STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00394172. Survey dates: November 2, 3, 4, 7, and 9, 2022 Facility number: 000283 Provider number: 155586 AIM number: 100275020 Census Bed Type: SNF/NF: 104 Residential: 53 Total: 157 Census Payor Type: Medicare: 13 Medicaid: 80 Private: 28 Other: 36 Total: 157 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 10, 2022	F 0000	**This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal law and not because Lutheran Life Village Anthony Boulevard agrees with the allegations and citations listed in this statement of deficiencies. Lutheran Life Villages maintains that the alleged deficiency does not jeopardize the health and safety of the residents, nor does it constitute substandard quality of care or limit our capability to render adequate care. Please accept this plan of correction as our credible allegation of compliance.** **Lutheran Life Village Anthony Boulevard is respectfully requesting paper compliance.**	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that			

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

Shauna Shafer | HFA | 11/24/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to ensure care plans were updated to accommodate changes for 4 of 4 residents reviewed (Resident 19, Resident 40, Resident 53, and Resident 77). Findings include: 1. During a record review conducted on 11/2/22 at 11:21 AM, a Minimum Data Set (MDS) dated 8/10/22 indicated Resident 19 had diagnoses including COVID-19, non-pressure chronic ulcer of other part of right foot, unspecified severity, and peripheral vascular disease. An interview was deferred due to positive COVID-19 status.	F 0657	**1. 1. Resident Impacted: DON/ADON/MDS updated care plans of the four residents identified on 11.3.2022 to include wound care and O2 as required.** **2. 2. Other Residents: DON/ADON/MDS audited care plans of residents with orders for wound care and 02 and no other residents were impacted.** **3. 3. Training: Care Plans policy was reviewed and no changes were necessary. Nursing employees were re-educated regarding care plan documentation on**	11/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	A physician's order dated 10/21/22 gave instructions to wash the right great toe and apply betadine for enzymatic debridement. The comprehensive care plan was reviewed and no records addressing care of a non-pressure ulcer of the foot were available for review. During an interview conducted with the Director of Nursing (DON) on 11/3/22 at 1:40 PM, the DON confirmed the right great toe ulcer was present and indicated the care plan should address the wound care. 2. During an interview with Resident 40 on 11/2/22 at 12:14 PM, Resident 40 indicated staff provided dressing changes to her foot. During a record review conducted on 11/2/22 at 12:16 PM, a Minimum Data Set (MDS) dated 10/30/22 indicated Resident 40 had diagnoses including diabetes mellitus type 2 without complications, pressure ulcer of other site, unspecified stage, and major depressive disorder. A physician's order dated 10/22/22 indicated Resident 40's left 5th toe and right great toe wounds should be washed with wound cleanser, rinsed, and treated with medihoney, covered with gauze, and wrapped with kerlix. The comprehensive care plan was reviewed and no records addressing a plan of care for the ulcers were available for review. During an interview conducted with the Director of Nursing (DON) on 11/3/22 at 1:40 PM, the DON confirmed the left 5th toe and right great toe ulcers were present and indicated the care plan should address the wound care.		**11.10.2022 and 11.12.2022. See training agenda/education and employee sign in records.** **4. 4. Quality: DON/Designee will audit care plans in relationship to orders on a weekly basis for one month and on a monthly basis for 5 months. The audit results will be shared by the DON/ADON with the QAA/QAPI committee on a monthly basis for 6 months. See Audit Tool.** **Artifacts: Training Agenda Education /Signature, and Audit Tool**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	3. During an observation on 11/2/22 at 1:40 PM, Resident 53 was observed sitting in her recliner with oxygen administered by a nasal cannula from an oxygen concentrator at the bedside. During a record review conducted on 11/3/22 at 11:48 AM, a Minimum Data Set (MDS) dated 10/28/22 indicated Resident 53 had diagnoses including end stage heart failure, pulmonary hypertension, and bradycardia. Oxygen was ordered to be administered at 3 liters per minute by nasal cannula. The comprehensive care plan was reviewed and no records addressing oxygen in the care plan were available for review. An interview on 11/3/22 at 4:48 PM with the DON indicated oxygen should be addressed in the care plan. 4. During an interview with Resident 77 on 11/2/22 at 10:15 AM, Resident 77 indicated