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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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 Bldg. 00	This visit was for the Investigation of Complaints IN00438417 and IN00439226. Complaint IN00438417 - Federal/State deficiencies related to the allegations are cited at F600 and F609 . Complaint IN00439226 - Federal/State deficiencies related to the allegations are cited at F699 . Survey date: July 23, 2024 Facility number: 013293 Provider number: 155827 AIM number: 201273090 Census Bed Type: SNF/NF: 39 SNF: 9 Total: 48 Census Payor Type: Medicare: 3 Medicaid: 36 Other: 9 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complted July 25, 2024	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Isaac Lenon	Administrator	08/05/2024

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.

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	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 observation, interview and record review, the facility failed to protect a resident's right to be free from physical abuse by staff for 1 of 3 residents reviewed (Resident Q). The deficient practice was corrected on 7/11/24 prior to the start of the survey and was therefore past non-compliance. Findings include: An Indiana Department of Health (IDOH) incident report, submitted by the facility on 7/9/24 at 9:37 p.m., indicated an altercation between a resident and staff member had occurred. The resident had no apparent injury and the staff member was suspended pending investigation. The follow-up report, indicated on 7/9/24 at 9:15 p.m., Employee 2 notified the Administrator, she had witnessed Employee 5 slap Resident Q in the face while being pulled up in her wheelchair. Employee 2, Employee 3, and Employee 5 had been attempting to reposition the resident due to sliding down and potential for her to fall from the chair. The resident became combative during positioning and struck Employee 5 on the face, then Employee 5 struck Resident Q with an open hand. Resident Q was	F 0600	Past Non-Compliance, no POC required per 2567	08/05/2024

