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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Celebrate Senior Living of Fort Wayne	3420 East State Blvd Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the physician was notified of a resident's daily refusal of prescribed medication for 1 of 3 residents reviewed (Resident T).Findings include:On 11/17/25 at 2:00 p.m., Resident T's record was reviewed. Diagnoses included schizophrenia, heart failure, high blood pressure, and overactive bladder.A quarterly Minimum Data Set (MDS) assessment, dated 9/17/25, indicated Resident T had no cognitive impairment nor indicators of delirium. She had mood indicators of feeling down, depressed, and hopeless; trouble sleeping; feeling tired with little energy; and poor appetite or overeating almost every day. She had no indicators of psychosis, behaviors, nor rejection of care. She was frequently incontinent of bladder and was prescribed diuretics (water pills).Care plans indicated Resident T was prescribed anti-hypertensive and diuretic medications to treat high blood pressure. Interventions included giving the medications as ordered and monitoring side effects. The resident had behaviors including frequently refusing medications. Staff were to notify the physician of changes or increase in behaviors.A physician's progress note, dated 10/10/25, indicated Resident T had been seen by the Nurse Practitioner (NP) due to abnormal kidney function. The resident had lab work completed on 10/8/25. The lab results were creatinine elevated at 2.17. The resident did not have a history of chronic kidney disease, and her baseline creatinine was <1.0. During the visit, the abnormal lab results were discussed with the resident, and she was informed her current medication regimen would be adjusted and medications affecting her kidneys would be held. When asked, the resident denied any urinary tract infection (UTI) related symptoms. The plan was to obtain a urinalysis, discontinue her Ibuprofen, hold Losartan (blood pressure medication) and Spironolactone (water pill) for 5 days. Staff were to continue monitoring her.A nursing progress note, dated 10/10/25 at 12:23 p.m., indicated Resident T was seen by the NP and new orders received to collect a urinalysis for a diagnosis of Acute Kidney Injury (AKI), hold Losartan and Spironolactone for 5 days.An article, titled Creatinine and Acute Kidney Injury was retrieved from kidney.org on 11/17/25 at 3:25 P.M. The article indicated creatinine was a waste product from digestion of protein in food and normal breakdown of muscle tissue. It is removed from blood through the kidneys. Too much creatinine in the blood can be a sign of possible kidney problems. AKI was a sudden episode of kidney failure or damage that happens within a short period of time. AKI causes a build-up of waste products in the blood. This build up can affect other organs such as the brain, heart, and lungs. There are several causes of AKI including side effects of medications, or direct damage to the kidney or blockage of the urinary tract. Tests used to diagnose and investigate the cause of AKI include urinalysis which is a urine test used to find signs of kidney disease and kidney failure.Review of Medication Administration Records (MAR), dated September 2025, indicated Resident T had refused her oral medications, including Losartan and Spironolactone every day in September except 1 day. The MAR indicated she took her dose of Losartan on 9/26/25.A MAR, dated October 2025, indicated Losartan and Spironolactone were held 10/10/25 through 10/14/25 as ordered. Resident T took 1 dose of Losartan on 10/20/25 but refused the medication all other days of the month. She refused Spironolactone every day in the month of October.A MAR, dated November 2025, indicated the resident had not taken any oral (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, including Losartan and Spironolactone, from 11/1 through 11/17/25.There was no documentation completed, indicating the physician or NP had been notified of the residents refusal of oral medications, including refusals of Losartan and Spironolactone, in September, October, or November 2025. The NP treated Resident T's acute kidney injury in October 2025 by holding her doses of Losartan and Spironolactone from 10/10-10/14/25, however, the resident hadn't been taking the medications prior to or after the medications were held.On 11/18/25 at 12:44 P.M., the NP was interviewed. He indicated he was aware of Resident T's occasional refusal of medications but had not known the resident was not taking her medications routinely as ordered. He indicated he ordered