STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155255	A. BUILDING -- B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 09/19/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/15/22 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 At this PSR survey, Celebrate Senior Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 128 and had a census of 68 at the time of this survey. Quality Review completed on 11/22/22	E 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or – Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/19/22 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 11/15/22 Facility Number: 000158 Provider Number: 155255	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Hunter		12/14/2022

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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	AIM Number: 100291490 At this PSR survey, Celebrate Senior Living was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility is certified for 118 beds and licensed for 128 and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/22/22		law; or – Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge ramp with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 Guards complying	K 0227	Deficiency- K227 1. No residents were affected by the cited deficiency.	12/15/2022

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	with 7.2.2.4 shall be provided for ramps, 7.2.5.4.2 Handrails complying with 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. Findings include: Based on an observation with the Maintenance Director on 11/15/22 at 2:35 p.m., the handrails for the exit ramp from southwest hall were loose, broken from supports, and could be pushed back and forth. This condition made the handrails unsteady for someone using the handrails for support. Based on an interview at the time of observation, the Maintenance Director stated the railing was loose and has not been repaired due to the railing system was not yet purchased. The finding was reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 09/19/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		2. No residents were identified for potential to be affected by the cited deficiency. 3. Handrail was replaced. Administrator and/or designee will monitor the structural integrity of the ramp handrail to ensure continued compliance. The monitoring tool will be completed by the Maintenance Director or designee weekly. 4. Monitoring tool will be reviewed/discussed in QA for 6 months or until a 100% compliance is obtained to ensure timely repairs. 5. The above changes will be in place by 12-15-22.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have			

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	fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 10/15/22 at 2:12 p.m., the sets of smoke barrier doors to the North and South halls had new door coordinating devices installed but did not put the hardware back into the existing holes of the old coordinators. This condition does not restrict the movement of smoke for at least 20 minutes due to the six unsealed holes through the door frames. Based on interview during the time of observations, the Maintenance Director agreed holes were in the two smoke door frames. The finding was reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 09/19/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0374	Deficiency- K374 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. North and South hall smoke doors had holes sealed. 4. Monitoring tool put in place to be completed monthly by the Maintenance Director or designee. Monitoring tool will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 12-15-22.	12/15/2022

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K 0761 SS=E Bldg. 01	Based on records review and interview, the facility failed to conduct annual testing of 1 of 1 separation fire doors in accordance with NFPA 80 5.2.1 which requires fire door assemblies to be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 25 residents in on smoke compartment. Findings include: Based on observation with the Maintenance Director on 11/15/22 at 2:30 p.m., there was no documentation for review of an annual inspection for the fire door that separated health care and assisted living. Based on interview at the time of observation, the Maintenance Director stated the separation fire door has not been inspected per requirements of NFPA 80. The finding was reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 09/19/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0761	Deficiency- K761 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The annual door inspection was completed 11-25-22. A monthly monitoring tool was put in place to ensure that compliance is continued with documentation/monitoring of fire door maintenance, inspection, and testing of fire door assemblies. 4. Monitoring tool and annual inspection will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 12-15-22.	12/15/2022