| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00398528.<br><br>Complaint IN00398528 - Unsubstantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: January 11, 12, 13 and 17, 2023.<br><br>Facility number: 013293<br>Provider number: 155827<br>AIM number: 201273090<br><br>Census Bed Type:<br>SNF/NF: 33<br>SNF: 13<br>Total: 46<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 33<br>Total: 46<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed January 19, 2023 | F 0000 | This plan of correction is prepared and submitted as a requirement by State and Federal law. This plan of correction shall operate as Sage Bluff Health & Rehab's written credible allegation of compliance effective February 17, 2023. | |
| F 0698<br>SS=D<br>Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. | | | |

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 |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | Based on record review and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 2 residents reviewed. (Resident 142)<br><br>Findings include:<br><br>Resident 142's record review began on 1/11/23 at 11:53AM. Resident 142's diagnosis included dependency on renal dialysis, heart disease, and chronic pain.<br><br>Resident 142's 5day admission MDS (Minimum data Set) assessment indicated he required dialysis in Section O, Special Treatments, Procedures, and Programs. Resident 142's Section C (Brief Interview Memory Status) indicated he was without memory deficits.<br><br>In an interviewon 1/11/23 at 10:58AM, Resident 142 indicated he went to dialysis in the afternoon. He indicated he did not take any form of paperwork with him to or from dialysis.<br><br>In an interview on 1/11/23 11:01AM, RN (Registered Nurse) 3 indicated if Resident 142 had a dialysis communication book it was located at nursing station, but there was no dialysis communication book. RN 3 indicated he did not recall sending one with any resident going to dialysis. RN 3 indicated there was no specific assessment or paperwork prior to or after dialysis however, he completed an assessment prior to dialysis by doing vital signs and ensuring Resident 142 was functioning per his normal. RN 3 indicated he was not frequently there upon Resident 142's return.<br><br>On 01/11/23 at 11:53 AM, a binder with Resident | F 0698 | The affected Resident #142 was reviewed by the IDT and communication forms now, and moving forward, will be sent with resident to all dialysis appointments.<br>This finding has the potential to affect any residents who receive dialysis treatments. DON audited all residents who receive dialysis treatments on 1/18/2023 and found communication forms in place for 1 other dialysis resident (Resident # 20).<br>To prevent recurrence the Director of Nursing will educate all licensed nursing staff on the Hemodialysis Care Policy to include utilization of the communication form.<br>To monitor ongoing compliance, the DON or designee will audit dialysis communication forms weekly x 12 weeks, monthly x 3 months. All audits will be submitted to the QAPI committee for review and recommendation. Any negative findings will require an additional month of audits<br>Effective date of correction: February 17, 2023. | 02/17/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | 142's name was provided by RN 3. RN 3 indicated the binder was in the DON's (Director of Nursing) office, and therefore unavailable to him. The binder had assessments from 1/2/23 at noon, 1/2/23 at 7pm, 1/6/23 at 3PM, 1/4/23 at 7PM, 1/9/23 at 3PM, 1/9/12 at 8PM. The assessments did not include a face sheet or other information provided to the dialysis center.<br><br>In an interview on 1/11/23 at 12:06PM, the DON and Regional Nurse Consultant indicated the ADON (Assistant Director of Nursing) put together a new binder due to the inability to locate the old one.<br><br>On 1/11/23 at 1:42PM, the Regional Nurse Consultant indicated there was no form sent with Resident 142 for dialysis to fill out. The Regional Nurse Consultant indicated dialysis assessments were printed and sent with Resident 142; she further indicated the driver took them not the resident.<br><br>On 1/11/23 at 2:18PM, the Regional Nurse Consultant provided lab reports, a nutrition profile from the dialysis center printed 1/11/23 at 11:54AM, and an email sent by Registered Dietician on 1/11/23 at 11:35AM requesting the information from the dialysis center.