STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155255	A. BUILDING 00 B. WING	10/01/2024

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00442998, IN00443546 and IN00444048. Complaint IN00442998 - No deficiencies related to allegations are cited. Complaint IN00443546 - No deficiencies related to the allegations are cited. Complaint IN00444048 - Federal/state deficiencies related to the allegations are cited at F609. Survey date: October 1, 2024 Facility number: 00158 Provider number: 155255 AIM number: 100291490 Census Bed Type: SNF/NF: 75 SNF: 2 Total: 77 Census Payor Type: Medicare: 2 Medicaid: 68 Other: 7 Total: 77 This deficiency reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 1, 2024.	F 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.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Hunter	Administrator	10/16/2024

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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	Based on interview and record review the facility failed to report a fall with a fracture to the Indiana Department of Health (IDOH) for 1 of 3 falls reviewed (Resident H). Findings Include: A facility reported incident was provided by the Administrator on 10/1/24 at 10:14 AM. The report, dated 9/25/24 at 10:01 AM, indicated Resident H was found on the floor in her room in a pool of blood coming from her nose. The report indicated Resident H was sent to the hospital and was found to have a probable subtle acute nondisplaced bilateral nasal bone fracture. Resident H's record was reviewed on 10/1/24 at 1:33 PM. Diagnosis included chronic pulmonary disease and type 2 diabetes mellitus. A nursing note, dated 9/22/2024 at 3:22 PM, indicated Resident H was found on the floor in her room in a pool of blood. The note indicated Resident H had a hematoma to her head and a swollen/bruised nose. The note also indicated Resident H was sent to the hospital. A nursing note, dated 9/22/24 at 10:19 PM, indicated a nurse spoke with the hospital regarding Resident H. The note indicated the nurse was informed Resident H was admitted for a fall, septal fracture and subdural hematoma. An interdisciplinary team (IDT) note, 9/24/24 at 11:05 AM, indicated a meeting was completed with the IDT team to determine the root cause and result of Resident H's fall. During an interview on 9/24/24 at 1:43 PM, the Administrator indicated Resident H fell on 9/22/24	F 0609	**F-609** • 1 No residents were found to be directly affected by the deficient practice. Resident “X” no longer resides at facility. Education on-going with all staff and to include signature for the following information: what to report, to whom information needs to be reported to, and in what time period incident needs to be reported. • 2 A facility audit was completed on falls in the past 30 days with no other deficiencies found. All further incidents will be included in the plan of correction audit to ensure on-going compliance. • 3 All staff will be in-serviced on the proper chain of command for reporting incidents and new hires will receive training as well. All notes and incidents will be reviewed by the interdisciplinary team once every 24 hours Monday through Friday and by a designated staff member on the weekends. • 4 The Administrator/ Designee will ensure that all staff have completed the in-service on proper chain of command for reporting incidents. All notes and incidents will be reviewed by the interdisciplinary team once every	10/17/2024

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	with the result of a nasal fracture. The Administrator indicated she reported the incident to the IDOH on 9/25/24. The Administrator indicated she should have reported the fall with fracture within 24 hours of being notified of the fracture. A current policy, last reviewed 3/1/20, titled "Abuse, Neglect and Exploitation Policy," was provided by the Administrator on 10/1/24 at 2:24 PM. The policy did not indicate when a fall with fracture should be reported. This citation relates to Complaint IN00444048. 3.1 - 28(e)		24 hours Monday through Friday and by a designated staff member on the weekends. The Administrator/ Designee will monitor and complete audits Monday through Friday for four weeks, three times a week for four weeks, weekly for four weeks, bi-weekly for four weeks, and then monthly reviews completed for QAPI to ensure continued compliance. All audit tools will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is obtained • DOC 10/17/2024	