STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/04/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434365. Complaint IN00434365 - State deficiencies related to the allegations are cited at R0036 and R0214. Survey date: June 4, 2024 Facility number: 014419 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 6, 2024.	R 0000	Please accept this as our credible allegation of compliance to our recent ISDH complaint survey that was completed on 06/04/2024. 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. Supportive Documents Uploaded: In-Service Attendance Record Policies provided to staff during In-Service 0036- Audit tool re: Physician Notification 0214- Audit tool re: Service Plan Updates	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure physician notification of a	R 0036	R 036 Resident's Rights	06/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	significant change in condition for 1 of 3 residents reviewed (Resident H). Findings include: On 6/4/24 at 10:31 A.M., Resident H's record was reviewed. Diagnoses included altered mental status and insomnia. He admitted to the facility following brief stay at a skilled facility for rehabilitation. He resided on the secured memory care unit due to room availability. A nurse note, dated 5/11/24 at 3:43 p.m., indicated Resident H's family had been in to visit the resident and found a suicide note from the resident indicating he no longer wanted to live. His family tried to comfort him and shared the note with facility staff. The Resident Care Coordinator (RCC) /nurse was notified and indicated the resident should be placed on 15 minute checks for 24 hours. The family was notified staff would monitor closely and report any changes. Staff removed all items from his room that could potentially cause harm. -At 3:51 p.m., staff went to check on the resident and he was observed crying and indicated he had lived a good life and hadn't wanted to live like this. A staff member stayed with him and tried to provide comfort. -At 6:58 p.m., the resident was up and took his evening medications without issue. He had a cheerful spirit with no complaints. A nurse note, dated 5/12/24 at 1:41 a.m., indicated staff had entered the resident's room for the 15 minute check and found the resident in his bathroom with blood all over the shower floor. He had attempted to cut his wrists with a table knife he had sharpened with a nail file. He told staff that he couldn't even do this right (kill himself). First		1. Residents Identified: On 6/12/24, reviewed Resident H's chart. No other changes of condition identified out of compliance. Review and updated service plan as needed. 2. Other Residents: Reviewed all residents for significant change of conditions. Physician notification completed for other residents identified. 3. Training: On 6/19/24, reviewed facility Change in Condition Policy, no changes required to policies. On June 5th, 2024 reviewed policy with Interim Director of Nursing. On June 19th and 20th , in serviced nursing department staff regarding notification to the physician/extender of any significant change. See uploaded documents: Agenda POC 6.19.24_In-Service and In-Service Sign-In Forms. 4. Quality Assurance: Notification Audit Form created for identifying significant change in conditions. See uploaded document: Audit Form_Notification Audit. DON/ designee will monitor audit form completion by Leadership staff. The results will also be reviewed weekly for 4 weeks with Administrator. The DON/designee will report results monthly at the QAA Meeting. The	

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	aid was provided and the bleeding stopped. Resident H's family came to the facility and transported him to the hospital. On 6/4/24 at 12:50 P.M., the RCC was interviewed. She indicated staff had notified her of the resident's suicide note and she had instructed them to complete 15 minute checks on the resident. When asked if the physician had been notified, she indicated he had notified the physician, but it wasn't documented in the resident's chart. She indicated the notification was on her phone as she communicated to the provider via text message. She did not indicate the physician had given direction or answered her text. On 6/4/24 at 1:35 P.M., the Administrator and a Director of Nursing (DON) were interviewed. They provided a copy of the secured text message sent to the healthcare provider by the RCC, notifying them of the resident's suicide note and facility actions. The message indicated the PA (Physician Assistant) had been notified of the resident's suicide note and attempt to end his life on 5/13/24 at 9:29 a.m. after the resident's suicidal attempt and subsequent psychiatric hospitalization. The Administrator and DON indicated the physician/PA/NP should've been notified immediately upon finding the resident's suicide note. A current facility policy, titled "Change in Condition", was provided by the Administrator on 6/4/24 at 2:11 P.M. The policy stated: "Significant change includes but not limited to...behavioral or mood changes that are uncharacteristic for the resident...Physician notification will occur as soon as possible but at least within 24 hours of identified significant change...."		audit will continue monthly for at least a minimum period of six months through December 2024. 5. Date Certain: June 20, 2024	

