STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155827	A. BUILDING 00 B. WING	11/07/2024

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SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING FORT WAYNE, IN 46804

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00444425. Complaint IN00444425 - No deficiencies related to the allegations are cited. Survey dates: October 31, November 4, 6, & 7, 2024. Facility number: 013293 Provider number: 155827 AIM number: 20127309 Census Bed Type: SNF/NF: 34 SNF: 12 Total: 46 Census Payor Type: Medicare: 7 Medicaid: 31 Other: 8 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed November 8, 2024	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review the facility failed to report elopement in a timely manner for 1 of 1 residents reviewed. (Resident 199)	F 0609	We respectfully request paper compliance due to low scope and severity of the citations.	12/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Isaac Lenon	Administrator	11/21/2024

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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	Findings include: Resident 199's record was reviewed on 11/07/2024 at 10:15 AM. Diagnoses included cognitive communication deficit, muscle weakness, and dependence on renal dialysis. A review of Resident 199's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 10 (moderately impaired). A review of progress notes dated 10/26/2024 4:59 PM indicated the 200 hall door alarm was heard, Resident 199 was observed on the sidewalk outside, and staff immediately assisted resident back into facility. Resident 199 stated he was going to find his sister, was then given snacks and placed in a visible area. In an interveiw on 11/07/24 at 10:15 AM, the Administrator indicated the incident was not reported to the Indiana State Department of Health until 10/28/2024 A current policy dated 11/07/2024 provided by the Administrator indicated facilities are required to report incidents within 24 hours of occurrence to the Long Term Care Division. 3.1-28 (c)		**Element 1** It is the policy of this facility to report elopement events to the Administrator, DON, and attending physician immediately. Administrator can then report the event via the ISDH Gateway within 24 hours of the event occurring, in accordance with state regulation. On 10/29/2024, the elopement event for Resident #199 was reported by the Administrator via the ISDH Gateway. **Element 2** Residents who reside in the facility that have a BIMs score less than 12 will have an Elopement Evaluation Observation completed and residents identified to be at risk for elopement will be reviewed by the Social Worker to ensure they have effective interventions in place to address and manage the risk for elopement. This audit along with identified corrections will be completed by the Social Worker on or before 12/2/24 utilizing the Elopement Audit Tool (Attachment F) **Element 3** On 11/7/2024 the Administrator and Director of Nursing was educated by the Regional Director of Clinical Services on the Indiana Resident Abuse Policy (Attachment E) to review reporting requirements of abuse and	

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			elopements to applicable local and state agencies. The current facility policy titled "Elopement/Unauthorized Absence Policy" (Attachment A) was reviewed and remains appropriate. Staff to be educated by Administrator or Designee on policy with an emphasis on reporting expectations. This education will be complete on or before 12/2/24. **Element 4** Using the "Reporting Audit Tool" (Attachment B), reportable events will be audited by the Regional Nurse for timeliness of reporting weekly for 4 weeks then monthly for 5 months. Findings will be reviewed monthly in QAPI meeting.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on interview and record review, the facility failed to ensure non-pharmacological interventions were attempted before administering (PRN) as needed pain medication for 1 of 2 residents reviewed (Resident 5). Findings include: A record review began on 11/6/24 at 9:41 AM for Resident 5. Diagnoses included unspecified dementia, mild with psychotic disturbance. A review of the physician orders indicated to give Percocet (oxycodone-acetaminophen)-Schedule II	F 0697	**Element 1** Resident specific non-pharmacological interventions were added to Resident 5's PRN pain medication orders on 11/11/24 by DON. Pain care plan updated by DON to include resident specific non-pharmacological interventions. **Element 2** Residents with orders for PRN pain medication had the potential to be affected. An audit of PRN	12/02/2024

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	tablet; 5-325 milligrams (mg); 1 tablet oral severe pain 7-10. Do not exceed 3 grams/24 hours every 8 hour- as needed (PRN) start date 9/10/2024. There were no other physician orders to indicate non-pharmacological interventions were to done before administering the PRN medication. A review of the current care plan, edited on 10/17/2024, indicated the focus was: Resident 5 has pain/potential for pain related to color cancer, fibromyalgia. The Goal was: the resident (capitalize only if the identifier follows the word resident) will verbalize reduction of pain through next review date. The approach was: Handle gently and try to eliminate any environment stimuli. Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviation factors, aggravating factors. Monitor and record any non-verbal signs of pain: crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal. Position for comfort with physical support as necessary. There were no personalized care plans related to non-pharmacological interventions for Resident 5. A review of vitals sign- pain scale indicated the following: The last recorded pain rate was dated 7/13/2024: 0 of 10. A review of the Medication Administration Record indicated the following: Dated August 2024: On the following dates PRN (as needed) pain medication was given: 8/6, 8/14, 8/19, 8,25. On 8/6, 8/14, and 8/19, the MAR did not indicate non-pharmacological interventions were attempted before administering the PRN pain		pain medications for non-pharmacological interventions using “Pain Management Audit Tool” (Attachment G) along with identified corrections will be completed by DON. This audit will be completed by 12/2/24. **Element 3** Nurses will be educated by the DON or designee on the Pain Management Policy with a focus on providing and documenting non-pharmacological interventions prior to administering PRN pain medications (Attachment H).This education will be completed on or before 12/2/24. **Element 4** Residents with PRN pain medication orders will be audited for non-pharmacological interventions by the DON or designee weekly for 4 weeks and monthly for 5 months utilizing the Pain Management Audit Tool (Attachment G). Findings will be forwarded to QAPI Committee for review.	

