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	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	8075 GLENCARIN BOULEVARD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 27, 28, and 29, 2023 Facility number: 013612 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 30, 2023	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Ciak	Executive Director	04/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review the facility failed to ensure community emergency drills were attempted twice yearly for 12 of 12 drills reviewed. Findings include: During an initial tour and interview, on 3/27/23 at 9:18AM, the Maintenance Director indicated they put the system on test during fire drill to ensure the monitoring company did not call the fire department. The Maintenance Director further indicated he was unaware of the expectation to have the local fire company participate in 2 drills per year. The Maintenance Director indicated the process for fire drills being a code over the radio and staff education regarding what to do in case of fire. The Maintenance Director did not indicate they pull an alarm. There was no indication of using different pull stations to ensure all were working as expected in case of an emergency. A review of fire drills on 3/27/23 at 9:22AM, indicated the date and time the drills were completed with staff name and signatures. Those drills dated March, April, May, and June of 2022 did not include alarm signal. The Maintenance Director was listed as the drill leader on the 12 drill forms. There was no indication the facility had contacted the local fire departmenet to simulate drills. During an interview on 3/28/23 at 8:46AM, the Maintenance Director indicated the alarm system has a record of the facility system being checked daily for ability to communicate, ability to give	R 0092	Please accept this as our credible allegation of compliance to our recent ISDH Annual Recertification and state licenseure survey that was completed on 3/29/23. Submission of this Plan of Correction does not constitute an admission or 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. No residents were affected by this deficient practice All resident could have been affected by this deficient practice. The corrective action will be as follows ¿ Maintenance Director or designee will contact the FWFP at least every 6 months to invite them to participate in the communities fire and disaster drill. The ED will monitor communication between Maintenance Director and the FWFD to ensure that the deficient practice will not reoccur. The Quality Assurance team will monitor all fire drills and	05/15/2023

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	and receive information between the facility's system and the alarm company's system (ping). The daily check was not an ability to ensure they received an emergency message or the amount of time it took for them to act. The communication was an assurance the system was online. The Maintenance Director was able to provide the name of emergency company and a 1-800 number. An attempt was made to contact the emergency company on 3/27/23 at 11:06AM, 1:36PM, and 2:46 PM. The emergency company transferred the call twice and each time a message was left. In an interview on 3/27/23 at 2:12PM, the ED (Executive Director) indicated the facility did not pull the alarm stations related to all the residents with diagnoses of dementia, resultant confusion, increased accidents, and anxiety. The ED gave the name and number of local fire chief. The ED indicated they were out on 2/23/23 at 3:30PM for an unrelated issue. The ED indicated the fire department did not have any problems with their system or drill procedures. In an interview on 3/28/23 at 9:22AM, Fire Chief 5 indicated the department was present at the facility regarding an issue from the year prior. He indicated they were walked around in a circle and refamiliarized with the layout of the facility. Fire Chief 5 indicated they did not review the facility procedures or practices for fire safety. Fire Chief 5 indicated to his knowledge there were no drills set up with the fire department in advance and no alarms at the facility recently. There was no policy or procedure available at time of exit to indicate fire drill compliance.		communication with FWFD monthly to ensure practice does not reoccur. By 5/15/23 the systemic changes will be completed.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review the facility failed to ensure service plans were reviewed and signed for 5 of 19 residents reviewed (Resident 5, Resident 7, Resident 15, Resident 3, and Resident 11). Findings include:	R 0217	5 residents were affected by this deficient practice. All potentially effected residents were reviewed by the administrator. The ED or designee will audit all new admissions within 7 days of admission to ensure the practice	05/15/2023