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	This tag relates to Complaint IN00434365.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to ensure re-assessment and evaluation of a resident's needs following a significant change in condition for 1 of 3 residents reviewed (Resident H). Findings include: On 6/4/24 at 10:31 A.M., Resident H's record was reviewed. Diagnoses included altered mental status and insomnia. He admitted to the facility following brief stay at a skilled facility for rehabilitation. He resided on the secured memory care unit, due to room availability but would move downstairs, off the secured unit, to a one bedroom apartment when available. He was prescribed Trazodone to help him sleep at night but was on no other psychotropic medications. A pre-admission assessment, dated 4/12/24, indicated the resident was independent with all activities of daily living, had no behaviors but had sleeping problems, and had a history of depression. He had not required a locked secure environment. On 6/4/24 at 11:15 A.M., Resident H was observed	R 0214	R 214 Evaluation 1. Residents Identified: On 6/12/24, reviewed Resident H's chart. No other changes of condition identified out of compliance. Review and updated service plan as needed. 2. Other Residents: Reviewed all residents for significant change of conditions. Other residents identified for significant change in condition had service plan reviewed and updated. 3. Training: On 6/19/24, reviewed facility Care Plan/ Service Plans Policy, no changes required to policies. On June 5th, 2024 reviewed policy with Interim Director of Nursing. On June 19th and 20th , in serviced nursing department staff regarding reassessment and evaluation of residents needs following a significant change in condition,	06/20/2024

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	standing in the hall outside his room with a family member. He was unshaven, pale in color with dull eyes and flat, depressed affect. He engaged in small talk and when asked about living at the facility, indicated it was a nice place "unless you have to live in it". He then indicated the facility was good and he'd give it a high rating. Nurse notes indicated: -4/15/24 at 4:47 p.m., the resident admitted to the facility accompanied by family. He was to reside in a room on the secured memory care unit until a one bedroom apartment became available on the 1st floor which was not a secured unit. He would be coming down to the first floor for the majority of his day. -5/1/24 at 10:54 a.m., the resident had been agitated off and on during the day shift. When asked what was wrong, he replied he was having a hard time adjusting to living in a facility and not at home. Staff would continue to monitor agitation and report as needed. -5/3/24 at 6:38 p.m.,a female resident wandered into the resident's apartment. He was heard yelling at the female resident as he walked her down the hall by her arm. He stated "You staff do not keep an eye on these people"! He was encouraged to lock his door to keep others out of his room. -5/7/24 at 1:04 p.m., the resident was agitated off and on during the shift. When asked, he indicated he was still having a hard time adjusting to living in a facility. -5/9/24 at 11:37 a.m., a care plan conference had been held with Resident H and his family on 5/8/24. At the meeting, the resident requested to		including any behavioral, cognitive, or secured Memory Care needs. See uploaded documents: Agenda POC 6.19.24_In-Service and In-Service Sign-In Forms. 4. Quality Assurance: Service Plan Audit Form created for completing resident need evaluation and assessment. See uploaded document: Audit Form_Service Plan Audit. DON/ designee will monitor audit form completion by Leadership staff. The results will also be reviewed weekly for 4 weeks with Administrator. The DON/designee will report results monthly at the QAA Meeting. The audit will continue monthly for at least a minimum period of six months through December 2024. 5. Date Certain: June 20, 2024 -	

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	see the PA (Physician Assistant) during his next scheduled visit as he couldn't recall seeing him since admitting to the facility. He stated several times "I don't belong up here". The resident and family were asked if they were still interested in him moving to the first floor (unsecured unit) if a 1 bedroom apartment became available, and all indicated they would be. -At 3:28 p.m., the resident refused menu and alternative menu choices for supper. He stated he hadn't wanted anything from the facility and hadn't wanted anything from the staff member who was trying to assist him. -5/11/24 at 3:43 p.m., Resident H's family had been in to visit the resident and found a suicide note from the resident indicating he no longer wanted to live. His family tried to comfort him and shared the note with facility staff. The RCC (Resident Care Coordinator/nurse) was notified and indicated the resident should be placed on 15 minute checks for 24 hours. The family was notified staff would monitor closely and report any changes. Staff removed all items from his room that could potentially cause harm. -5/12/24 at 1:41 a.m., staff had entered the resident's room for the 15 minute check and found the resident in his bathroom with blood all over the shower floor. He had attempted to cut his wrists with a table knife he had sharpened with a nail file. He told staff that he couldn't even do this right (kill himself). First aid was provided and the bleeding stopped. Resident H's family came to the facility and transported him to the hospital. -5/20/24 at 4:03 p.m., the resident re-admitted from the behavioral hospital to his room on the secured memory care unit, accompanied by family. He was alert and oriented. An incision to the skin on his			

