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	06/06/2023

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 a Recertification and State Licensure Survey. This visit was inconjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint(s) IN00406062 and IN00406174 completed on April 17, 2023. This visit was also in conjunction with the Investigation of Complaint IN00409575 Survey dates: May 30, 2023, June 1, 2, 5 and 6, 2023 Facility number: 000158 Provider number: 155255 AIM number: 100291490 Census Bed Type: SNF/NF:76 SNF:4 Total:80 Census Payor Type: Medicare:4 Medicaid:67 Other:9 Total:80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 12, 2023	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 the to meet requirements established by the 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.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tammy Hunter 06/25/2023

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.

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	06/06/2023

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
	(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	06/06/2023

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
	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the			

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	06/06/2023

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
	notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to give proper notice of transfer or discharge before 4 of 4 residents were transferred or discharged. (Resident 2, Resident 51, and Resident 83). Findings include: 1. Resident 2's record was reviewed on 05/31/23 at 2:08 PM. Diagnoses included COPD (chronic obstructive pulmonary disease), presence of cardiac pacemaker, and history of TIA (transient ischemic attack, a stroke lasting a short period of time). A review of Resident 2's current Significant Change MDS (Minimum Data Set) indicated their BIMS (Basic Interview for Mental Status) score was 10 (moderate cognitive impairment). A review of progress notes dated 03/22/23 at 09:17 AM indicated Resident 2 was sent to the hospital from a routine pre-operative appointment due to low blood pressure and confusion. There was no transfer paperwork documented, notice of bed	F 0623	Deficiency ID: F623 SS: D Date of Completion: 1. An audit was performed on the transfers/discharges for the last 30 days. Any identified discrepancies were corrected on those found still residing in the facility to ensure that proper documentation has been implemented and that notification is completed and documented, discharge planning completed, and if needed a physician's order has been completed. 2. Licensed nursing staff and SS Director have been in-serviced as of 6-19-23 and ongoing until all necessary staff have been in-serviced on proper transfer or discharge procedures. 3. Audits will be completed by the DON and/or designee on residents being transferred or discharged. This will be performed at least 5X's a week for one	06/25/2023

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	06/06/2023

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
	hold policy, or documentation of the facility providing pertinent medical information to the receiving hospital. 2. Resident 51's record was reviewed on 06/01/23 at 02:09 PM. Diagnoses included legal blindness, GAD (generalized anxiety disorder), and major depressive disorder. A review of Resident 51's quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 4 (severe cognitive impairment). A review of physician's orders indicated no orders for transfer to the hospital for evaluation and treatment after a witnessed fall on 02/27/23 at 9:50 AM. A review of progress notes indicated no documentation the Bed Hold Policy was provided to the resident or POA (Power of Attorney) prior to transfer to the accepting facility. In an interview on 06/01/23 at 4:30 PM the DON indicated the facility would send transfer documents with the resident to the hospital. They Indicated no copies were kept for resident records. In an interview on 06/02/23 at 2:25 PM, LPN 6 indicated the transfer on 2/27/2023 was a planned surgical procedure. LPN 6 indicated they did not do a transfer to hospital form but the resident's information was sent to the hospital prior to the procedure. No order to transfer for the planned procedure was present. In an interview on 06/02/23 at 2:30 PM the SSD (Social Services Director) indicated they were not aware a copy of the bed hold policy was to be		month, then 2X's a week for one month. Random monitoring will be completed X 4 months, to assure residents are properly discharged by reviewing notification conducted monthly via log to area ombudsman, including hospitalizations in real time, with information on reason for transfer and diagnosis. 4. Audits will be reviewed in the monthly QAPI/QA meetings for 6 months or until100% compliance is achieved. 5. The above will be completed by 6-25-23.	

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	06/06/2023

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
	given with each transfer. A review of Notice of Transfer or Discharge form dated 02/27/23 was provided by LPN 6 at 2:25 PM. There was no address for the receiving facility, the ombudsman information was not filled out, and there was no bed hold policy or pertinent medical information included for the receiving facility. 3. Resident 83's closed record was reviewed on 06/05/23 at 9:25 AM. Diagnoses included PTSD (post-traumatic stress disorder), heart failure, and muscle weakness. A review of progress notes dated 06/05/23 at 9:35 AM indicated Resident 83 was discharged on 03/31/23 at 07:23 AM. There was no documentation to indicate transfer forms or discharge instructions were completed. In a phone interview on 06/02/23 at 3:01 PM Resident 81 indicated the discharge was facility initiated, and they were given 3 days of notice. There was no discharge paperwork or care plan in place. Resident 83 indicated they signed no paperwork upon leaving the facility, received 3 days of meds, got on a CitiLink bus at 6:30 AM, and went to live with their husband in a motel room. A current Transfer and Discharge policy presented by the DON (Director of Nursing) on 06/02/23 at 2:25 PM indicated the facility will: * Obtain physician order for transfer. * Send the original state transfer/discharge/bedhold notice with the resident and/or representative responsible for care. * Make 2 copies of the health record necessary			

