STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. BUILDING 00 B. WING	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00424824 and IN00425355. Complaint IN00424824 - Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00425355 - No deficiencies related to the allegations are cited. Survey date: Feburary 7, 2024. Facility number: 000240 Provider number: 155349 AIM number: 100274960 Census Bed Type: SNF/NF: 94 SNF: 5 Residential: 75 Total: 174 Census Payor Type: Medicare: 6 Medicaid: 50 Other: 118 Total: 174 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 8, 2024	F 0000	**What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.** Resident involved in the abuse allegation was monitored for 72 hours post incident. Team members in-serviced on resident interventions and appropriate actions following resident's resistance and during times resident is not easily re-directed. All team members in-serviced on abuse. Agencies working through Saint Anne Communities provided their abuse in-servicing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents with wandering tendencies have the potential to be affected by the deficient practice. All team members have received in-service education on abuse, reporting, signs, and symptoms. Verification by staffing agencies used has been received in regards to abuse in-service education provided to their team members. CNA sheets have been audited to ensure all resident appropriate interventions are easily accessible.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elaine Wilson	COO	03/08/2024

Any defiencystatement 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 disclo 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.

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Team members in-serviced on abuse reporting, interventions, signs and symptoms. All agencies working with Saint Anne Communities reported their in-service education on abuse. Resident lists given to those working at Saint Anne's audited to ensure interventions are easily accessible by all who may care for a resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place** All monthly in-services will hold information on abuse reporting, signs, & symptoms.10 Resident lists per floor (1st, 2nd, & 3rd) will be audited randomly every month to ensure compliance. Audits will be presented during the monthly QA committee. **By what date the systemic changes for each deficiency will be completed** February 20th, 2024	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and			

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	Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed to ensure residents were free of physical abuse for 1 of 3 residents reviewed (Resident D). Findings include: A continuous video recording was provided for review by the Administrator on 2/7/24 at 11:39 AM. The video was time stamped 12/27/23 at 4:46 AM. Resident D was observed sitting in a chair in the hallway and Qualified Medication Aide (QMA) 4 was observed at the medication cart down the hall. Resident D was observed walking into room 213. QMA 4 followed Resident D into the room. The video showed QMA 4's head bobbing up and down. Resident D was not visible at the time while in the room. QMA 4 was then observed pulling Resident D out of the room with her hands around both the resident's arms. The video showed Resident D resisted and tried to hit QMA 4. QMA 4 was then observed stepping back, Resident D lost his balance and fell to the floor in the hallway into an over the bedside table. Next, QMA 4 and Licensed Pratical Nurse (LPN) 5 were observed standing over Resident D. QMA 4	F 0600	**What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recurHow the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into placest, 2nd, & 3rd) will be audited during the monthly quality assurance meetings for 12 months to ensure the information is correct and that no additional information is	02/20/2024

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	was observed performing a hand motion as if scolding Resident D. Then, QMA 4 and LPN 5 were observed assisting Resident D up into the chair for an assessment. An investigation file was provided by the Director of Nursing (DON) on 2/7/24 at 11 AM. The file included the following: A incident report, dated 12/27/23 at 4:56 AM, was completed by LPN 5. The report indicated Resident D wandered into room 213. The report indicated QMA 4 attempted to redirect Resident D, but Resident D began to shout and grab QMA 4. The report indicated Resident D swung to hit QMA 4 in the face, but QMA 4 stepped out of the way. The report indicated Resident D then lost his balance and fell to the floor. The report also indicated Resident D made comments of "it was her fault" and "f*** you" while on the floor. The file included the following statements : LPN 5's statement indicated he was at the nurse's station when he saw Resident D wander into room 213. LPN 5 indicated QMA 4 followed Resident D. LPN 5 indicated he overheard QMA 4 telling Resident D "Hey, this is not your room. Come with me, if you need the bathroom, I can show you one". At that time, Resident D began to shout at QMA 4. The resident indicated "I have had enough of you." LPN 5 indicated at that time he heard a physical struggle between the resident and QMA 4. LPN 5 got up to try to deescalate the situation, but before he arrived at the area, LPN 5 observed Resident D had attempted to hit QMA 4 and QMA 4 stepped back. LPN 5 then overheard Resident D fall on the floor. LPN 5 indicated he overheard QMA 4 indicate to Resident D "See? Now you fell." LPN 5 and QMA 4 then assisted		needed. Following the 12 months of audits, if all audits have been deficiency free then the audits will cease. If there have not been 12 months of deficiency free audits, the audits will continue to be presented at the monthly QA meetings until 12 months of continual compliance is achieved. By what date the systemic changes for each deficiency will be completed February 20th, 2024	

