PRINTED: 10/12/2022

DEPARTMENT	FORM APPROVED OMB NO. 0938-039						
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIE	R NG OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 09/19 Facility Number: 0 Provider Number: AIM Number: 1009 At this Emergency Celebrate Senior L not in compliance of Requirements for M Participating Provides 3.73. The facility census of 68 at the Quality Review conductive of the second conducted by the Indiana.	9/22  00158 155255 291490  Preparedness survey, iving of Fort Wayne was found with Emergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR y has a capacity of 118 and had a time of this survey.  mpleted on 09/26/22  42 CFR, Subpart 483.73 is NOT	E 00	000	This Plan of Correction constitutis facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and feder law; or – Preparation and submission of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the fact alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared submitted solely because of requirements under state and federal laws.	of s this ists ts an e ss he	
E 0004 SS=F Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62	5(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 620(a), 486.360(a),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),

> 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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§494.62(a).

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	OF CORRECTION				COM	IPLETED 19/2022
	PROVIDER OR SUPPLIER ATE SENIOR LIVIN	G OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZII AST STATE BLVD WAYNE, IN 46805	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive en program that meet section. The emer program must include the following elem (a) Emergency Pladevelop and mainting preparedness plar and updated at least must do all of the following elem (b) * [For hospitals at \$485.625(a):] Emergency Plander (c) Emerg	blish and maintain a mergency preparedness as the requirements of this gency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital uply with all applicable id local emergency ulirements. The [hospital or p and maintain a mergency preparedness is the requirements of this in all-hazards approach.  Bes at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  Ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated], in the content of this must be [evaluated], in that must be [evaluated], in that must be [evaluated], in the content of this must be [evaluated], in that must be [evaluated], in that must be [evaluated], in the content of this main an emergency in that must be [evaluated], in the content of this main an emergency in that must be [evaluated], in the content of this main an emergency in that must be [evaluated], in the content of this main an emergency in that must be [evaluated], in the content of this main and the content of t				

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DEPARTMEN CENTERS FO	FORM APPROVED OMB NO. 0938-039						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	ľ	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIEI	NG OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIE EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FORT WAYNE, IN 46805  ID PREFIX TAG  PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODETICIENCY)  E 0004  Deficiency- E004  1. No residents were a by the cited deficiency. 2. No residents were in for potential to be affected cited deficiency. 3. A facility form was perplace to show annual reviewed updates of the Facility Emplan. The current facility pereviewed and updated on by the Administrator and Maintenance Director. 4. The sign off form purplace will be reviewed in Compliance is obtained to any changes/updates have reviewed and signed off of ED and/or designee timely		1. No residents were affect by the cited deficiency. 2. No residents were identifor potential to be affected by cited deficiency. 3. A facility form was put in place to show annual review a updates of the Facility Emerge Plan. The current facility plan reviewed and updated on 9-28 by the Administrator and Maintenance Director. 4. The sign off form put in place will be reviewed in QA for months or until a 100% compliance is obtained to ensign any changes/updates have be reviewed and signed off on by ED and/or designee timely. 5. The above changes will	eted  iified the  and ency was 3-22  or 6  ure een	COMPLETION DATE  10/10/2022
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §410 §441.184(b), §460	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),					

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§494.62(b).

§485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b),

develop and implement emergency

(b) Policies and procedures. [Facilities] must

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155255		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 09/19/2022				
	PROVIDER OR SUPPLIEI	ROF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	on the emergency (a) of this section paragraph (a)(1) of communication pl section. The polic be reviewed and of years.	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2							
	and procedures. develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The police	s at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.							
	ESRD Facilities:  *[For PACE at §4	60.84(b):] Policies and							
	develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The polic address manager nonmedical emerglimited to: Fire; edfailure; care-related disasters likely to safety of the particular control	PACE organization must ement emergency icies and procedures, based plan set forth in paragraph prisk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public.							
		lated at least every 2 years.							

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JENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155255	B. WING	<del></del>	09/19/2022		
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	*[For ESRD Facilia and procedures.develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policible reviewed and uyears. These emenot limited to, fire, failures, care-relat supply interruption likely to occur in tharea. Based on record revialled to review and Preparedness Plan (at least annually in 483.73(a). This definition occupants.  Findings include:  Based on records reand Maintenance Dam., the EEP Policirevision date 04/23/could be found to sl Procedures were revialst year. Based on review, the Administ Director stated the definition of the policies and Procedures and Proce	ties at §494.62(b):] Policies The dialysis facility must	E 0013	Deficiency- E013  1. No residents were affect by the cited deficiency. 2. No residents were ident for potential to be affected by cited deficiency. 3. A facility form was put in place to show annual review a updates of the Facility Emerge Policies and Procedures. The current facility plan was review and updated on 9-28-22 by the Administrator and Maintenanc Director. 4. The sign off form put in place will be reviewed in QA for months or until a 100% compliance is obtained to ensany changes/updates have be reviewed and signed off on by ED and/or designee timely.	10/10/2022  ted  ified the  and ency  wed e e  or 6  ure een		

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This finding was reviewed with the Administrator

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The above changes will be

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155255	A. BUILDING B. WING	<u></u>	COMPI 09/19		
		133233			09/19	72022	_
NAME OF I	PROVIDER OR SUPPLIER	₹		EET ADDRESS, CITY, STATE, ZIP COD			
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		0 EAST STATE BLVD RT WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	-
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		BE .	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	_
	and Maintenance D	rector during the exit		in place by 10-10-22.			
	conference.						
E 0029 SS=F Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §466 §483.73(c), §485. §485.68(c), §485. §485.920(c), §486 §494.62(c).  (c) The [facility] m an emergency pre plan that complies local laws and mu at least every 2 years	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					
	failed to review and Preparedness Plan (least annually in ac 483.73(a). This def occupants.  Findings include:  Based on records reand Maintenance Da.m., the EEP Comdate 04/23/21, no of found to show the I reviewed and update and u	view and interview, the facility dupdate the Emergency (EPP) Communication plan at cordance with 42 CFR ficient practice could affect all eview with the Administrator pirector on 09/19/22 at 10:01 munication plan had a revision ther documentation could be EPP Communication plan was ted within the last year. Based ring records review, the	E 0029	Deficiency- E029  1. No residents were affl by the cited deficiency. 2. No residents were ide for potential to be affected be cited deficiency. 3. A facility form was purplace to show annual review updates of the Facility Eme Communication Plan. The confacility plan was reviewed a updated on 9-28-22 by the Administrator and Maintena Director. 4. The sign off form put	entified by the  t in v and rgency current nd	10/10/2022	

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Administrator and Maintenance Director stated

the documentation to show the EEP

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place will be reviewed in QA for 6

months or until a 100%

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er (Temp To)	MEDICARE & MEDIC	HID SERVICES			OHB 110: 0700 007	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155255	B. WING		09/19/2022	
		100200			00/10/2022	
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	NG OF FORT WAYNE		WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	RRECTION (X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	N
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Communication pla	an has been reviewed or		compliance is obtained to ens	ure	
	-	last year could not be found.		any changes/updates have be		
	-F			reviewed and signed off on by		
	This finding was re	viewed with the Administrator		ED and/or designee timely.		
	_	virector during the exit		5. The above changes will	he	
		nector during the exit		in place by 10-10-22.	De	
	conference			In place by 10-10-22.		
E 0036	402 740/d\ 446 E	(4/4) 419 112/4)				
SS=F	403.748(d), 416.5					
	` ''	5(d), 483.475(d), 483.73(d),				
Bldg	484.102(d), 485.6					
	, ,	20(d), 486.360(d),				
	491.12(d), 494.62	` '				
	EP Training and T	<u> </u>				
	- , , -	6.54(d), §418.113(d),				
	- , , -	0.84(d), §482.15(d),				
	- , , -	475(d), §484.102(d),				
	§485.68(d), §485.	625(d), §485.727(d),				
	§485.920(d), §486	6.360(d), §491.12(d),				
	§494.62(d).					
	-	§403.748, ASCs at §416.54,				
	Hospice at §418.1	l13, PRTFs at §441.184,				
	PACE at §460.84	, Hospitals at §482.15,				
	HHAs at §484.102	2, CORFs at §485.68,				
	CAHs at §486.625	5, "Organizations" under				
		at §485.920, OPOs at				
		HC/FHQs at §491.12:] (d)				
	-	ng. The [facility] must				
	-	tain an emergency				
	•	ning and testing program				
		ne emergency plan set forth				
	in paragraph (a) o					
	,	ragraph (a)(1) of this				
	·					
	•	nd procedures at paragraph				
	, ,	and the communication				
		(c) of this section. The				
	•	g program must be				
	reviewed and upd	ated at least every 2 years.	1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIE	R NG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP CO EAST STATE BLVD WAYNE, IN 46805	D
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	and testing. The and maintain and training and testing the emergency p of this section, ris (a)(1) of this section at paragraph (b) communication procedures annually.  *[For ICF/IIDs at testing. The ICF/IIDs at testing. The ICF/IIDs at testing. The ICF/IIDs at testing progremergency plans this section, risk (a)(1) of this section at paragraph (b) communication procedures at paragraph (b) communication procedurements for at §483.470(i).  *[For ESRD Facily Training, testing, dialysis facility memergency preparance on the emergency procedures at paragraph (a)(1) procedures at paragraph (a)(1) procedures at paragraph (a)(1) procedures at paragraph (a)(1) procedures at paragraph (b) (a)(1) procedures at paragraph (a)(1) procedures at paragraph (a)(1) procedures at paragraph (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness and program that is based on an set forth in paragraph (a) is assessment at paragraph ion, policies and procedures of this section, and the lan at paragraph (c) of this ning and testing program di and updated at least (§483.475(d):] Training and ID must develop and regency preparedness training am that is based on the set forth in paragraph (a) of assessment at paragraph ion, policies and procedures of this section, and the lan at paragraph (c) of this ning and testing program di and updated at least every (IID must meet the evacuation drills and training lation program that is based by plan set forth in paragraph (c) it is at §494.62(d):] and orientation. The cust develop and maintain an aredness training, testing tation program that is based by plan set forth in paragraph (c) this section, policies and ragraph (b) of this section, ication plan at paragraph (c) the training, testing and am must be evaluated and			