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	06/06/2023

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
	for care of the resident (physician's orders, history & physical, x-rays, lab work, etc.), and send with the resident/representative. * Fax the transfer order to the pharmacy. 483.15(c)(3-5)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure adequate supervision to support smoking for 4 of 4 residents reviewed. (Resident 43, Resident 4, Resident 51, and Resident 33) Findings include: During an observation, Resident 51, Resident 4, and Resident 33 were observed in courtyard smoking on 05/30/23 at 10:54 AM. Resident 51 required guidance (he held onto staff's shoulder and walked slightly behind her) out to the courtyard and his cigarette lit. Resident 51 then sat with Resident 4 and Resident 33 between him and the staff member. When Resident 51 was finished smoking he wiped ashes off of his clothes prior to being led back into the building. Resident 4 and Resident 33 remained in the courtyard. The staff member did not return after taking Resident 51 back into the building.	F 0689	Deficiency ID: F689 SS: E Date of Completion: 1. An audit was performed on residents actively smoking to ensure that proper assessments and qualifications have been completed. Smoker's list has been updated to reflect current residents with an updated smoking assessment if needed. 2. Licensed nursing staff and SS Director have been in-serviced as of 6-19-23 and ongoing until all necessary staff have been in-serviced on building policy, attached, and educated on proper supervision to ensure adequate to smoking support and use of smoking devices to ensure an area free of hazards. 3. Audits on residents that are	06/25/2023

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	06/06/2023

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
	Resident 33 was handing Resident 4 his stubbed cigarette after tapping it on his walker. Resident 33 dropped the blunted end of the cigarette on Resident 4's lap. There was no fire protection wear worn or visibly available during the observation of Resident 51, Resident 4, and Resident 33. During an observation, on 05/31/23 at 2:08 PM, 3 unidentified female residents were outside smoking in the courtyard. There were no staff present or within eyesight of the courtyard. There was no fire protection wear on the residents or visibly available to wear. In an interviewon 5/31/23 at 2:13PM, CNA 5 (Certified Nursing Assistant) identified Resident 43 as among the female smokers. The CNA indicated staff were to monitor while residents were smoking. CNA 5 indicated management remind them frequently to stay in courtyard when residents were smoking. The CNA further indicated Resident 43 did not follow rules and did what she wanted. On 5/30/23 at 11:16AM the ED provided a list of smokers as requested. Resident 43 was not listed as a smoker in the facility. The ED (Executive Director) indicated when Resident 43 came she was not smoking due to illness. The ED was unable to determine when Resident 43 began smoking again. 1. Resident 43's record was reviewed on 6/1/23 at 9:09AM. Resident 43's diagnoses included chronic pulmonary disease and altered mental status.		smoking will be performed at least 5X's a week for one month, then 2X's a week for one month. Random monitoring will be completed in X 4 months, to assure residents and staff are following proper safety supervision and guidelines. 4. Audits will be reviewed in the monthly QAPI/QA meetings for 6 months or until 100% compliance is achieved. 5. The above will be completed by 6-25-23.	

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	06/06/2023

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
	A review of Resident 43's current MDS dated 4/23/23 indicated: Section C- BIMS (Basic Interview for Mental Status) score was 11 (mildly impaired). Section G-ADLs (Activities of Daily Living) one-person physical assist for all activities assessed. Section J-Health Conditions indicated no tobacco use. A review of Resident 43's smoking risk assessment dated 3/8/23 indicated she did not smoke. A smoking risk assessment done on 6/1/23 indicated: A. All residents who smoke must be supervised. B. Smoking Cessation was declined. C. Orientation no problem D. Behavior no problem E. Mobility no problem F. Injury Potential none G. History no problem H. Safety Gear none needed. I. Comments; May independently be able to handle smoking materials. A review of Resident 43's current care plan was updated on 6/1/23. The care plan indicated she used tobacco and was allowed to smoke independently in the courtyard. 2. Resident 4's record was reviewed on 5/30/23 at 10:54 AM. Resident 4's diagnoses included major depressive disorder, muscle weakness, vascular dementia, and history of a stroke. A review of Resident 4's current comprehensive MDS dated 12/23/22 indicated: Section C- BIMS (Basic Interview for Mental Status) score was 8 (moderately impaired). Section G-ADLs (Activities of Daily Living)			