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	assessed for injury and none were observed. Employee 2, Employee 3, and Employee 5 were suspended on 7/10/24. The investigation was conducted, the local police department and resident's guardian were notified of the incident. Following the facility's investigation, Employee 5 was terminated for striking the resident. On 7/23/24 at 12:54 P.M., Resident Q's record was reviewed. Diagnoses included brain damage due to trauma, major depressive disorder, dependence on wheelchair, and abnormal posture. A quarterly MDS (Minimum Data Set) assessment, dated 7/4/24, indicated Resident Q had severely impaired cognition. She'd had no behaviors, moods, or signs of delirium. She was dependent on staff for all her ADL's (Activities of Daily Living) except eating. Care plans included: -Dated 11/17/23: The resident displayed behaviors of throwing food at others, striking others during care, when in the hall and dining room, and placed her feet on tables. The goal was for her to be free of behavioral outbursts or unusual behaviors daily. Inventions were: administer medications as ordered; allow resident to vent feelings and thoughts; approach in a calm, relaxed manner; attempt to reduce stressors; and do not place her within reach of other residents. -Dated 12/22/22, the resident had a past history of trauma and abuse. The goals were for her to display a positive affect and to not exhibit signs of isolation. Interventions included: remove her from negative stimuli and report signs of isolation. On 7/23/24 at 11:10 A.M., Employee 2 was			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	interviewed. She indicated, on 7/9/24 at approximately 8:30 a.m., she observed Resident Q sliding down in her wheelchair and she didn't want her to fall. Employee 2 summoned Employee 3, also in the dining room, to assist her to pull the resident up in her chair. Both tried but were unable to pull her up themselves. Employee 5 went to assist Employee 2 and Employee 3 to pull up the resident. Employee 2 was on the resident's right side, Employee 3 on her left side and Employee 5 was behind the resident's chair by the residents head. They attempted to pull her up in the chair when the resident raised her right arm and hand over her head and hit Employee 5 in the face. They attempted again to pull her up. Employee 2 saw Employee 5 slap Resident Q on her cheek and say something to the resident but didn't hear what she'd said. The resident didn't react to the slap on her cheek nor appear distressed. Employee 2 left the area and continued with her job duties. She indicated, as the day went on and she thought more about what had occurred, she became uncomfortable and believed what Employee 5 had done was wrong and needed to be reported to the Administrator. After leaving for the day and later into the evening, she contacted the Administrator and told him of the incident which had occurred that morning (7/9/24). Employee 2 indicated staff should never retaliate by slapping or hitting a resident in response to their behaviors and she regretted not reporting the incident immediately. On 7/23/24 at 1:45 P.M., Resident Q was observed awake and lying in her bed. Her face was observed to be relaxed without signs of distress or discomfort. She smiled and held her hand out as a greeting. She was non-verbal but shook her head yes or no when asked questions. When asked if staff were kind to her and if she felt safe			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	here, she shook her head yes to both questions. On 7/23/24 at 3:20 P.M., the Administrator and DON (Director of Nursing) were interviewed. Both indicated Employee 2 and Employee 3 were suspended on 7/10/24 for not reporting the incident immediately. Employee 5 was suspended, then terminated for striking the resident in the face. The DON indicated the resident had no observed physical effects from the incident nor had her mood changed or behaviors increased. Resident Q was being monitored for psychosocial effects and was being followed closely by the psychiatric Nurse Practitioner (NP) for any changes. A current facility policy, titled "Indiana Resident Abuse Policy", was provided by the Administrator on 7/23/24 at 10:20 A.M. and stated: "This facility will not tolerate abuse, neglect, mistreatment, exploitation of resident, and misappropriation of resident property by anyone...Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy...." The past non-compliance deficiency began on 7/9/24 and deficient practice corrected on 7/11/24 after the facility suspended the 2 employees for not reporting immediately, terminated employment of the employee involved in the incident, reported the incident to local law authorities and IDOH as required. Resident Q was observed for injury and monitored for psychosocial distress related to the incident. On 7/10/24, the facility took steps to identify other residents with the potential to be			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	affected by completing interviews on all interviewable residents, skin assessments on non-interviewable residents, and reviewed 72 hours of documentation on all residents with none exhibiting combative behaviors. There were no negative findings. All staff were educated on the facility abuse policies and caring for residents with combative behaviors on 7/11/24. To ensure ongoing compliance, staff and residents would be interviewed and skin assessments completed on non-interviewable residents weekly x 4 then monthly x 5 to ensure the facility remained free of abuse. This tag relates to Complaint IN00438417. 3.1-27(a)(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report timely, physical abuse of 1 of 3 residents reviewed for abuse reporting (Resident Q). The deficient practice was corrected on 7/11/24 prior to the start of the survey and was therefore past non-compliance. Findings include: An Indiana Department of Health (IDOH) incident report, submitted by the facility on 7/9/24 at 9:37 p.m., indicated an altercation between a resident and staff member had occurred. The resident had no apparent injury and the staff member was suspended pending investigation. The follow-up report, indicated on 7/9/24 at approximately 8:30 a.m., Employee 2, Employee 3, and Employee 5 had been attempting to reposition the resident due to sliding down and potential for her to fall from the chair. The resident became combative while positioning her and struck Employee 5 on the face, then Employee 5 struck the resident in the face with an open hand. Employee 2 nor Employee 3 reported the abuse until after 8:00 p.m. on 7/9/24, when Employee 2 contacted the Administrator. On 7/23/24 at 12:54 P.M., Resident Q's record was	F 0609	Past Non-Compliance, no POC required per 2567	08/05/2024

