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	05/29/2025

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 Complaints IN00458104, IN00460004 and IN00460237. Complaint IN00458104 - No deficiencies related to the allegations are cited. Complaint IN00460004 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00460237 - No deficiencies related to the allegations are cited. Survey dates: May 28 and 29, 2025 Facility number: 000283 Provider number: 155586 AIM number: 100275020 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 2 Medicaid: 75 Other: 19 Total: 96 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 30, 2025	F 0000	F0000 Please accept this as our credible allegation of compliance to our recent ISDH complaint survey that was completed on 5.28.25. 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 In-Service Sign-In Forms Audit Form	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility	F 0684	F684	06/13/2025

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

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	failed to ensure a resident was assessed and the physician notified timely following acute changes in condition, advance directives for transfer to a hospital were followed, and physician orders followed for 1 of 3 residents reviewed (Resident B). Findings include: A report, dated 5/21/25 at 12:41 p.m., indicated Resident B had been transferred to the hospital where she passed away. A family member alleged the resident hadn't been assessed and sent to the hospital timely, per the resident's advanced directives, when she required emergency care for a change in condition. The family member alleged the resident had been administered a higher dosage of medication than prescribed which she believed, led to the resident's demise. She alleged when family spoke with facility staff about the medication, the staff's explanations were inconsistent as was documentation of the administered medication in the resident's medical record. On 5/28/25 at 11:43 A.M., Resident B's record was reviewed. Diagnoses included congestive heart failure, syncope (fainting) and collapse, hypomagnesemia (low levels of magnesium in blood), muscle weakness, and malaise. A hospital discharge summary, dated 1/2/2024, indicated Resident B had been hospitalized for weakness, syncope, and low blood levels of sodium and magnesium twice in December 2023. She was admitted to the facility for rehabilitation with the goal of returning to her home. An Admission Summary note, dated 1/2/24 at 6:54 p.m., indicated the resident had arrived at the		1. Residents Identified: As of 6.9.25, 1 identified resident(Resident B) no longer in facility. Discharged to hospital on 1.12.24 2. Other Residents: By 6/13/25, DON and/or designee will audit of all residents who experienced a change in condition over the past 30 days to ensure timely physician notification, adherence to advance directives, and compliance with physician orders. Any discrepancies were immediately corrected and addressed with appropriate follow-up and documentation. 3. Training: On 6.9.25, reviewed Notification of Changes Policy, Advanced Directives Policy, and EMR-Physicians Orders Policy- no changes required to policies. On 6/11/25 re-inserviced nursing staff regarding following physician notification, change in condition, and advance directives--Timely assessment and documentation of acute changes in condition, prompt physician notification per policy, verifying and honoring resident advance directives, adhering to and accurately documenting implementation of physician orders.– see uploaded documents, Agenda and Sign- In Forms. 4. Quality: Audit tool was created on 6/10/25 – see	

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	facility via ambulance. Initially, facility transportation had attempted 2 times to bring her to the facility however, when sitting in the wheelchair, she fainted. She arrived to the facility at 5:42 p.m., accompanied by family. Family indicated the resident had a "huge" decline in drinking fluids. Assessment of skin turgor indicated she had slight tenting (indicator of dehydration) of her skin. Resident B was alert, able to make her needs known and was able to use her call light. Her vital signs were: Blood pressure-112/55, Pulse-84 very irregular, Respirations-16, Temperature-97.1 and blood oxygen saturation level-94%. Admission physician orders, dated 1/2/24, included Magnesium Oxide (supplement) 420 milligrams (mg)-give 1 tablet by mouth every day for 14 days. A History and Physical progress note, dated 1/3/24 and completed by the Medical Director/Physician, indicated the resident had been admitted from her home to the hospital following episodes of fainting and weakness. She was admitted to skilled care for physical and occupational therapies to restore her baseline activities of daily living (ADL) and discharge back to her home. A discussion between the Medical Director and Resident B's son, indicated concern the resident's continued weakness and eye drooping could be due to a medical condition. The Medical Director was going to order medication to treat the medical condition for 3 days and then re-evaluate. The resident was to continue on the magnesium supplement at the dose prescribed by the hospital (420 mg) in addition to her other prescribed medications. The resident was to continue with physical, occupational therapy and her progress closely monitored.		uploaded document, Audit Form. DON and/or designee will monitor changes in condition, advance directives and physician orders during IDT meeting. The results will also be reviewed weekly with Administrator for the first 4 weeks then monthly after. The DON/designee will report results at the QAA Meeting. The audit will continue for at least a minimum period of six months through December 2025.	