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>	COMPL	
		155255	B. W			09/19/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
OEL EDD	ATE CENIOD LIVIN	IC OF FORT WAYNE			AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT	WAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC! )		DATE
	updated at every 2	riew and interview, the facility	E 0	036	Deficiency- E036		10/10/2022
		update the Emergency		030	Deliciency- 2000		10/10/2022
		EPP) Training and Testing			1. No residents were affect	ted	
	plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all				by the cited deficiency.		
					No residents were ident	ified	
	occupants.				for potential to be affected by	the	
					cited deficiency.		
	Findings include:	Findings include:			3. A facility form was put in		
	Rosed on masands ma	view with the Administrator			place to show annual review a updates of the Facility EPP	ına	
		irector on 09/19/22 at 10:01			Training and Testing Plan. The	_	
		ing and Testing plan had a			current facility plan was review		
		21, no other documentation			and updated on 9-28-22 by the		
		now the EPP Training and			Administrator and Maintenand		
	Testing plan was re-	viewed and updated within the			Director.		
	-	an interview during records			4. The sign off form put in		
	•	strator and Maintenance			place will be reviewed in QA for	or 6	
		locumentation to show the			months or until a 100%		
		Testing plan has been reviewed ne last year could not be			compliance is obtained to ens		
	found.	ie last year could not be			any changes/updates have be reviewed and signed off on by		
	Tourid.				ED and/or designee timely.	uic	
	This finding was rev	viewed with the Administrator			5. The above changes will	be	
	and Maintenance D	irector during the exit			in place by 10-10-22.		
	conference.						
E 0037		6.54(d)(1), 418.113(d)(1),					
SS=F Bldg	, , , ,	2.15(d)(1), 483.475(d)(1),					
blug	, , , ,	102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 483.						
	EP Training Progr						
		116.54(d)(1), §418.113(d)(1),					
	- ,,,,	160.84(d)(1), §482.15(d)(1),					
	. , , , .	33.475(d)(1), §484.102(d)(1),					
	. , , , , .	85.625(d)(1), §485.727(d)					
	(1), §485.920(d)(1	), §486.360(d)(1),					
	§491.12(d)(1).						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	ONSTRUCTION	(X3) DATE COMPI	LETED
		155255	B. W	ING		09/19	12022
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE			AST STATE BLVD WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	*[For RNCHIs at § Hospitals at § 482. HHAs at § 484.102 § 485.727, OPOs at § 491.12:]  (1) Training prograll of the following (i) Initial training ir policies and proceexisting staff, indivunder arrangemer consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docur preparedness train (iv) Demonstrate semergency proceed (v) If the emergen and procedures at [facility] must concupated policies at The hospice must (i) Initial training ir policies and procedures and procedures at The hospice must (ii) Initial training ir policies and procedures and procedures and procedures at The hospice must (ii) Initial training ir policies and procedures and procedures and procedures at The hospice must (ii) Initial training ir policies and procedures and proc	A403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, 2, "Organizations" under at §486.360, RHC/FQHCs at §486.360,		TAG	DEFICIENCY		DATE
	consistent with the						
	(ii) Demonstrate si emergency proced	•					
		gency preparedness training					
	at least every 2 ye						
		view and rehearse its					
	, ,	redness plan with hospice					
		ling nonemployee staff),					
		asis placed on carrying out					
	-	ecessary to protect patients					
	and others		1		i		1

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED	
		155255	B. W	NG		09/19/	/2022	
				CTD FET	ADDRESS OF VICTATE ZID COD			
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
CELEDD.	ATE CENIOD LIVIA	IC OF FORT MAYNE			AST STATE BLVD			
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT	VAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(v) Maintain docur	mentation of all emergency						
	preparedness trai	ning.						
	(vi) If the emerger	ncy preparedness policies						
	and procedures a	re significantly updated, the						
	hospice must con-	duct training on the						
	updated policies a	and						
	procedures.							
	*[For PRTFs at §4	l41.184(d):] (1) Training						
	program. The PR	TF must do all of the						
	following:							
	(i) Initial training in emergency preparedness							
		edures to all new and						
	1 '	viduals providing services						
	_	nt, and volunteers,						
		eir expected roles.						
		ning, provide emergency						
	1 ' '	ning every 2 years.						
	1 ' '	staff knowledge of						
	emergency proced	_						
		mentation of all emergency						
	preparedness trai							
	' '	cy preparedness policies						
	1 ' '	re significantly updated, the						
	1	ict training on the updated						
	policies and proce	- · · · · · · · · · · · · · · · · · · ·						
	ļ ·							
	*[For PACE at §46	60.84(d):] (1) The PACE						
		do all of the following:						
		n emergency preparedness						
	, · ·	edures to all new and						
	1 '	viduals providing on-site						
	•	rangement, contractors,						
		olunteers, consistent with						
	their expected role							
	· ·	ency preparedness training						
	at least every 2 ye	* · · · · · · · · · · · · · · · · · · ·						
		staff knowledge of						
	,, _ 56.15ti ato t				İ		1	

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emergency procedures, including informing participants of what to do, where to go, and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING COMPLETED					
		155255	B. W			09/19/	
	PROVIDER OR SUPPLIER	NG OF FORT WAYNE	1	3420 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated						
	*[For LTC Facilities Training Program. of the following: (i) Initial training in policies and proceexisting staff, indivender arrangement consistent with the (ii) Provide emergat least annually. (iii) Maintain document preparedness train (iv) Demonstrate semergency proceexisting staff, indivender arrangement of the provide emergency proceed to the preparedness train (iv) Demonstrate semergency proceed to the provide initial training services under arrangement with the (ii) Provide emergat least every 2 yes (iii) Maintain document (iv) Demonstrate semergency proceed must be oriented a responsibilities responsibi	edures.  es at §483.73(d):] (1)  The LTC facility must do all  n emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected role. ency preparedness training  mentation of all emergency ning. staff knowledge of dures.  485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's					
	workday. The trair	vithin 2 weeks of their first ning program must include ocation and use of alarm als and firefighting					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155255		 JILDING	NSTRUCTION	COMPL 09/19/	ETED	
	PROVIDER OR SUPPLIER	NG OF FORT WAYNE	3420 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	equipment.  (v) If the emerge and procedures and CORF must condupolicies and procedures and procedures and program. The CAI following:  (i) Initial training in policies and procedures and procedures and exiting protection, and who for patients, person prevention, and conductive and disaster author existing staff, individuals arrangement (ii) Provide emergency procedures and procedures to all remergency preparence and procedures to all remergency preparencedures to all remergency preparencedures to all remergency procedures to all remergency preparencedures to al	ncy preparedness policies re significantly updated, the uct training on the updated edures.  35.625(d):] (1) Training H must do all of the nemergency preparedness edures, including prompt inguishing of fires, here necessary, evacuation innel, and guests, fire properation with firefighting porties, to all new and viduals providing services int, and volunteers, eir expected roles. Hency preparedness training ears. Hency preparedness policies in resignificantly updated, the extraining on the updated edures.  485.920(d):] (1) Training. Provide initial training in redness policies and hew and existing staff, ing services under volunteers, consistent with	TAG	DEPALENCE		DATE
	emergency proced CMHC must provi	dures. Thereafter, the de emergency				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD  CELEBRATE SENIOR LIVING OF FORT WAYNE  CYAPITE OF THE SENIOR LIVING OF FORT WAYNE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD  FORT WAYNE, IN 46805  (X4) ID  PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (X5)  COMPLETED  O9/19/2022			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  CELEBRATE SENIOR LIVING OF FORT WAYNE  STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805	AND PLAN	OF CORRECTION		1		<del></del>			
CELEBRATE SENIOR LIVING OF FORT WAYNE  SUMMARY STATEMENT OF DEFICIENCIE  3420 EAST STATE BLVD FORT WAYNE, IN 46805			100200	D. W1			03/13/		
CELEBRATE SENIOR LIVING OF FORT WAYNE  FORT WAYNE, IN 46805	NAME OF I	PROVIDER OR SUPPLIER	₹						
(VA) ID SUMMADV STATEMENT OF DEFICIENCIE ID (VS)	CELERD	DATE SENIOD I IVIN	NG OF FORT WAYNE						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETION		THE SENIOR LIVIN		-	FORT	77ATNE, IN 40003		ı	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETION						PROVIDER'S PLAN OF CORRECTION			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		`				CROSS-REFERENCED TO THE APPROPRIA	ATE .		
preparedness training at least every 2 years.	TAU	+			TAG			DATE	
Based on record review and interview, the facility $E 0037$ Deficiency- E037 $E 0037$				E 00	037	Deficiency- E037		10/10/2022	
failed to conduct annual training for the					001			10/10/2022	
Emergency Preparedness Program (EPP). The LTC  1. No residents were affected		Emergency Prepare	edness Program (EPP). The LTC			1. No residents were affect	cted		
facility must do all of the following: (i) Initial by the cited deficiency.			- · · ·			1 -			
		training in emergency preparedness policies and							
procedures to all new and existing staff,  for potential to be affected by the		_				1	the		
individuals providing services under arrangement, and volunteers, consistent with their expected  cited deficiency.  3. An all staff in-service is		_				· · · · · · · · · · · · · · · · · · ·			
and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness  3. An all staff in-service is being completed on annual EEP			-						
training at least annually; (iii) Maintain  training. In-service completed with		* *							
documentation of all emergency preparedness department heads on		_					With		
training; (iv) Demonstrate staff knowledge of demonstrating comprehension of						<b>■</b>	n of		
emergency procedures in accordance with 42 CFR staff drills and documentation on									
483.73(d) (1). This deficient practice could affect effectiveness. Education		483.73(d) (1). This	deficient practice could affect			effectiveness. Education			
all residents in the facility.  completed by facility		all residents in the f	facility.						
Administrator.									
Findings include:  4. New hires, annual training		Findings include:							
Based on records review with the Administrator and required staff drills will be reviewed in QA for 6 months or		Based on records re	eview with the Administrator			-			
and Maintenance Director on 09/19/22 at 10:11 until a 100% compliance is							וכ		
a.m., no documentation of annual EEP training and obtained to ensure compliance.						•	e.		
no documentation to show staff could 5. The above changes will be						1			
demonstrate knowledge of the EPP was available in place by 10-10-22.		demonstrate knowle	edge of the EPP was available			in place by 10-10-22.			
for review. Based on an interview at the time of									
records review, the Maintenance Director and the									
Administrator stated annual staff EPP training			9						
documentation was not found.		documentation was	not found.						
This finding was reviewed with the Administrator		This finding was re-	viewed with the Administrator						
and Maintenance Director during the exit									
conference.			Č						
E 0039 403.748(d)(2), 416.54(d)(2), 418.113(d)(2),		` ' ' '							
SS=C 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),		, , , ,							
Bldg 483.73(d)(2), 484.102(d)(2), 485.625(d)(2),	ыад	, , , ,							
485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)		, , , ,							
EP Testing Requirements		, , , ,							
§416.54(d)(2), §418.113(d)(2), §441.184(d)(2),									

