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 _____	C 04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00430994, IN00430998, IN00431004, IN00431014, IN00431018, IN00431190, and IN00431182. Complaint IN00430994 - No deficiencies related to the allegations are cited. Complaint IN00430998 - No deficiencies related to the allegations are cited. Complaint IN00431004 - No deficiencies related to the allegations are cited. Complaint IN00431014 - No deficiencies related to the allegations are cited. Complaint IN00431018 - No deficiencies related to the allegations are cited. Complaint IN00431190 - No deficiencies related to the allegations are cited. Complaint IN00431182 - No deficiencies related to the allegations are cited. Survey dates: April 3, and 4, 2024. Facility number: 013293 Provider number: 155827 AIM number: 201273090 Census Bed Type: SNF/NF: 36 SNF: 13 Total: 49	F 000		

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.

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 _____	C 04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	Continued From page 1 Census Payor Type: Medicare: 5 Medicaid: 33 Other: 11 Total: 49 Sage Bluff Health and Rehab Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00430994, IN00430998, IN00431004, IN00431014, IN00431018, IN00431190, and IN00431182. Quality review completed April 4, 2024.	F 000		