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	medication. 8/25 indicated non-pharmacological interventions were attempted and were not successful. Dated September 2024: On the following dates PRN pain medication was given: 9/3, 9/7, 9/8, 9/16, 9/21, 9/25, 9/26. There was no documentation to indicate non-pharmacological interventions were attempted before administering PRN. Dated October 2024: On the following dates PRN pain medication was given: 10/9, 10/10, 10/23. There was no documentation to indicate non-pharmacological interventions were attempted before administering PRN. A review of the progress notes from 7/1/24 to 11/6/24 indicated there was no documentation to indicate attempts of non-pharmacological interventions were made. In an interview, on 11/06/24 at 10:25 AM, the Director of Nursing (DON) indicated, the staff are supposed to be attempting non-pharmacological interventions and documenting. If there is no documentation in the progress notes then non pharmacologic attempts weren't documented. A current facility policy, Pain Management policy, dated 8/1/2024, was provided by the DON on 11/6/24 at 12:11 PM. The policy indicated..."Pharmacological and non-pharmacological interventions used in the past to address pain and the efficacy of such interventions. This will include use of opioids and any history opioid use disorder (OUD) and/or medication assisted treatment for OUD...Non-pharmacological intervention(s) will be attempted prior to the administration of PRN pain medications. If non-pharmacological			

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	intervention(s) fail(s) then when multiple PRN medications are available with corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the PRN order...." 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on interview and record review the facility failed to ensure communication with dialysis center for 1 of 2 patients reviewed. (Resident 30) Findings include: A record review for Resident 30 began on 11/01/24 at 09:42 AM. Resident 30's diagnoses included dependence on renal dialysis, hepatic encephalopathy, kidney failure, cirrhosis of the liver, and general weakness. Resident 30's orders included- Dialysis communication tool completed and sent with resident (dated 8/29/24) , Dialysis Monday, Wednesday, and Friday (dated 5/11/24), renal diet (dated 5/13/24), and Check fistula every shift (dated 5/17/24). The dialysis communication book was reviewed. Within the book the current orders, emergency contact, and care plan were present, as well as blank communication forms. Within the book the following documentation was discovered: Dated 9/19/24, a communication form from End-Stage Renal Disease Disease Network Program) IPRO with the section blank from nursing home center related to resident mental	F 0698	**Element 1** Resident #30 had a dialysis communication observation completed by licensed nurse and dialysis center on 11/8/2024. Resident #30 suffered no ill effects related to incomplete dialysis communication observations. **Element 2** Current residents and new admissions requiring dialysis have the potential to be affected. The DON or designee will complete an audit along with identified corrections using the "Hemodialysis Audit Tool" (Attachment J) for residents requiring dialysis. Audit and corrections will be complete by 12/2/2024. **Element 3** Licensed Nurses will be educated by the DON or designee using the "Hemodialysis Care Policy" (Attachment I) with a focus on communication with the dialysis center by 12/2/2024.	12/02/2024

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	status. From the dialysis center the section of amount of fluid removed, meal consumption, and any medications given were not completed. Dated 9/20/24, an observation tool form from Sage Bluff, section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center not completed included time of discharge, and fluid removed. Dated 9/23/24, an observation tool form from Sage Bluff, section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center not completed included time of discharge, pre dialysis weight, post dialysis weight, fluid removed, most recent vital signs, labs drawn, follow up orders, appointments made, medications/treatments given at dialysis, significant alerts/communication, and dialysis nurse signature. Dated 9/23/24, a communication form from End-Stage Renal Disease Disease Network Program) IPRO with the section blank from nursing home was blank From the dialysis center the section of updated doctor orders, did dietician make any recommendations, did social worker make recommendations, food/fluid consumed during dialysis, meal consumption, vascular access condition, and dialysis nurse signature. Dated 9/25/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned.		**Element 4** DON or Designee will audit dialysis communication using the "Hemodialysis Audit Tool" (Attachment J) weekly for 4 weeks and monthly for 5 months. Findings will be forwarded to the QAPI committee for review and recommendation.	