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255			UILDING	NSTRUCTION	(X3) DATE COMPL 09/19/	LETED	
	PROVIDER OR SUPPLIEI	ROG OF FORT WAYNE	•	3420 EA	DDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.475(d)(2), §	82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) , §494.62(d)(2).					
	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:						
	(2) Testing. The [	facility] must conduct					
	exercises to test the emergency plan annually. The [facility] must do all of the following:  (i) Participate in a full-scale exercise that is community-based every 2 years; or  (A) When a community-based exercise is						
	functional exercis (B) If the [fac	enduct a facility-based e every 2 years; or ility] experiences an actual					
	activation of the e	ade emergency that requires mergency plan, the [facility] agaging in its next required					
	functional exercis	or individual, facility-based e following the onset of the					
		lditional exercise at least posite the year the full-scale					
	or functional exer	cise under paragraph (d)(2) s conducted, that may					
		limited to the following: scale exercise that is					
	community-based functional exercis	l or individual, facility-based					
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
		and includes a group					
	discussion using	~ ·					
	_	emergency scenario, and a					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPI	
		155255	B. W	ING		09/19	/2022
NAME OF P	PROVIDER OR SUPPLIEF		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	set of problem sta						
	messages, or prepared questions designed to challenge an emergency plan.						
	, ,	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	· · -					
	. ,	spices that provide care in					
	the patient's home	e. The hospice must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The hospice must do					
	the following:						
	(i) Participate in a	a full-scale exercise that is					
	community based	every 2 years; or					
	(A) When a comm	nunity based exercise is not					
	accessible, condu	ct an individual facility					
	based functional e	exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	•	tional exercise following the					
	onset of the emer	-					
	(ii) Conduct an ad	dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted, that may					
	The state of the s	limited to the following:					
		scale exercise that is					
	<u> </u>	or a facility based					
	functional exercise						
	(B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is						
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tomonte directed					İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL		
		155255	B. W	ING		09/19/	/2022	
NAME OF P	DROWNED OF GIRDI ICI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER			3420 E	AST STATE BLVD			
CELEBR	ATE SENIOR LIVIN	NG OF FORT WAYNE		FORT V	VAYNE, IN 46805			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEI ICEA CT		DATE	
	to challenge an e	pared questions designed mergency plan						
	10 0.14.1191.go 4.11 0.	geney planii						
	(3) Testing for hos	spices that provide inpatient						
	care directly. The	hospice must conduct						
		he emergency plan twice						
	l · · ·	spice must do the following:						
		an annual full-scale exercise						
	that is community	-based; or nunity-based exercise is not						
	l ` '	ict an annual individual						
		ctional exercise; or						
	1	experiences a natural or						
	man-made emerg	ency that requires activation						
	of the emergency	plan, the hospice is						
		aging in its next required						
		nity based or facility-based						
		e following the onset of the						
	emergency event							
		dditional annual exercise but is not limited to the						
	following:	but is not inflited to the						
		-scale exercise that is						
	1 ' '	or a facility based						
	functional exercis							
	(B) A mock disas	ter drill; or						
	(C) A tabletop ex	ercise or workshop led by a						
		udes a group discussion						
	using a narrated,	-						
		rio, and a set of problem						
		ted messages, or prepared						
		ed to challenge an						
	emergency plan.	nospice's response to and						
	1 ' '	ntation of all drills, tabletop						
		nergency events and revise						
		ergency plan, as needed.						
	*IFor PRETs at \$/	141.184(d), Hospitals at						
	[FULFIXE 15 at 92	14 1. 104(u), 1 105pilais al						

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CENTERS FO	R MEDICARE & MEDIC					ON	<b>1B NO. 0938-039</b>
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMP	LETED
		155255	B. W	ING		09/19	9/2022
				CTDFFT A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			AST STATE BLVD		
CELEDE	DATE SENIOD I IVIN	NG OF FORT WAYNE			VAYNE, IN 46805		
CELEBR	RATE SENIOR LIVIN	NG OF FORT WATNE		FORT	VATINE, IIN 40000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF	BE PRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§482.15(d), CAHs	s at §485.625(d):]					
	(2) Testing. The [I	PRTF, Hospital, CAH] must					
	conduct exercises	s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	-	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	, ,	ict an annual individual,					
		ctional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
		ration of the emergency					
		is exempt from engaging in					
		ull-scale community based					
	1	ity-based functional exercise					
		et of the emergency event.					
	_						
	` '	an [additional] annual					
		nat may include, but is not					
	limited to the follo	_					
	1 ' '	-scale exercise that is					
	community-based						
		ctional exercise; or					
	1 ' '	ock disaster drill; or					
	` '	p exercise or workshop that					
	_ ·	tor and includes a group					
	discussion, using	•					
		emergency scenario, and a					
	set of problem sta						
	I	pared questions designed					
	to challenge an e	• • •					
	(iii) Analyze t	he [facility's] response to					
		umentation of all drills,					
	tabletop exercises	s, and emergency events					
	and revise the [fa	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60.84(d):]					
	(2) Testing. The F	PACE organization must					

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conduct exercises to test the emergency

