STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155827	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING FORT WAYNE, IN 46804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0603 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were not secluded to their rooms for 6 of 6 residnets reviewed. (Resident B, Resident C, Resident D, Resident L, Resident M, and Resident N) Findings include: On 7/2/2020 at 2 p.m., no residents were observed in the Main Lobby lounge. On 7/6/2020 at 12:22 p.m., no residents were observed on the 300 and 400 hall, and there were no residents in the TV lounge across from the nurses station. On 7/6/2020 at 12:24 p.m., no residents were observed on the 100 hall and there were no resident's in the TV lounge across from the 100 hall nurses station. 1. A review of Resident B's record on 7/6/2020 at 1:10 p.m., indicated a BIMS (Brief Interview of Mental Status) score of 15 out of 15, meaning cognitively intact. The score was obtained from the MDS (Minimum Data Set) Quarterly Assessment, dated 4/13/2020. [DIAGNOSES REDACTED]. A Progress Note, dated 6/26/2020 at 10:59 a.m., indicated the resident continued to refuse all care and told staff to get out and leave him alone. A Progress Note, dated 6/25/2020 at 4:17 p.m., indicated the resident was refusing medications and care. He would yell at staff to get out. A Social Service Note, dated 6/24/2020 at 10:22 p.m., indicated Resident B was upset and had barricaded himself in his room. The resident would not talk to the SSD (Social Service Director). A Progress Note, dated 6/2/2020 at 4:11 p.m., indicated the resident's mood was irritable, angry, anxious, and was easily annoyed due to the continued facility restrictions. On 7/6/2020 at 12:25 p.m., Resident B was observed in his room, sitting in his wheelchair, working on his computer. During an interview on 7/6/2020 at 12:30 p.m., Resident B indicated the residents have been confined to their rooms for months. He indicated when they would go out into the hall way, they were told by staff to go back to their room. He indicated on 6/24/2020 he was informed by the staff that he was not allowed to go outside to the front parking lot after supper. On 6/26/2020, Resident B indicated it was a Friday, the ED (Executive Director) came to his room and informed him he was not allowed to go outside because of the State and CDC (Centers for Disease Control) rules. Resident B indicated this made him mad. The ED had further told the resident that the nursing staff was not allowed to take any residents to the courtyard either. Later that same day, the ED came back to Resident B's room and informed him that only he could go out to the courtyard. Resident B indicated this was not a solution for several reasons, the courtyard doors were always locked, and all the other residents would see him in the courtyard while they all were confined to their rooms. On 5/27/2020 Resident B received an email to participate in the Fairbank's Covid testing from the Governor, the staff would not let him go to the testing, and indicated that the test was experimental, and not medically necessary. Resident B indicated on 7/5/2020 he went out front in his motorized chair, and was informed he had to come back inside by a staff member. He then indicated the ED came to the facility and told him if he went outside again he would call the police. Resident B indicated he was being an advocate for all the other residents who were confined to their rooms, and he wanted to do what was right. On 7/6/2020, at 1:05 p.m., all doors to the courtyard were observed as being unlocked. During an interview on 7/6/2020 at 3:15 p.m., Employee 8 indicated on 7/5/2020 they were instructed by the ED to bring Resident B back inside the facility, and that he was only allowed to go into the courtyard. Employee 8 indicated the courtyard was never unlocked, therefore not easily accessible. Employee 8 further indicated they were instructed to call law enforcement should Resident B go outside again. 2. Resident C was identified by the facility as being alert, oriented, and interviewable on 7/6/2020. During an interview on 7/6/2020 at 4:42 p.m., Resident C indicated they wanted to get out of their room, but were only allowed to go as far as the door of their room. They further indicated if they were to go in the hall way, they would be told to go back to their room. Resident C also indicated they would like to go outside. 3. Resident D was identified by the facility as being alert, oriented, and interviewable on 7/6/2020. During an interview on 7/6/2020 at 4:50 p.m., Resident D indicated they wanted to get out of there and go live at an Assisted Living. They indicated they were not allowed to be out in the hall way because of the coronaries, and they weren't allowed to go outside either. They indicated they just sit and look out the window. At times they would put on a mask and go to the office. When they went outsode their room, the staff told them they had to go back in their room. 4. Resident L was identified by the facility as being alert, oriented, and interviewable on 7/6/2020. During an interview on 7/6/2020 at 5:02 p.m., Resident AL indicated they were not allowed out of their rooms, and were told to go back to their rooms if they were in the hallway. They further indicated they were not allowed to go outside either. Resident L indicated .They are keeping us pinned up here, and it's been this way for 3-4 months now . 5. Resident M was identified by the facility as being alert, oriented, and interviewable on 7/6/2020. During an interview on 7/6/2020 at 5:13 p.m., Resident M indicated they were not doing so well. They indicated they didn't think they were getting enough therapy to be getting better. They indicated their legs do not get enough exercise, and they were only able to go as far as the door way in their room. Resident M indicated they were not able to go in the halls, or outside. .I'm supposed to get out of here soon, and I hope they will let me out . 6. Resident N was identified by the facility as being disoriented, and not interviewable on 7/6/2020. During an interview on 7/6/2020 at 3:15 p.m., Employee 8 indicated Resident N loved to go outside, and it's been so difficult for them to stay in their room. Employee 8 indicated they messaged the ED and asked if they could take Resident N outside to the court yard, and feed the fish. The ED replied .No . During an interview on 7/6/2020 at 2:50 p.m., Nurse 2 indicated the residents were not allowed to be out of their rooms. If they would come out, the staff directs them back to their rooms. Nurse 2 indicated many of the resident's wanted to come out and watch TV in the lounge, or just be out of their rooms. They further indicated they felt bad for them, but it was the states rules management said. During an interview on 7/6/2020 at 3:05 p.m., Nurse 9 indicated the residents were not allowed out of their rooms unless they were getting therapy. They were trying to clarify the visits, and window visits, but that stopped when the state did not move forward into Phase 5. Nurse 9 further indicated the resident's pretty much stay in their rooms. During an interview on 7/6/2020 at 5:36 p.m., the DON indicated ongoing discussions have been implemented, regarding the outside visits. The facility did not want to start them when the heat index was so high. The DON indicated the corporate nurse, ED, and herself were trying to work on a plan to start integrating the resident's back into the dining room and activities. The DON could not answer why the resident's had been confined to their rooms. During the survey exit conference on 7/6/2020 at 6:34 p.m., the Corporate ED indicated they thought as a whole corporation they were doing the right thing by keeping the resident's in their rooms since the facility had remained Covid free. A form, Saber Recommendations For Visitation Restrictions Due to Covid-19, dated 3/12/2020, and provided by the Regional Nurse Consultant on 7/6/2020, indicated the following: .Try to keep residents in rooms or with a minimum of 6 feet distance . A current facility policy, Indiana Resident Abuse Policy, dated 6/5/2020, provided by the Regional Nurse Consultant on 7/6/2020 at 3:50 p.m., indicated the following: .Residents, interest family members, or other persons may contact any member of administration or the facility's nursing staff at any time with concerns relating to Involuntary Seclusion. In addition, such persons may file a grievance with the Facility and/or with the applicable DOH concerning any instance or suspicion of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0603 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) resident involuntary seclusion . This Feceral citation is related to Complaint IN 741 3.1-27(1)(4)