DEPARTMENT OF HEALTH AND HUM	IAN SERVICES	
CENTERS FOR MEDICARE & MEDICA	AID SERVICES	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155255		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2024		
	PROVIDER OR SUPPLIER	G OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG E 0000	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg			E 0	E 0000 This Plan of Correction constitut this facility's written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency existor 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 a 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 a submitted solely because of requirements under state and federal laws.		of s f this sists	
K 0000							
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/10/24 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490		K 0	000	This Plan of Correction constitution this 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	of s f this cists	

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

TITLE (X6) DATE

Tammy Hunter Administrator 09/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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EPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES								
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					
	455055	n umra	07/40/0004					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155255	A. BUILDING <u>01</u> B. WING		COMPLETED 07/10/2024			
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	3420 E	STREET ADDRESS, CITY, STATE, ZIP COD 3420 EAST STATE BLVD FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
K 0131 SS=E	Living of Fort Way, compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Care Occupancies at This one story facility Type V (111) const sprinklered. The fact with smoke detection to the corridors, and Rehabilitation Hall, rooms had battery of facility is certified for 128 and had a census survey. All areas where the access were sprinkle facility services were	equirements for Participation in 4, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC) Chapter 19, Existing Health and 410 IAC 16.2. The ty was determined to be of ruction and was fully editive has a fire alarm system on in the corridors, areas open a seven resident rooms on the The remaining 57 resident appeared smoke detectors. The for 118 beds and licensed for as of 65 at the time of this residents have customary ered. All areas providing the sprinklered.		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.	e s ne			
Bldg. 01	failed to ensure the walls that separated living was maintain of the barrier. LSC facilities to be main minimize the possib requiring the evacua 8.3.5.1 requires pen	on and interview, the facility penetration in 1 of 1 fire barrier health care from assisted ed to ensure the fire resistance 19.1.1.3 requires all health care tained and operated to bility of a fire emergency ation of the occupants. LSC etrations for cables, cable es, tubes, combustion vents	K 0131	This Plan of Correction constite this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and feder	of s this ists			

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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. Bl	UILDING	01	COMPL	LETED
		155255	B. W	ING		07/10	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	NG OF FORT WAYNE			WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUIDEDIG TV . V OV CONTROL		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\ E	DATE
	and exhaust vents,	wires, and similar items to			law; or – Preparation and		
	accommodate electrical, mechanical, plumbing,				submission of this Plan of		
	and communications systems that pass through a				Correction does not constitute	an	
	wall, floor, or floor/ceiling assembly constructed				admission of agreement by th	е	
	as a fire barrier sha	ll be protected by a firestop			provider of the truth of the fac	ts	
	system or device. T	The firestop system or device			alleged or the correctness of t	he	
		ecordance with ASTM E 814,			conclusions set forth in the		
		nod for Fire Tests of Through			statement of deficiencies. The	;	
		ops, or ANSI/UL 1479,			Plan of Correction is prepared	l and	
		ests of Through-Penetration			submitted solely because of		
	_	ficient practice could affect 20			requirements under state and		
	residents on rehab-hall.				federal laws.		
	Findings include:				K-131		
	Based on observation	on with the Maintenance			No residents were affected	by	
	Director on 07/10/2	24 at 1:00 p.m., above the drop			the cited deficiency. Hole in th	ie	
	ceiling of the separa	ation fire barrier between			fire barrier wall was corrected	with	
	assisted living and	healthcare had a one-inch			fire rated caulk on 7-11-24.		
		igh the wall. Based on			2. An audit of all fire barrier wa	alls	
		ne of observation, the			was completed with no further	-	
		tor agreed the separation fire			issues found.		
	barrier had an unse	aled hole through the wall.			Maintenance Director and		
					maintenance assistants were		
	1	eviewed with the Administrator			re-educated on correcting any		
		Director during the exit			all penetrations to fire barrier	walls	
	conference.				immediately. This will be		
	2.1.10(1)				monitored by the maintenance		
	3.1-19(b)				director and/or designee throu	ıgh	
					TEL's for 6 months.	اد میں	
					4. Monthly audits will be revie		
					in the monthly QAPI/QA meet	ings	
					for 6 months or until 100%		
					compliance is obtained. 5. The above corrections will lead to the compliance is obtained.	20	
					completed by 7-11-24	Je	
					' '		
K 0161	NFPA 101						
SS=F		tion Type and Height					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155255	B. WING 07/10/2024			2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				AST STATE BLVD			
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	WAYNE, IN 46805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bldg. 01	Based on observation failed to maintain the ensuring 1 of 1 one-between the attic and to ensure the fire resident to ensure the fire resident. This deficient visitors, and resident Findings include: Based on observation Director on 07/10/2 and laundry room the collapsed in January Based on interview Maintenance Direct barrier collapsed duthe ceilings collapsed not been repaired du The finding was reverber to the collapsed of the finding was reverbed to the collapsed duthe finding was reverbed to the collapsed duther the finding was reverbed to the collapsed duther the finding was reverbed to the collapsed duther the co	on and interview, the facility he building type of V (111) by shour ceiling smoke barrier d living areas were maintained sistance of the one-hour nt practice affects all staff, tts. Ons with the Maintenance 4 at 11:10 a.m., in the kitchen he one-hour ceiling fire barrier of 2024 due to a broken pipe. At the time of observation, the or agreed the ceiling fire he to a broken pipe, and stated he din January of 2024 and has he to insurance complications. The work of the facility of the facil	K 0	TAG 161	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 ex or 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. K-161 1. No staff, visitor, or residents have been affected by the cite deficiency. 2. The kitchen will remain out of use until the construction has been completed. Construction both areas will be completed 10-7-24 day. 3. Staff reminded the kitchen a will remain out of use until construction has been completed. Upon completion this will be reviewed in the monthly QAPI/	autes of s this iists . ts an e s he and of for area ted.	DATE 10/07/2024	
					meetings for 6 months or until			