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	The section from dialysis center not completed included time of discharge, pre dialysis weight, post dialysis weight, fluid removed, most recent vital signs, labs drawn, follow up orders, appointments made, medications/treatments given at dialysis, significant alerts/communication, and dialysis nurse signature. Dated 10/02/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from the dialysis center not completed included time of discharge, labs drawn, follow up orders, appointments made, medications/treatments given at dialysis, significant alerts/communication, and dialysis nurse signature. Dated 10/04/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center not completed included fluids removed, labs drawn, follow up orders, appointments made, significant alerts/communication, and dialysis nurse signature. Dated 10/09/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from the dialysis center was completed entirely. Dated 10/11/24, an observation tool form from			

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	Sage Bluff was completed other than was dialysis chair cleaned. The section from the dialysis center was without documentation. Dated 10/14/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center was not completed; the dialysis center communication portion was blank. Dated 10/16/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center was not completed; the dialysis center communication portion was blank. Dated 10/18/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center was not completed; the dialysis center communication portion was blank. Dated 10/21/24, an observation tool form from Sage Bluff; section from nursing center included significant alerts/communication and dialysis chair cleaned. The diet section indicated resident was on a regular diet. The section from the dialysis center was completed. Dated 10/23/24, an observation tool form from Sage Bluff; section from nursing home not			

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	completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from the dialysis center was completed. Dated 11/04/24, an observation tool form from Sage Bluff; section from nursing home not completed included significant alerts/communication, needs meal, needs snack, n/a, diet, fluid restriction, amount allowed per day, dialysis chair cleaned. The section from dialysis center was not completed; the dialysis center communication portion was blank. In an interview on 11/06/24 at12:49 PM, the Director of Nursing (DON) and Regional Nurse Consultant; the DON indicated the forms should have been filled out in their entirety. The Regional Nurse Consultant indicated when dialysis did not return forms completed, the dialysis center should have been contacted and information requested. The request should have been documented in Resident 30's chart. A policy and procedure titled "Hemodialysis Care Policy", dated 6/16/17 last revised 8/24/23 provided by the DON on 11/6/24 at 2:19PM; indicated ...Communication between the dialysis provider and facility staff will occur before and after each hemodialysis treatment and as needed ... 3,1-37(a)			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns Based on observation, interview, and record review the facility failed to manage behaviors for 1	F 0742	**Element 1** Resident 14 and Resident 40 were	12/02/2024

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	of 8 residents reviewed. (Resident 40). Findings include: During an observation, on November 1, 2024, at 9:31AM, Resident 40 was pbserved grabbing at the Administrator's wrist while he was standing in the hall speaking and walking with her. The Administrator then held her hand and continued to walk with her down the hall. This behavior was not documented. During a continuous observation and interviews, on November 4, 2024, from 7:02AM through 8:11AM, during 300 hall medication pass; observed Resident 40 grabbing the right wrist of Resident 14 more than 10 times. Resident 40 grabbed Resident 14's inner right thigh once while in the presence of the Licensed Practical Nurse (LPN4). LPN 4 did not intervene to prevent Resident 40 from grabbing Resident 14. The observation occurred at the end of 300 hall within eyesight of the nursing desk with several various staff sitting, as well as coming and going from the area. The two residents were sitting at a table within arm's reach of each other; at a 90-degree angle. Resident 40 was in a wheelchair and visibly able to manipulate and move without difficulty. Resident 14 was in an anti-tilt wheelchair with breaks locked, pulled up to the table, with nothing in her lap, facing the wall. There was nothing on the table and no activities. Resident 14's shoulders curved in, her body leaned forward slightly, and her hands were kept in a "C" shape position. Resident 40 continued to reach over and grab Resident 14's right inner wrist and at times was pulling the arm near her while talking to Resident		separated from each other on 10/29/24 at 8:00 AM by the Director of Nursing. Resident 14's skin was assessed on 10/29/24 by the Assistant Director of Nursing with no negative findings from the behavior. **Element 2** Residents residing at the facility have the potential to be affected by other residents' behaviors. Current residents who reside in the facility will be reviewed by the Social Worker to identify current residents with behaviors and ensure they have resident specific interventions in place to address and manage the identified behavior. Utilizing the Behavior Management Audit Tool (Attachment C). This audit, along with identified corrections, will be completed on or before 12/2/24 by the Social Worker. **Element 3** Staff will be educated by the Social Services Director or Designee on the Behavior Management Program Policy (Attachment D). This education will be complete on or before 12/2/24. **Element 4** To monitor and maintain ongoing compliance, the Social Service Director or Administrator will complete weekly audits for 4 weeks them monthly for 5 months	

