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	01/03/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/03/24 Facility Number: 013293 Provider Number: 155827 AIM Number: 201273090 At this Emergency Preparedness survey, Sage Bluff Health and Rehabilitation 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 46 at the time of this survey. Quality Review completed on 01/05/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/03/24 Facility Number: 013293 Provider Number: 155827 AIM Number: 201273090 At this LSC survey, Sage Bluff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Isaac Lenon	Administrator	01/22/2024

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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	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 46 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 01/05/24			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This	K 0226	We respectfully request paper compliance due to low scope and severity of citations. Element 1 The latch to the horizontal fire door will be repaired so that it will latch automatically upon release of the fire door. The repair was completed by maintenance director on 1/8/2024.	01/19/2024

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	deficient could affect 40 residents in 2 smoke compartments when occupied. Findings include: Based on observations with the Administrator and Environmental Services Director on 01/03/24 at 11:43 a.m., the 1 ½ hour rated fire door set to the 300/400 wing was use as a horizontal exit and as a smoke barrier. When tested the doors failed to latch into the frame due the latch sticking. Based on interview at the time of observation, the Environmental Services Director stated the fire door set was not latching into the frame because the latch was not working properly. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		Element 2 Like areas are identified as fire doors noted throughout the facility. An audit utilizing the Fire Door Audit Tool (Attachment A) will be completed to ensure fire doors throughout the facility automatically latch upon release of the fire door. This audit will be completed by the maintenance director on or before 1/19/24. Element 3 The Maintenance Director will be educated by the Administrator on the Life Safety Regulation K226 (Attachment J) as it relates to ensure fire doors automatically latch upon release this education will be completed on or before 1/19/24. Element 4 All fire doors will be audited by maintenance director or designee for functioning latch using the Fire Door Audit Tool (Attachment A) weekly x8, followed by monthly x4. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour			

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	period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Administrator and Environmental Services Director on 01/03/24 at 10:13 a.m., the fire watch plan stated to contact the department of health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and monitoring company but the space to list phone numbers was blank. Based on interview during the record review, the Environmental Services Director acknowledged the fire watch documentation contact information was missing from the form. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference.	K 0346	Element 1 The fire watch plan included in the Emergency Operations Plan was updated by the Administrator on 1/12/24 to include contact information for all parties who should be notified in the event that a fire watch is necessitated by the failure of the fire alarm system. Element 2 There were no like areas identified for the cited deficiency. Element 3 The Maintenance Director will be educated by the Administrator on the Life Safety Regulation K346 (Attachment J) as it relates to including contact information on the fire watch plan on or before 1/19/24. Element 4 Emergency Operation Plan will be reviewed and signed off annually by administrator	01/19/2024

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K 0353 SS=F Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed ensure 1 of 1 sprinkler systems completed all required testing in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition This deficient practice could affect all residents in the facility. Findings include: #1.) NFPA 25, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of	K 0353	Element 1 Documentation of backflow testing (Attachment D) and 2023 Quarter 4 Sprinkler Test (Attachment E) was requested and received from Ryan Fire Protection Inc., who performed the testing. 5 year pipe test was last completed in January of 2019 and is scheduled to be completed again on January 30, 2024 (Attachment C). Documentation was placed in the Emergency Operations Plan binder by the Maintenance Director on 1/12/24. Element 2	01/30/2024

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	inspecting for the presence of foreign organic and inorganic material. Based on record review with the Administrator and Environmental Services Director on 01/03/24 at 11:03 a.m., no documentation of an internal pipe inspection was available for review. Based on interview at the time of record review, the Environmental Services stated the internal pipe inspection documentation could not be found. #2.) NFPA 25, 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. Based on record review with the Administrator and Environmental Services Director on 01/03/24 at 11:02 a.m., the annual backflow preventer test was past due. The last backflow preventer test took place in November of 2022. Based on interview during records review, the Environmental Services Director agreed the backflow preventer test was past due. #3.) NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. Based on records review with the Administrator and Environmental Services Director on 01/03/24 at 11:09 a.m., there was no quarterly sprinkler system inspection report available for the fourth quarter (Oct. Nov. Dec.) of 2023. Based on interview at the time of record review, the Environmental Services Director stated the fourth quarter sprinkler inspection documentation could not be found. The findings were reviewed with the		There were no like areas identified for the cited deficiency. Element 3 A copy of all fire system inspection reports to be retained by both maintenance supervisor and administrator for the duration of the year it is active going forward. The Maintenance Director will be educated by the Administrator on the Life Safety Regulation K353 (Attachment J) as it relates to including testing documentation is received, reviewed and placed in the Emergency Operation Plan binder. This education will be completed on or before 1/19/24. Element 4 Copy of inspection reports added to Emergency Operations Plan Binder. Emergency Operations Plan Binder to be reviewed and signed off annually by the administrator.	