i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155255	A. BUILDING <u>01</u> COMPLETED B. WING 07/10/2024				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER			3420 E	AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	G OF FORT WAYNE		FORT \	WAYNE, IN 46805		
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					100% compliance is obtained ensure all corrections have be made and areas are functionir properly for staff use. 5. The above corrections will be completed by 10-7-24	en ng	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress -	General					
	failed to ensure 1 of were continuously robstructions. This desired residents on the Hope Findings include: Based on observation Director on 07/10/2 Hopesprings short established by two cleas bucket. Based on an observation, the Mathere were items blocitems were removed.	on with the Maintenance 4 at 12:15 p.m., the xit corridor was completely ning carts and a mop with interview at the time of intenance Director agreed ocking the exit corridor and the	K 0:	211	This Plan of Correction constitt this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or 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. K-211 1. No residents have been affectly the cited deficiency. 2. Housekeeping carts were removed from in front of the H	of s it it is stated and estand	08/01/2024

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

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		A. BUILDING B. WING	01	COMPLETED 07/10/2024		
	ROVIDER OR SUPPLIER ATE SENIOR LIVIN	G 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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				Springs short exit corridor immediately upon being notified findings. Housekeepers were re-educated immediately. Education for all staff began of 7-24-24. 3. An audit of Egress doors with conducted weekly x4 weeks, the monthly x6 months in TEL's by maintenance director and/or designee to ensure there is not blockage. 4. Audits will be reviewed in the monthly QAPI/QA meetings for months or until 100% compliant is obtained to ensure all corrections have been made at areas are functioning properly staff use. 5. The above corrections will be completed by 8-1-24	n II be hen y o e r 6 nce		
K 0324 SS=F Bldg. 01	failed to ensure 1 of systems were maint coverage for equipm noncompliant. NFP, fire-extinguishing sy nonoperational or in tagged as noncompl representative shall	on and interview, the facility I kitchen hood extinguishing ained to ensure complete then or tag system as A 96, 11.1.6.1 states where the system or exhaust system is impaired, the systems shall be iant, and the owner or owner's be notified in writing of the ficient practice could affect 25 oke compartment.	K 0324	This Plan of Correction constitution 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	of s this ists		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		A. BUILDING <u>01</u> COM		(X3) DATE SURVEY COMPLETED 07/10/2024	
	PROVIDER OR SUPPLIER	IG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE BLVD WAYNE, IN 46805	
(X4) ID PREFIX TAG	EFIX (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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	Director on 07/10/2 hood system in the January of 2024 due. The kitchen still conthe UL 300 hood systagged as noncomplethe time of observat stated the kitchen is system has not been currently non-opera.	on with the Maintenance 4 at 12:20 p.m., the UL 300 kitchen was activated in the to the collapse of the ceiling. Intains cooking equipment, and stem has not been reset or liant. Based on an interview at tion, the Maintenance Director closed but the UL 300 hood a reset or tagged and is tional. In the Maintenance of the ceiling of the		provider of the truth of the fact alleged or the correctness of conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared submitted solely because of requirements under state and federal laws. K-324 1. No residents were affected cited deficiency. 2. Kitchen is not being operate currently. Construction is expected to be completed by 10-7-24 3. Facility is working with Safe Care vendor to tag as noncompliant until completion construction. 4. Upon completion of construction will be reviewed monthly QAPI/QA meetings for months or until 100% complia is obtained will the kitchen how extinguishing system. 5. The above corrections will completed by 10-7-2024.	the ed and by ed en of in the or 6 ance od
K 0345 SS=E Bldg. 01	failed to ensure 1 of continuously in pro NFPA 72, National 2010 Edition, Section	on and interview, the facility If if if alarm systems was per operating condition. Fire Alarm and Signaling Code, on 14.2.1.2.2 states system etions shall be corrected. This	K 0345	This Plan of Correction const this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex	of of es f this