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CENTERS FO	R MEDICARE & MEDIC					ON	4B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPI	LETED
		155255	B. W	ING		09/19	9/2022
	PROVIDER OR SUPPLIEI	R NG OF FORT WAYNE	•	3420 E	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	plan at least annu	ıallv. The PACE					
	organization must	_					
	_	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ict an annual individual,					
		ctional exercise; or					
	1	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
		ngaging in its next required					
	1	nity based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		an additional exercise every					
	1 ' '	the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited t						
		-scale exercise that is					
	community-based	l or individual, a facility					
	based functional	exercise; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
		atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	mergency plan.					
	(iii) Analyze the F	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emerg	gency plan, as needed.					
	*[For LTC Facilitie	es at 8483 73(d):1					
	-	ity] must conduct exercises					
	_ , ,	ency plan at least twice per					
	_	announced staff drills using					

the emergency procedures. The [LTC facility,

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155255		, ,	JILDING	NSTRUCTION	(X3) DATE COMPL 09/19/	ETED
	F PROVIDER OR SUPPLIE BRATE SENIOR LIVIN	R NG OF FORT WAYNE		3420 EA	DDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, condu- facility-based function (B) If the [LTC fac- actual natural or requires activation LTC facility is exe- required a full-sca- individual, facility- following the onse (ii) Conduct an actual may include, following: (A) A second full- community-based based functional (B) A mock disas (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem sta- messages, or pre- to challenge an er- (iii) Analyze the [ response to and re- all drills, tabletop events, and revise emergency plan,  *[For ICF/IIDs at 8 (2) Testing. The Ir- exercises to test to twice per year. The following:	an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual, ctional exercise. cility] facility experiences an man-made emergency that n of the emergency plan, the empt from engaging its next ale community-based or based functional exercise et of the emergency event. diditional annual exercise but is not limited to the  -scale exercise that is a or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.  \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255			UILDING	NSTRUCTION	(X3) DATE COMPL 09/19	LETED	
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP COD AST STATE BLVD	•	
CELEBR	RATE SENIOR LIVIN	NG OF FORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAU		nunity-based exercise is not		IAU			DATE
		uct an annual individual,					
		ctional exercise; or.					
		experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	emergency plan, the ICF/IID					
	is exempt from er	ngaging in its next required					
		nity-based or individual,					
		ctional exercise following the					
	onset of the emer	-					
	1 ' '	Iditional annual exercise					
	that may include, but is not limited to the						
	following:						
	(A) A second full-scale exercise that is community-based or an individual,						
		ctional exercise; or					
	(B) A mock disast						
		ercise or workshop that is					
		and includes a group					
	discussion, using						
		emergency scenario, and a					
	1	atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	mergency plan.					
		CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	84.102]					
	(d)(2) Testing. Th	e HHA must conduct					
		the emergency plan at					
	1	e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	` '	community-based exercise					
	· ·	conduct an annual					
	1	-based functional exercise					
	every 2 years; or.						1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155255	B. W	ING		09/19/	/2022
C. o			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		3420 E	AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual, stional exercise following the					
	onset of the emer	_					
		ditional exercise every 2					
	` '	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
		limited to the following:					
		full-scale exercise that is					
	community-based						
	_	ctional exercise; or					
		isaster drill; or					
	, ,	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	- ·					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the H	HA's response to and					
	maintain documer	ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	36.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test t	he emergency plan. The					
	OPO must do the	<del>-</del>					
		er-based, tabletop exercise					
	•	ast annually. A tabletop					
	_	a facilitator and includes a					
	group discussion, using a narrated, clinically						
	relevant emergency scenario, and a set of						
	problem statements, directed messages, or						
		ns designed to challenge an					
	emergency plan. I	f the OPO experiences an					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPI	LETED	
	155255		B. Wl	NG		09/19	/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD			•
NAME OF I	PROVIDER OR SUPPLIE	R		l	AST STATE BLVD			
CELEBR	ATE SENIOR LIVIN	NG OF FORT WAYNE		l	WAYNE, IN 46805			
					1		1	_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	-
		man-made emergency that						
		n of the emergency plan, the						
		om engaging in its next						
		xercise following the onset						
	of the emergency							
	(ii) Analyze the O	PO's response to and						
	maintain docume	ntation of all tabletop						
	exercises, and en	nergency events, and revise						
	the [RNHCI's and	OPO's] emergency plan, as						
	needed.							
	*[ RNCHIs at §40	=						
		e RNHCI must conduct						
		the emergency plan. The						
	RNHCI must do ti	he following:						
	(i) Conduct a pap	er-based, tabletop exercise						
	at least annually.	A tabletop exercise is a						
	group discussion	led by a facilitator, using a						
	narrated, clinically	y-relevant emergency						
	scenario, and a s	et of problem statements,						
	directed message	es, or prepared questions						
	designed to challe	enge an emergency plan.						
	(ii) Analyze the R	NHCI's response to and						
	maintain docume	ntation of all tabletop						
	exercises, and en	nergency events, and revise						
	the RNHCI's eme	rgency plan, as needed.						
	Based on record re	view and interview, the LTC	E 00	)39	Deficiency- E039		10/10/2022	
	facility failed analy	ze the facility's response to and						
	maintain complete	documentation of all			No residents were affect	ted		
	Emergency Prepare	edness Program drills. The LTC			by the cited deficiency.			
	facility must do the	e following:			No residents were ident	tified		
	(i) Participate in an	annual full-scale exercise that			for potential to be affected by	the		
	is community-base	d; or			cited deficiency.			
	_	nity-based exercise is not			In-service completed wi	th		
		t an annual individual,			department heads on			
	facility-based funct				demonstrating comprehension	n of		
	_	ty experiences an actual natural			staff drills and documentation			
		gency that requires activation			effectiveness. Education			

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of the emergency plan, the LTC facility is exempt

from engaging its next required full-scale in a

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on 9-28-22.

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completed by facility Administrator

