STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING -- B. WING	11/06/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/06/24 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 At this Emergency Preparedness survey, Lutheran Life Villages was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 142 and had a census of 95 at the time of this survey. Quality Review completed on 11/08/24	E 0000	K 0000 The 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 Villages 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. At this time, we are respectfully requesting paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/06/24 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 At this Life Safety Code survey, Lutheran Life	K 0000	K 0000 The 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 Villages 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark	Price	11/25/2024

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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	Villages was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Health and Rehabilitation building is a one story sprinklered building of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and battery-operated smoke detector in the resident rooms. The facility has a capacity of 142 and had a census of 95 at the time of this survey. Quality Review completed on 11/08/24		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. At this time, we are respectfully requesting paper compliance.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems were installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Executive Director (ED), the Administrator (AD) Maintenance Director (MD) and the Administrator in Training	K 0341	K 341 1 Fire alarm installation. Findings: Maintenance Director/Designee/Team repaired identified smoke detector relocating it at required distance. 2 Other Building Smoke Detectors: Maintenance Director/Designee/Team completed a review of the AB Health Center campus smoke detectors on 11.19.2024 and did not identify any other smoke detectors that required repairs. 3 Training: Maintenance Team educated on 11.13.2024 regarding deficient practice. 4 Quality: Maintenance	11/19/2024

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	(AIT) on 11/06/24 1:15 p.m., there was a smoke detector less than three feet from an air supply vent where air flow would prevent proper operation of the detector next to room 118A. Based on interview at the time of observation, the MD stated the detector was about 18 inches from the air supply vent. This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference. 3.1-19(b)		Director/Designee will audit smoke detector placement. The audit will be completed weekly for 7 weeks and monthly for 3 months for a total of 5 months. The audit results will be reviewed with the QAA/QAPI committee on a monthly basis for the duration of the audit. QAA/QAPI will monitor for need to continue past this time frame based on criteria of no deficiencies found during this internal audit process. 5 Artifacts: Education/Signature. Photos of Completed Repairs. 1 Identified Hall. Audit Form.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be	K 0353	K 353 1 Sprinkler System Maintenance and Testing. Findings: Maintenance Director/Designee/Team visually inspected wet system control valves and documented as required. 2 Other Building Wet System Control Valves: Maintenance Director/Designee/Team completed a review of the AB Health Center campus wet system control valves on 11.13.2024 and did not identify any wet system control valves that required repairs. 3 Training: Maintenance Team	11/13/2024

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	inspected monthly. This deficient practice could affect all occupants. Findings include: During records review with the Executive Director (ED), the Administrator (AD), Maintenance Director (MD) and the Administrator in Training (AIT) on 11/06/24 at 11:40 a.m., the documentation in the TELS computer system indicated gauges on the wet system were inspected weekly but the monthly wet system control valves were not documented. Based on observation at 2:20 p.m., there were four supervised control valves for the sprinkler system. Based on an interview at the time of record review, the MD stated the supervised valves are inspected but the checks are not recorded. This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference. 3.1-19(b)		educated on 11.13.2024 regarding deficient practice. 4 Quality: Maintenance Director/Designee will audit wet system control valves. The audit will be completed weekly for 7 weeks and monthly going forward as required per NFPA 101 recommendations. The audit results will be reviewed with the QAA/QAPI committee monthly for a period of 3 months. QAA/QAPI will monitor for need to continue past this time frame based on criteria of no deficiencies found during this internal audit process. 5 Artifacts: Education/Signature. Audit Form.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to inspect and document 2 of 4 portable fire extinguishers in the front smoke compartment each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility	K 0355	K 355 1 Portable Fire Extinguisher. Findings: Maintenance Director/Designee/Team visually inspected portable fire extinguishers and documented as required. 2 Other Building Wet System Control Valves: Maintenance Director/Designee/Team completed a review of the AB Health Center campus portable fire extinguishers on 11.12.2024 and	11/12/2024

