STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155827	A. BUILDING -- B. WING	04/04/2023

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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/30/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/23 Facility Number: 013293 Provider Number: 155827 AIM Number: 201273090 At this PSR survey, Sage Bluff Health & Rehab Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 84 and had a census of 48 at the time of this survey. Quality Review completed on 04/04/23	E 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 April 7, 2023. We respectfully request paper compliance for this survey resolution.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/30/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 04/04/23 Facility Number: 013293 Provider Number: 155827 AIM Number: 201273090 At this PSR survey, Sage Bluff Health & Rehab Center was found not in compliance with	K 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 April 7, 2023. We respectfully request paper compliance for this	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Rees	Executive Director	04/14/2023

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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	155827	A. BUILDING 01 B. WING	04/04/2023

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, LSC, Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 84 and had a census of 48 at the time of this survey. All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled except a small storage shed. Quality Review completed on 04/04/23		survey resolution.	
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge ramp was equipped with handrails. LSC Section 7.2.5.4.1 Guards complying with 7.2.2.4 shall be provided for ramps. This deficient practice could affect 25 residents evacuated from the 400-hall. Findings include: Based on observation with the Administrator and	K 0227	The handrails for the exit discharge ramp were installed and the work was completed on April 7, 2023	04/07/2023

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	Environmental Services Director on 01/30/23 at 2:01 p.m. and again on 04/04/23 at 10:00 a.m., the exit discharge from the 400-hall had a slope with a 35 feet long ramp. No handrails were provided for the ramp. Based on an interview at the time of observation, the Environmental Services Director agreed the egress exit sloped down and was not provided with handrails. The Administrator stated contactors have been delayed and should install the handrails within in the next two weeks. The finding was reviewed with the Administrator during the exit conference. This deficiency was cited on 01/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			