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	Administrator and Environmental Services Director during the exit conference. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person	K 0354	Element 1 The fire watch plan included in the Emergency Operations Plan was updated by the Administrator on 1/12/24 to include contact information for all parties who should be notified in the event that a fire watch is necessitated by the failure of the fire alarm system. Element 2 There were no like areas identified for the cited deficiency. Element 3 The Maintenance Director will be educated by the Administrator on	01/19/2024

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	should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Administrator and Environmental Services Director on 01/03/24 at 10:13 a.m., the fire watch plan stated to contact the department of health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan stated to contact the fire department, insurance carrier, facility operator, and monitoring company but the space to list phone numbers was blank. Based on interview during the record review, the Environmental Services Director acknowledged the fire watch documentation contact information was missing from the form. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		the Life Safety Regulation K354 (Attachment J) as it relates to including contact information on the fire watch plan on or before 1/19/24. Element 4 Emergency Operation Plan will be reviewed and signed off annually by administrator.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only			

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	used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in front office area. Findings include: Based on observation with the Administrator and Environmental Services Director on 01/03/24 at 12:34 p.m., a refrigerator was plugged into and supplied power by an extension cord in the 100-hall med room. Based on interview at the time of observation, the Environmental Services Director acknowledged an extension cord was in	K 0920	On 1/8/24 the extension cord was removed by the Maintenance Director and the refrigerator is now plugged directly into the wall outlet. (Attachment F) Element 2 Like areas are identified as areas that have equipment plugged into outlets. Utilizing the Extension Cord Audit Tool (Attachment K) an audit will be completed to ensure there are no unauthorized extension cords utilized within the facility. This audit will be completed by the Maintenance Director on or before 1/19/24.	01/19/2024

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	use as fixed wiring. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		Element 3 Use of unapproved extension cords will be discontinued. All appliances to be plugged directly into wall outlet. The Maintenance Director will be educated by the Administrator on the Life Safety Regulation K920 (Attachment J) as it relates to utilizing extension cords within the nursing facility. This education will be completed on or before 1/19/24. Element 4 Areas where equipment is plugged into outlets will be randomly audited utilizing the Extension Cord Audit Tool (Attachment K) to ensure unauthorized extension cords are not utilized. This audit will be completed by the Maintenance Director or designee weekly for 8 weeks then monthly for 4 months. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior			

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	space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms were provided with a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED. This deficient practice could affect up to 20 residents in one smoke compartment.	K 0923	Element 1 A sign was posted outside of the oxygen storage room stating there are oxidizing gases inside and that smoking is prohibited (Attachment G). This sign was posted by the Administrator on 1/11/24.	01/19/2024

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	Findings include: Based on observations with the Administrator and Environmental Services Director on 01/03/24 at 12:25 p.m., the oxygen storage room contained oxygen cylinders. The door to the room was not provided with a precautionary sign that indicates storage that stated "CAUTION: OXIDIZING GAS(ES) STORED." Based on interview at the time of observation, the Environmental Services Director stated there was not a precautionary sign that indicates storage of oxidizing gasses. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		Element 2 There were no like areas identified for the cited deficiency. Element 3 The Maintenance Director will be educated by the Administrator on the Life Safety Regulation K923 (Attachment J) as it relates to required postings for oxygen storage rooms. This education will be completed on or before 1/19/24. Element 4 Warning sign is in place as evidenced by the photo in attachment C.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place.	K 0927	Element 1 The oxygen transfilling policy was added to the Emergency Operations Plan by the	01/19/2024

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	155827	A. BUILDING 01 B. WING	01/03/2024

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
	NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on records review Administrator and Environmental Services Director on 01/03/24 at 10:13 a.m., no oxygen trans-filling policy nor documentation to indicate if staff were properly trained on trans-filling liquid oxygen was available for review. Based on interview at the time of observation, the Administrator stated the oxygen trans-filling policy and training paperwork could not be found. The finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		Maintenance Director on 1/16/24 (Attachment E). Element 2 There were no like areas identified for the cited deficiency. Element 3 Staff who fill oxygen cylinders will be educated on the Oxygen Transfilling policy by the Administrator or Maintenance Director (Attachment I) on or before 1/19/24. Element 4 Emergency Operations Plan will be reviewed and signed off annually by administrator to ensure the oxygen transfilling policy along with staff education is present and updated as applicable.	