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	07/10/2024

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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/10/24 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 At this Life Safety Code survey, Celebrate Senior Living of Fort Wayne 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 65 at the time of this survey. Quality Review completed on 07/16/24	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 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 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	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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	At this Life Safety Code survey, Celebrate Senior Living of Fort Wayne 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 65 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 07/16/24		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 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents	K 0131	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	07/11/2024

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	and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 20 residents on rehab-hall. Findings include: Based on observation with the Maintenance Director on 07/10/24 at 1:00 p.m., above the drop ceiling of the separation fire barrier between assisted living and healthcare had a one-inch unsealed hole through the wall. Based on interview at the time of observation, the Maintenance Director agreed the separation fire barrier had an unsealed hole through the wall. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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-131 1. No residents were affected by the cited deficiency. Hole in the fire barrier wall was corrected with fire rated caulk on 7-11-24. 2. An audit of all fire barrier walls was completed with no further issues found. 3. Maintenance Director and maintenance assistants were re-educated on correcting any and all penetrations to fire barrier walls immediately. This will be monitored by the maintenance director and/or designee through TEL's for 6 months. 4. Monthly audits will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. 5. The above corrections will be completed by 7-11-24	
K 0161 SS=F	NFPA 101 Building Construction Type and Height			

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Bldg. 01	Based on observation and interview, the facility failed to maintain the building type of V (111) by ensuring 1 of 1 one-hour ceiling smoke barrier between the attic and living areas were maintained to ensure the fire resistance of the one-hour barrier. This deficient practice affects all staff, visitors, and residents. Findings include: Based on observations with the Maintenance Director on 07/10/24 at 11:10 a.m., in the kitchen and laundry room the one-hour ceiling fire barrier collapsed in January of 2024 due to a broken pipe. Based on interview at the time of observation, the Maintenance Director agreed the ceiling fire barrier collapsed due to a broken pipe, and stated the ceilings collapsed in January of 2024 and has not been repaired due to insurance complications. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0161	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-161 1. No staff, visitor, or residents have been affected by the cited deficiency. 2. The kitchen will remain out of use until the construction has been completed. Construction for both areas will be completed 10-7-24 day. 3. Staff reminded the kitchen area will remain out of use until construction has been completed. 4. Upon completion this will be reviewed in the monthly QAPI/QA meetings for 6 months or until	10/07/2024

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			100% compliance is obtained to ensure all corrections have been made and areas are functioning properly for staff use. 5. The above corrections will be completed by 10-7-24	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 2 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 25 residents on the Hopesprings hall. Findings include: Based on observation with the Maintenance Director on 07/10/24 at 12:15 p.m., the Hopesprings short exit corridor was completely blocked by two cleaning carts and a mop with bucket. Based on an interview at the time of observation, the Maintenance Director agreed there were items blocking the exit corridor and the items were removed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	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-211 1. No residents have been affected by the cited deficiency. 2. Housekeeping carts were removed from in front of the Hope	08/01/2024

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			Springs short exit corridor immediately upon being notified of findings. Housekeepers were re-educated immediately. Education for all staff began on 7-24-24. 3. An audit of Egress doors will be conducted weekly x4 weeks, then monthly x6 months in TEL's by maintenance director and/or designee to ensure there is no blockage. 4. Audits will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained to ensure all corrections have been made and areas are functioning properly for staff use. 5. The above corrections will be completed by 8-1-24	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure 1 of 1 kitchen hood extinguishing systems were maintained to ensure complete coverage for equipment or tag system as noncompliant. NFPA 96, 11.1.6.1 states where the fire-extinguishing system or exhaust system is nonoperational or impaired, the systems shall be tagged as noncompliant, and the owner or owner's representative shall be notified in writing of the impairment. This deficient practice could affect 25 residents in one smoke compartment. Findings include:	K 0324	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	10/07/2024

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	Based on observation with the Maintenance Director on 07/10/24 at 12:20 p.m., the UL 300 hood system in the kitchen was activated in January of 2024 due to the collapse of the ceiling. The kitchen still contains cooking equipment, and the UL 300 hood system has not been reset or tagged as noncompliant. Based on an interview at the time of observation, the Maintenance Director stated the kitchen is closed but the UL 300 hood system has not been reset or tagged and is currently non-operational. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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-324 1. No residents were affected by cited deficiency. 2. Kitchen is not being operated 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 of construction. 4. Upon completion of construction will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained will the kitchen hood extinguishing system. 5. The above corrections will be completed by 10-7-2024.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This	K 0345	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	08/01/2024

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	deficient practice could affect all residents in North-Hall. Findings include: Based on observation with the the Maintenance Director on 07/10/24 at 11:56 a.m., a heat detector was not mounted and was hanging from the ceiling in North-Hall. Based on interview at the time of observation, the Maintenance Director agreed the heat detector was not properly mounted. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		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-345 1. No residents were affected by cited deficiency. 2. Safe Care was in on 7/29/24 to correct the heat detector. 3. Monthly inspection will be completed via TELS. Any actions needed will be done within 72 hours of findings. 4. This will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. 5. The above corrections will be completed by 8/1/24.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system piping was	K 0353	This Plan of Correction constitutes this facility's written allegation of	08/01/2024

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	not use to support Non-System Components accordance with NFPA 13, 2010 edition, Section 9.1.1.7 Support of Non-System Components. Sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/10/24 at 12:50 p.m., in the attic above the main nurse's station the sprinkler lines were supporting electrical wires. Based on interview at the time of observation, the Maintenance Director agreed there were wires laying on sprinkler piping in the attic. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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-353 1. No residents were affected by cited deficiency. 2. Wires laying on top of sprinkler pipes will be tied up off pipes by 8-1-24. 3. Walk through will be completed monthly by Maintenance Director and/or designee. Any corrections will be made within 72 hours. 4. This will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. 5. The above corrections will be completed by 8/1/24.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for 1 of 3 shifts. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the Maintenance Director on 07/10/24 at 10:00 a.m., all second shift fire drills were not conducted at unexpected times. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place around 4:00 p.m. Based on interview at the time of record review, the Maintenance Director agreed fire drills for second shift were not held at unexpected times. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	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-712 1. No residents were affected by cited deficiency. 2. Maintenance staff re-educated on assuring varying times are selected when conducting fire drills. 3. Next 2nd shift fire drill is scheduled for August 15, 2024 at 6pm. 4. This will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance	08/01/2024

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			is obtained. 5. The above corrections will be completed by 8/1/2024.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service exit and 8 residents in therapy. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/10/24 from 9:30 a.m. to 1:00 p.m., staff were noticed smoking outside of therapy exit and employee entrance which are not smoking areas. Based on records review at 11:00 a.m., the smoking policy stated smoking is allowed on the facility's property in the designated smoking area out by the back road by the railings. Based on interview at the time of observation and records review, the Maintenance Director agreed staff were smoking in non-designated smoking area. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0741	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-741 1. No residents were affected by cited deficiency. 2. Staff re-education completed on smoking policy and designated smoking areas. 3. Monitoring will be done daily x6 months to ensure staff are	08/01/2024

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			smoking in the designated areas by maintenance director and/or desginee. 4. This will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. 5. The above corrections will be completed by 8/1/2024.	