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i i i i i i i i i i i i i i i i i i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155255	B. W	ING		09/19/	2022
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION or individual, facility-based	+	TAG			DATE
	1	l exercise for 1 year following			<ol> <li>Emergency Preparedne</li> <li>Drills required staff drills will be</li> </ol>		
	the onset of the actu				reviewed in QA for 6 months of		
	(ii) Conduct an additional exercise that may				until a 100% compliance is		
	1 1	imited to the following:			obtained to ensure compliance	<del>)</del> .	
	a. A second full-sca	le exercise that is			5. The above changes will		
		r an individual, facility-based			in place by 10-10-22.		
	functional exercise.						
	b. A mock disaster						
	_	se or workshop that is led by a					
		des a group discussion, using y-relevant emergency scenario,					
		n statements, directed					
		red questions designed to					
	challenge an emerg						
		CC facility's response to and					
	maintain documents	ation of all drills, tabletop					
		gency events, and revise the					
		gency plan, as needed in					
		CFR 483.73(d)(2). This					
	deficient practice co	ould affect all occupants.					
	Findings include:						
	Based on records re	view with the Administrator					
	and Maintenance D	irector on 09/19/22 at 10:41					
		n for the annual exercises					
		/22 and on 08/19/22 were					
	_	xercises did not show if the					
		vas analyzed to ensure the EPP					
	_	ive. Based on interview at the					
		ew, the Administrator and the tor stated no documentation					
		IC facility's response was					
	completed.	1 & facility of responde was					
	<u>F</u> <del></del> -						
	This finding was reviewed with the Administrator						
	and Maintenance D	irector during the exit					
	conference.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING COMPLETED  B. WING 09/19/2022			LETED	
	PROVIDER OR SUPPLIE RATE SENIOR LIVII	R NG OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
E 0041 SS=F Bldg	482.15(e), 483.73 Hospital CAH and §482.15(e) Condi (e) Emergency ar The hospital mus standby power sy emergency plans this section and in procedures plans (i) and (ii) of this s §483.73(e), §485 (e) Emergency ar The [LTC facility a implement emerging systems based of forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requing Care Facilities Counterim Amendments TIA and TIA 12-4), and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §48 Emergency generator the eminspection, testing requirements four four facilities of the control of	G(e), 485.625(e)  ILTC Emergency Power tion for Participation: and standby power systems. It implement emergency and estems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1) section.  G25(e) and standby power systems. It is and the CAH] must ency and standby power in the emergency plan set in (a) of this section.  83.73(e)(1), §485.625(e)(1) reator location. The elected in accordance with rements found in the Health and (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim  12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new or when an existing					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155255		A. Bl	A. BUILDING B. WING			COMPLETED 09/19/2022		
		PROVIDER OR SUPPLIER	IG OF FORT WAYNE		3420 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
	X4) ID REFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		Emergency general and LTC facilities] source to power e have a plan for ho power systems opemergency, unless *[For hospitals at § §483.73(g), and C The standards incomposed this section are appreference by the E Federal Register in \$52(a) and 1 CFR the material from the You may inspect a Information Resource and Recomposed the Marchives and Recomposed the Standards in the E announce the characteristic forms and the E announce the Characteristic forms and the E announce the Characteristic forms and the E announce the Characteristic forms and E announce the Characteristic forms announce the Characteri	§482.15(h), LTC at AHS §485.625(g):] orporated by reference in opproved for incorporation by Director of the Office of the accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It is a copy at the CMS arce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or accessov/federal_register/code ations/ibr_locations.html. This edition of the Code are afference, CMS will publish a dederal Register to a federal Reg					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPLE	
		155255	B. WI	NG		09/19/2	2022
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
CELEBR	ATE SENIOR LIVIN	NG OF FORT WAYNE		3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL				TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2013.						
	<ul> <li>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</li> <li>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</li> <li>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</li> </ul>						
		NFPA 101, issued August					
	11, 2011.						
	<ul> <li>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</li> <li>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</li> <li>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</li> </ul>						
		Standard for Emergency and					
	, ,	ystems, 2010 edition,					
	including TIAs to a 2009	chapter 7, issued August 6,					
		eview and interview, the facility	E 00	141	Deficiency- E041		10/10/2022
		t the emergency power system		, 11			10/10/2022
	_	l in the Health Care Facilities			1. No residents were affect	ted	
	Code, NFPA 110, a	and Life Safety Code in			by the cited deficiency.		
		CFR 483.73(e)(2). This			No residents were ident	I	
	deficient practice co	ould affect all occupants.			for potential to be affected by cited deficiency.	the	
	Findings include:				Facility Maintenance     Director or designee is now		
	Based on records re	eview with the Administrator			completing the weekly genera	<sub>itor</sub>	
		Director on 09/19/22 at 10:22			testing for under-load and run		
	a.m., the generator	lacked monthly load testing			SafeCare contracted for 4 hou		
		nd NFPA 110. Based on			load bank testing and fuel		
		ne of record review, the			sampling test. Maintenance		
		tor stated the generator was			Director and maintenance		
	missing some of the	e required testing.			assistant educated on needed documentation by the facility	i	
	The findings were i	reviewed with the			Administrator.		
		Maintenance Director at the			Generator testing will be	e	
	exit conference.				reviewed in QA for 6 months of	I	
					until a 100% compliance is		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155255	B. WING 09/19/2022				
	PROVIDER OR SUPPLIER	G OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETI	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		DATE	
					obtained to ensure compliance 5. The above changes will in place by 10-10-22.		
K 0000							
Bldg. 01							
	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 09/19  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety 0 Living of Fort Ways compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Care Occupancies a  This one story facility Type V (111) consts sprinklered. The fac with smoke detection to the corridors, and Rehabilitation Hall. rooms had battery of	20158 55255 91490 Code survey, Celebrate Senior ne was found not in quirements for Participation in quirements for Participati	K 0	000	This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and feder law; or – Preparation and submission of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the fact alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared submitted solely because of requirements under state and federal laws.	of sthis ists ts al an es snee	
		residents have customary ered. All areas providing resprinklered.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
		155255	B. WI	NG		09/19/	/2022
	ROVIDER OR SUPPLIER	IG OF FORT WAYNE		3420 E	STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Т	ID	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
K 0131	Quality Review con	npleted on 09/26/22					
SS=E	Multiple Occupand	cies					
Bldg. 01		cies - Sections of Health					
Ü	Care Facilities Sections of health care facilities classified as						
	other occupancies	meet all of the following:					
	o They are not in	tended to serve four or					
	more inpatients fo	r purposes of housing,					
	treatment, or custo	•					
	-	rated from areas of health					
	care occupancies	-					
		aving a minimum two hour					
	fire resistance rati	_					
	accordance wit	· · · · · · · · · · · · · · · · · · ·					
	by an approved, s	ding is protected throughout					
		ikler system in accordance					
	with Section 9.7.	inci system in accordance					
	with Codacin cirr.						
	Hospital outpatien	t surgical departments are					
		ssified as an Ambulatory					
	Health Care Occu	pancy regardless of the					
	number of patients	s served.					
	19.1.3.3, 42 CFR	482.41, 42 CFR 485.623					
		on and interview, the facility	K 0	131	Deficiency- K131		10/10/2022
		penetration in 1 of 1 fire barrier					
	_	health care from assisted			No residents were affect	ted	
		ed to ensure the fire resistance			by the cited deficiency.		
		19.1.1.3 requires all health care			2. No residents were ident		
		tained and operated to			for potential to be affected by t	ne	
	_	oility of a fire emergency ation of the occupants. LSC			cited deficiency.  3. Penetration in the barrie	ır	
		etrations for cables, cable			wall was corrected. The unsea		
		es, tubes, combustion vents			ends of the pipe sleeves in the		
		vires, and similar items to			wall were corrected. A facility		
		rical, mechanical, plumbing,			through was completed to ider		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155255		A. BUILDING <u>01</u> COMPLETED B. WING 09/19/2022				
		100200	D. W	_		03/13/	2022	
NAME OF P	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD			
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT WAYNE, IN 46805				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
TAG		s systems that pass through a		TAG	any other needed repairs to be			
		ceiling assembly constructed			walls.			
		l be protected by a firestop			4. Repairs identified will be			
	system or device. The firestop system or device				reviewed in QA for 6 months of	or		
		cordance with ASTM E 814,			until a 100% compliance is			
		od for Fire Tests of Through ops, or ANSI/UL 1479,			obtained to ensure compliance			
		ests of Through-Penetration			The above changes will be in by 10-10-22			
	Fire Stops. This deficient practice could affect 20				by 10-10-22			
	on rehab-hall.							
	Findings include:							
	Based on observation with the Maintenance Director on 09/19/22 at 1:00 p.m., above the drop							
		ation fire barrier in rehab had						
		of pipe sleeves in the wall.						
		at the time of observation, the						
		or agreed the separation fire						
		d pipe sleeves through the						
	wall.							
	The finding was rev	viewed with the Administrator						
	and Maintenance D	irector during the exit						
	conference.							
	3.1-19(b)							
K 0222	NFPA 101							
SS=E	Egress Doors							
Bldg. 01	Egress Doors							
	· ·	d means of egress shall not						
		a latch or a lock that						
		f a tool or key from the susing one of the following						
	special locking arr	-						
		OR SECURITY THREAT						
	LOCKING							
	Where special loc	king arrangements for the						
	clinical security ne	eds of the patient are						

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PRINTED: 10/12/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIEI	ROG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE BLVD WAYNE, IN 46805		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION	
TAG	used, only one loopermitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks afety needs of the Clinical or Secare being met. In electrical locks the release upon loss building is protect automatic sprinkle space is protected detection system at an attended lockspace); and both systems are arrarupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servir contents in buildir an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2.	cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ied by staff at all times; or a means available to the a.2.2.6, 19.2.2.2.5.1, a. LOCKING Sching arrangements for the patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to a of power to the device; the ed by a supervised er system and the locked at by a complete smoke (or is constantly monitored action within the locked the sprinkler and detection aged to unlock the doors a.2.2.5.2, TIA 12-4 SS LOCKING Schelayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system2.4 COLLED EGRESS	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE DATE	
	Access-Controlled	d Egress Door assemblies				

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10/12/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/19/2022 155255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3420 EAST STATE BLVD CELEBRATE SENIOR LIVING OF FORT WAYNE FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 **ELEVATOR LOBBY EXIT ACCESS** LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility K 0222 10/10/2022 Deficiency- K222 failed to ensure the means of egress through 2 of 9 exit doors were readily accessible for residents No residents were affected without a clinical diagnosis requiring specialized by the cited deficiency. security measures. Doors within a required means No residents were identified of egress shall not be equipped with a latch or for potential to be affected by the lock that requires the use of a tool or key from the cited deficiency. egress side unless otherwise permitted by LSC The code was posted on 19.2.2.2.4. Door-locking arrangements shall be the key pad to the identified exit permitted in accordance with 19.2.2.2.5.2. This door noted in violation to Egress deficient practice could affect over 15 residents State requirements. Staff using 2 exits education being completed by facility Administrator and/or Findings include: designee. 4. Further compliance will be Based on observation with the Maintenance reviewed/discussed in QA for 6 Director on 09/19/22 between 12:10 p.m. and 12:30 months or until a 100% p.m., the exit doors in therapy and on the compliance is obtained to ensure rehab-hall were marked as a facility exits, were no further exit doors are without magnetically locked, and could be opened by codes posted. entering a four-digit code on the access control The above changes will be pads, but the codes were not posted at the exits. in place by 10-10-22. Based on interview at the time of observation, the Maintenance Director agreed the codes to open the two exit doors were not posted by the access

