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	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Life Villages	6701 S Anthony Blvd Fort Wayne, IN 46816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure the root cause of falls was assessed, care plan interventions were developed and implemented to prevent further falls from occurring for 1 of 3 residents reviewed for accidents (Resident B). Findings include: A report, dated 6/5/25, indicated Resident B had 2 falls, within a couple days, resulting in a fractured leg. Resident B's family member alleged the facility hadn't provided adequate supervision and care to prevent the falls and injury. On 6/23/25 at 11:41 A.M., Resident B's record was reviewed. Diagnoses included Alzheimer's dementia and post-hip fixation after a fall causing fracture. The resident was admitted to the facility for rehabilitation with a goal of discharging back to her daughter's home where she had lived. A nursing admission screen form, dated 5/8/25 at 10:26 a.m., indicated Resident B was alert and oriented to self and time; had short-term memory issues; used briefs for bladder and bowel incontinence; had unsteady gait, weakness, poor balance; and was to stand/pivot/sit using her left leg only. An admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated Resident B had severely impaired cognition; no moods or behaviors; used a walker and wheelchair; walked 10 feet with moderate assistance; and required maximal assistance for transfers to chair/bed/toilet, toileting hygiene, and putting on/taking off her footwear. The MDS assessment indicated the resident was frequently incontinent of bladder and occasionally incontinent of bowel however, no trial of a toileting program had been attempted. A Fall Care Area Assessment (CAA), dated 5/15/25, triggered for falls due to risk of injury related to balance issues. The resident was not stable and required stabilization with assistance of 1 staff member. She required help moving on and off the toilet and surface to surface. Resident B was to receive physical and occupational therapy services. She required assistance from nursing staff for care and was at high risk for falls. The care plan would address falls with a goal of no fall related injuries. A Urinary Incontinence CAA, dated 5/15/25, triggered due to Resident B being frequently incontinent of urine and requiring staff assistance of 1 for toileting. The resident was at risk for skin breakdown, falls, isolation, and urinary tract infection. The care plan would address urinary incontinence for monitoring and minimizing risks. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Life Villages	6701 S Anthony Blvd Fort Wayne, IN 46816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plans indicated: -5/8/25: Resident B required assistance with Activities of Daily Living (ADL) from staff related to deconditioning secondary to multiple falls prior to admission. The goal was to improve her physical function with bed mobility, eating, toileting and transfers. One intervention had been put in place, dated 6/2/25, which was for staff to provide limited assistance with bed mobility. -6/2/25: Resident B was at moderate risk for falls related to confusion and gait/balance problems. The goal was to be free from falls. Interventions, all initiated on 6/2/25 after the resident's falls and discharge to the hospital, included: ensure proper footwear and call light within reach; Stat x-ray ordered and sent to hospital ER, staff to increase scheduled toileting; anticipate and meet her needs; be sure the call light is within reach and encourage her to use it; staff to provide prompt response to all requests for assistance; encourage to participate in activities to promote exercise; ensure she is wearing appropriate footwear; and follow facility fall protocol. -6/2/25: Resident B had stress bladder incontinence related to history of urinary tract infection with a goal of being free from skin breakdown due to incontinence and brief use. Intervention, dated 6/2/25, was for staff to monitor, document, and report any possible causes of incontinence-bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, etc. Resident B's care plans had not indicated the amount of assistance required for ADL's other than bed mobility. The care plan hadn't indicated her weight bearing status, ability to ambulate and which assistive devices to use. She had no scheduled toileting plan but had a fall intervention to increase her scheduled toileting after being discharged to the hospital following her fall with fracture. A nurse note, dated 5/29/25 at 8:09 p.m., indicated staff heard a noise and turned around to observe Resident B falling. She had gotten up from the recliner (in her room) to toilet and had been wearing slick shoes causing her to loose balance and fall. She was