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	reviewed. Diagnoses included brain damage due to trauma, major depressive disorder, dependence on wheelchair, and abnormal posture. A quarterly MDS (Minimum Data Set) assessment, dated 7/4/24, indicated the resident had severely impaired cognition. She'd had no behaviors, moods, or signs of delirium. She was dependent on staff for all her ADL's (Activities of Daily Living) except eating which she had done independently. Care plans included: - Revised 7/18/24: The resident displayed behaviors of throwing food at others, striking others during care, when in the hall and dining room, and placed her feet on tables. The goal was for her to be free of behavioral outbursts or unusual behaviors daily. Inventions were: administer medications as ordered; allow resident to vent feelings and thoughts; approach in a calm, relaxed manner; attempt to reduce stressors; and do not place her within reach of other residents. -Revised 7/10/24, the resident had a past history of trauma and abuse. The goals were for her to display a positive affect and to not exhibit signs of isolation. Interventions included: remove her from negative stimuli and report signs of isolation. On 7/23/24 at 11:10 A.M., Employee 2 was interviewed. She indicated, on 7/9/24 at approximately 8:30 a.m., she observed Resident Q sliding down in her wheelchair in the dining room and she didn't wanted her to fall. Employee 2 summoned Employee 3, to assist her to pull the resident up in her chair. Both tried but were unable to pull her up themselves. Employee 5 went to assist Employee 2 and Employee 3 to pull			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	up the resident. Employee 2 was on the resident's right side, Employee 3 on her left side and Employee 5 was behind the resident's chair by the residents head. The staff attempted to pull her up in the chair when the resident raised her right arm and hand over her head and hit Employee 5 in the face. The staff attempted again to pull the resident up. Employee 2 saw Employee 5 slap Resident Q on her cheek and say something to the resident but didn't hear what she'd said. The resident didn't reacted to the slap on her cheek nor appear distressed. Employee 2 left the area and continued with her job duties. She indicated, as the day went on she thought more about what had occurred. She became uncomfortable, believed what Employee 5 had done was wrong and needed to be reported to the Administrator. After leaving the facility, later in the evening, she contacted the Administrator, told him of the incident, and the incident had occurred that morning (7/9/24). Employee 2 indicated staff should never retaliate by slapping or hitting a resident in response to their behaviors and she regretted not reporting the incident immediately. On 7/23/24 at 3:20 P.M., the Administrator and DON (Director of Nursing) were interviewed. Both indicated Employee 2 and Employee 3 were suspended on 7/10/24 for not reporting the incident immediately. Employee 5 was suspended and then terminated. A current facility policy, titled "Indiana Resident Abuse Policy", was provided by the Administrator on 7/23/24 at 10:20 A.M. and stated: "This facility will not tolerate abuse, neglect, mistreatment, exploitation of resident, and misappropriation of resident property by anyone...Facility staff must immediately report all such allegations to the Administrator/Abuse			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	Coordinator. ...." The past non-compliance deficiency began on 7/9/24 and deficient practice corrected on 7/11/24 after the facility suspended the 2 employees for not reporting immediately, reported the incident to local law authorities and IDOH as required. Resident Q was observed for injury and monitored for psychosocial distress related to the incident. On 7/10/24, the facility took steps to identify other residents with the potential to be affected by completing interviews on all interviewable residents, and reviewed 72 hours of documentation on all residents with no further need for reporting noted. All staff were educated on the facility abuse policies, including immediate reporting of abuse on 7/11/24. To ensure ongoing compliance, staff and residents would be interviewed and reports to IDOH and other authorities as needed weekly x 4 then monthly x 5 to ensure the facility reported abuse within 24 hours. This tag relates to Complaints IN00438417. 3.1-28(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review, the facility failed to ensure triggers were identified and	F 0699	We respectfully request paper compliance due to low scope and	08/05/2024

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	resident specific approaches implemented in providing trauma informed care for 1 of 1 residents reviewed (Resident Q). Findings include: On 7/23/24 at 12:54 P.M., Resident Q's record was reviewed. Diagnoses included brain damage due to trauma, major depressive disorder, dependence on wheelchair, and abnormal posture. A quarterly MDS (Minimum Data Set) assessment, dated 7/4/24, indicated Resident Q had severely impaired cognition. She'd had no behaviors, moods, or signs of delirium. She was dependent on staff for all her ADL's (Activities of Daily Living) except eating. Care plans included: -Initiated 11/17/23 and revised 7/18/24: The resident displayed behaviors of throwing food at others, striking others during care, when in the hall and dining room, and placed her feet on tables. The goal was for her to be free of behavioral outbursts or unusual behaviors daily. Inventions were: administer medications as ordered; allow resident to vent feelings and thoughts; approach in a calm, relaxed manner; attempt to reduce stressors; and do not place her within reach of other residents. -Initiated 12/22/22 and revised 7/10/24, the resident had a past history of trauma and abuse. The goals were for her to display a positive affect and to not exhibit signs of isolation. Interventions included: remove her from negative stimuli, report signs of isolation, attempt to identify any activities which would help decrease negative symptoms of past trauma.		severity of the citation. Element 1 On 7/10/24 Resident Q was evaluated via telehealth by the psych NP and had no negative psychosocial impact related to the incident. Resident continues at baseline. The trauma care plan for Resident # Q was reviewed and updated by the Social Services Director on 8/2/24 to ensure it contained appropriate interventions for the resident. Element 2 Like Residents are identified as residents residing at the facility who have a history of a traumatic event. Identified like residents will be audited utilizing the Trauma Informed Care Audit Tool (Attachment A) by the Social Service Director to ensure their trauma care plan is in place with accurate interventions. This audit along with identified corrections, will be completed on or before 8/5/24. Element 3 To prevent recurrence, the following systemic changes will be implemented to promote, protect and improve the health and safety of residents with a known past traumatic event. On 7/29/24 the Regional Director of Clinical	

