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	08/04/2022

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 IN00384697, IN00385819, IN00386145, IN00386601, and IN00387097. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00384697 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607. Complaint IN00385819 - Unsubstantiated due to lack of evidence. Complaint IN00386145 - Unsubstantiated due to lack of evidence. Complaint IN00386601 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387097 - Unsubstantiated due to lack of evidence. Survey dates: August 1, 2, and 4, 2022 Facility number: 013293 Provider number: 155827 AIM number: 201273090 Census Bed Type: SNF/NF: 36 SNF: 6 Total: 42 Census Payor Type: Medicare: 3 Medicaid: 27 Other: 12 Total: 42	F 0000	We respectfully request that paper compliance be considered based on our plan of correction due to the citation given is minor and isolated constituting no harm or even potential for harm.	

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

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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	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 8, 2022			
F 0607 SS=E Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to follow up on inconclusive criminal background checks for 8 of 15 employees reviewed (Employee 5, Employee 6, Employee 10, Employee 11, Employee 12, Employee 13, Employee 14, and Employee 15). Findings include: On 8/1/22 at 11:30 A.M., the Administrator provided a current copy of the facility policy titled "Indiana Resident Abuse Policy". The policy indicated the following: "Screening: facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, or mistreatment of residents by a court of law...It is the policy of the facility to undertake background checks of all employees...The facility will do the	F 0607	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for the purpose of general liability, professional malpractice, or any other court proceeding. It is the practice of this facility to assure that all staff receive criminal backgrounds checks prior to being hired. If the Background reveals an inconclusive check those employees must submit a finger print for conclusive results.	08/26/2022

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	following prior to hiring a new employee...a.iv. Conduct a criminal background check in accordance with State law and facility policy...." On 8/1/22 at 2:40 P.M., employee records were reviewed for limited criminal background checks completed prior to employment at the facility. The following employees had inconclusive criminal background checks per the Indiana Central Repository. Each was recommended to have their fingerprints checked for conclusive results. The facility did not complete the criminal background check recommendations of fingerprinting for the following employees: -Employee 5's background check was inconclusive on 6/8/22. -Employee 6's background check was inconclusive on 7/7/22. -Employee 10's background check was inconclusive on 7/5/22. -Employee 11's background check was inconclusive on 6/2/22. -Employee 12's background check was inconclusive on 6/17/22. -Employee 13's background check was inconclusive on 6/21/22. -Employee 14's background check was inconclusive on 3/22/22. -Employee 15's background check was inconclusive on 6/13/22. On 8/1/22 at 3:43 P.M., the Administrator was		The corrective action taken for those residents found to be affected by the deficient practice include: All employee files will be reviewed for completed background checks. All inconclusive checks will be reviewed for a finger print with a conclusive result. Other residents that have the potential to be affected have been identified by: All employee files will be reviewed for completed background checks. All inconclusive checks will be reviewed for finger print with a conclusive result. The Measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Tonya Church, HR/PR is no longer employed. Upon Hiring the New HR/PR position, they will be orientated/trained on the policies and procedures for Onboarding. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Quality Assurance Tool has been developed and implemented to monitor the compliance of Background checks for New Hires. The tool will review new hires and assure that they receive a background check with conclusive results. Finger prints will be submitted for inconclusive results per policy. This tool will be	

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	interviewed. She indicated the employees who had inconclusive limited criminal background checks should have been fingerprinted, as recommended by the Indiana Central Repository, prior to being employed at the facility to ensure these potential employees had no history of abuse, neglect, exploitation, or misappropriation of property. This Federal tag relates to Complaint IN00384697. 3.1-28(a) 3.1-28(b)(1)(A)		completed by HR, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. The date the systemic changes will be completed: 08/26/2022	