. Diagnoses included unspecified dementia.

A review of physician orders included an order, dated 12/26/24, for ibuprofen 600 mg three times a day for pain. A physician order, dated 8/13/24, indicated Resident 2 should receive tramadol 50 mg four times daily for pain.

3) Resident 11's record was reviewed on 11/6/25 at 2:17 PM. Diagnoses included Alzheimer's disease and cellulitis right second toe.

A review of physician orders, dated 11/3/25, indicated levaquin 500 mg should be given one time a day for

	infection/cellulitis right 2nd toe for 7 days. In an interview, on 11/6/25 at 11:49 AM, QMA 2 indicated she should have closed her computer screen and turned her resident worksheet over each time she walked away from the medicine cart. In an interview, on 11/6/25 at 11:52 AM, the Director of Nursing indicated the computer screen containing resident information should be locked and worksheets containing resident information should be turned over to protect privacy. A current policy titled Electronic Medical Safeguards, dated 12/21/16 provided by the Administrator on 11/7/25 at 11:16 AM indicated computer display screens should be arranged in a way that access was only available to those needing to know.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:	R 0148	**R148– Sanitation and Safety Standards-HVAC inspection** 1 Director of Maintenance completed a Preventative Maintenance audit on 11/20/25 throughout the community. No concerns were identified. Annual inspection with new contractor has been completed on 11/20/25.	11/24/2025

	(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to ensure yearly inspections of heating and ventilation (HVAC) systems were completed. 39 people resided in the facility. Findings include: On 11/7/25 at 9:55 AM, a current HVAC inspection checklist was reviewed. The inspection checklist was dated 9/25/24. In an interview, on 11/7/25 at 11:25 AM, the Administrator indicated the facility had initiated a new HVAC contractor on 9/1/25. The Administrator indicated the HVAC system was to be inspected on 11/12/25. A current facility policy, titled		(see attached report) 2 Education: Heating Ventilation and Air Conditioning policy was reviewed on 11/18/2025 and no changes were necessary. ED provided in-service education to maintenance staff on 11/18/25 regarding IDOH regulation, HVAC inspection process, preventative maintenance schedule/calendar, documentation, reporting, staff roles, and audit tool. (See attached In-Service Agenda & Sign-In Sheets) Quality: Audit tool was developed by RCA to monitor monthly preventative maintenance to ensure equipment is clean, in good repair, and free of potential hazards. Audit will be completed by the Director of Maintenance/designee monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the Maintenance Director/designee. (See attached audit tool). Annual Inspection and monthly preventative maintenance audit was added to the community Maintenance portal to be completed each	

	Heating, Ventilation, and Air Conditioning, dated 11/7/25, provided by the Administrator on 11/11/25 at 9:32 AM, indicated the facility should have an HVAC inspection annually. Based on interview and record review, the facility failed to ensure yearly inspections of heating and ventilation (HVAC) systems were completed. 39 people resided in the facility. Findings include: On 11/7/25 at 9:55 AM, a current HVAC inspection checklist was reviewed. The inspection checklist was dated 9/25/24. In an interview, on 11/7/25 at 11:25 AM, the Administrator indicated the facility had initiated a new HVAC contractor on 9/1/25. The Administrator indicated the HVAC system was to be inspected on 11/12/25. A current facility policy, titled Heating, Ventilation, and Air Conditioning, dated 11/7/25, provided by the Administrator on 11/11/25 at 9:32 AM, indicated the facility should have an HVAC inspection annually.		November going forward. (see attached)	
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e)	R 0304	**R304– Pharmaceutical Services-Medication Storage**	11/21/2025