<br><br>A policy titled "Hemodialysis Care Policy", dated 06/16/2017 last revision on 4/20/22, was provided by Regional Nurse Consultant on 1/12/23 at 2:36PM. The policy indicated to document assessment in the Dialysis Communication Tool. Assessment includes vital signs, pretreatment weight, medications administered prior to treatment, time of last meal, fluid intake, and any additional alerts or information. Post Dialysis process: received report from dialysis provider | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | and or receive Dialysis Communication Tool documentation by the dialysis provider. Contact dialysis promptly with any questions. Information post dialysis will include amount of fluid removed, vital signs, post treatment weight, lab draws and results, medications administered during or after treatment, any new orders, any additional alerts, or information, monitor for dizziness, and meal and fluids consumed at dialysis.<br><br>3.1-37 (a) | | | |
| F 0758<br>SS=D<br>Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>Based on interview and record review the facility failed to ensure medication prescribed had appropriate diagnoses identified for 2 of 5 residents reviewed. (Resident 39 and Resident 142).<br><br>Findings include:<br><br>1.A record review for Resident 39 began on 1/12/23 at 10:37AM. Resident 39 diagnoses were high blood pressure, heart palpitations, hyperlipidemia, covid 19, history of falls, traumatic brain injury, and vascular disease. Resident 39's record did not include insomnia, depression, and anxiety.<br><br>Resident 39's admission MDS (Minimal Data Set) indicated diagnoses were hypertension, atrial | F 0758 | The affected residents Resident #39 and Resident #142 was reviewed by the DON and NP. For Resident # 39: NP gave diagnosis for Major Depressive Disorder and Generalized Anxiety Disorder; orders were updated as needed; and side effects monitoring for both medications were added; care plan review and revised for new diagnoses. For Resident #142: NP reviewed diagnoses and gave diagnoses of Psychotic Disorder with Hallucinations Due to Known Physiological Condition; order was updated as necessary; and side effect monitoring was added; care plan review and | 02/17/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | fibrillation or other dysrhythmias, peripheral vascular disease, hyperlipidemia, and history of falling. Resident 39's assessment did not indicate any psychiatric or mood disorders. Resident 39's Section C of MDS indicated the resident was rarely understood and had severely impaired cognition. The assessment indicated each symptom was not assessed through interview of resident or staff. The assessment was not scored to indicate severity of mood. A depression assessment was completed after start of survey with a score of zero.<br><br>Resident 39 had physician orders for Effexor (venlafaxine) to be used for depression, increased during her stay from 75mg daily to 150mg daily. The resident had an order for buspirone 5mg at bedtime for insomnia and anxiety. Resident 39 did not have an active diagnosis of depression, anxiety, or insomnia. Resident 39's record indicated no documentation of monitoring for side effects for venlafaxine or buspirone.<br><br>Resident 39's current care plan did not include interventions related to depression, but did include she was receiving an antidepressant.<br><br>Resident 39 was seen by rounding providers (psychiatric nurse practitioner) on December 22, 2022 for a follow-up visit regarding facility reported increased tearfulness. Resident 39 had no documentation of increased tearfulness, no interdisciplinary team meetings, and no documentation of behaviors in December.<br><br>2. Resident 142's record review began on 01/12/23 09:59 AM. Resident 142 diagnoses included heart disease, stroke, chronic pain, convulsions, sleep apnea, end stage renal disease, and lung disease. Resident 142 did not have a diagnosis of | | revised for new diagnosis.<br>The finding has the potential to effect any resident who receives psychotropic medications. DON and/or designee audited all residents who receive psychotropic medications for appropriate diagnoses and side effects monitoring. DON and/or designee audited all residents who receive psychotropic medications by 2/4/2023. Orders and care plans were updated as needed.<br>To prevent recurrence the DON will educate all licensed nursing staff and Social Services on the Psychoactive Medication Policy.<br>To monitor ongoing compliance, the DON or designee will audit all new psychoactive medication orders daily x 4 weeks, weekly x 5 months. All audits will be submitted to the QAPI committee for review and recommendation. Any negative findings will require an additional month of audits<br>Effective date of correction: February 17, 2023. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | insomnia.