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	06/06/2023

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
	one-person physical assist for all activities assessed. Section J-Health Conditions indicated tobacco use. A review of Resident 4's smoking risk assessment dated 9/1/22 indicated: A. All residents who smoke must be supervised. B. Smoking Cessation was declined C. Orientation no problem. D. Behavior no problem. E; Mobility no problem. F. Injury Potential no problem. G. History no problem H. Safety Gear none needed. I. Comments; 3/14/22 smoke with supervision ensuring hair was pulled away from face. There were no other smoking assessments documented. A review of Resident 4's current care plan dated 4/4/23 indicated the following; she used tobacco, was allowed to smoke independently without complications and the facility only allowed supervised smoking. An intervention was; assess smoking abilities; upon admission, quarterly, and as needed. 3. Resident 51's record was reviewed on 5/31/23 at 11:17AM. Resident 51's diagnoses included legal blindness, encephalopathy, pulmonary disease, and traumatic brain injury. A review of Resident 51's current MDS dated 4/14/23 indicated: Section C- BIMS (Basic Interview for Mental Status) score was 4 (severely impaired). Section G-ADLs (Activities of Daily Living)			

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	06/06/2023

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
	two-person physical assist for all activities assessed. Section J-Health Conditions indicated tobacco use. A review of Resident 51's most recent smoking risk assessment dated 3/14/22 indicated: A. All residents who smoke must be supervised. B. Smoking Cessation was declined C. Orientation minimal problem. D. Behavior no problem. E; Mobility minimal problem. F. Injury Potential minimal problem. G. History no problem H. Safety Gear none needed, and someone was to light his cigarette. I. Comments; 3/14/22 Resident 51 was legally blind and required supervision when smoking. A review of Resident 51's current care plan dated 4/4/23 had a focus on blindness. There was no care planned indication of tobacco use. 4. Resident 33's record was reviewed on 05/30/23 at 09:12 AM. Resident 33's diagnoses included lung disease, muscle weakness, and neurological disease. A review of Resident 33's comprehensive MDS dated 11/16/22 indicated: Section C- BIMS (Basic Interview for Mental Status) score was 12 (minimally impaired). Section G-ADLs (Activities of Daily Living) one-person physical assist for all activities assessed. Section J-Health Conditions indicated no tobacco use. A review of Resident 33's most recent smoking			

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	06/06/2023

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
	risk assessment dated 9/1/22 indicated: A. All residents who smoke must be supervised. B. Smoking Cessation was declined C. Orientation no problem. D. Behavior no problem. E; Mobility no problem. F. Injury Potential no problem. G. History no problem H. Safety Gear none needed. I. Comments: Resident 33 was allowed to smoke independently. A review of Resident 33's current care plan dated 11/14/22 indicated Resident 33 was an active smoker and able to smoke independently without complications. The interventions included assess smoking abilities quarterly, as needed and smoking materials to be kept at the nurse's station. An undated current facility smoking safety policy was provided by the ED, on 6/1/23 at 10:26 AM. The policy indicated ... 2. the designated smoking area shall maintain appropriate safety devices including but not limited to; available smoking aprons, extinguishing blanket, and ashtrays made of noncombustible material and safe design. Metal containers with self-closing covers into which ashtrays can be emptied shall be readily available. An updated smoking regulation dated 3/10/22 provided by the ED, on 6/1/23 at 10:26AM indicated smoking schedule 10am-1015am; 1pm-115pm, and 4p-415pm. 1. Smoking breaks would be 15minutes or 2 cigarettes whichever comes first. 2. No borrowing or lending of cigarettes. 3. All smoking material would be kept at the nurse's station. 4. Residents were to provide their own smoking materials. 5. Residents could smoke with visitors in the courtyard but could not			

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	06/06/2023

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
	take other residents with them. 6. Smoking breaks would be cancelled upon inclement weather related conditions. 7. Smoke times could be affected by whether staff is available. 3.1-45(a)			