her Losartan and Spironolactone held for 5 days, 10/10-10/14/25, to see if the medications had contributed to the rise in her blood creatinine. He had not been aware the resident had refused these medications months prior to or after the medications were ordered to be held.In a confidential interview, staff member 2 indicated ordering providers were to be notified of resident's refusal to take prescribed medication.During a confidential interview, staff member 3 indicated when a resident refused a medication, the MAR would be marked with a 2 meaning refusal and a note documented in the nurse progress notes. The NP or doctor would be notified and documented in the nurse progress notes. A current facility policy, titled Change in a Resident's Condition or Status, was provided by the Director of Nursing on 11/18/25 at 2:24 P.M. The policy indicated staff would promptly notify the attending physician of changes in the resident's medical/mental condition and/or status. The nurse was to notify the resident's physician when there had been a refusal of treatment or medications 2 or more consecutive times.This Citation relates to Intake 2646144.3.1-5(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure labs were completed as ordered by the physician for 1 of 3 residents reviewed (Resident T).Findings include:On 11/17/25 at 2:00 p.m., Resident T's record was reviewed. Diagnoses included schizophrenia, heart failure, high blood pressure, and overactive bladder.Care plans indicated Resident T was prescribed anti-hypertensive and diuretic medications to treat high blood pressure. She was at risk for fluctuations in fluid balance and complications from bladder incontinence. Interventions included obtaining and monitoring lab/diagnostic work as ordered.A physician order, dated 10/10/25, was to collect a urinalysis (UA) for culture and sensitivity.A physician's progress note, dated 10/10/25, indicated Resident T had been seen by the Nurse Practitioner (NP) due to abnormal kidney function. The resident had lab work completed on 10/8/25. The lab results indicated blood creatinine level was elevated at 2.17. The resident did not have a history of chronic kidney disease, and her baseline creatinine was <1.0. When asked, the resident denied any urinary tract infection (UTI) related symptoms. The plan included obtaining a urinalysis to check for possible causes of her elevated blood creatinine level.An article, titled Creatinine and Acute Kidney Injury (AKI) was retrieved from kidney.org on 11/17/25 at 3:25 P.M. The article indicated too much creatinine in the blood could be a sign of possible kidney problems. AKI was a sudden episode of kidney failure or damage within a short period of time. AKI causes a build-up of waste products in the blood, affects other organs such as the brain, heart, and lungs. There are several causes of AKI including side effects of medications, direct damage to the kidney or blockage of the urinary tract. Tests used to diagnose and investigate the cause of AKI include urinalysis (a urine test used to find signs of kidney disease and kidney failure).A nurse progress note, dated 10/16/25 at 4:02 p.m., indicated the UA results were in and no pathogens (disease causing organisms) were detected. The Nurse Practitioner (NP) was notified with no new orders given.A lab report, dated 10/16/25, was provided by the Director of Nursing (DON) on 11/18/25 at 12:32 P.M. The report indicated there were no organisms detected in Resident T's urine test. The DON indicated only a culture and sensitivity was done on the urine and not a urinalysis as ordered by the NP but should have been. The DON indicated the specialty lab where the urine test had been sent, detected only pathogens in the urine but didn't process urinalysis tests.On 11/18/25 at 12:44 P.M., the NP was interviewed. He indicated he had ordered a urinalysis with culture and sensitivity if indicated as follow-up to the residents abnormal blood creatinine level. When asked, he indicated, the facility used a special laboratory, able to detect pathogens in the urine as well as best medications to use in treating the organisms. He indicated his understanding from the laboratory, was urinalysis would be completed in addition to detection of pathogens. A facility policy, provided by the nurse manager on 11/19/25 at 10:14 A.M., indicated the facility would obtain laboratory services through licensed laboratories, upon the order from a facility medical provider. Nursing staff would initiate providers orders, ensure timely collection, and collect specimens as ordered per the nurse's scope of practice.This Citation relates to Intake 2646144.