<br><br>Resident 142 had a physician order dated 12/31/22 to give quetiapine tablet 25 MG, 1 tablet by mouth at bedtime for Insomnia. Resident 142 was documented as being administered this medication on 12/31/22, 1/1/23, 1/2/23, 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/9/23, 1/10/23, 1/11/23, and 1/12/23.<br><br>An admission MDS (minimal data set) assessment section I (active diagnosis) completed on January 5, 2023, indicated Resident 142 diagnosis were hypertension, renal insufficiency, hyperlipidemia, seizure disorder, malnutrition, chronic lung disease, cardiomyopathy, nonrhematic aortic stenosis, history of malignant neoplasm of prostate, hx of TIA (cerebral infarct), hypercalcemia, benign neoplasm of parathyroid gland, sleep apnea, dependence on renal dialysis, and rotator-cuff tear. No diagnosis of insomnia was listed in the assessment.<br><br>In an interviewon 1/12/23 at 3:29PM, the Regional Nurse indicated any medication prescribed required a diagnosis to support the medication use.<br><br>A task list of Resident 142's mood and behaviors dated January 2023 was reviewed. No tracking of sleep was available for review. The Regional Nurse indicated there was no specific tracking for sleep.<br><br>On 1/12/23 at 2:36PM the current facility policy was provided by Regional Nurse and reviewed. A policy titled, "Psychoactive Medication Policy " effective 07/16/2013 with last revision date 5/26/21 indicated .... Resident specific behaviors will be documented. Diagnosis supporting the use of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | psychoactive medication will be documented in the medical record.<br><br>3.1-48(a)(4) | | | |
| F 0865 SS=D Bldg. 00 | 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>§483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:<br><br>§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.<br><br>§483.75(b) Program design and scope.<br>A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:<br><br>§483.75(b)(1) Address all systems of care and management practices;<br><br>§483.75(b)(2) Include clinical care, quality of life, and resident choice;<br><br>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.<br><br>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.<br><br>§483.75(f) Governance and leadership.<br>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:<br><br>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;<br>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;<br><br>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.<br><br>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and<br><br>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>Based on interview and record review, the facility failed to ensure a process was in place to identify and correct quality deficiencies for 1 of 1 review.<br><br>Findings include: | F 0865 | No plan of Correction will be submitted as 2567 states 'Past noncompliance; no plan of correction required.' | 02/17/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155827 | A. BUILDING 00<br>B. WING | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAGE BLUFF HEALTH & REHAB CENTER | 4180 SAGE BLUFF CROSSING<br>FORT WAYNE, IN 46804 |

| (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 |
|---|---|---|---|---|
| | A QAPI (Quality Assurance Performance Improvement) committee list was provided by the Administrator on 1-12- 2023 at 2 PM. The member list included the Executive Director, Medical Director, Director of Nursing, Human Resources, MDS (Minimum Data Set) Coordinator, Director of Plant Operations, Social Services, Director of Rehabilitation, Social Services/Activities, Business Office Manager and the Unit Manager.<br><br>There was no policy and procedure provided prior to exit regarding QAPI.<br><br>In an interview on 1-17-23 at 9:45 AM, the Administrator indicated problems and issues in the facility were tracked and trended through the QAPI committee monthly. He indicated the QAPI process was utilized to improve processes within the facility and the facility had a schedule of processes to review each month to ensure improvement of operations. Focusi included nursing processes, risk management and reportable incidents. He indicated the process for dialysis communication imporvement had been completed prior to his arrivel at the facility.<br><br>The facility annual survey completed on December 10, 2021 identified noncompliance regarding dialysis communication and psychotropic medication use. The facility was also found to be noncompliant regarding dialysis communication and psychotropic medication use on January 17, 2023. Refer to tag F0698 and F0758.<br><br>3.1-52 | | | |