assisted to her feet and walked to the bathroom per her request. She had no observed injuries and full range of motion (ROM) to her extremities. She had no complaints of discomfort. Resident B was dressed for bed and taken out to the dining room where staff could observe her. An Interdisciplinary Team (IDT) review, dated 5/30/25 at 3:09 p.m., indicated Resident B had a fall on 5/29/25 at 8:00 p.m. when she got up from her room recliner and attempted to walk to the bathroom. The IDT determined the root cause of the fall was weakness and the intervention was to ensure she wore proper footwear and her call light was within reach. A nurse note, dated 5/31/25 at 12:48 p.m., indicated at 12:00 p.m., Resident B was observed on the floor in her room. She indicated she had walked herself to the bathroom and when returning to her recliner, her legs gave out and she went down on her bottom. She complained of pain in the back of her upper leg, above the knee. She was assisted to stand up, was able to bear weight and pivot into her recliner chair, but indicated it had hurt. The nurse administered pain medication and notified the on-call Nurse Practitioner (NP) and resident's family. Resident B was educated to not get up by herself and use the call light for assistance. Staff were to monitor her more frequently to anticipate her needs. (continued on next page)

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	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Life Villages	6701 S Anthony Blvd Fort Wayne, IN 46816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5:28 p.m., a STAT x-ray of the resident's right leg and knee was ordered, completed, and results received at 4:38 p.m. The X-ray indicated a fracture to the resident's distal femur (above the knee). An order was given to send the resident to the hospital for evaluation and treatment. An IDT review, dated 6/2/25 at 3:20 p.m., indicated Resident B had an unwitnessed fall on 5/31/25 at 12:00 p. m. after getting up by herself and going to the bathroom. Resident B was walking in her room back to the recliner chair after using the bathroom when her legs gave out and she went down on her bottom. The root cause of the fall was weakness and poor balance. The new intervention to her care plan was to increase her scheduled toileting. On 6/23/25 at 3:00 P.M., the Executive Director, Assistant Administrator, and Unit Manager (UM) were interviewed regarding investigation of falls and development of fall interventions to prevent further falls. The Assistant Administrator indicated the IDT reviewed fall reports at morning meetings where all disciplines were present, including therapy staff. She indicated falls were reviewed, analyzed, root cause analysis determined, and appropriate interventions put into place. Review of the facility fall reports for Resident B on 5/29 and 5/31/25, indicated both falls occurred when the resident was trying to get to/from the bathroom. The UM indicated the resident had not been on a scheduled toileting plan nor had an assessment been completed to indicate the need for a plan. The Executive Director, Assistant Administrator and UM indicated Resident B's root cause of her falls was needing to use the bathroom, incontinence, and not having an established toileting plan for staff to follow. The care plan should have been updated to indicate her increased risk for falls related to need for toileting. On 6/23/25 at 3:41 P.M., the Rehabilitation Therapy Director and Physical Therapist were interviewed. Both indicated Resident B always required staff assistance for ambulation in her room. She required a staff member to stand by and provide cues and stabilization due to confusion and weakness at times. On 6/23/25 at 10:48 A.M., the Assistant Administrator provided a current copy of the facility policy, titled Fall Policy-Resident Safety which stated: This policy establishes guidelines and explains the methods used to assess/screen residents at risk for falling and develop interventions to assist in the prevention of further falls . Standard safety precautions will be implemented on all residents upon entry into the nursing home setting . non-skid shoes/slippers; mobility devices .If the resident falls: assess for injury; notify medical staff; document all factors contributing to the falls; interventions currently in place and implementation of any additional safety measures and assessments of resident; an incident report will be completed in the record . the fall care plan interventions will be reviewed and revised if necessary. The resident's fall risk will be communicated to caregivers .Additionally all resident falls will be reviewed daily by the IDT to ensure all documentation and interventions are correct and root cause analysis determined This Citation relates to Complaint IN00460903. 3.1-45(a)