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	1) Resident 5's record was reviewed March 28, 2023, at 10:00 AM. Resident 5's diagnoses included Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, and hypertension. Resident 5's service plan was completed December 28, 2022. The document did not contain a date or signature of the resident's responsible party. 2) Resident 7's record was reviewed March 27, 2023, at 11:20 AM. Resident 7's diagnoses included dementia, dysphagia, chronic obstructive pulmonary disorder (COPD), and agitation. Resident 7's service plan was completed on March 5, 2022. The document did not contain a date or signature of the resident's responsible party. 3) Resident 15's record was reviewed March 28, 2023, at 2:00 PM. Resident 13's diagnoses included Alzheimer's disease, hypertension, heart disease, hyperlipidemia, and glaucoma. Resident 15's service plan was completed March 28, 2023. The document did not contain a date or signature of the resident's responsible party. 4) Resident 3's record review began March 27, 2023, at 9:17AM. Resident 3's diagnoses included pancreatic cancer, urinary infection, liver disease and heart disease. Resident 3 service plan was completed 2/24/23. The service plan was signed and dated by staff. There was no date or signature by resident or responsible party.		does not reoccur. The corrective action will be monitored by using an audit tool “Service Plan Audit” 1 X week for 4 weeks, monthly X 3 months and quarterly x 1 year. The results of these audits will be reviewed by Administrator and DON at QA monthly. By 5/15/23 the systemic changes will be completed.	

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	5) Resident 11's record review began on March 27, 2023, at 9:42AM. Resident 11's diagnoses included dementia, heart disease, deaf, and arthritis. Resident 11's service plan was dated and signed by staff on 12/21/22; there was no date or signature by Resident 11 or the responsible party. In an interview on 3/28/23 at 1:32PM, the DON (Director of Nursing) indicated the first service plan did not require a signature. The DON indicated the residents were new and the service plan was a result of initial assessments. The DON indicated the following 6 months the services were to be signed. In an interview on 3/29/23 at 9:26 AM, the ED (Executive Director) indicated there was no policy and procedure regarding service plans.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies.			

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	(7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review the facility failed to ensure updated emergency files for 13 of 19 residents reviewed. (Resident 3, Resident 11, Resident 15, Resident 17, Resident 21, Resident 23, Resident 25, Resident 27, Resident 31, Resident 33, Resident 35, Resident 37, and Resident 39) Findings include: A review of emergency file records began on 3/27/23 at 9:41 AM, the emergency file had current residents listed except Resident 3, Resident 11, Resident 15, Resident 17, Resident 19, Resident 21, Resident 23, Resident 25, Resident 27, and Resident 29. The emergency files were printed for these residents after the start of the survey. In an interview on 3/27/23 at 10:24 AM, the DON (Director of Nursing) indicated the emergency files were printed after entrance of survey due to the need for updated files. Resident 11's emergency file was printed 12/9/22 but did not include the orders for medication; Norvasc 5mg every morning, Tylenol 500 mg 2 tablets as needed, and Vit D3 50mcg daily. Resident 31's emergency file was printed 9/27/22 but did not include the following orders; hospice was ordered on 12/30/22, Eliquis 2.5 mg daily (a blood thinner) and tramadol 50mg (for pain) twice a day. Resident 33's emergency file was printed 10/04/22 but did not include the following orders; amlodipine 25mg daily, boost 1 as needed if not	R 0356	10 residents could have been affected by this deficient practice as identified by the administrator. The measurement to ensure that this doesn't recur will be; DON or designee will present the emergency binder to review after each census change including admissions, discharges, or room moves. This will be monitored by reviewing the emergency binder 1 X week for 4 weeks, monthly X 3 months and quarterly x 1 year. The results of these audits will be reviewed by Administrator and DON at QA monthly. By 5/15/23 the systemic changes will be completed.	05/15/2023

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	eating meals, buspirone 10mg (an antianxiety medication) four times a day, Imodium 2 mg as needed for diarrhea, Lexapro 10mg (an antidepressant medication) every evening, lorazepam 0.5mg (a control substance antianxiety medication) four times a day as needed for anxiety, and mirtazapine 7.5mg every evening. Resident 35's emergency file was dated 4/25/18. Resident 37's emergency file was printed on 9/27/22 but did not include the following orders; check blood sugar as needed was daily prior to 2/6/23 and sertraline 50mg (an antidepressant) one daily was 1 and a half tablets prior to 3/13/23. Resident 39's emergency file was printed on 5/17/22 but did not include the following orders boost as needed for missed meals up to two per day, buspirone 10mg (an antianxiety medication) three times a day, Haldol injection 5mg/ml (an antipsychotic) inject 0.5ml every eight hours as needed for agitation. Nystatin powder twice daily under breast and as needed, pataday (eye drop) 1 drop each eye per day, and Prozac 10 mg (an antidepressant) one daily. There was no policy and procedures available at time of exit conference related to emergency files.			