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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 CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/10/2024	
	PROVIDER OR SUPPLIEF	IG OF FORT WAYNE		3420 E	ADDRESS, CITY, STATE, ZIP COD AST STATE BLVD WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF deficient practice of North-Hall. Findings include: Based on observation Director on 07/10/2 was not mounted ar ceiling in North-Ha time of observation agreed the heat determounted. The finding was reveraged.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Duld affect all residents in on with the the Maintenance 4 at 11:56 a.m., a heat detector and was hanging from the II. Based on interview at the better was not properly wiewed with the Maintenance histrator during the exit		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) or that one was cited correct! This Plan of Correction is submitted to meet requireme 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 conclusions set forth in the statement of deficiencies. The Plan of Correction is prepare submitted solely because of requirements under state and federal laws. K-345 1. No residents were affected cited deficiency. 2. Safe Care was in on 7/29/2 correct the heat detector. 3. Monthly inspection will be completed via TELS. Any act needed will be done within 72 hours of findings. 4. This will be reviewed in the monthly QAPI/QA meetings findings or until 100% compliant.	y. nts eral e an ne cts the d and d d by 24 to cions 2	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Maintenance and Testing			is obtained. 5. The above corrections will completed by 8/1/24.	be	
Ü	Based on observation	on and interview, the facility	K 03	353	This Plan of Correction const	itutes	08/01/2024

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failed to ensure 1 of 1 sprinkler system piping was

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this facility's written allegation of

