CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155586	B. WING		11/06/2024	
				ADDRESS STELL ST. TO ST. TO ST.		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES	}		WAYNE, IN 46816		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42		E 0000	K 0000 The Plan of Correction is prepand executed because it is required by the provisions of the second sec		
	Survey Date: 11/06 Facility Number: 0			state and federal law and not because Lutheran Life Village Anthony Boulevard agrees wit	•	
	Provider Number:			allegations and citations listed		
	AIM Number: 1002			this statement of deficiencies.		
		-		Lutheran Life Villages maintai	ns	
	At this Emergency 1	Preparedness survey, Lutheran		that the alleged deficiency doe		
		ound in compliance with		not jeopardize the health and		
	_	dness Requirements for		safety of the residents, nor do	es it	
		caid Participating Providers		constitute substandard quality		
	and Suppliers, 42 C			1	OI	
	and Suppliers, 42 C	FR 703./3.		care or limit our capability to		
	The facility has	anguity of 142 and had a		render adequate care. Please		
	-	pacity of 142 and had a		accept this plan of correction a	15	
	census of 95 at the t	line of this survey.		our credible allegation of	ro	
	Quality Review con	npleted on 11/08/24		compliance. At this time, we are respectfully requesting paper compliance.		
K 0000						
Bldg 01						
Bldg. 01	A Life Sefety C-1-	Description and State	17,0000	K 0000		
	_	Recertification and State	K 0000	K 0000		
	_	ras conducted by the Indiana		The Plan of Correction is prep	ared	
	-	th in accordance with 42 CFR		and executed because it is		
	483.90(a).			required by the provisions of t	he	
	Survey Date: 11/06	5/24		state and federal law and not because Lutheran Life Villages Anthony Boulevard agrees with the		
	Facility Number: 0	00283		allegations and citations listed		
	Provider Number:			this statement of deficiencies.		
	AIM Number: 1002			Lutheran Life Villages maintains		
	- 11 1.0111001. 1002			_		
	At this Life Safety (	Code survey, Lutheran Life		that the alleged deficiency does not jeopardize the health and		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Mark Price 11/25/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/06/2024 155586 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6701 S ANTHONY BLVD **LUTHERAN LIFE VILLAGES** FORT WAYNE. IN 46816 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Villages was found not in compliance with safety of the residents, nor does it Requirements for Participation in constitute substandard quality of Medicare/Medicaid, 42 CFR Subpart 483.90(a), care or limit our capability to Life Safety from Fire and the 2012 edition of the render adequate care. Please National Fire Protection Association (NFPA) 101, accept this plan of correction as Life Safety Code (LSC), Chapter 19, Existing our credible allegation of Health Care Occupancies and 410 IAC 16.2. compliance. At this time, we are respectfully requesting paper The Health and Rehabilitation building is a one compliance. 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 K 0341 **NFPA 101** SS=E Fire Alarm System - Installation Bldg. 01 Based on observation and interview, the facility K 0341 K 341 11/19/2024 failed to ensure 1 of 1 fire alarm systems were Fire alarm installation. installed in accordance with 19.3.4.1. LSC 9.6.1.3 Findings: Maintenance requires a fire alarm system to be installed, tested, Director/Designee/Team repaired and maintained in accordance with NFPA 70, identified smoke detector National Electrical Code and NFPA 72, National relocating it at required distance. Fire Alarm Code. NFPA 72, 17.7.4.1 requires in Other Building Smoke spaces served by air handling systems, detectors Detectors: Maintenance shall not be located where air flow prevents Director/Designee/Team operation of the detectors. This deficient practice completed a review of the AB could affect 20 residents in one smoke Health Center campus smoke compartment. detectors on 11.19.2024 and did not identify any other smoke Findings include: detectors that required repairs. Training: Maintenance Team Based on observation with the Executive Director educated on 11.13.2024 regarding (ED), the Administrator (AD) Maintenance deficient practice. Director (MD) and the Administrator in Training Quality: Maintenance

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION 2	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155586	B. WING		11/06/2024
	PROVIDER OR SUPPLIER		6701 S	ADDRESS, CITY, STATE, ZIP COD S ANTHONY BLVD WAYNE, IN 46816	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	detector less than the vent where air flow operation of the det Based on interview MD stated the detect the air supply vent.  This finding was re	1:15 p.m., there was a smoke three feet from an air supply would prevent proper ector next to room 118A. at the time of observation, the ctor was about 18 inches from viewed with the ED, AD, MD, the exit conference.		Director/Designee will audit smodetector placement. The audit were be completed weekly for 7 week 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 tir 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.	vill ks  f or me
K 0353 SS=C Bldg. 01		- Maintenance and Testing	K 0353	K 353	11/13/2024
	interview, the facili sprinkler systems in LSC 9.7.5 requires shall be inspected a with NFPA 25, Star Testing, and Mainte Protection Systems 5.1.1.2 indicates the inspection and testi gauges on wet pipe inspected monthly a (5.2.4.2) shall be in normal water or air NFPA 25 13.3.2.1 s	ty failed to maintain 1 of 1 n accordance with LSC 9.7.5. all automatic sprinkler systems and maintained in accordance andard for the Inspection, cenance of Water-Based Fire NFPA 25, 2011 edition, Table are required frequency of ang. NFPA 25, 5.2.4.1 states sprinkler systems shall be and gauges on dry systems spected weekly to ensure pressure is being maintained. states valves should be are valves secured locks or	K 0333	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 ar did not identify any wet system control valves that required repa	y m em nd