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	Resident D to a chair for an assessment. QMA 4's statement indicated she was trying to redirect Resident D from another resident's room. Resident D became agitated, angry and combative. QMA 4 indicated Resident D tried to hit her and told her to get off him. QMA 4 indicated she got off him and then Resident D lost his balance and fell. An assignment sheet was included in the file. The sheet indicated Resident D was a fall risk, was alert and confused at times. The sheet indicated Resident D had poor vision, needed frequent cues for care and had become aggressive at times. The sheet also indicated when Resident D became aggressive, was unable to be redirected, the staff were instructed to give Resident D space. A progress note, dated 12/27/23, by QMA 4 and LPN 5 indicated Resident D wandered into room 213. QMA 4 attempted to redirect the resident and the resident began to shout and grab QMA 4. The note indicated LPN 5 approached the situation due to Resident D's physical aggression towards QMA 4. The note indicated Resident D tried to hit QMA 4. QMA 4 stepped back, then Resident D lost his balance then fell to the floor. A progress note, dated 1/1/24, indicated the Interdisciplinary Team (IDT) met for review on 12/28/23. The note indicated video cameras were reviewed and visualized Resident D wandered into a different resident's room. The note indicated as the resident entered the room, QMA 4 followed. QMA 4 was partially seen in the doorway of the room. The note indicated Resident D exited as QMA 4 was holding Resident D's arms. A struggle between the resident and QMA 4 was visualized. Resident D then attempted to swing			

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	his arm/fist at QMA 4 but lost his balance and fell. In an interview, on 2/7/24 at 11:03 AM, the DON indicated Resident D fell on 12/27/23 around 4:30 AM. The DON indicated she reviewed the cameras for the time period. The DON indicated she observed QMA 4 followed Resident D into a room, then QMA 4 pulled Resident D out of the room. The DON indicated she observed Resident D start to swing at QMA 4, lost his balance and fell. The DON indicated post fall, she observed QMA 4 stand over Resident D and made a hand motion as is sscolding Resident D. Certified Nurse Aide (CNA) 2 and Registered Nurse (RN) 3 were interviewed on 2/7/24 at 10:44 AM. CNA 2 and RN 3 indicated Resident D had been agitated and resistant with care before. CNA 2 indicated she reapproached or provided distraction at times of Resident D's care resistance. CNA 2 also indicated alternate staff assisted with Resident D's care. CNA 2 and RN 3 indicated when Resident D was resistant with care, the staff were to let him be peaceful and let him do what he wanted as long as he was safe. Resident D's record was reviewed on 2/7/24 at 11:48 AM. Diagnosis included Alzheimer's disease, delusional disorders, muscle weakness and abnormalities of gait/mobility. Resident D's quarterly assessment, dated 1/17/24, indicated Resident D had a Brief Interview Mental Status score of 03/15 (severely impaired). Resident D's current care plan indicated Resident D had behaviors. Resident D's care plan interventions indicated to stop and return if agitated.			

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	A current policy, dated 2022, was provided by the DON on 2/7/24 at 11 AM. The policy indicated "abuse is a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." The policy indicated mistreatment included inappropriate treatment of a resident. This citation relates to Complaint IN00424824. 3.1-27(b)			