he receives wound care and assistance with dressing, showering, and transferring in and out of his wheelchair. During a record review conducted on 11/2/22 at 4:25 PM, a Minimum Data Set (MDS) dated 9/29/22 indicated Resident 77 had diagnoses including Type 2 diabetes, unspecified fracture of lower end of right femur with routine healing, and muscle weakness. The MDS indicated Resident 77 received extensive assistance from staff to complete his dressing, grooming, hygiene, transferring and toileting tasks. A physician's order dated 10/21/22 indicated Resident 77's sacral ulcers should be washed with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	wound cleanser, patted dry and treated with santyl and bordered foam dressings. The comprehensive care plan was reviewed. Care plans pertaining to assistance with activities of daily living, such as hygiene and transfers, and wound care were not available for review. During an interview conducted with the Director of Nursing (DON) on 11/3/22 at 1:40 PM, the DON confirmed the right great toe ulcer was present and indicated the care plan should address the activities of daily living and wound care. A current policy titled "Care Plans" dated 11/28/16 indicated the comprehensive care plan should include measurable objectives and timeframes to meet a resident's medical needs and indicate services furnished to provide quality of care. 3.1-35(d)(2)(B)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure residents received appropriate respiratory care for 2 of 2 residents reviewed. (Resident 20 and Resident 53.)	F 0695	**1. Resident Impacted: DON/ADON/MANAGER ensured O2 was supplied to resident #20**	11/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	Findings include: 1. During an observation on 11/2/22 at 9:49 PM, Resident 20 was observed sitting in her wheelchair with oxygen administered by a nasal cannula (tubing used to deliver oxygen through the nostrils) from a portable oxygen tank attached to the back of her wheelchair push handles. The portable oxygen machine flow rate was set to deliver 2 liters of oxygen per minute. The oxygen pressure gauge indicated the tank was empty. A record review was conducted on 11/03/22 at 3:32 PM. The resident diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified systolic congestive heart failure, paroxysmal atrial fibrillation, cerebral infarction due to embolism of right middle cerebral artery and severe morbid obesity. Resident 20's quarterly Minimum Data Set (MDS) assessment, dated 8/10/22, was reviewed. The MDS indicated the resident has been on oxygen while a resident at the facility and would get short of breath while lying flat. A physician order, dated 7/8/22, indicated oxygen was ordered to be administered at 2 liters per minute nasal cannula continuous every shift related to chronic obstructive pulmonary disease. In an interview on 11/3/22 at 5:05 PM, the DON indicated when Resident 20 was assisted back to her room after breakfast the staff member should had hooked her oxygen tubing to her oxygen concentrator (a machine used to produce oxygen) at the bedside. The DON indicated the staff member should have checked the resident's		**at time of observation and ensured tubing was changed and dated for resident #53.** **2. Other Residents: DON/ADON/MANAGER observed portable O2 use for other residents and no other residents were impacted. DON/ADON/MANAGER audited O2 tubing and no other residents were impacted.** **3. Training: Oxygen policy reviewed and no changes were necessary. Nursing employees were educated on 11.10.2022 and 11.12.2022 regarding O2 use and maintenance. See training agenda/education and employee sign in records.** **4. Quality: DON/Designee will audit O2 in relationship to use and maintenance on a weekly basis for one month and monthly for 5 months. The audit results will be shared by the DON/ADON with the QAA/QAPI committee on a monthly basis for 6 months. See audit tool.** **Artifacts: Training Agenda Education / Signature and Audit Tool**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	portable oxygen tank to see if it needed refilled and refilled the tank as needed. 2. During an observation at on 11/2/22 at 1:40 PM, Resident 53 was observed sitting in her recliner with oxygen administered by a nasal cannula (tubing used to deliver oxygen through the nostrils) from an oxygen concentrator (a machine used to produce oxygen) at the bedside. The oxygen concentrator was set to deliver 3 liters of oxygen per minute. The nasal cannula used by Resident 53 was not dated. A nasal cannula attached to a portable tank on Resident 53's wheelchair was dated 10/25/22. During a record review conducted on 11/3/22 at 11:48 AM, a Minimum Data Set (MDS) dated 10/28/22 indicated Resident 53 had diagnoses including end stage heart failure, pulmonary hypertension, and bradycardia. A physician's order, dated 10/7/22, indicated oxygen was ordered to be administered at 3 liters per minute by nasal cannula. In an interview on 11/2/22 at 1:42PM with Licensed Practical Nurse 2 indicated oxygen tubing should be changed and dated every seven days. A current policy titled "Oxygen", last revised 2/16/18, indicated all portable tanks should be filled nightly and as needed, with levels assessed during hourly rounds and filled when needed. The policy also indicated oxygen tubing should be changed weekly on the night shift. 3.1-47(a)(6)			