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	A Physician Orders for Scope of Treatment (POST) form, dated 1/3/2023, indicated Resident B's wishes regarding end of life medical interventions. If she had a pulse and was breathing, she wanted to receive full interventions including transfer to the hospital and/or intensive care unit to meet her medical needs. A Nurse Practitioner (NP) progress note, dated 1/4/24, indicated the resident was visited due to being a new admission to the skilled unit. Resident B's medications were reviewed and current. The resident had been prescribed a short course of medication to treat a medical condition possibly contributing to her weakness. The resident was alert during her assessment but weak. She required 1 person assist with transfers to her wheelchair. The Assessment and Plan included: Generalized weakness-there was concern about a medical condition as potential cause of her weakness. Labs to test for the condition were ordered and a short course of medication prescribed to see if it improved her weakness; Advanced Care Planning-the resident was alert but unable to make her own medical decisions. Her family wanted her advanced directives to continue as she'd written them. Family understood if the resident would become medically unstable, she would be returned to the hospital with all life saving measures intiated. She was to continue taking her Magnesium supplement and other medications as prescribed. An NP progress note, dated 1/8/24, indicated Resident B was seen for a post-acute visit due to syncope, weakness, and fatigue. The resident had recently completed a 3 day course of medication for her weakness. During the visit, she appeared tired but was able to open her eyes, move her			

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	arms and legs and follow commands. She was still waiting on results of lab tests done last week to confirm if she had a medical condition causing her symptoms. Since her admission, she had lost weight. From 1/6-1/7/24, she experienced nausea and was started on anti-nausea medication. She was tested for respiratory pathogens due to fluctuating blood oxygen saturation levels. Assessment and Plan included: Her magnesium supplementation was temporarily discontinued due to a recent bout of diarrhea-staff were to monitor her bowel movements and her medications adjusted accordingly. Nurse progress notes, dated 1/6-1/8/24 hadn't indicated Resident B had diarrhea. A nurse progress note, dated 1/8/24 at 11:23 a.m., indicated Resident B had been involved in some therapy but remained lethargic. She was observed with low blood oxygen levels and was started on oxygen which initially, increased her oxygen levels to 97% (normal blood oxygen saturation levels >90%), but declined to the 80's with exertion. - At 5:29 p.m., the resident complained of nausea and was given medication to treat which was effective. -7:35 p.m., Resident B complained of pain in her body and she couldn't get comfortable. She was administered Acetaminophen (Tylenol) 650 mg by mouth for the pain. -8:56 p.m., the resident continued with pain. She indicated she'd had no relief from the Acetaminophen and rated her pain at a 7 on a scale of 1-10 with 10 being the worst pain. There was no documentation in Resident B's record to indicate the Physician/NP or family had been notified of the resident's unrelieved pain.			

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	A nurse progress note, dated 1/9/24 at 1:56 a.m., indicated Resident B had been assisted with care and her vital signs checked which were: blood pressure (BP)-94/70 (normal above 100/60), pulse-93, respirations-16 and blood oxygen saturation was 81%. Her oxygen was re-applied and oxygen level increased to 92%. -At 7:13 a.m., the resident's magnesium supplement was held with no reason documented. -2:38 p.m., a new order was given to restart the medication used to treat her weakness, previously administered 1/5-1/7/24. A nurse progress note, dated 1/10/24 at 3:27 p.m., indicated the resident had an episode of low blood pressure following therapy. Her BP had been 79/44. Resident B was becoming dehydrated due to not taking in what the facility gave her and she did not eat full meals. She had been sleeping most of the day with family at her bedside. A physician progress note, dated 1/10/24 at unknown time, indicated the Medical Director had visited the resident. There were no concerns relayed by the resident, staff or family. Her systolic (top number) blood pressure ranged from 89-158. Resident B had recently completed a short term medication treatment for her weakness which afforded her notable improvement. Her oxygen saturation levels had been fluctuating between 87-97% and she was currently on 2 liters of nasal oxygen. She had transitioned from requiring 1 assist to 2 assist for mobility. She was eating well and denied pain. The resident's magnesium supplement was placed on hold due to a recent bout of diarrhea otherwise, there were no changes in her medications. On 1/6-1/7/24, she had complained of nausea and was started on anti-nausea medication. She finished her therapy			

