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	03/10/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00454576. Complaint IN00454576 - Deficiencies related to the allegations are cited at F744. Survey date: March 10, 2025 Facility number: 000283 Provider number: 155586 AIM number: 100275020 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 10 Medicaid: 65 Other: 15 Total: 90 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 14, 2025	F 0000	F0000 Please accept this as our credible allegation of compliance to our recent IDOH complaint survey that was completed on 3.10.25. 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 Training Agenda—Agenda 1 and Agenda 2 In-Service Sign-In Forms Audit Form Memory Care Course Outline Activity Calendar	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview and record review, the facility failed to ensure dementia care and services was provided to 2 of 3 residents reviewed for dementia care (Resident J and Resident K). Findings include:	F 0744	F744 1. Residents Identified: On March 24, 2025, the Social Services Director (SSD) completed a comprehensive review of care plans for the two identified residents. Each care plan was	04/04/2025

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

Mark Price 03/28/2025

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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	On 3/10/25 at 10:30 A.M., the secured Memory Care Unit (MCU) was toured. Several residents were observed seated at tables in the dining room/activity area. Some were sleeping while others stared blankly ahead. There were no activities occurring. A television, mounted on the wall was not turned on and there was no music played. In one corner of the room, on shelves, were games and other activity equipment. The equipment was not being used by any residents in the area. One resident was observed standing near one of the tables, repetitively wiping the table while his table mate sat across from him looking on. A female resident, with a white/yellow substance on her teeth and lips, sat at another table fidgeting with her hair and clothing while another female resident, was propelling her wheelchair and asking if anyone could help her to the bathroom. The resident fidgeting with her clothing, removed her shirt, looked at it and put it back on. She remained fidgeting and moving around in her wheelchair, muttering to herself. No staff were seen in the area. -At 11:28 A.M., residents were observed to be served drinks while waiting for lunch. The area was quiet except for a few residents talking in low voices with each other. There was little conversation between staff and residents as they were served lunch. The television wasn't on nor other background music. -At 1:20 p.m., several residents were observed in the dining area, sleeping or just staring out. There were no activities occurring nor staff present in the room. 1. On 3/10/25 at 11:19 A.M., Resident J's record was reviewed. Diagnoses included dementia with mood disturbance, insomnia, major depressive disorder, anxiety disorder and diabetes.		updated with personalized, resident-specific behavior interventions, addressing their unique needs, including recommendations for placement in the memory care unit. Staff care sheets were revised to incorporate the updated interventions and reflect the residents' current Activities of Daily Living (ADL) status. Additionally, the activity calendar was reviewed and adjusted to include tailored evening and weekend activities. 2. Other Residents: By March 26, 2025, the Social Services Director (SSD) or their designee will conduct a comprehensive review of all care plans for the remaining residents in the memory care unit. This review will ensure that specific behavior interventions are included, along with confirmation of the need for placement in the memory care unit. Staff care sheets will be updated to reflect the behavior interventions and the residents' current Activities of Daily Living (ADL) status. The Activity Director will continue to monitor and verify that evening and weekend activities are being conducted as planned and properly documented. 3. Training: On March 20, 2025, the Memory Care Admission Criteria Policy and Oral Care Policy were reviewed. In-service	

