| 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 | 02/13/2023 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00400977.<br><br>Complaint IN00400977 - Substantiated. Deficiencies related to the allegations are cited at F689.<br><br>Survey dat: February 13, 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: 17<br>Total: 50<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 28<br>Other: 12<br>Total: 50<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quallity reivew completed February 15, 2023 | F 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective February 28, 2023. We respectfully request paper compliance for this survey resolution. | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Katie Robinson | Administrator | 02/27/2023 |

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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| | §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview and record review the facility failed to ensure the door alarm sounded loud enough to be heard in resident care areas to prevent a resident from exiting outside of the facility for 1 of 3 residents reviewed. (Resident B)<br><br>Findings include:<br><br>Review of the Facility's State Reportable Incident dated 2/3/2023 at 8:40 PM. indicated the incident involved Resident B. Resident B's diagnoses included dementia with agitation, stroke and aphasia. It was reported at approximately 8:38 P.M. Nurse 1 came out of a resident's room located around the corner from the front door. The report indicated Nurse 1 heard the front door alarm sounding and was going toward the front door when she met Nurse 2. Nurse 2 indicated she received a phone call reporting a resident in a wheelchair was outside on the drive on Sage Bluff Crossing by Aboite Center Road. The resident was located on the sidewalk by the parking lot and Sage Bluff crossing. Two nurses found Resident B in his wheelchair, dressed in 3 layers with long sweat pants and shoes on. Resident B's wander guard was in place. Resident B was resistant and combative when staff attempted to return him into the facility. Two other staff drove a car near the resident. The staff was able to coax the resident to get into the care, the resident was taken to the main entry and returned to his room.<br><br>A review of Resident B's records began at 10:00 A.M., diagnoses included dementia with agitation, cerebral infarction (stroke) and aphasia (disorder | F 0689 | Resident was placed on 1:1 monitoring immediately following the incident and continued on 1:1 monitoring until resident transfer on 2/6/2023. Resident's wife was notified of the incident and SSD discussed transfer to a secured unit for resident safety. Wife agreed but asked transfer to take place on Monday when a family member would be available to assist with transfer.<br><br>All residents are have the potential to be affected by the deficiency. All residents received elopement assessments, resident care plans and interventions were updated as needed. Additionally, although the alarm was working as it should, the sound the alarm made was not loud enough to be heard in resident care areas. On 2/4/2023 new alarms were installed at the front door with a loud 'screeching' sound that is audible in resident care areas.<br><br>New alarms were installed and staff were educated on the use of these alarms. Employees were also educated on the elopement policy. Elopement drills were conducted on all three shifts following the event to ensure retention of procedure and | 02/28/2023 |

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| | affecting ability to communicate, loss of language/speech) following a stroke. Review of a Quarterly MDS (Minimum Data Set) Assessment dated 1/21/2023 indicated Resident B did not have a BIMS (Brief Interview for Mental Status) due to refusal to participate. The staff assessment indicated the resident had memory problems, but was able to recall. During the assessment time, the resident did not have documented behaviors of wandering. The Functional Status indicated he required supervision for locomotion of 1 person. His range of motion was limited on one side of his upper extremities with no limitations for lower extremities. The assessment indicated he used a wheelchair.<br><br>A review of Resident B's physician's orders indicated on 2/3/2023 at 21:30 (9:30 P.M.) Ativan (to treat anxiety) 1 mg (milligram, a dose measurement) was to be given IM (intramuscularly) injection for severe agitation. On 2/4/2023 at 6:00 A.M., an order was given for a UA (urinalysis, a urine test) with C&S (culture and sensitivity, a test for type of infection) due to confusion. An order dated 5/22/2022 was given to place a Wanderguard check function and placement to wheelchair every shift for elopement risk. The Wandergaurd was noted to have an expiration date of 09/2024. An order was dated 2/4/2023 for the Wanderguard to be placed on the right ankle, placement and function were to be checked every shift. This Wandergaurd was noted to have an expiration date of 09/2024.<br><br>A review of Resident B's TAR (Treatment Administration Record) dated January 2023 and February 2023 indicated the placement and function was documented every 12-hour shift every day in January 2023 and February 2023. | | appropriate response.<br><br>The Administrator or designee will conduct elopement drills weekly x 4 weeks on all three shifts and monthly x 6 months on all three shifts. The Administrator or designee will audit door checks weekly x 4 weeks and monthly x 6 months to ensure alarms are armed and functioning properly. | |

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| | Review of Resident B's progress note dated 2/3/2023 at 21:29 (9:29 P.M.) indicated Ativan 1 mg was injected IM one time for Severe Agitation.<br><br>An event report dated 2/4/2023 at 00:01 (12:01 A.M.) indicated the immediate intervention was to bring the resident back to the facility. Vital signs on 2/3/2023 at 9:45 P.M. were 98.2 degrees, Oxygen saturation was 97% on room air, Blood Pressure 143/69, Pulse 72 with a regular rhythm, and Respirations 18. Resident had combative behavior. He was yelling, screaming, refusing assistance from staff, and grabbing the arms of staff. Resident B had full range of motion to all extremities. His neurological checks were with within normal limits (WNL). His skin was warm and dry, lung sounds were clear. No edema was noted, right and left pedal (foot) pulses were present. Resident B had been incontinent of bladder. Bowel sounds were present in all four quadrants of the abdomen. Resident B's family was notified, the Nurse Practitioner (NP) and DON (Director of Nursing) was notified. 15 minutes checks were initiated at 8:45 P.M. and were continued.<br><br>A Social Service (SS) note dated 2/4/2023 at 10:46 A.M., indicated the SS spoke with Resident B's family member regarding safety and recommended moving to a locked unit at their sister facility would be the best. The family member requested to wait until 2/6/23 when another family member to be available for the move.<br><br>A review of the Resident Observation/Monitoring Tool, indicated 1:1 moinitoring began at 9:30 PM on 2/3/2023 and continued 24 hours daily until 2/6/2023 at 1:00 PM when he was discharged to a sister facility with a secured unit. | | | |