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	on 1/10/24 but appeared more lethargic afterward. Assessment and Plan included: Diarrhea-recent bout of diarrhea led to the temporary discontinuation of her magnesium supplement. There had been no other changes in her medication regimen. The plan was to continue to monitor the resident's bowel movements and adjust medications as necessary; Generalized weakness-the resident was able to move her extremities and follow commands during visit. She had responded to the 3 day medication challenge so this would be continued and she would be encouraged to continue with therapies. There was no documentation in Resident B's record to indicate the Physician/NP had been notified of the resident's episode of low blood pressure following therapy or the resident exhibiting signs of dehydration due to poor drinking/eating. A nurse progress note, dated 1/10/24 at 9:02 p.m., indicated Resident B put on her call light and reported she couldn't breathe. Nasal oxygen was applied and she indicated she felt better. Nurse progress notes, dated 1/11/24, indicated the following: -At 1:29 a.m., Resident B had been coughing and stating she was having a hard time breathing. Her lung sounds were clear but her oxygen saturation level was 88%. Oxygen was put on and her oxygen level went to 100%. Her BP was 110/62, pulse-84 and respirations 16. (There was no documentation of the resident's temperature). The resident was anxious so staff stayed with her and provided reassurance. She was administered Tylenol for general discomfort but promptly vomited it back up. Staff remained at her bedside.			

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	-2:58 a.m., the resident was given her anti-nausea medication which she stated had been "helpful". -3:58 a.m., the resident was restless but denied pain. Staff had been with her frequently; most recently, the past 20 minutes, reassuring her, holding her hand, adjusting the room temperature, her blankets, etc. Her lungs remained clear, bowel sounds present, and skin without changes (sweating). The resident finally settled and staff continued to monitor her. There was no documentation in Resident B's record to indicate the Physician/NP or family had been immediately notified of the acute change in the resident's condition of difficulty breathing, anxiety, restlessness and vomiting. An NP progress note, dated 1/11/24 at unknown time, indicated the resident had been visited due to increased lethargy, poor appetite and weakness for the past 6 weeks. Her family member reported Resident B hadn't eaten, had been more tired and lethargic than usual and was mostly wanting to sleep. The resident was reportedly awake until 4 a.m. and hadn't slept much since. She had been having diarrhea and later reported vomiting. Her magnesium supplement had been put on hold due to complaints of diarrhea and she was started on a new medication for gastritis (stomach inflammation). Assessment and Plan included: Diarrhea: The resident's diarrhea was likely related to the magnesium supplementation- placed on hold; Nausea: She had been having nausea possibly related to her medications; Vomiting: She had vomited twice possibly related to nausea and decreased appetite. The plan was to monitor her vomiting and adjust medications as necessary. A nurse progress note, dated 1/11/24, indicated at 11:50 a.m., the respiratory pathogens lab result			

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	was received and were negative. A new panel of blood labs were ordered and drawn. -A late entry at 1:15 p.m., indicated the resident was given her medications in applesauce, however, her family member at the bedside, reported she vomited them back up approximately 5 minutes after given. The resident was alert; would only take sips of water and then would go back to sleep. The resident had diarrhea 4 times. She required full assistance with personal care. The resident would awaken if her name was called but her words were soft and not understandable. Her daughter remained at bedside. -At 2:47 p.m., the resident continued with diarrhea x 3. She was very tired and not communicating well. Her daughter was present to talk about options and medications. The nurse was going to message the resident's Power of Attorney (POA) about the medication suggestions made by the NP. -A late entry at 4:15 p.m., indicated Resident B's daughter was at bedside. The resident had been very fatigued and had not participated in therapy due to weakness. Her daughter asked how long had the resident been this weak and was told it had started the morning of 1/11/24 with assessment. The resident had been weak, fatigued, and unable to answer questions. The night shift nurse had reported the resident had been restless overnight. Blood work had been done but the results had not yet been received. Approximately an hour later, the daughter came to the nurse's station where the day and evening shift nurses were giving report, and asked if her mother "was dying". The daughter was crying and asked the 2 nurses to be "honest" with her. Both nurses indicated the resident was close to dying and suggested the daughter contact other family members to advise. The daughter texted her family members at approximately 4:30 p.m. The			