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	He was hospitalized 1/27-2/6/25 at a psychiatric hospital for medication management and was prescribed antipsychotic medication to control his dementia related behaviors. A quarterly Minimum Data Assessment (MDS), dated 1/14/25, indicated the resident had moderately impaired cognition with no mood indicators. He had physical and verbal behaviors towards others 4-6 days and rejection of care 1-3 days during the assessment. He required supervision for eating and oral hygiene, maximum assistance with dressing and personal hygiene, and was dependent for transfers, toileting, and bed mobility. He was non-ambulatory and used a wheelchair for mobility. He was prescribed antipsychotic, antianxiety, antidepressant medications as well as blood thinners for atrial fibrillation. Care plans were: -12/20/24: Resident J was resistant to care, verbally aggressive, would barricade self in room, curse at staff, yell and scream due to dementia. Interventions included: allow resident to make decisions about his care; approach him in a calm, friendly manner; educate him on outcomes of not complying with care/treatment; give clear explanation of all care activities prior to contact; if resident resists care, reassure and leave to calm; return 5-10 minutes later and try again; negotiate a time for care; offer reassurance and emotional support; update and involve staff, physician/NP, and family in care and changes. -10/23/24: the resident's preferred activities included bible study, bingo, conversing with friends, country rides, exercises, physical games,		training was conducted on activity programming within the memory care unit, incorporating Resident-Directed Engagement Activities with an emphasis on evening and weekend activities. (See attached document labeled In-Service 1) Additional in-service training covered behavior documentation and the application of behavior interventions on 3/26/25. (See attached document label In-Service 2) Current memory care staff will have the opportunity to participate in additional (MCA) training to be held on 4/3/25. Specialized training focused on dementia care, activity planning, and approaches to managing challenging behaviors. —please refer to the attached course outline. 4. Quality: On March 24, 2025, the Administrator in Training (AIT) developed a care plan, behavior, and activity incorporation audit tool (see attached document labeled audit form) The Resident Care Coordinator (RCC) or their designee will audit care plans to ensure that residents have documented justification and personalized behavior interventions. The Activity Director or their designee will conduct weekly audits within the unit to verify that dementia-specific programming is available, implemented, and integrated into the activity calendar. The	

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	going outside, special visitors such as children and pets, student volunteers, quiet time by self, mentally challenging games, music programs, reading, social hour, worship and hymns. The goal was for the resident to be involved with activities of choice, maximizing participation with encouragement and assistance. Interventions included: assist to each activity; encourage interaction and facilitate participation with other residents of similar backgrounds/interests; provide a program of activities of interest which provides empowerment by encouraging choice, self-expression and responsibility. Resident J had no specific care plan for need to reside on a secured memory care unit or benefits of dementia care programming. On 3/10/25 at 10:38 A.M., Resident J was observed seated in his wheelchair alone in a back hallway. He moved slowly with his left arm appearing flaccid as it lay on his lap. He was drooling and had a washcloth beneath his chin. He was observed to repeatedly put his right hand on the door knob of a room with a sign stating it was a shower room. When asked, he indicated he was having a bad day and hadn't wanted to share what his name was. -At 11:28 A.M., Resident J was observed seated by himself at a dining room table in the corner of the room, facing a bookcase, where he ate his lunch. He was observed to be more alert while eating. -At 1:15 P.M., Resident J was observed seated in his wheelchair, sitting in the doorway to his room. He appeared alert, wide awake and engaged in small talk. He was then observed to quickly roll his wheelchair across the hallway, frontward's and backwards, in between the doorway of his room and another residents room.		completion of Memory Care Assistance (MCA) training and related in-service sessions will be closely monitored. Results from these audits will be reviewed weekly during the first four weeks in collaboration with the Executive Director and will transition to monthly reviews for a minimum of six months, through September 2025. The AIT or their designee will report on the findings during Quality Assurance and Assessment (QAA) Meetings.	

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	Nurse progress notes indicated: -2/26/25 at 11:20 p.m., the Resident was rolling on the mat when in bed and pushed his call light for help. He would demand staff pick him up off the floor. Staff tried to put him in his wheelchair but he would fall out of the chair and was observed with a skin tear to his right elbow. He kicked the door and trash can in his room. He was offered a snack and to watch a movie. The supervisor was notified of the behavior. -2/28/25 at 9:58 a.m., a nurse tried to enter the secured unit and when going through the door, the resident told the nurse to hold the door open so he could get out. After the door closed, the resident was upset and stated now he was stuck here. He was upset the nurse hadn't held the door open for him. He hadn't wanted to move away from the door as he was leaving and going back to his home. The nurse stayed with him while he stayed by the door and kept pushing on the handle and buttons on the key pad. An activity was offered and individual attention but were ineffective in changing the behavior. -At 8:55 p.m., Resident J was threatening to hit staff and had been found on the floor and mattress next to his bed. There were no interventions documented to respond to the behaviors. -At 10:17 p.m., the resident rolled around on his mat and refused assistance from staff to get back in bed or his chair. He told staff to leave him alone or he would punch them in the face. After an hour, the resident allowed staff to assist him back into bed. He had refused supper and assistance with care. He had been offered coffee and snack, coloring, and movie, but refused. A Psychiatric Nurse Practitioner (NP) progress note, dated 3/2/25, indicated the resident was seen			