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supervised (13.3.2.1.1) shall be permitted to be

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Training: Maintenance Team

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ZI I ZIKO I OI	THE CONTENTS OF THE CONTENTS	THE SERVICES					21.0.0,00	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
1555		155586	B. W.	ING		11/06/2024		
NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP COD 6701 S ANTHONY BLVD FORT WAYNE, IN 46816					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
IAG		This deficient practice could	+	IAG	advected on 11 12 2024 regard	dina	DATE	
	affect all occupants	_			educated on 11.13.2024 regard	allig		
	affect all occupants.				deficient practice.			
	T' 1' ' 1 1				4 Quality: Maintenance			
	Findings include:				Director/Designee will audit we			
					system control valves. The aud	lit		
	_	ew with the Executive Director			will be completed weekly for 7			
		rator (AD), Maintenance			weeks and monthly going forwa	ard		
	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				as required per NFPA 101			
					recommendations. The audit			
					results will be reviewed with the	Э		
	-	e inspected weekly but the			QAA/QAPI committee monthly	for		
	monthly wet system	n control valves were not			a period of 3 months. QAA/QA	PI		
	documented. Based	on observation at 2:20 p.m.,			will monitor for need to continue	е		
	there were four sup	ervised control valves for the			past this time frame based on			
	sprinkler system. Ba	ased on an interview at the			criteria of no deficiencies found	j		
	time of record revie	ew, the MD stated the			during this internal audit proces	SS.		
	supervised valves a	re inspected but the checks						
	are not recorded.	•			5 Artifacts:			
					Education/Signature. Audit For	m		
	This finding was reviewed with the ED, AD, MD, and the AIT during the exit conference.  3.1-19(b)							
K 0355	NFPA 101							
SS=E	Portable Fire Extir	nguishers						
Bldg. 01	Pagad an al	on and interview the fe-!!!	17. ^	255	V 255		11/12/2024	
		on and interview, the facility	K 0	355	K 355		11/12/2024	
	_	document 2 of 4 portable fire			1 Portable Fire Extinguishe	r.		
	-	front smoke compartment			Findings: Maintenance			
		10, Standard for Portable Fire			Director/Designee/Team visual	ly		
		ion 7.2.1.2 states fire			inspected portable fire			
	-	be inspected either manually or			extinguishers and documented	as		
	_	etronic device / system at a			required.			
	-	intervals. Section 7.2.2 states			2 Other Building Wet Syste	m		
		or electronic monitoring of fire			Control Valves: Maintenance			
	_	include a check of at least the			Director/Designee/Team			
	following items:				completed a review of the AB			
	(1) Location in desi	gnated place			Health Center campus portable	fire		
	(2) No obstruction t	to access or visibility			extinguishers on 11.12.2024 ar	nd		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155586		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/06/2024			
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP COD 6701 S ANTHONY BLVD FORT WAYNE, IN 46816					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	(3) Pressure gauge operable range or p (4) Fullness determ self expelling-type cartridge-operated (5) Condition of time nozzle for wheeled (6) Indicator for no using pushto-test processed for the section 7.2.4.1 stationspections shall ke extinguishers insperequire corrective a where at least mont conducted, the date performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a transpection 7.2.4.5 requare conducted on file, Section 7.2.4.5 requare conducted at inspections have be practice could affect compartment.  Findings include:  Based on observation (ED), the Administ Director (MD) and (AIT) on 11/06/24 inspection tag on the located in the Beautin the mechanical reinterview at the time confirmed the two or the section of	reading or indicator in the osition ined by weighing or hefting for extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers in-rechargeable extinguishers ressure indicators. The present of all fire eted, including those found to ection. Section 7.2.4.3 requires they manual inspections are the manual inspection was initials of the person section shall be recorded. The person in the per		TAG	did not identify any portable fir extinguishers that required rep 3 Training: Maintenance T educated on 11.12.2024 regardeficient practice. 4 Quality: Maintenance Director/Designee will audit se 2 portable fire extinguishers. T select audit will be completed weekly for 7 weeks and month going forward as required to p NFPA 101 recommendations. audit results will be reviewed with e QAA/QAPI committee morfor a period of 3 months. QAA/QAPI will monitor for need to continue past this frame based on criteria of no deficiencies found during this internal audit process. 5 Artifacts: Education/Signature. Audit For TELS Monthly Portable Fire Extinguisher Log.	pairs. ream rding relect rhe ally er The with anthly or	DATE	
