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	10/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safety and prevention of abuse for 1 of 3 residents reviewed (Resident A). Findings include:Resident A's record was reviewed on 10/20/25 at 12:59 PM. Diagnoses included cognitive communication deficit and generalized anxiety disorder.Resident A's quarterly Minimum Data Set, (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 7 (moderate cognitive loss).A summary of incident report, dated 10/9/25, indicated Resident A's spouse had made contact with the Resident A's face. The report indicated Adult Protective Services had been contacted. The report indicated Resident A's daughter was concerned about the spouse's decline and attempts to correct the spouse.A progress note, dated 8/23/25 at 11:59 PM, indicated Resident A's spouse had been present when the resident's skin tear had reopened.A progress note, dated 8/27/25 at 11:59 PM, indicated Resident A had reopened a skin tear on their arm. The skin tear had been reopened when Resident A's spouse had pulled the resident's arm to reposition.A progress note, dated 9/9/25 at 4:52 PM, indicated Resident A's spouse had given the resident an aspirin. Resident A's spouse stared at the staff member and did not respond when they were told they could not give Resident A medicine. Resident A's daughter was notified.A progress note, dated 9/20/25 at 7:45 PM, indicated Resident A had been verbally aggressive with their spouse. Resident A had told their spouse to get the hell out and do not return. Resident A's spouse stayed in the resident's room for 45 minutes after the resident had told them to get out.A progress note, dated 9/21/25 at 12:37 AM, indicated Resident A had been verbally aggressive to their spouse. Resident A's spouse had indicated they were not sure of what was going on.A progress note, dated 9/27/25 at 6:12 PM, indicated Resident A had been screaming at their spouse in the dining room. Resident A's spouse had been feeding the resident unsafe food items at Resident A's command.A progress note, dated 9/28/25 at 6:29 PM, indicated Resident A's spouse had given the resident a pain pill. Resident A's spouse would not identify the pill. The supervisor had been notified.A progress note, dated 10/1/25 at 9:53 PM, indicated Resident A had been yelling throughout the shift. Resident A had screamed to get out of their room even though no one else was present. Resident A's spouse left their visit early. Resident A's spouse indicated they could not take all of that.A progress note, dated 10/5/25 at 1:15 PM, indicated Resident A's spouse had come to visit. Resident A yelled at their spouse a few times.A progress note, dated 10/15/25 at 12:57 PM, indicated Resident A's spouse had repositioned the resident to a reclining position while the staff was feeding the resident. Resident A's spouse became argumentative with the staff when the staff placed the resident in an upright position to eat. The note indicated the resident became more anxious and aggressive when their spouse was present at meals. The note indicated Resident A and their spouse triggered each other during meals.A progress note, dated 10/19/25 at 2:44 PM, indicated Resident A began yelling when their spouse came to visit. Resident A had been bossing their spouse and making commands to their spouse.Resident A's care plan, dated 9/22/25, indicated the resident had potential to become verbally aggressive. Interventions included analyzation and documentation of circumstances, triggers and actions known to de-escalate aggressive behavior, assessment of Resident A's coping skills, intervention before agitation escalates and support system and a psychiatric consultation. Resident A's care plan did not indicate the resident should be monitored when their spouse was present. The care plan did not indicate staff members were directed to intervene and safeguard the resident if needed.The care plan did not indicate the resident's spouse had given them medication.The care plan did not indicate the resident's spouse had fed the resident.The care plan did not indicate the resident's spouse had repositioned the resident.The care plan did not indicate the resident's spouse had made contact with the resident's face.A unit assignment sheet for direct care staff, (resident profile) dated 8/28/25, provided various categories of care areas for each resident. Some residents had listed behaviors such as anxiety at times and combativeness with care. The resident profile indicated Resident A did not have behaviors. Some residents had listed safety concerns such as fall risk or appropriate footwear. The resident profile indicated Resident A did not have safety issues as the safety category for Resident A was blank.In an interview, on 10/20/25 at 2:07 PM, Licensed Practical Nurse (LPN) 2 indicated they had been verbally instructed to monitor Resident A when their spouse was present. LPN 2 indicated Resident A's spouse resided at the facility's independent living unit and visited Resident A frequently. LPN 2 indicated Resident A's spouse would get frustrated when the resident got aggressive with them. LPN 2 indicated Resident A's family interactions among the daughter and the spouse were tense. LPN