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	for medication management. Staff reported aggression, agitation, and intermittent exit seeking. He was seen on the MCU where he was cooperative and had fair eye contact. He'd had a visitor who he indicated made him feel safe when they were present. Staff indicated his behaviors tended to worsen in the evening hours. The plan was to continue use of Risperidone (antipsychotic) for dementia with agitated and aggressive behaviors and increase medication if symptoms intensified. Staff were to provide 1:1 time, activities including card games, music, television and other activities as distraction. He was prescribed antianxiety medication (Ativan) 1 mg by mouth 2 times per day as needed for 14 days with follow up in 2 weeks. An activity report for dementia programming for the past 14 days was requested. The report provided by the Activity Director on 3/10/25 at 1:45 P.M. was for the past 11 days. The report indicated Resident J was provided with no activities on 2/25, 3/1, and 3/2/25. He was offered and participated in activities the following days/times: 2/26, 2/27, and 2/28/25-2 activities during the day and none in the evening; 3/3 and 3/4/25- 1 activity during the day and none in the evening; 3/5 and 3/6/25-3 activities during the day and none in the evening; and 3/7/25- 2 activities during the day and none in the evening. There were no activities provided in the evenings when his behaviors usually worsened nor was his dementia care plan updated with new interventions related to his behaviors. 2. On 3/10/25 at 10:30 A.M., Resident K was observed seated at a table, in her wheelchair, with legs down on the pedals. She had a white/yellow colored substance on her teeth and lips, was			

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	fidgety, putting her hands in her hair, eyebrows furrowed and she making unintelligible noises. She was playing with the a short sleeve shirt she had on and was observed with multiple bruises on her forearms. A Certified Nurse Aide (CNA) was observed to sit next to the resident and attempted to make small talk with her. When asked, the CNA indicated she hadn't known who the resident was because it had been her first day back after an extended leave. The CNA got up from the table and went to help another resident. The resident continued fidgeting with her clothing, removed her shirt, looked at it and put it back on. She remained fidgety, moving around in her wheelchair and muttering to herself. No staff were seen in the area. -At 11:28 A.M., Resident K remained in her wheelchair with her legs down on the pedals, at the same table she was observed at earlier. The white/yellow colored substance remained on her teeth and lips. A staff member placed a plate of food in front of her. She then pushed the food away across the table. She continued to be fidgety, playing with her clothes and attempting to remove her shirt. Her table mates kept telling her not to remove her clothes. The nurse tried to put the plate of food back in front of the resident but she pushed it away. The resident indicated she wanted to go lie down and didn't want any lunch. She was removed from the table and taken back to her room to lie down. -At 1:15 P.M., Resident K was observed lying in bed on her left side. Her eyes were closed and she appeared asleep. -At 3:32 P.M., the resident remained lying in bed on her left side. Licensed Practical Nurse (LPN) 2 went to the resident's room and asked her if she would turn over on her back. On 3/10/25 at 2:14 P.M., Resident K's record was reviewed. Diagnoses included dementia with			

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	behavioral disturbance, anxiety disorder, essential thrombocythemia (type of blood cancer) and venous and arterial ulcers on her lower legs/feet. A quarterly MDS assessment, dated 1/11/25, indicated the resident had severely impaired cognition. She had clear speech, was usually understood and was able to understand others when communicating. She had no mood indicators but had verbal behaviors and wandering 1-3 days during assessment. She required supervision with eating and oral hygiene; moderate assistance with dressing, personal hygiene, bed mobility and transfers; and maximal assistance with toileting. Care plans included: -1/7/25: the resident had severely impaired cognition and could have difficulty making her needs known. Interventions included: ask yes or no questions when communicating; provide mind-stimulating materials to keep mind active and provide a safe environment. -10/23/24: Resident K was dependent on staff for meeting her emotional, intellectual, physical and social needs due to physical limitations and cognitive impairments. Religious services and music were important to her. Interventions included: address the resident by her desired name; encourage staff to converse with her while providing care; encourage religious and music program attendance and provide escort to/from activities. -1/7/25: the resident used psychotropic medications due to dementia. Interventions included: observe/record occurrences of targeted behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, and aggression towards others. Resident K had no specific care plan for need to			