	documentation of a	monthly visual inspection.						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			· ′	) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER					COMPLETED	
		155586	B. WING 11/06/2024					
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES		STREET ADDRESS, CITY, STATE, ZIP COD 6701 S ANTHONY BLVD FORT WAYNE, IN 46816						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	This finding was revand the AIT during 3.1-19(b)	viewed with the ED, AD, MD, the exit conference.						
K 0372 SS=E	NFPA 101 Subdivision of Bui	lding Spaces - Smoke						
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 barriers. 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		K 03	72	K372  1 Smoke Barrier Construct Findings: Maintenance Director/Designee/Team visual 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 identify any additional smoke barriers that required repairs.  3 Training: Maintenance Teducated on 11.19.2024 regardeficient practice.  4 Quality: Maintenance Director/Designee will audit smoke barrier walls. The select audit be completed weekly for 7 were and monthly for 3 months. The audit results will be reviewed with QAA/QAPI committee more for a period of 3 months.  QAA/QAPI will monitor for need continue past this time frame based on criteria of no deficier found during this internal audit process.	not eam rding noke will eks e with hthly ed to	11/19/2024	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COM			ETED
		155586	B. W	B. WING		11/06/	/2024
		<u>[</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	ROVIDER OR SUPPLIER				ANTHONY BLVD		
LUTHERAN LIFE VILLAGES					WAYNE, IN 46816		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	all smoke wall there were pipes			Education/Signature. Photos of		
		caulk, but the caulk was falling			Completed Repairs. 1 Identifie	ea	
		from the wall. Based on			Hall. Audit Form.		
		e of observation, the MD					
	300-hall smoke barr	needed replaced in the					
	500-half smoke barr	ner.					
	This finding was rev	viewed with the ED, AD, MD,					
	and the AIT during						
	and the fift during	the Cart Comercines.					
	3.1-19(b)						
K 0754	NFPA 101						
SS=E							
Bldg. 01	Conou Emon and	Taen Comamore					
Ŭ	Based on observation	on and interview, the facility	K 0	754	K 754		11/07/2024
	failed to ensure tras	h and soiled linen carts in 1 of			1. Soiled Linen and Trash		
	6 corridors were ma	intained in accordance with			Container Storage. Findings:		
	19.7.5.7. Soiled line	en or trash collection			Maintenance		
	receptacles shall no	t exceed 32 gallons in			Director/Designee/Team visua	ally	
	capacity. The average	ge density of container			inspected and stored appropri	ately	
		or space shall not exceed 0.5			Soiled Linen and Trash Conta	iners	
		A total container capacity of			greater than 32 gallons.		
		be exceeded within any 64			2. Other Building Soiled Linen	and	
	-	obile soiled linen or trash			Trash Container Storage:		
		es with capacities greater than			Maintenance		
	_	ocated in a room protected as			Director/Designee/Team		
	a hazardous area wh				completed a review of the AB		
		ice could affect staff and up to			Health Center campus storage		
	20 residents in the A	Ash Hall.			11.20.2024 and did not identif	•	
	E' 1' ' 1 1				any additional storage contain	ers	
	Findings include:				improperly stored.		
	D11				3. Training: Nursing Director/S		
		ons with the Executive			educated on 11.07.2024 regar	aing	
	Director (ED), the A				deficient practice.		
		or (MD) and the Administrator			4. Quality: Maintenance	ilad	
		n 11/06/24 at 1:00 p.m., there			Director/Designee will audit so		
		sh barrel next to a double linen			linen and trash container stora	-	
		allons next to the soiled utility  Based on an interview at the			The select audit will be completed weekly for 7 weeks and month		
	L TOUTH ON ASH DALL I	DASCA OH AH HUGI VICW AL IUC			I WEEKIVIUI / WEEKS AND MONIC	IIV	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155586	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/06/2024	
NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP COD 6701 S ANTHONY BLVD FORT WAYNE, IN 46816				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR time of observation, was a 33-gallon bar cart exceeding 32 gr on Ash Hall.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION the MD and AD stated there rels of trash and a double linen allons in a 64 square foot area viewed with the ED, AD, MD, the exit conference.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  for 3 months. The audit results be reviewed with the QAA/QA committee monthly for a perio 3 months. QAA/QAPI will mor for need to continue past this frame based on criteria of no deficiencies found during this internal audit process. 5. Artifacts: Education/Signatu Audit Form.	s will PI d of nitor time	(X5) COMPLETION DATE

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