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	(3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Executive Director (ED), the Administrator (AD) Maintenance Director (MD) and the Administrator in Training (AIT) on 11/06/24 at 11:58 a.m., the monthly inspection tag on the ABC fire extinguishers located in the Beauty Shop and on the mezzanine in the mechanical room were left blank. Based on interview at the time of observation, the MD confirmed the two extinguishers were missing documentation of a monthly visual inspection.		did not identify any portable fire extinguishers that required repairs. 3 Training: Maintenance Team educated on 11.12.2024 regarding deficient practice. 4 Quality: Maintenance Director/Designee will audit select 2 portable fire extinguishers. The select audit will be completed weekly for 7 weeks and monthly going forward as required to per NFPA 101 recommendations. The audit results will be reviewed with the QAA/QAPI committee monthly for a period of 3 months. QAA/QAPI will monitor for need to continue past this time frame based on criteria of no deficiencies found during this internal audit process. 5 Artifacts: Education/Signature. Audit Form. TELS Monthly Portable Fire Extinguisher Log.	

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	This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 1 of 7 smoke barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in one two smoke compartments. Findings include: During records review with the Executive Director (ED), the Administrator (AD) Maintenance Director (MD) and the Administrator in Training (AIT) on 11/06/24 at 2:00 p.m., above the drop	K 0372	K372 1 Smoke Barrier Construction. Findings: Maintenance Director/Designee/Team visually inspected and repaired smoke barriers as necessary. 2 Other Building Smoke Barriers: Maintenance Director/Designee/Team completed a review of the AB Health Center campus smoke barrier on 11.19.2024 and did not identify any additional smoke barriers that required repairs. 3 Training: Maintenance Team educated on 11.19.2024 regarding deficient practice. 4 Quality: Maintenance Director/Designee will audit smoke barrier walls. The select audit will be completed weekly for 7 weeks and monthly for 3 months. The audit results will be reviewed with the QAA/QAPI committee monthly for a period of 3 months. QAA/QAPI will monitor for need to continue past this time frame based on criteria of no deficiencies found during this internal audit process. 5 Artifacts:	11/19/2024

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	ceiling in the 300-hall smoke wall there were pipes and wires with fire caulk, but the caulk was falling out or pulled away from the wall. Based on interview at the time of observation, the MD stated the fire caulk needed replaced in the 300-hall smoke barrier. This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference. 3.1-19(b)		Education/Signature. Photos of Completed Repairs. 1 Identified Hall. Audit Form.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Based on observation and interview, the facility failed to ensure trash and soiled linen carts in 1 of 6 corridors were maintained in accordance with 19.7.5.7. Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. This deficient practice could affect staff and up to 20 residents in the Ash Hall. Findings include: Based on observations with the Executive Director (ED), the Administrator (AD) Maintenance Director (MD) and the Administrator in Training (AIT) on 11/06/24 at 1:00 p.m., there was a 33-gallon trash barrel next to a double linen cart exceeding 32 gallons next to the soiled utility room on Ash Hall. Based on an interview at the	K 0754	K 754 1. Soiled Linen and Trash Container Storage. Findings: Maintenance Director/Designee/Team visually inspected and stored appropriately Soiled Linen and Trash Containers greater than 32 gallons. 2. Other Building Soiled Linen and Trash Container Storage: Maintenance Director/Designee/Team completed a review of the AB Health Center campus storage on 11.20.2024 and did not identify any additional storage containers improperly stored. 3. Training: Nursing Director/Staff educated on 11.07.2024 regarding deficient practice. 4. Quality: Maintenance Director/Designee will audit soiled linen and trash container storage. The select audit will be completed weekly for 7 weeks and monthly	11/07/2024

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	time of observation, the MD and AD stated there was a 33-gallon barrels of trash and a double linen cart exceeding 32 gallons in a 64 square foot area on Ash Hall. This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference. 3.1-19(b)		for 3 months. The audit results will be reviewed with the QAA/QAPI committee monthly for a period of 3 months. QAA/QAPI will monitor for need to continue past this time frame based on criteria of no deficiencies found during this internal audit process. 5. Artifacts: Education/Signature. Audit Form.	