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	right wrist was well approximated with slight redness; his left wrist incision was red and the wound edges gaping. The resident and family were told the resident would remain on 30 minute checks until seen by the psychiatric NP (Nurse Practitioner) the following day. -At 4:54 p.m., the resident walked to the nurses station and yelled out "What am I even here for? I have to be babysat? Where is my razor? I have to ask for my things?". Staff explained it was only temporary until he was seen by the psychiatric NP. He rolled his eyes and said "whatever" and went back to his room. -5/21/24 at 3:15 p.m., staff checked on the resident who was in his living room. When asked how he was doing, he replied he needed his toiletries returned to him. He was agitated and wanted to know when the doctor would be in. -5/23/24 at 3:33 p.m., the resident came out of his apartment demanding care staff let him off the locked unit and downstairs to assisted living. He was asked why he wanted to go downstairs and he replied "What am I, a prisoner? I want a newspaper. You know what-forget it!" -5/27/24 at 9:15 a.m., the resident complained of it being too "damn" cold in his room. He indicated he'd complained to maintenance several times and they couldn't get it right. He was also upset his TV station wasn't on the TV and he was "tired" of things not working. -5/29/24 at 3:13 p.m., per the psychiatric NP, hourly checks of the resident could be discontinued and staff were to restart routine checks (every 2-3 hours). The resident had been cooperative, friendly, made no negative statements or had any self harming behaviors.			

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	-At 7:40 p.m., the resident refused dinner and refused all his medications. Staff indicated they would check back with him in an hour and the resident indicated there was no need to do so. He decided he'd taken enough medications, didn't need or want them, and staff shouldn't bother to come back. A Service Plan, dated 4/15/24, indicated the following: -Cognition: Resident was independent with decisions about his care and environment. He had no apparent memory loss and was oriented and able to recall information. He made safe judgments and functioned appropriately in social situations. -Eating/meals/nutrition: He would maintain independence with eating and would dine in the 1st floor dining room. An intervention, dated 5/20/24, was for his meals to be served on disposable dinnerware and plastic silverware related to suicide attempt. The service plan did not indicate it had been updated following the resident's note or suicide attempt or address behavioral interventions to be utilized when the resident becasme agitated. A Nurse Practitioner Progress note, dated 5/21/24 at 4:19 p.m., indicated the resident was seen following a suicide attempt, depression, and insomnia. According to hospital records, the resident indicated he hadn't had anything to live for since his spouses passing; he was alone, not sleeping, depressed and anxious. While hospitalized, he was started on an anti-depressant medication and was continued on his current dose of Trazodone for sleep. During visit, he easily engaged, was alert and had good eye contact. He			

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	talked about the incident and was adamant he wasn't feeling suicidal today. He indicated he would not try and do that again and he would like to have back his grooming items. He reported his appetite was fair and sleep improved. He was depressed at times but denied feeling hopeless currently. He was on 30 minute checks which were to be continued through this day and hourly checks started tomorrow. On 6/4/24 at 11:22 A.M., CNA 2 (Certified Nurse Aid) was interviewed. She indicated she worked part-time on the memory care unit with Resident H. She indicated he'd always been cordial with her but indicated her only contact with him was during meals. When asked, she indicated staff were just to observe him closely however, the resident didn't wear his emotions and it was difficult to figure out what he was thinking so she just would report anything which seemed off to her. She indicated she had been shocked by his suicide attempt because he hadn't appeared depressed nor verbalized feeling depressed. On 6/4/24 at 12:29 P.M., QMA 3 (Qualified Medication Aid) was interviewed. She indicated she worked full time on the memory care unit. When questioned about interventions or precautions to be taken following the resident's hospitalization, she indicated staff were just monitoring him closely but were no longer doing hourly checks. She was unsure if the resident would have follow up care related to the incident but assumed the family would take care of it. She indicated she and Resident H spoke often and he would seek her out to talk about his frustrations with living in the facility, hard time adjusting, and his forgetfulness. She offered him support and an outlet to vent. When asked, she indicated prior to the suicide attempt, the plan had been for him to			

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	move downstairs to a one bedroom apartment when available but since returning from the hospital, she wasn't sure if he would be allowed to reside downstairs outside of a secured unit. There was no assessment of the resident's needs nor changes made to his service plan following hospitalization for suicide attempt. The service plan hadn't indicated any ongoing behavioral needs nor addressed his cognition and plans for remaining on the secured memory care unit or being allowed to resident on the unsecured 1st floor. On 6/4/24 at 1:35 P.M., the Administrator and a Director of Nursing (DON) from a sister facility, were interviewed. They indicated an assessment and update to the resident's service plan hadn't been completed but should have been done. A current policy, titled "Care Plans/Service Plans", provided by the Administrator on 6/4/24 at 2:11 P.M., stated "LLV will develop and implement a service plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care...." This tag relates to Complaint IN00434365.			