STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155744	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Life Villages	351 N Allen Chapel Rd Kendallville, IN 46755

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were secured for 1 of 12 residents observed (Resident 48). Findings include:In an observation, on 02/24/2026 2:04 PM, a bottle of Tums (over the counter antacid tablets) about 20% full, 1 full bottle of Tums, 1 full box of Pepto Bismol (over the counter medication for gastro-intestinal discomfort) tablets and a jar of Vicks Vapo Rub (topical ointment) with visible fingerprints in the gel and a small amount missing were observed on a bedside table beside Resident 48 in her room. In an interview, on 02/24/2026 2:05 PM, Resident 48 indicated her family brought the full bottle of Tums and the box of Pepto Bismol that day. Resident 48 indicated the partial bottle of Tums had been in her room for a long time and the bottle was normally on her bedside table. Resident 48 indicated she always kept a supply of Tums in her room but no one ever said anything about it. In an interview, on 02/24/2026 2:15 PM, Licensed Practical Nurse (LPN) 2 indicated Resident 48's family visited, probably brought in the unopened bottle of Tums and box of Pepto Bismol, but was not aware of when Resident 48 obtained the open bottle, about 20% full of Tums and open jar of Vicks Vapo Rub. LPN 2 indicated Resident 48 did not have current orders for Tums, Vicks Vapo Rub, or Pepto Bismol. LPN 2 indicated she removed the medications from Resident 48's room because all medications should be locked in a medication cart or medication room. Resident 48's record was reviewed on 02/24/2026 2:07 PM. Diagnoses included gastro-esophageal reflux disease without esophagitis. A current quarterly Minimum Data Set assessment dated [DATE] indicated Resident 48 had a Basic Interview for Mental Status score of 15 (cognitively intact). A self administration of medications kept at bedside assessment was not available for review. A review of current physicians orders for Resident 48 did not include orders for Tums, Pepto Bismol, or Vicks Vapo Rub. In an interview, on 02/26/2026 11:28 AM, the Director of Nursing indicated staff had not been aware of Resident 48 storing medication at her bedside prior to the surveyor bringing it to their attention. She indicated all over the counter medications should be secured in a medication cart or storage area. In an interview, on 03/02/2026 11:18 AM, the Administrator indicated a self- administration of medication assessment had not been completed for Resident 48. She indicated she did not believe Resident 48 would pass the assessment criteria for self-administration. A current policy, titled Medication Storage, dated 11/29/18, provided by the Administrator on 2/26/26 at 11:59 AM, indicated all drugs should be stored in a safe, secure, and orderly manner. A current policy, titled Self Administer Medications, dated 11/28/16, provided by the Administrator on 3/3/26 at 11:48 AM, indicated a resident desiring to self administer medications at bedside should be assessed for ability to do so safely. The policy indicated the assessment should be reviewed by the interdisciplinary team and documented. 3.1-25(m)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure hand hygiene procedures were maintained during direct resident care for 1 of 2 residents reviewed (Resident 36).Findings include:During a continuous observation on 2/26/26 at from 8:40 AM -8: 55 AM, Certified Nurse Aide (CNA) 5 was observed providing indwelling urinary catheter care for Resident 36.Resident 36 was in their bed with the head of the bed up in a sitting position. CNA 5 sanitized their hands, lowered the resident's bed and filled a basin with warm water. CNA 5 moved the bedside table, folded the resident's blanket down, removed their plush toy and placed the bed in lying position. CNA 5 applied gloves and unfastened Resident 36's brief. CNA 5 cleansed the resident's genitalia using a different section of the washcloth for each fold. CNA 5 cleansed the catheter tubing in a downward motion away from the body using a different section of the washcloth. CNA 5 rinsed the area with a new washcloth and patted the area dry with a towel. CNA 5 then refastened the resident's brief, covered the resident with their blanket and replaced the resident's plush toy. CNA 5 did not remove their gloves or perform hand hygiene prior to touching Resident 36's personal items. CNA 5 raised the head of the bed up to the prior position and returned the bedside table. CNA 5 did not remove their gloves r perform hand hygiene prior to touching Resident 36's personal items. CNA 5 placed the used articles in a plastic bag. CNA 5 removed their gloves and discarded the gloves into the trash. The CNA washed their hands in the sink.In an interview, on 2/26/26 at 8:55 AM, CNA 5 indicated they had been instructed to only change gloves during direct resident care if the gloves were damaged or visibly soiled. CNA 5 indicated they should have removed their gloves prior to touching items in the resident's room.In an interview, on 2/26/26 at 11:25 AM, the Director of Nursing (DON) indicated CNA 5 should have removed their gloves after direct resident care. The DON indicated CNA 5 should have washed their hands prior to touching Resident 36's personal belongings.A current facility policy, titled Catheter Care, last revised 3/23/22, indicated after the resident was towel dried, all disposable items should be discarded, the resident should be assisted into a comfortable position, call light should be placed in reach and the room returned to the original order.483.25(d)(1)(2)- 3.1-18(a)(b)(1)