	(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review the facility failed to ensure medications were secured during the medication pass process for 2 of 5 residents reviewed (Resident 2 and Resident 10). Findings include: During an observation, on 11/6/25 at 11:36 AM, Qualified Medicine Aide (QMA) 2 prepared medicine for Resident 10 in the commmon area adjacent to the main hallway. QMA 2 walked over to Resident 10 and presented her medication. QMA 2 had her back turned to the medication cart during the process. The medicine cart was unlocked when she walked over to Resident 10. Several residents ambulated past the cart as it was unattended. QMA 2 returned to the cart and prepared medication for Resident 2. She walked away from the cart to administer the medication to Resident 2. QMA 2's back was turned to the		1 ADON audited staff on resident neighborhoods at various times on 11/19/2025 to ensure proper medication that medication carts were locked when not attended, medication room was locked, and no medications were left on top of medication cart unattended. No concerns were identified. 2 Education: Medication Administration policy was reviewed on 11/19/2025 and no changes were necessary. ADON and ED provided in-service education to nursing staff on 11/19/25 regarding proper medication storage. (See attached In-Service Agenda & Sign-In Sheets) 3 Quality: Audit tool was developed by RCA to monitor staff to ensure proper precautions are taken to ensure that medication is stored properly. Audit will be completed by the ADON/designee weekly for 4 weeks and then monthly for a total of 6 months. Audit results will be reported monthly during the QAA meeting by the ADON/designee.	

	medicine cart. The cart remained unlocked with residents in proximity. 1) Resident 10's record was reviewed on 11/6/25 at 2:14 PM. Diagnoses included Alzheimer's disease, and mild protein-calorie malnutrition. A review of physician orders, dated 10/23/2024, indicated Resident 10 should be given Buspirone three times a day for anxiety. 2) Resident 2's record was reviewed on 11/5/25 at 11:22 AM. Diagnoses included unspecified dementia. A review of physician orders included an order, dated 12/26/24, for ibuprofen 600 MG three times a day for pain. A physician order, dated 8/13/24, indicated Resident 2 should receive tramadol 50 mg four times daily for pain. In an interview, on 11/6/25 at 11:49 AM, QMA 2 indicated she should have locked the medicine cart each time she walked away to administer medicine. In an interview, on 11/6/25 at 11:52 AM, the Director of Nursing indicated medicine carts should be locked when not directly attended.		(See attached audit tool)	

A current policy titled Medication Administration, dated 2/9/2018, provided by the Administrator on 11/6/25 at 12:22 PM, indicated the medication cart should be locked when not in the sight of the medication aide or nurse.

Based on observation, interview, and record review the facility failed to ensure medications were secured during the medication pass process for 2 of 5 residents reviewed (Resident 2 and Resident 10).

Findings include:

During an observation, on 11/6/25 at 11:36 AM, Qualified Medicine Aide (QMA) 2 prepared medicine for Resident 10 in the commmon area adjacent to the main hallway. QMA 2 walked over to Resident 10 and presented her medication. QMA 2 had her back turned to the medication cart during the process. The medicine cart was unlocked when she walked over to Resident 10. Several residents ambulated past the cart as it was unattended. QMA 2 returned to the cart and prepared medication for Resident 2. She walked away from the cart to administer the medication to Resident 2. QMA 2's back was turned to the medicine cart. The cart remained unlocked with

residents in proximity.

1) Resident 10's record was reviewed on 11/6/25 at 2:14 PM. Diagnoses included Alzheimer's disease, and mild protein-calorie malnutrition.

A review of physician orders, dated 10/23/2024, indicated Resident 10 should be given Buspirone three times a day for anxiety.

2) Resident 2's record was reviewed on 11/5/25 at 11:22 AM. Diagnoses included unspecified dementia.

A review of physician orders included an order, dated 12/26/24, for ibuprofen 600 MG three times a day for pain.

A physician order, dated 8/13/24, indicated Resident 2 should receive tramadol 50 mg four times daily for pain.

In an interview, on 11/6/25 at 11:49 AM, QMA 2 indicated she should have locked the medicine cart each time she walked away to administer medicine.

In an interview, on 11/6/25 at 11:52 AM, the Director of Nursing indicated medicine carts should be locked when not directly attended.

A current policy titled Medication Administration, dated 2/9/2018,

	provided by the Administrator on 11/6/25 at 12:22 PM, indicated the medication cart should be locked when not in the sight of the medication aide or nurse.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAmy Saalfrank	TITLEExecutive Director	(X6) DATE11/25/2025