F 0812 SS=E	483.60(i)(1)(2) Food			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure cookware was properly air dried and stored. 103 of 104 residents residing in the facility consume food from the kitchen. Findings include: During an observation with the Dietary Manager on 11/2/22 at 9:06 AM, metal pans used to contain food were observed stacked together on a storage rack. Upon separation of the pans, water dripped from each separated pan. During an interview with the Dietary Manager on 11/2/22 at 9:06 AM, he indicated the pans should	F 0812	**Resident Impacted: Director of Dining Services spaced out pans on drying racks on 11.2.2022.** **2. Other Residents: Director of Dining Services observed all other pans for moisture and spacing and no other issues were found.** **3. Training: Handling Cleaned Equipment and Utensils policy reviewed and no changes were necessary. Dining employees were educated on 11.10.2022 and 11.12.2022 regarding the spacing and wet nesting of the**	11/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	be air dried prior to stacking. A current policy last revised 11/10/09 titled Handling Cleaned Equipment and Utensils indicated pots, pans and utensils should be air dried before being stored. 3.1-21(i)(3)		**pans. See training agenda/education and employee sign in records.** **4. Quality: Director of Dining Services/Designee will audit pans in regards to spacing and wet nesting on a weekly basis for 1 month and then weekly for 5 months. The audit results will be shared by the director of dining services with the QAA/QAPI committee on a monthly basis for 6 months. See audit tool** **Artifacts: Training Agenda Education / Signature, and Audit Tool.**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00394172. Survey dates: November 4, 7, and 9, 2022 Facility number: 000283 Residential Census: 53 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000	**This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal law and not because Lutheran Life Village Anthony Boulevard agrees with the allegations and citations listed in this statement of deficiencies. Lutheran Life Villages maintains that the alleged deficiency does not jeopardize the health and safety of the residents, nor does it constitute substandard**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
	Quality review completed November 10, 2022		**quality of care or limit our capability to render adequate care. Please accept this plan of correction as our credible allegation of compliance.** **Lutheran Life Village Anthony Boulevard is respectfully requesting paper compliance.**	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure cookware was properly air dried and stored. 53 of 53 residents residing at the facility consume food from the kitchen. Findings include: During an observation with the Dietary Manager on 11/2/22 at 9:06 AM, metal pans used to contain food were observed stacked together on a storage rack. Upon separation of the pans, water dripped from each separated pan. During an interview the Dietary Manager on 11/2/22 at 9:06 AM, indicated the pans should be air dried prior to stacking. A current policy last revised 11/10/09 titled Handling Cleaned Equipment and Utensils indicated pots, pans and utensils should be air dried before being stored.	R 0273	**1. Resident Impacted: Director of Dining Services spaced out pans on drying racks on 11.2.2022.** **2. Other Residents: Director of Dining Services observed all other pans for moisture and spacing and no other issues were found.** **3. Training: Handling Cleaned Equipment and Utensils policy reviewed and no changes were necessary. Dining employees were educated on 11.10.2022 and 11.12.2022 regarding the spacing and wet nesting of the pans. See training agenda/education and employee sign in records.** **4. Quality: Director of Dining Services/Designee will audit pans in regards to**	11/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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
			spacing and wet nesting on a weekly basis for 1 month and then weekly for 5 months. The audit results will be shared by the director of dining services with the QAA/QAPI committee on a monthly basis for 6 months. See audit tool **Artifacts: Training Agenda Education / Signature, and Audit Tool.**	