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	14. The right wrist grabbing occurred 6 times prior to escalating to right inner thigh grabbing. The behavior was redirected by staff after the behavior was pointed out to them. In an interview, on November 1, 2024 at 8:15 AM, Resident 40 explained she was working with Resident 14 on her mobility during these behaviors and making progress. Resident 40 showed pride in Resident 14's perceived progress. Resident 14 did not make any sound, movement, or pull away during these interactions. During this interview Resident 40 indicated Resident 14 loved to be touched, especially in specific places. Resident 40 used her hand to indicate an area on her thighs. During Resident 14's medication administration by LPN 4; Resident 40 reached over and grabbed Resident 14's inner right thigh above the knee. Resident 14 immediately turned her head to Resident 40. Resident 14's face was grimaced and angry in presentation. Resident 14 did not make any noise or say any words. LPN 4 redirected Resident 40 to keep her hands to herself and respect Resident 14's personal space. Resident 40 removed her hand from Resident 14's inner thigh. Resident 40 went on to grab Resident 14's right wrist more than 4 additional times with verbal redirections following each grab given by LPN 4. During an attempted grab LPN 4 offered Resident 40 her own hand to hold and Resident 40 refused. LPN 4 attempted to ask Resident 14 twice if she consented to having Resident 40 "holding her hand" and Resident 14 did not answer despite being given extended periods of time to form words. During an interview, on November 1, 2024 at 8:24 AM, LPN 4 indicated Resident 14 was mainly		utilizing the Behavior Management Audit Tool (Attachment C) to ensure resident specific interventions are in place to address and manage the identified behavior. The results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

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(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
	nonverbal and slow to move most of the time. LPN 4 indicated Resident 14 did speak a few words intermittently. LPN 4 explained Resident 14's speech was slow and soft. LPN 4 indicated Resident 14 could not purposefully move in the wheelchair throughout the facility and would be unable to move away Resident 40 on her own. During an observation, on November 1, 2024 at 8:25 AM, LPN 4 assessed Resident 14's wrist and indicated it was bruised. LPN 4 was unable to find prior documentation of bruising noted. LPN 4 indicated Resident 40 did not mean any harm to Resident 14 and therefore did not consider the hand holding a behavior. A record review for Resident 40 began on 11/01/24 at 10:26 AM. Resident 40's diagnoses included dementia and depression. Resident 40's Minimal Data Set (MDS) assessment, dated 10/14/24, indicated the following: Under Section C Brief Interview for Mental Status (BIMS) her mental status score was a 3, the score of 3 indicated severe cognitive decline. Under Section E Behavior indicated a score of zero to indicate Resident 40 had no behaviors. The assessment was scored zero for the question of physical behavior of physical behavior towards others (e.g. hitting, kicking, scratching, grabbing, abusing others sexually). Resident 40's care plan did not directly address behaviors. A record review for Resident 14 began on 11/06/24 at 09:41 AM. Resident 14's diagnoses included			

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	155827	A. BUILDING 00 B. WING	11/07/2024

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	osteoporosis, degenerative disease, dementia, muscle weakness, and dysphagia. Resident 14 was care planned for ADL function status with a goal of. "Resident will show no decline in function to bilateral lower extremities as evidenced by ability to rotate feet in and out, move feet up and down, rotate legs up and down." The care plan clearly indicated Resident 14 had issues with mobility. Resident 14 was care planned for Skin Integrity approaches included pressure reducing cushions to wheelchair, pressure reducing mattress to bed, and handle resident with care. The care plan clearly indicated Resident 14 had issues with skin integrity. In an interview, on November 4, 2024, at 1:39PM, the Director of Nursing (DON), indicated Resident 40 had no behavior tracking due to the fact she had no behaviors. The DON indicated the bruising on Resident 14's right wrist should have been documented in physician ordered weekly skin assessments. The DON indicated the bruising was from a blood test performed on 10/16/24, 19 days prior to the observation of behavior and bruising. In an interview on 11/6/24 at 12:46PM, the DON and the Regional Nurse Consultant indicated the behavior was overlooked as handholding and no harm or ill intent was intended. A policy and procedure titled, 'Behavior Management Program" dated 3/1/2013 and last revised on 5/15/24, provided by the Administrator on November 7, 2024 at 9:08AM indicated ...The Facility will assess and track a behavior(s) that negatively impacts each resident in regards to			

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	their quality of life... 3.1-43(a)(1)			