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	resident's son and daughter in law/POA, texted the daughter to have the resident sent out to the emergency room. -4:41 p.m., Resident B was declining and she appeared to be dying. Family was notified and they wanted her sent to the ER. The EMS was called per family request. -5:09 p.m., the resident left with the EMS. A nurse progress note, dated 1/12/24 at 12:31 a.m., indicated the hospital had been contacted for an update on Resident B's condition. She spoke with the resident's POA who indicated the resident had passed away. A Medication Administration Record (MAR) dated January 2024, indicated by nurse initials, Resident B had been administered Magnesium Oxide, as ordered, 1 time per day on 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/10, and 1/11/24. The MAR, indicated on 1/9/24, the Magnesium supplement was held without documentation of reason. The MAR had not indicated Magnesium Oxide had been temporarily discontinued or held due to diarrhea. The MAR indicated an as-needed order for anti-diarrheal medication had been given on 1/8/24 but had not indicated the medication had been administered. On 5/28/25 at 3:37 P.M., Resident B's daughter was interviewed. She verbalized her continued anguish over her mother's death and belief her death could have been prevented. She had been in to see her mother the morning of 1/11/24 and had returned in the afternoon. She indicated the resident looked "dreadful" and was declining quickly. She had asked the day and evening shift nurses if her mother was dying because she would want to go to the hospital for treatment.			

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	The 2 nurses told her she was dying and should contact her family for further guidance. She indicated the resident was supposed to return home where she had lived with her prior to being hospitalized. The daughter indicated 6 weeks prior to her death, the resident had been driving a car and walking her dog. She alleged her mother's death was due to an excess of magnesium administered. On 5/29/25 at 10:05 A.M., Resident B's POA was interviewed. The POA was a nurse and her husband/resident's son, a physician. After her mother in laws death, copies of her medical records were requested and provided by the facility. The family had several questions about inconsistencies in the resident's care and medical records which had not been fully explained nor understood. She indicated the family had been upset because the resident's advance directives had been very clear about her wish to be hospitalized and all life saving interventions initiated. On the day of the resident's death, the evening shift nurse indicated to the resident's daughter, the resident was dying and he hadn't wanted to call the EMS, rather he wanted her to be comfortable and stay at the facility against the resident's wishes. The family felt guilt and remorse because they hadn't been able to honor her wishes even though, her death may have still occurred. The POA indicated family had been told Resident B had a fever the night before her death and her blood pressure normal but her medical record hadn't indicated this. The resident had experienced acute restlessness and anxiety the night prior to her death. This was not normal for her indicating something was wrong and neither the doctor nor family were notified. On 5/29/25 at 11:35 A.M., the Nurse Practitioner			

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	was interviewed. She indicated, on 1/11/24, she had seen the resident sometime between 12 and 2 p.m. At the time of her visit, Resident B hadn't appeared different from prior visits on 1/4 and 1/8/24. The NP indicated there had been no signs of the resident's decline or need for emergent transfer to the hospital when visited. She had been notified, the morning of 1/11/24, Resident B had been more tired and lethargic than usual. Orders had been given for labs. The labs were drawn immediately that morning. She indicated, at the time of her visit, the lab results had not been in and weren't available. When questioned about the resident's magnesium supplement, she indicated she had not written an order, rather had verbally told the nurse to hold the medication due to diarrhea. She was not notified the resident had received the magnesium supplements every day but 1 and had not been held as verbally ordered. She indicated belief the resident's diarrhea was related to the administration of the magnesium supplements. She had been told the supplements were held on 1/11/24. She indicated she had not been notified of the resident's decline in condition following her visit. On 5/29/25 at 2:30 P.M., the Executive Director (ED) and Director of Nursing (DON) were interviewed. Neither the ED or DON had been in their positions at the time of the resident's stay and had no knowledge of the events. When asked, the DON indicated staff were expected to notify the physician/NP, resident, and families of changes in condition and follow resident's advance directives and physician orders. On 5/29/25 at 4:23 P.M., the DON provided current copies of facility policies as follows: "Notification of Changes": "Staff will immediately			

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	inform the resident; consult with the resident's physician; and notify the resident representative when there is a...significant change in the resident's condition...a need to alter treatment...decision to transfer or discharge the resident from the facility...." "Advanced Directives": "Resident's have the right to make decisions concerning medical care, including the right to accept, refuse, or discontinue medical treatment...Resident wishes will be communicated to the staff via the person-centered care plan noted in the medical record, and to the resident physician...." "Electronic Medical Record-Physician Orders": "Practitioners will enter orders directly into the EMR to provide timely resident care...Physician orders shall be written in a manner to clearly convey the intent of the physician to any nurse...The nurse should provide, to the practitioner, any additional information needed for the practitioner to write an effective order...The nurse is required to electronically acknowledge orders. The nurse should review the order for clarity and completeness, making an entry into the nurse notes, adding an additional care plan problem or augmenting an existing problem...Acknowledging/noting orders takes place in the EMR...." This Citation relates to Complaint IN00460004. 3.1-37			