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	On 7/23/24 at 10:25 AM., Resident Q's guardian was interviewed. The guardian indicated the resident had a long history of trauma and abuse which led to her current and permanent condition. The guardian had been appointed to make decisions about her care needs and to ensure the resident's safety. She indicated due to the alleged severe trauma and abuse suffered by the resident, she needed to remain in a safe place where the abusers could not gain access to her. There was a visitor statement, provided to staff, with names and pictures of persons not allowed to visit. If anyone else were to try and visit, they weren't allowed until the guardian was contacted. She indicated she visited the facility at odd times to check on the resident's care and when came in after hours, she would ring the doorbell and just be allowed in despite there being no staff at the front desk or lobby. A family member, not on the visitor list, had recently visited after hours and was let into the facility without being questioned or the guardian notified and she was concerned for the resident's continued safety in the facility. The guardian indicated the resident had been hit by a staff member on 7/9/24 and she hadn't been notified until the following day. She indicated, she was told the staff member had been helping to move the resident up in her chair and the resident hit out at the staff member who then hit the resident back in her face. The resident may have been startled when the staff member had come up behind her to pull her up and in defense, hit out at the staff member due to the type of abuse she'd been through in the past (strangulation). She indicated the resident was mostly non-verbal and at times, would respond with shaking her head yes or no, but her behaviors, at times, were her only way of communicating with others.		Services provided education to the Administrator and Social Services Director on the requirements of F699 Trauma Informed Care. The Administrator and/or Social Services Director will educate facility staff on the requirements of F699 Trauma Informed Care. This education will be completed on or before 8/5/24. Element 4 Utilizing the Trauma Informed Care Plan Audit Tool (Attachment A) the Social Services Director or Administrator will audit residents with a known history of trauma to ensure the trauma care plan is in place along with appropriate interventions. This audit will be completed weekly x 4 weeks followed by monthly x 5 months. Findings of the audit will be sent to QAPI Committee for review.	

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	On 7/23/24 at 1:45 P.M., Resident Q was observed awake and lying in her bed. Her face was observed to be relaxed without signs of distress or discomfort. She smiled and held her hand out as a greeting. She was non-verbal but shook her head yes or no when asked questions. When asked if staff were kind to her and if she felt safe here, she shook her head yes to both questions. On 7/23/24 at 3:05 P.M., Nurse 6 and Nurse 7, assigned to care for Resident Q, were interviewed. Both indicated the resident could have visitors and weren't aware of any restrictions. When questioned, Nurse 6 indicated the resident at times, would be combative when staff were providing care. Both indicated they had heard the resident had a history of abuse but weren't aware of what had happened, triggers to prevent re-traumatization, or interventions to put in place when she had behaviors. Neither was aware of the visitor restrictions to prevent the residents abusers from coming in to see her. The care plan didn't indicate what triggers staff should avoid to prevent the resident from being retraumatized, lashing out or approaches to keep the resident safe from persons who abused and traumatized her by screening visitors. On 7/23/24 at 3:45 P.M., the Director of Nursing indicated the facility had no policy specific for trauma informed care but provided a current copy of the facility policy, titled "Social Services Policy" which stated: "The facility provides social services to assure that each resident can attain or maintain his/her highest practicable, physical, mental and/or psychosocial well-being...Social Services will assist in implementing interventions for the resident's needs by developing and maintaining care plans which are individualized,			

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	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING 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
	realistic, with measurable goals, including, but not limited to...Trauma, PTSD (Post Traumatic Stress Disorder...and be Responsible for assessing and ensuring residents who are trauma survivors receive culturally competent, trauma-informed care/approaches including: psychiatric referrals as needed, identifying triggers and implementing approaches/interventions to help reduce risk of retraumatization...." This tag relates to Complaint IN00439226.			