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control pads.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155255	B. WI	NG		09/19/	/2022
	ROVIDER OR SUPPLIER	IG OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	viewed with the Administrator irector during the exit					
K 0227	NFPA 101						
SS=E	-	Fxits					
Bldg. 01	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 with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 states guards complying with Section 7.2.2.4 shall be provided for ramps, Section 7.2.5.4.2 states handrails complying with Section 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 in. (150 mm). This deficient practice could affect 25 residents evacuated from the southwest hall and smoking area.		K 0.	227	1. No residents were affect by the cited deficiency. 2. No residents were ident for potential to be affected by cited deficiency. 3. Handrail will be replace. Staff education being complet by facility Administrator and/or designee on handrail requirem and completing maintenance orders if/when identified.	iified the d. ed r nents	10/10/2022
	Director on 09/19/2 the exit ramp from a broken from their suback and forth. This unsteady for someo support. Based on a observation, the Ma railing was loose an	observation with the Maintenance 9/19/22 at 12:35 p.m., the handrails for from southwest hall were loose, their supports, and could be pushed h. This condition made the handrails someone using the handrails for d on an interview at the time of the Maintenance Director stated the ose and needed repaired.			4. Work orders will be reviewed/discussed in QA for months or until a 100% compliance is obtained to ens timely repairs.  5. The above changes will in place by 10-10-22.	ure	
	_	irector during the exit	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155255	B. W	ING		09/19	/2022
	ROVIDER OR SUPPLIER	IG OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	conference.						
	3.1-19(b)						
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas						
		are protected by a fire					
		our fire resistance rating					
	_	rated doors) or an					
	automatic fire exti	nguishing system in					
	accordance with 8	3.7.1 or 19.3.5.9. When the					
	approved automat	tic fire extinguishing system					
	option is used, the	e areas shall be separated					
	-	by smoke resisting					
		rs in accordance with 8.4.					
	Doors shall be sel	_					
	_	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
		that are deficient in					
	REMARKS. 19.3.2.1, 19.3.5.9						
	19.3.2.1, 19.3.3.9						
	Area Separation	Automatic Sprinkler N/A					
	a. Boiler and Fuel	-Fired Heater Rooms					
	b. Laundries (large	er than 100 square feet)					
	c. Repair, Mainter	nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	- '	classified as Severe					
	Hazard - see K32						
	Based on observation	on and interview, the facility	K 0	321	Deficiency- K321		10/10/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE COMPL 09/19/	ETED
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	;	STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
1.70	failed to ensure 1 of which contained fur separated from othe partitions. This defi residents in one smorth small states around a drywall pain the maintenance of the time of the observation of the observ	I laundry/maintenance rooms If fired equipment were r spaces by smoke resistant cient practice could affect 20			1. No residents were affect by the cited deficiency. 2. No residents were iden for potential to be affected by cited deficiency. 3. Unsealed gap around drywall in laundry/maintenance room was corrected. Staff education being completed by facility Administrator with the Maintenance Director and Maintenance assistant. 4. Work orders will be reviewed/discussed in QA for months or until a 100% compliance is obtained to enstimely repairs. 5. The above changes will in place by 10-10-22.	tified the e ,	DATE
K 0341 SS=E Bldg. 01	and components a accordance with N Code, and NFPA Code to provide expart of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously n is installed at each fire In new occupancy, astalled at notification ower extenders, and n transmitting equipment.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED	
155255 B. WING 09/19/2022	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD	
3420 EAST STATE BLVD	
CELEBRATE SENIOR LIVING OF FORT WAYNE FORT WAYNE, IN 46805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X:	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED OF THE APPROPRIATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DAT	Ξ
integrity.	
18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8  Based on observation and interview, the facility  K 0341  Deficiency- K341  10/10/	2022
Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was	2022
installed in accordance with 19.3.4.1. LSC 9.6.1.3	
requires a fire alarm system to be installed, tested,  by the cited deficiency.	
and maintained in accordance with NFPA 70,  2. No residents were identified	
National Electrical Code and NFPA 72, National for potential to be affected by the	
Fire Alarm Code. NFPA 72, 17.7.4.1 requires in cited deficiency.	
spaces served by air handling systems, detectors  3. Smoke detector was moved	
shall not be located where air flow prevents away from the air return.	
operation of the detectors. This deficient practice  4. Smoke detectors audit will	
could affect 5 in the therapy gym. be reviewed/discussed in QA for 6	
months or until a 100%	
Findings include: compliance is obtained to ensure	
no other concerns are identified on	
Based on observation with the Maintenance location.	
Director on 09/19/22 at 12:25 p.m., in the therapy  5. The above changes will be	
gym there was a smoke detector next to an air in place by 10-10-22.	
return where air flow would prevent proper	
operation of the detector. The detector was about	
12 inches from the vent. Based on interview at the	
time of observation, the Maintenance Director	
agreed the smoke detector was in the direct airflow from the return and was within 12 inches of	
the vent.	
uic vent.	
The finding was reviewed with the Administrator	
and Maintenance Director during the exit	
conference.	
3.1-19(b)	
K 0345 NFPA 101	
SS=F Fire Alarm System - Testing and	
Bldg. 01   Maintenance	
Fire Alarm System - Testing and	
Maintenance	
A fire alarm system is tested and maintained	
in accordance with an approved program	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY  COMPLETED  09/19/2022	
	PROVIDER OR SUPPLIER	NG OF FORT WAYNE	3420 ا	FADDRESS, CITY, STATE, ZIP COD EAST STATE BLVD WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	National Electric Control National Fire Alar Records of syster and testing are re 9.6.1.3, 9.6.1.5, Notes and testing are re 9.6.1.3, 9.6.1.5, Notes and record record records are failed to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual insperaccordance with the more often if requiring jurisdiction. Table must be visually instance and the control unit trought. Remote annunciated. Initiating devices fire alarm boxes, he etc.)  d. Notification applies. Magnetic hold-off This deficient practifacility.  Findings include:  Based on records reand Maintenance Dam., no documentate visual inspection of months after the an conducted on 12/23 time of records reviagreed a visual inspection of records reviagr	FPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ections shall be performed in e schedules in Table 14.3.1, or eed by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors a (e.g. duct detectors, manual eat detectors, smoke detectors,	K 0345	Deficiency- K345  1. No residents were affect by the cited deficiency. 2. No residents were ident for potential to be affected by cited deficiency. 3. Visual fire inspection of fire alarm system was completed by Safecare. 4. Required inspections wireviewed in QA for 6 months of until a 100% compliance is obtained to ensure no further delays. 5. The above changes will in place by 10-10-22.	ified the the ted ill be or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  09/19/2022	
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE BLVD WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and Maintenance D conference.  3.1-19(b)	viewed with the Administrator irector during the exit			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing				
	failed to maintain 1 accordance with LS automatic sprinkler and maintained in a Standard for the Ins Maintenance of Wa Systems. NFPA 25 indicates the require testing. NFPA 25, 5 pipe sprinkler syste and gauges on dry standard process.	of 1 sprinkler system in C 9.7.5. LSC 9.7.5 requires all systems shall be inspected ecordance with NFPA 25, pection, Testing, and ter-Based Fire Protection, 2011 edition, Table 5.1.1.2 ed frequency of inspection and i.2.4.1 states gauges on wet ms shall be inspected monthly systems (5.2.4.2) shall be ensure normal water or air	K 0353	1. No residents were affect by the cited deficiency. 2. No residents were identified potential to be affected by cited deficiency. 3. The monitoring form was put in place for the weekly dry pipe gauge checks and month wet pipe gauge and valve che This monitoring form will be maintained by the Maintenance.	tified the as ally ecks.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING	01	COMPLE OO/10/	
		155255	B. W.	_		09/19/2	2022
NAME OF P	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD		
CELERD	ATE SENIOD I IVIN	IG OF FORT WAYNE			AST STATE BLVD WAYNE, IN 46805		
					T		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		aintained. NFPA 25 13.3.2.1		1110	Director or designee.		
		be inspected weekly or			4. The monitoring form will	l be	
		s or supervised (13.3.2.1.1)			reviewed in QA for 6 months of		
	shall be permitted to	o be inspected monthly. This			until a 100% compliance is		
	deficient practice co	ould affect all occupants.			obtained.		
					5. The above changes will		
	Findings include:  Based on records review with the Administrator				in place by 10-10-22.		
		irector on 09/19/22 at 10:19					
		weekly dry pipe gauge checks					
	and no monthly wet	t pipe gauge and valve checks					
	-	ths. During an interview at the					
	time of record review, the Maintenance Director						
		tation of gauge and valve					
	Director and could	the previous Maintenance					
	Director and could	not be found.					
	This finding was re	viewed with the Administrator					
	and Maintenance D	irector during the exit					
	conference.						
	3.1-19(b)						
K 0361	NFPA 101						
SS=E	Corridors - Areas	Open to Corridor					
Bldg. 01	Corridors - Areas						
	Spaces (other tha	n patient sleeping rooms,					
		and hazardous areas),					
	-	se's stations, gift shops,					
	-	ies, open to the corridor are					
		n the criteria under 18.3.6.1					
	and 19.3.6.1. 18.3.6.1, 19.3.6.1						
		and observation; the facility	K 0	361	Deficiency- K361		10/10/2022
		f 2 rehabilitation patient		501	25		10/10/2022
		e not open to the corridor. LSC			No residents were affect	ted	
		dors shall be separated from all			by the cited deficiency.		
		tions complying with 19.3.6.2			No residents were ident	ified	
	through 19.3.6.5 (see	ee also 19.2.5.4), 19.3.6.1 (7)			for potential to be affected by	the	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	ľ	UILDING	onstruction 01	(X3) DATE COMPL <b>09/19</b> /	ETED
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	states spaces, other treatment rooms, ar permitted to be ope in area. This deficie residents.  Findings include:  Based on observation Director on 09/19/2 equipment was set adining room which Based on interview Maintenance Direct stated the therapy to dining room which  The finding was rev	than patient sleeping rooms, and hazardous areas, shall be an to the corridor and unlimited and practice could affect 5  on with the Maintenance 2 at 1:01 p.m., therapy up and being used in the was open to the corridor. at the time of observation, the for and the Administrator pook place in the back of the was open to the corridor.		TAG	cited deficiency.  3. Therapy equipment and treatments were moved back the therapy gym. Staff educati being completed.  4. Education will be review in QA for 6 months or until a 1 compliance is obtained.  5. The above changes will in place by 10-10-22.	to on /ed 00%	DATE
K 0363 SS=E Bldg. 01	than required enciexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I. CMS regulation. T	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in a fire for at least 20 fully sprinklered smoke exponentially required to resist the exportant corridor doors and doors in an analysis of the same prohibited by these requirements do not spaces that do not contain					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIEF	IG OF FORT WAYNE	;	3420 EA	DDRESS, CITY, STATE, ZIP COD AST STATE BLVD JAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION bustible material.	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	covering is not ex doors complying wif provided with a the door closed wapplied. There is closing of the doorelease when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire s or frames in window					
	483, and 485 Show in REMARK fire protection ratio devices, etc. Based on observation	Parts 403, 418, 460, 482,  (S details of doors such as ngs, automatics closing on and interview, the facility f 50 room corridor doors on the	K 036	3	Deficiency- K363		10/10/2022
	suitable for keeping impediment to closs	re provided with a means g the door closed, had no eng, latching and would resist e. This deficient practice dents in one smoke			<ol> <li>No residents were affect by the cited deficiency.</li> <li>No residents were ident for potential to be affected by cited deficiency.</li> <li>Door was corrected to latch. An audit was completed found no other concerns.</li> </ol>	ified the	

