

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Celebrate Senior Living of Fort Wayne		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45243</b></p> <p>Based on observation, interview, and record review the facility failed to ensure dignity was maintained for 1 of 18 residents reviewed. (Resident 52)</p> <p>Findings include:</p> <p>During an observation on the secured unit, on 4/28/25 at 10:11 AM, Licensed Practical Nurse (LPN) 4 was heard yelling from across the hall inside room [ROOM NUMBER] to another staff member at the nurses' station. LPN 4 yelled over to the other staff member at the station, Resident 52 has a boil the doctor wants to take a look at; he has to be laid down. There were 3 unidentified residents in close proximity to room [ROOM NUMBER] and could hear LPN 4.</p> <p>During an observation, on 04/28/25 at 10:22 AM, LPN 4 was easily overheard telling the Wound Nurse Practitioner Resident 52 was now laying down if she also wanted to look at the boil.</p> <p>In an interview, on 4/30/25 at 10:05 AM, the Unit Manager of the secured unit indicated LPN 4 was disciplined for his inappropriate behavior. The Unit Manager indicated the facility recently held an in-service regarding resident rights but LPN 4 did not attend the in-service.</p> <p>A record review on 4/30/25 at 1:15PM, indicated Resident 52's diagnosis included dementia, unspecified</p> <p>A current policy, titled Resident Rights dated 12/2024, indicated . 1. Dignity and Respect. Be treated with consideration, respect and full recognition of dignity and individuality. 5. Privacy and Confidentiality. Personal and medical information must be kept confidential. Residents are entitled to privacy in care, communication, and personal space .</p> <p>3.1-3(a)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45243</p> <p>Based on interview and observations the facility failed to ensure sanitation measures were followed for 2 of 3 observations. 71 of 71 residents who resided in the facility received food prepared in the kitchen.</p> <p>Findings include:</p> <p>During an observation on 4/28/25 at 9:30 AM, a medal scoop was observed inside a tub of brown sugar. There was debris of grease like food around and under the sink. There were dried noodles, raisins and plastic debris observed under the racks in the pantry. There were small pieces of paper, dust in the corners, and unidentifiable small particles observed in the chemical room on the floor.</p> <p>During an observation on 4/29/25 at 10 AM, there were small cereal particles, dried meat of different shapes/sizes observed under the stand-up cooler, meal carts and stove area.</p> <p>In an interview on 4/28/25 at 9:30 AM, the Dietary Manager (DM) indicated the facility did not have a cleaning schedule. DM indicated the scoop from the brown sugar tub should not be left inside the tub. The DM indicated there should not be debris or dried particles on the floor or around/under the sink and appliances.</p> <p>In an interview on 4/30/25 at 2:03 PM, the Director of Nursing (DON) indicated the facility did not have a policy regarding sanitation in the kitchen. The DON indicated 71 of 71 residents received food prepared in the kitchen.</p> <p>3.1-(i)3</p>		