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	reside on a secured memory care unit or benefits of dementia care programming. An activity report for dementia programming for the past 14 days was requested. The report provided by the Activity Director on 3/10/25 at 1:45 P.M. was for the past 11 days. The report indicated Resident K was provided with no activities on 2/25, 3/1, and 3/2/25. She was offered and participated in activities the following days/times: 2/26 and 2/27/25-2 activities during the day and none in the evening; 2/28/25-1 activity during the day and none in the evening; 3/3 and 3/4/25- 1 activity during the day and none in the evening; 3/5, 3/6 and 3/7/25, the resident was provided 2 activities during the day and none in the evening. On 3/10/25 at 1:19 P.M., Registered Nurse 5 (RN) was interviewed. She indicated the MCU was her usual assigned hallway. When questioned, she indicated resident's were kept busy on the unit and provided with many activities daily. She opened a closet door filled with activity equipment and supplies and indicated staff were able to use these to keep residents engaged. There was no specific activity programming for residents on the dementia unit but they had a facility wide activity schedule on a white board facing the wall. The board was unable to be seen by staff or residents. When asked why there had been no activities on 3/10/25, she indicated on Mondays, several ladies went to the beauty shop so there were no activities on the unit until the afternoon when there would be church services. RN 5 was asked about resident behaviors on the unit and dementia interventions used to decrease them. She indicated staff documented behaviors however, there were no specific behavioral interventions other than re-direct and try and			

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	engage the resident in another activity. On 3/10/25 at 1:38 P.M., the dementia unit manager, LPN 7, was interviewed. She indicated there had been several changes in personnel at the facility, their dementia program was being reviewed and changes made. Residents were to be provided with dementia programming with activities and behavior modifications with dementia specific interventions. A current facility policy, titled "Memory Care Program Philosophy and Memory Care Admission Criteria", was provided by the Administrator in Training (AIT) on 3/10/25 at 2:31 p.m. The policy indicated the following: "Alzheimer's disease and related dementia disorders are relentless and irreversible...We believe that the quality of life for our residents is enriched when their days are filled with meaningful and enjoyable structured activity. We believe that this activity serves as a powerful coping mechanism in times of fear and stress...We believe that the behaviors displayed by Alzheimer's and related dementia disorders are caused by a progressive degeneration of the brain, and that these residents have very little control of their behavior. Based on this belief, we avoid reprimanding inappropriate behavior. We choose rather to modify the environment, change our expectations, and focus on intervention and redirection...It is the intent of LLV to admit residents to the memory care unit that meet the agreed upon criteria for a specialized dementia unit. This is to ensure that the resident's receive appropriate care regarding the cognitive impairment disease process...Resident should have a primary diagnosis of Alzheimer's or other related untreatable dementia, be a safety risk at home, elopement/wandering risk, and require close monitoring. Does not demonstrate danger to			

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	self or others. Communication skills and/or limited language does not prevent the resident from participating in the memory care program. Easily over-stimulated, responds best to 1:1 intervention and small groups. Behaviors are easily redirected through the use of intervention up to and including psychiatric consult, adaptive programming and treatments that are appropriate for admission. Display of behaviors that are unmanageable through therapeutic approaches or moderate medication would warrant an immediate care plan meeting to determine appropriateness of continued placement...Resident should be able to participate, even to a limited degree, in some aspects of self-care and program activities...Resident should be ambulatory whether this is walking without assistance or walking with an assistive device or wheelchair...." This Citation relates to Complaint IN00454576. 3.1-37			