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	05/19/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/19/25 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 At this Emergency Preparedness 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 is certified for 118 beds and licensed for 128 and had a census of 73 at the time of this survey. Quality Review completed on 05/21/25	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: 05/19/25 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 law; or – Preparation and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Hunter	Administrator	06/10/2025

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 73 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 05/21/25		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 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall	K 0353	K353- Sprinkler System, Maintenance and Testing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the cited deficiency. How other residents having	06/30/2025

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	be recalibrated or replaced. This deficient practice affects all residents. Findings include: Based on observations with the Maintenance Director on 05/19/25 at 1:26 p.m., the facility's sprinkler system had four pressure gauges with a manufacturer's date of 2019, and no recalibration date information was affixed to the sprinkler system gauges. Based on interview at 1:26 p.m., the Maintenance Director agreed the four gauges were older than five years and have not been recalibrated or replaced. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The gauges were replaced on 5-30 by Safe Care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director and assistants were re-educated on frequency of changing the gauges and following up to ensure vendors complete the requested services/repairs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Monthly vendor testing will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained to ensure completion of monthly and yearly testing/repairs. By what date will the systemic changes for each deficiency be completed. The above will be completed by June 30th, 2025.	

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K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on interview and observation, the facility failed to ensure 1 of 1 rehabilitation patient treatment areas were not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7) states that spaces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. This deficient practice could affect all residents that use the therapy gym. Findings include: Based on observation with the Maintenance Director and The Administrator on 05/19/25 at 12:36 p.m., the south wing lounge area was turned into a resident therapy gym but there was a 175-foot hallway attached to the treatment area that was used for storage/staff offices and was not used for therapy. This condition made the treatment area open to the corridor due to no doors between the treatment area and the storage/office hallway. Based on an interview at 12:36 p.m., the Administrator stated the therapy	K 0361	K361-Corridors, Areas Open to Corridor What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the cited deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Maintenance staff and therapy staff were educated by the facility Administrator on keeping the therapy treatment area separated from an open corridor. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The therapy treatment area will be moved to a location with a door where it is not opened directly to an open corridor. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Monitoring outcomes will be	06/30/2025

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	gym was recently moved, the attached hallway was used for offices and storage, and there were no doors between the therapy treatment area and the storage/office hallway. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)		reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. - By what date will the systemic changes for each deficiency be completed. The above will be completed by June 30th, 2025.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 8 of 75 receptacles within 6 feet from a wet location were provided with functioning ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages,	K 0511	K511- Utilities, Gas and Electric What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the cited deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An electrician is scheduled to have the 8 receptacles corrected with GFCI protection against electrical shock. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance will continue to check receptacles through facility TEL's.	06/30/2025

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	service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director on 05/19/25 between 11:30 a.m. and 1:40 p.m., the following receptacles were within 6 feet from a water source and were not GFCI protected or did not function when tested: a. The GFCI receptacle in the restroom of room 11 did not trip when tested. b. The GFCI receptacle in the restroom of room 14 did not trip when tested. c. The GFCI receptacle in the restroom of room 17 did not trip when tested. d. The GFCI receptacle in the restroom of room 29 did not trip when tested. e. The GFCI receptacle in the restroom of room 114 did not trip when tested. f. The GFCI receptacle in the restroom of room 115 did not trip when tested. g. The receptacle by the sink in the dining room was not GFCI Protected. h. The receptacle in the soiled utility closet by the mop sink on the Hope Springs wing was not GFCI Protected. Based on an interview at 11:30 a.m. and 1:40 p.m., the Maintenance Director agreed the aforementioned electric receptacles were within 6 feet of a water source and failed to function when tested or were not GFCI protected.		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and TEL's receptacle checks will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. By what date will the systemic changes for each deficiency be completed. The above will be completed by June 30th, 2025.	

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	This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to maintain 1 of 1 complete documentation of inspections for Patient-Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.	K 0921	K921- Electrical Equipment, Testing and Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the cited deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit will be conducted by the vendor to see what equipment needs to be tested. Testing scheduled to be completed June 11th, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Education completed with Administrator and Maintenance Director on new requirements for PCREE testing. Log will be maintained of all electrical	06/30/2025

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	Findings include: Based on records review with the Maintenance Director on 05/19/25 at 11:00 a.m., there was no documentation available for review to show testing of PCREE used in the facility. Based on observation from 11:30 a.m. to 1:45 p.m., each resident room contained PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interviews at 11:00 a.m. and 1:45 p.m. the Maintenance Director stated PCREE has not been inspected for physical integrity, resistance, leakage current, and touch current. This was reviewed with the Administrator and Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)		equipment to be used by residents to ensure they are tested prior to using. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Equipment log will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained. By what date will the systemic changes for each deficiency be completed. The above will be completed by June 30th, 2025.	