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| | A review of staff statements indicated the following: Nurse 1's statement dated 2/3/2023 indicated when exiting room 118, she headed to the front door becasue the alarm was sounding. She met Nurse 2 on the 300/400 Hall and was informed there was a resident in a wheelchair heading out of teh building. Nurse 1 headed to the front door and nursing staff began room checks. Nurse 1 found Resident B in a wheelchair heading towards Sage Bluff Crossing, but was stopped by a citizen. The nurse attempted to redirect Resident B into the building but the resident became combative and refused to go back. Additional staff were notified while Nurse 1 remained with Resident B and prevented injury.<br><br>A review of Nurse 2's written statement dated 2/3/23, indicated Nurse 2 was called to the receptionist desk at approximately 7:25 P.M., to redirect Resident B back to his hall. At approximately 8:38 PM, she noticed Resident B exiting the front door and went to retrieve him when she met Nurse 1 in the hall. A person in the community called in and reported they saw a person outside in a wheelchair going towards the street. The Rehab Nurse started facility resident checks. Resident B was chatting with a man from the surrounding community. The resident was talking loudly and started to wheel off the sidewalk. One staff stood in front of the wheelchair. The other staff member went to get help. Nurse 2 assisted several staff to put Resident B into the van and take him back into the facility. A police officer arrived. He requested to speak to and see the resident. The police asked if everyone was alright and if Resident B needed to be transferred. Nurse 1 told him no, then the NP was notified.<br><br>A review of CNA 4's written statement dated | | | |

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| | 2/3/2023, indicated at approximately 8:45 P.M., Nurse 1 came down the hall informing the staff Resident B was outside. CNA 4 indicated when the alarm was triggered, she was in the middle of the 300 hall in a room doing care and didn't hear the alarm.<br><br>In an interview on 2/13/2023 at 11:55 A.M., Nurse 5 indicated he had worked at the facility for 3 months, was weekend supervisor and worked 12-hour shifts on Saturday, Sunday and Monday. He indicated he could hear the front door alarm sounding when he was at the nurses station. He indicated the tone of the alarm was higher and faster than the call lights. He indicated he front door alarm would sound when a resident with a wanderguard got near the door. He indicated they had been educated on elopement and have had elopement drills. He also indicated both nurses' stations had elopement books with residents identified at risk for elopement. He further indicated residents' with wanderguards are checked each shift and would be documented on the TAR.<br><br>In an interview On 2/13/2023 at 12:10 P.M., Nurse 6 indicated he had worked at the facility for 7 months. He indicated he was not working when Resident B eloped. He indicated he worked 12 hour shift 6:00 AM to 6:00 PM. He indicated the door alarm sounds in the 100 Hall nurses station and also sounds at the 200 Hall nurse's station. He indicated the alarm beeps differently than the call lights. He indicated the alarm would be hard to hear when in a resident room with the door closed. He also indicated when the door alarmed, staff would go to the door to check why is was going off. He indicated when a resident with a wander guard was near the door, the alarm would sound. There has to be a code entered to shut | | | |

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| | off the alarm. He indicated the residents with wanderguards are checked for function and documented in the resident's record. He indicated the facility had elopement drills on every shift.<br><br>In an interview on 2/13/2023 at 1:00 P.M., CNA 7 indicated she has worked at the facility for 7 years, was the scheduler and fills in on the units as needed. She indicated a new very loud alarm was put on the front door after Resident B went out. She indicated the new alarm was activated when the receptionist leaves at 7:00 P.M. She indicated the prior door alarm was no very audible, and staff could not have heard it when in a room. She indicated the alarm was similar to the call light. She indicated they have received education and do routine drills on elopement.<br><br>In an interview on 2/13/2023 at 2:30 P.M., the Administrator indicated she was notified when Resident B was found outside. She indicated the investigation of the incident has been completed and determined the door alarm was not loud enough to be heard on all units. She indicated the ADON assessed all residents for elopement and identified residents who were at high risk of elopement. She indicated the residents' orders were updated with wanderguards when placed. The Administrator indicated she had checked the security of all doors and windows in the facility. She indicated she had contacted a company to assess the alarm system, to equip all of the units with an audible and visual alarm when the door alarms were triggered. She indicated they had put a mounted alarm on the front entrance. The alarm had a screeching sound and could not be turned off without a key. She indicated Resident B had been very combative and was difficult to get to come back into the facility. The NP was notified and an order was given for an Ativan injection. | | | |

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| | When Resident B calmed down, he was assessed. He was placed on 1:1 observation until he was transferred to their sister facility on 2/6/23. The Administrator indicated Resident B's family member was notified and was in agreement for the transfer to the secured unit.<br><br>Review of the current facility policy, Elopement/Unauthorized Absence Policy, with a revision Date of 03/18/2022. The policy was provided by the Administrator on 2/13/2023 at 2:30 P.M., indicated, "...The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner...."<br><br>This Federal citation is related to Complaint IN00400977<br><br>3.1-45(a) | | | |