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Based on observation with the Maintenance

Director on 09/19/22 at 10:01 a.m., the corridor

door to room # 2 did not latch into the frame when

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Audits will be reviewed in

The above changes will be

QA for 6 months or until a 100%

compliance is obtained.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE		3420 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	tested. Based on int observation, the Ma corridor door would The finding was rev	erview at the time of intenance Director stated the I not latch into the door frame.			in place by 10-10-22.		
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers sh 1/2-hour fire resist barriers shall be p atrium wall. Smok in duct penetration systems where an is installed for smot to the smoke barri 19.3.7.3, 8.6.7.1(1) Describe any med system in REMAR	nall be constructed to a tance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent ter.					
	failed to ensure pen barrier walls smoke maintain the smoke barrier. LSC Section barriers to be constructed Section 8.5 and sharesistive rating. LSC smoke barriers to be wall to an outside we from a smoke barrier of a combination th	on and interview, the facility etrations through 1 of 4 smoke barriers were protected to resistance of each smoke on 19.3.7.5 requires smoke ructed in accordance with LSC III have a minimum ½ hour fire C Section 8.5.2.1 requires e continuous from an outside vall, from a floor to a floor, or er to a smoke barrier, or by use ereof. 8.5.6.2 requires eles, cable trays, conduits,	K 03	72	1. No residents were affect by the cited deficiency. 2. No residents were identifor potential to be affected by tocited deficiency. 3. The corridor door on southwest unit was fixed. Audicompleted and found no other concerns. 4. Audit will be reviewed in for 6 months or until a 100%	fied he	10/10/2022

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	ľ	JILDING	nstruction  01	(X3) DATE : COMPL 09/19/	ETED
	PROVIDER OR SUPPLIER	G OF FORT WAYNE		3420 EA	DDRESS, CITY, STATE, ZIP COD AST STATE BLVD VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	accommodate electrand communication wall, floor, or floor/as a smoke barrier, membrane of the roassembly, shall be praterial capable of smoke. This deficie and at least 30 residucompartments.	wires, and similar items to rical, mechanical, plumbing, as systems that pass through a ceiling assembly constructed for through the ceiling of/ceiling of a smoke barrier protected by a system or restricting the movement of the practice could affect staff ents in one two smoke			compliance is obtained.  5. The above changes will in place by 10-10-22.	be	
	Director on 09/19/2 Springs smoke wall inch hole around a p time of observation, agreed there were u Hope Springs smok	iewed with the Administrator					
	conference.  3.1-19(b)	rector during the exit					
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke ba solid bonded wood construction that r Nonrated protectiv are permitted. Door	Iding Spaces - Smoke Iding Spaces - Smoke  Arriers are 1-3/4-inch thick Id-core doors or of Lesists fire for 20 minutes. Le plates of unlimited height Lors are permitted to have Lessemblies per 8.5. Doors					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/19/2022	
	PROVIDER OR SUPPLIEI	RG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	require latching, a in the direction of provides a minimulator swinging or he 19.3.7.6, 19.3.7.8 Based on observation failed to ensure 2 or would restrict the mean 20 minutes. LSC 1 barriers shall compensures and the opening leaving necessary for propen practice could affect compartments.  Findings include:  Based on observation Maintenance Direct the sets of smoke be South halls had the removed allowing the sets of smoke do interview during the Maintenance Direct smoke doors required and stated the coord been removed by the Director.  The finding was reconstructed.		K 0374	Deficiency- K374  1. No residents were affect by the cited deficiency. 2. No residents were identifor potential to be affected by the cited deficiency. 3. North and South hall doccoordinating device are schedut to be replaced by facility vendor SafeCare. 4. Work orders will be reviewed in QA for 6 months of until a 100% compliance is obtained. 5. The above changes will in place by 10-10-22.	fied he or uled or,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  09/19/2022	
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	<u> </u>	3420 E	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD WAYNE, IN 46805	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical with NFF Code. Existing insights service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of the room 409 was secured requires electrical with NFPA 70, National 406.5 states Recept a boxes or assemblies and such boxes or a fastened in place untelsewhere in this Control This deficient practitithe room 409.  Findings include:  Based on observation Director on 09/19/2 main nurse's station out from the wall expending the main terminals.	Electric gas or related gas piping PA 54, National Fuel Gas uring and equipment PA 70, National Electric tallations can continue in no hazard to life. 9.1.1, 9.1.2 on and interview, the facility F4 electrical outlet boxes in rely fastened in place. LSC 9.1.2 riving and equipment to comply tonal Electrical Code. Article racles shall be mounted in redesigned for the purpose, resemblies shall be securely reserving electrical code. Rece could affect 2 residents in responsible to the mounted in responsible to the purpose, resemble and the purpose, resemble shall be securely reserving electrical code. The purpose of the purpose of the purpose of the purpose, resemble shall be securely reserving electrical code. The purpose of the purpose	K 0	511	Deficiency- K511  1. No residents were affect by the cited deficiency. 2. No residents were ident for potential to be affected by cited deficiency. 3. The outlet identified by nurses' station was corrected. audit was conducted and foun other issues. 4. Work orders will be reviewed in QA for 6 months of until a 100% compliance is obtained. 5. The above changes will in place by 10-10-22.	tified the the An ad no	10/10/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  O1		(X3) DATE SURVEY COMPLETED		
		155255	B. WI	NG		09/19/	/2022
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	•	3420 E	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD NAYNE, IN 46805		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include t	the transmission of a fire					
	-	simulation of emergency fire					
		ills are held at expected					
	-	mes under varying					
		t quarterly on each shift.					
		r with procedures and is					
		re part of established					
		ills are conducted between					
	9:00 PM and 6:00	·					
		ay be used instead of					
	audible alarms.						
	19.7.1.4 through 1						
		view and interview, the facility	K 07	712	Deficiency- K712		10/10/2022
		re drills or documented					
		on each shift for 2 of 4			No residents were affect	ted	
	-	1.6 states drills shall be			by the cited deficiency.		
		on each shift to familiarize			<ol><li>No residents were ident</li></ol>		
		nurses, interns, maintenance			for potential to be affected by	the	
	-	inistrative staff) with the			cited deficiency.		
	-	ncy action required under			3. Fire drills have been		
		QSO-20-31 1135 temporary			conducted with current		
	· ·	06/07/22) states in lieu of a			Maintenance Director and		
		documented orientation			Administrator. Staff education		
		lated to the current fire plan,			being completed on requirement	ents	
		rrent facility conditions, is			for fire drills.		
	-	ning will instruct employees,			4. Fire drills will be reviewed		
		new or temporary employees,			QA for 6 months or until a 100	1%	
		es, life safety procedures and			compliance is obtained.		
	•	evices in their assigned area.			5. The above changes will	be	
	-	ice affects all staff and			in place by 10-10-22.		
	patients.						
	Findings include:						
	Based on records re	view with the Administrator					
		irector on 09/19/22 at 10:01					
	a.m., the following						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155255	A. BU B. WI	JILDING NG	01	COMPL 09/19/	
		155255	D. WI	_		09/19/	2022
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD		
CELEBRA	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT WAYNE, IN 46805			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		completed fire drill or		TAG	BETTELLICIT		DATE
	documented orienta	_					
		e third quarter of 2021					
	· ·	fourth quarter of 2021.					
		I shifts in the first quarter of					
	2022						
	d) All shifts in the s	second quarter of 2022					
	Based on interview	at the time of record review,					
	the Maintenance Di	rector agreed there were					
	_	nd staff has not been trained in					
		edures and stated fire were not					
	conducted by the pr	evious Maintenance Director.					
	This finding was re	viewed with the Administrator					
		irector during the exit					
	conference.						
	3.1-19(b)						
	3.1-51(c)						
K 0761 SS=E							
Bldg. 01	Based on observation	on and interview, the facility	K <sub>0</sub>	761	Deficiency- K761		10/10/2022
		nual testing of 1 of 1 rolling	KU	/01	Beliefeliey- 17701		10/10/2022
		I separation fire doors in			No residents were affect	ted	
		FPA 80 5.2.1 which requires fire			by the cited deficiency.		
	door assemblies to l	be inspected and tested not			No residents were ident	ified	
	less than annually, a	and a written record of the			for potential to be affected by	the	
	_	signed and kept for inspection			cited deficiency.		
		eficient practice could affect 25			3. The rolling fire door		
	residents in the mai	n dining room.			inspection was being schedule prior to the survey on 9-19-22		
	Findings include:				inspection is scheduled 10-7-2 with SafeCare.		
	Based on observation	on with the Maintenance			Required Life Safety		
	Director on 09/19/2	2 between 11:30 a.m. and 12:30			inspections will be reviewed in	ı QA	
	p.m., there was a ro	lling fire door/window between			for 6 months or until a 100%		
	the kitchen and dini	ng room and the tag on the			compliance is obtained		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	1	LE CONSTRUCTION	r '	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>01</u>		PLETED
		155255	B. WING			9/2022
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, Z	ZIP COD	
CELEBRA	ATE SENIOR LIVIN	IG OF FORT WAYNE		20 EAST STATE BLVD PRT WAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION icated the last annual test was	TA	J	hanges will be	DATE
	_	/20. Also, there was no annual		in place by 10-10-2	•	
	_	re door that separated health			22.	
	_	ring. Based on interview at the				
		the Maintenance Director				
		g door/window has not been				
	inspected since Octo	-				
	_	tation could be found for the				
	separation fire door					
	The findings were re	eviewed with the				
	Administrator and N	Maintenance Director during				
the exit conference.						
	3.1-19(b)					
K 0911	NFPA 101					
SS=E	Electrical Systems	s - Other				
Bldg. 01	Electrical Systems	s - Other				
	List in the REMAR	RKS section any NFPA 99				
	Chapter 6 Electric	al Systems requirements				
		ssed by the provided				
	•	eficient. This information,				
		licable Life Safety Code or				
		tation, should be included				
	on Form CMS-256					
	Chapter 6 (NFPA	•	17 0011	Deficiency K044		10/10/2022
		on and interview, the facility ess and working space was	K 0911	Deficiency- K911		10/10/2022
		2 electrical room panels. NFPA		1. No residents	were affected	
		cilities Code, 2012 Edition,		by the cited deficie		
		es electrical installation shall be		1 -	were identified	
		NFPA 70, National Electric		for potential to be a		
		011 Edition, Article 110.26		cited deficiency.		
		orking space shall be			stored in front	
		ained about all electrical		of the electrical par		
	equipment to permi	t ready and safe operation and		moved to an appro	-	
	maintenance of sucl	n equipment. Working space		room. Staff educati		
	for equipment opera	ating at 600 volts, nominal, or		completed by facili	-	
	less and likely to red	quire examination, adjustment,		Administrator.		