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	01	COMPL	ETED
		155255	B. W	ING		07/10	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					AST STATE BLVD		
CELEBR	ATE SENIOR LIVIN	IG OF FORT WAYNE		FORT V	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	-	DATE
	not use to support N	Ion-System Components			compliance for the deficiencies	S	
	accordance with NF	TPA 13, 2010 edition, Section			cited. However, submission of	this	
	9.1.1.7 Support of N	Non-System Components.			Plan of Correction is not an		
		hangers shall not be used to			admission that a deficiency ex	ists	
		components. This deficient			or that one was cited correctly		
		t 30 residents in one smoke			This Plan of Correction is	•	
	compartment.	150 residents in one smoke			submitted to meet requiremen	te	
	comparament.						
	Dindings in the				established by state and feder	al	
	Findings include:				law; or – Preparation and		
	.	0.1 0.11			submission of this Plan of		
Based on observation during a tour of the facility				Correction does not constitute			
with the Maintenance Director on 07/10/24 at				admission of agreement by the			
12:50 p.m., in the attic above the main nurse's				provider of the truth of the fact			
	_	lines were supporting			alleged or the correctness of t	he	
	electrical wires. Bas	sed on interview at the time of			conclusions set forth in the		
	observation, the Ma	intenance Director agreed			statement of deficiencies. The		
	there were wires lay	ring on sprinkler piping in the			Plan of Correction is prepared	and	
	attic.				submitted solely because of		
					requirements under state and		
	This finding was re-	viewed with the Administrator			federal laws.		
	-	irector during the exit					
	conference.	2			K-353		
	3.1-19(b)				No residents were affected	by	
					cited deficiency.		
					2. Wires laying on top of sprin	kler	
					pipes will be tied up off pipes I	оу	
					8-1-24.		
					3. Walk through will be comple	eted	
					monthly by Maintenance Direc		
					and/or designee. Any correction		
					will be made within 72 hours.		
				4. This will be reviewed in the			
					monthly QAPI/QA meetings fo	r 6	
					months or until 100% complian		
				is obtained.	100		
						_	
					5. The above corrections will b	ре	
					completed by 8/1/24.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155255		X2) MULTIPLE CONSTRUCTION			
	PROVIDER OR SUPPLIEI RATE SENIOR LIVIN	R NG OF FORT WAYNE	3420 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE BLVD WAYNE, IN 46805	
(X4) ID PREFIX TAG K 0712	(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
SS=C Bldg. 01	Based on record refailed to conduct qualifies under varying. This deficient pract staff and visitors in Findings include: Based on records redirector on 07/10/2 fire drills were not All second shift (2: took place around a the time of record redirector agreed fire held at unexpected.	eview with the Maintenance 24 at 10:00 a.m., all second shift conducted at unexpected times. 00 p.m. to 10:00 p.m.) fire drills 4:00 p.m. Based on interview at review, the Maintenance et drills for second shift were not times.	K 0712	This Plan of Correction constituthis facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exior that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and federallaw; or – Preparation and submission of this Plan of Correction does not constitute 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 submitted solely because of requirements under state and federal laws. K-712 1. No residents were affected becited deficiency. 2. Maintenance staff re-education assuring varying times are selected when conducting fire drills. 3. Next 2nd shift fire drill is scheduled for August 15, 2024 6pm. 4. This will be reviewed in the monthly QAPI/QA meetings for	of so this ists ists

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months or until 100% compliance

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 155255 B. WING 07/10/2024 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 DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE is obtained. 5. The above corrections will be completed by 8/1/2024. K 0741 **NFPA 101** SS=E **Smoking Regulations** Bldg. 01 Based on observation, records review, and K 0741 This Plan of Correction constitutes 08/01/2024 interview, the facility failed to enforce 1 of 1 this facility's written allegation of non-smoking policies. This deficient practice compliance for the deficiencies could affect staff around the service exit and 8 cited. However, submission of this residents in therapy. Plan of Correction is not an admission that a deficiency exists Findings include: or that one was cited correctly. This Plan of Correction is Based on observations during a tour of the facility submitted to meet requirements with the Maintenance Director on 07/10/24 from established by state and federal 9:30 a.m. to 1:00 p.m., staff were noticed smoking law; or - Preparation and outside of therapy exit and employee entrance submission of this Plan of which are not smoking areas. Based on records Correction does not constitute an review at 11:00 a.m., the smoking policy stated admission of agreement by the smoking is allowed on the facility's property in the provider of the truth of the facts designated smoking area out by the back road by alleged or the correctness of the the railings. Based on interview at the time of conclusions set forth in the observation and records review, the Maintenance statement of deficiencies. The Director agreed staff were smoking in Plan of Correction is prepared and non-designated smoking area. submitted solely because of requirements under state and The finding was reviewed with the Maintenance federal laws. Director and Administrator during the exit conference. K-741 3.1-19(b) 1. No residents were affected by cited deficiency. 2. Staff re-education completed on smoking policy and designated smoking areas.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6BKN21

Facility ID: 000158

If continuation sheet

3. Monitoring will be done daily x6 months to ensure staff are

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

PRINTED: 10/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ 07/1	(X3) DATE SURVEY COMPLETED 07/10/2024	
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	(EACH CORRECT CROSS-REFERE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM		
				by maintena desginee. 4. This will b monthly QAF months or ur is obtained.	he designated areas nce director and/or be reviewed in the PI/QA meetings for 6 ntil 100% compliance e corrections will be by 8/1/2024.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6BKN21 Facility ID: 000158 If continuation sheet Page 12 of 12