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Event ID:

3DCX21 Facility ID: 000158

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155255		B. WI	B. WING 09/19/2022			2022	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER				3420 E	AST STATE BLVD		
CELEBRA	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	-	nance while energized shall			4. Storage areas will be		
		nensions of $110.26(A)(1), (2)$			reviewed in QA for 6 months o	or	
		(1) states the depth of the			until a 100% compliance is	•	
	working space in the direction of live parts shall not be less than that specified in Table 110.26(A)				obtained.  5. The above changes will be		
		num clear distance is 3 feet.			5. The above changes will be in place by 10-10-22.		
	, ,	the width of the working					
	` ' ` '	e electrical equipment shall be					
	-	sipment or 762 mm (30 in.),					
		r. In all cases, the work space					
	shall permit at least a 90 degree opening of						
	equipment doors or hinged panels. 110.26(A)(3)						
	states the work space shall be clear and extend						
	from the grade, floor, or platform to a height of						
	61?2 feet or the height of the equipment,						
	whichever is greater. Article 110.26(B) states the						
	working space required by this section shall not						
	be used for storage. This deficient practice could						
	all residents due to the access to the building's life safety electrical panel was blocked.  Findings include:  Based on observations with the Maintenance Director on 09/19/22 at 12:58 p.m. the life safety electrical panels and equipment electrical panels in the laundry mechanical room were blocked from						
		ored in front of the panels.					
	Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panels.  The finding was reviewed with the Administrator and Maintenance Director during the exit						
	conference.	<b>C</b>					
	3.1-19(b)						
			l				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G <u>01</u>	(X3) DATE SURVEY COMPLETED 09/19/2022				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD					
CELEBRATE SENIOR LIVING OF FORT WAYNE			FOR	RT WAYNE, IN 46805				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE			
K 0918	NFPA 101							
SS=F	Electrical Systems	s - Essential Electric Syste						
Bldg. 01	Electrical Systems	s - Essential Electric						
	System Maintenar	nce and Testing						
	The generator or	other alternate power						
		ated equipment is capable						
		ce within 10 seconds. If the						
		n is not met during the						
		ocess shall be provided to						
	_	his capability for the life						
	-	branches. Maintenance						
	_	generator and transfer						
	switches are performed in accordance with NFPA 110.							
		e inspected weekly,						
		pad 30 minutes 12 times a						
		intervals, and exercised						
		nths for 4 continuous hours.						
	•	der load conditions include						
	a complete simula							
	•	ual transfer of all EES						
		nducted by competent						
		nance and testing of stored						
	·	rces (Type 3 EES) are in						
		IFPA 111. Main and feeder						
	circuit breakers ar	e inspected annually, and a						
	program for period	dically exercising the						
	components is established according to							
	manufacturer requ	irements. Written records						
	of maintenance ar	nd testing are maintained						
	and readily availab	ole. EES electrical panels						
	and circuits are ma	arked, readily identifiable,						
	•	normal power circuits.						
		ssibility of damage of the						
		source is a design						
	consideration for r							
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.10				4			
		on, records review, and	K 0918	Deficiency- K918	10/10/2022			
	interview the facility	y failed to maintain 1 of 1 diesel						

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING 01		COMPLETED			
		155255	B. WING 09/19/2						
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD				
NAME OF TROVIDER OR SOLLEIER					AST STATE BLVD				
CELEBRA	ATE SENIOR LIVIN	NG OF FORT WAYNE		FORT WAYNE, IN 46805					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE		
	power generators in	n accordance with NFPA 99			1. No residents were affect	ted			
	2012 Chapter 6 wh	ich requires monthly testing of			by the cited deficiency.				
	the generator servir	ng the emergency electrical			No residents were identified				
	system to be in acc	ordance with NFPA 110, the			for potential to be affected by the				
	-	gency and Standby Powers			cited deficiency.				
	-	3. This deficient practice could			3. Facility Maintenance				
	affect all occupants	_			Director or designee is now				
					completing the weekly genera	tor			
	Findings include:				testing for under-load and run test. SafeCare is contracted for the				
	Based on records re	eview with the Administrator			4hour load bank testing and fu				
	and Maintenance Director on 09/19/22 at 11:01				sampling test. The battery				
	a.m., the following required testing documentation				powered generator light was				
	was not available for review:				repaired. Maintenance Directo	r			
	a.) Generator exercised under load monthly for a				and maintenance assistant wa				
	minimum of 30 minutes.				educated on needed				
	<ul><li>b.) Generator inspected weekly.</li><li>c.) Generator annual fuel quality test for diesel generators.</li><li>d.) Battery powered generator task lighting testing</li></ul>				documentation and functioning	n of			
					the battery powered generator				
					lighting.				
					4. Generator testing will be	_			
	for 30 seconds mor				reviewed in QA for 6 months of				
		d generator task lighting testing			until a 100% compliance is	<b>/</b> 1			
	for 90 minutes min				obtained.				
		on at 11:15 a.m., the battery			5. The above changes will	he			
					in place by 10-10-22.	50			
	powered light at the generator did not work when tested.  Based on an interview at the time of record review and observation, the Maintenance Director stated the inspection and testing documentation for the generator was lost by the previous Maintenance Director, no other generator paperwork could be found, and the battery powered light at the generator was not working.  The findings were reviewed with the Administrator and Maintenance Director during the exit conference.				111 place by 10-10-22.				
	3.1-19(b)								

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155255	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR SUPPLIER  CELEBRATE SENIOR LIVING OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD  3420 EAST STATE BLVD  FORT WAYNE, IN 46805					
(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	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-related (PCREE) assembled by quanthe conditions of 1 the patient care vinon-PCREE (e.g., except in long-termed on to use PCREE meet UL 1363A on for non-PCREE in (outside of vicinity non-patient care reother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3) Based on observation failed to ensure 1 of patient care location of 1363A or 60601-affect 5 residents in Findings include:  Based on observation with the Maintenance p.m., a power strip of the strip of	ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Cords and ent - Power Strips in ent that have been lified personnel and meet 0.2.3.6. Power strips in einity may not be used for personal electronics), ent care resident rooms that E. Power strips for PCREE e UL 60601-1. Power strips the patient care rooms ent) meet UL 1363. In element care rooms ent ul 1363. In elem	K 0		Deficiency- K920  1. No residents were affect by the cited deficiency.  2. No residents were ident for potential to be affected by the cited deficiency. The power struct mot meeting the required rating was removed from the therapy gym. Audit was completed and further power strip not meeting required rating were found.	ified the rip g / d no	10/10/2022	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/19/2022		
NAME OF PROVIDER OR SUPPLIER CELEBRATE SENIOR LIVING OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805				
(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
	meet 1363A or 6060 time of observation, agreed a power strip area and did not me	01-1. Based on interview at the the Maintenance Director was in use in a resident care et 1363A or 60601-1.			3. The appropriate power swith required UL rating was provided to the therapy department. Staff education be completed by the Administrate 4. The Audit will be review in QA for 6 months or until a 1 compliance is obtained.  5. The above changes will in place by 10-10-22.	eing or. ed 00%	

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