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	04/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure dignity for 4 of 5 residents reviewed. (Resident 3, Resident 11, Resident 16, and Resident 54)Findings include: 1) Resident 3's record review began on 4/12/2026 at 11:31 AM. Diagnosis included lung disease, heart disease, and diabetes.In an interview, on 4/13/26 at 10:03AM, Resident 3 complained of staff not knocking on doors prior to entering.2) Resident 11's record review began on 4/12/2026 at 10:02 AM. Diagnosis included lung disease and anxiety.In an interview, on 4/13/26 at 10:03AM, Resident 11 complained of staff not knocking on her door prior to entering.3) Resident 16's record review began on 04/14/2026 at 2:25 PM. Diagnosis included lung disease, hypertension, and depression.In an interview, on 4/13/26 at 10:03AM, Resident 16 complained of staff not knocking on her door prior to entering. 4) Resident 54's record review began on 04/12/2026 at 11:07 AM. Diagnosis included hypertension and schizophrenia. During an observation, on 04/12/2026 at 9:57 AM, Certified Nursing Assistant 5 (CNA) came into Resident 54's room without knocking, introducing herself, or asking permission to enter. CNA 5 asked Resident 54 if she was ready to shower. Resident 54 responded explaining her legs were hurting. CNA 5 stated, it smells like you need a shower. I will be back. Resident 54 put blanket over her head and did not respond. During a continuous observation on 04/14/2026 starting at 8:05 AM through 8:27AM the following was observed: At 8:09AM CNA 6 walked into a room in north hall and picked up a meal tray without knocking or announcing herself. At 8:18AM Licensed Practical Nurse (LPN) 4 walked into room [ROOM NUMBER], called out a resident name without knocking, announcing herself, or asking for admittance. CNA 6 walked in behind her and got a meal tray from within the room without speaking at all and exited the room. At 8:20AM Transportation staff walked into room [ROOM NUMBER] without knocking, announcing themselves, or asking for admittance. Upon exiting, she walked into room [ROOM NUMBER] without knocking, announcing herself, or asking for admittance. Upon exiting, she walked to room [ROOM NUMBER]. She walked in without knocking, announcing herself, or asking for admittance. A policy titled, Resident Rights Policy, dated 12/24 was provided by the Administrator on 4/15/26 at 11:33AM. The policy indicated.Residents have the right to dignity and respect. Be treated with consideration, respect, and full recognition of dignity and individuality. 410 IAC (Indiana Administrative Code) 16.2 3.1-3(a)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview the facility failed to provide the bed hold notification to 2 of 5 residents reviewed. (Resident 3 and Resident 6)Findings include:Resident 3's record review began on 04/12/2026 at 11:31 AM. Resident 3's diagnosis included diabetes, lung disease, and stroke.Resident 3 was sent to the hospital on the following dates according to his census; 7/1/25, 7/14/25, 8/14/25, 8/26/25, and 12/29/25.One hospital nursing transfer form was available to review. The form was dated for the hospitalization 7/14/25 and included demographics, transfer details, key clinical information, key contacts, and bed hold notice.The nursing transfer form and bed hold notice was not available for review related to hospitalizations on 7/1/25, 8/14/25, 8/26/25, and 12/29/25.A review of Resident 3's progress notes did not indicate a bed hold notice was discussed or given on the dates of 7/1/25, 8/14/25, 8/26/25, and 12/29/25 hospitalizations or within the 24 hours following.2. Resident 6's record review began on 04/12/2026 at 11:41 AM. Resident 6's diagnosis included Cerebral Palsy, malnutrition, and constipation.Resident 6 went to the hospital on the following dates according to her census 5/18/25, 6/2/25, 7/16/25, and 2/11/26.Resident 6 did not have any nursing transfer forms for review for the dates of 5/18/25, 6/2/25, 7/16/25, and 2/11/26 in her medical record.Resident 6 did not have any progress notes to indicate a bed hold notice was discussed or given on the dates of 5/18/25, 6/2/25, 7/16/25, and 2/11/26 or within 24 hours. In an interview, on 4/13/26 at 1:21PM, the Administrator indicated she could scan in the notice of transfer or discharge that included the bed hold policy but the notices did not require a signature or proof of receipt from resident or resident representative to have them in medical record.In an interview, on 04/13/2026 at 2:02 PM, Nursing Supervisor 2 indicated staff made a copy of the bed hold when staff send the resident out. Then staff keep the notices in a binder. The facility was under the understanding this was proof of receipt of the bed hold policy. There were no other documentation and no signatures on bed hold notices provided. A policy titled, Transfer Discharge, undated was provided by the Administrator on 4/15/26 at 11:33AM. The policy indicated.Bed hold policy was also required at time of transfer or, in case of emergency within 24 hours. No state rule applies.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to ensure proper technique during wound care treatment for 1 of 1 residents reviewed. (Resident 4)Findings include:During an observation, on 04/14/2026 at 10:09 AM: Employee 2 set up the supplies with no clean barrier between the supplies and the bedside table. She picked up a stack of 4x4 gauze pads from the treatment cart with bare hands and then placed the pads on the table. Employee 2 then donned a protective gown, sanitized her hands, and donned gloves. The 4X4 gauze was removed from the wound bed, gloves were removed, hands sanitized and gloves donned. Santyl cream (an agent to remove dead tissue) was applied to wound bed, then wet gauze soaked in Dakins (a wound care solution to decrease infective material in the wound) was packed into the wound. The wound was then covered with an Allevyn foam dressing.Resident 4's record was reviewed on 04/14/2026 at 12:00 PM. Diagnoses included Multiple Sclerosis, chronic pain, and decreased mobility.A review of Resident 4's current quarterly MDS indicated their BIMS was 15 (cognitively intact).A review of Resident 4's current care plan, titled Pressure Ulcer, indicated the resident had a problem of pressure ulcer infections, with a goal date of 03/27/2026. Interventions included administer supplements as ordered, monitor changes in skin status, and monitor nutritional status.A review of physician orders, dated 04/07/2026 at 12:00 PM, indicated Resident 4 received mighty shakes with meals (Protein fortified supplement), prostat (protein supplement) four times daily, and Dakins solution for wound care.A review of progress notes, dated 04/15/2026, indicated Resident 4 had an infection in their wound in January, February, and March 2026.In an interview, on 04/14/2026 at 1:15 PM, Employee 2 indicated they should have used a barrier between the table and supplies, and should not have picked up the 4x4 gauze with an ungloved bare hand.A current policy, dated 04/15/2026, indicated dressings should be changed using clean technique unless sterile technique is specified in the physician order.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure proper labeling and dating for tube feeding for 1 of 1 resident reviewed (Resident 6).Findings include:During an observation, on April 12, 2026, at 10:40 AM, Resident 6 was observed in her room. Her tube feeding bag was not labeled or dated to indicate when it was hung. The tube feed flush syringe was dated 04/10/2026.During an observation, on April 12, 2026, at 10:54 AM, Resident 6 was observed in her room. Her tube feeding bag was not labeled or dated to indicate when it was hung. The tube feed flush syringe was dated 04/10/2026.Resident 6's record was reviewed on April 13, 2026, at 12:14 PM. Diagnoses included cerebral palsy and severe protein calorie malnutrition.A physicians orders, dated 5/23/2024, included a regular, pureed textured, and thin consistency diet. An enteral feeding order, dated 10/6/2025, indicated to administer Vital 1.5 calorie (cal) at 30 milliliters (ml) per hour with a fluid flush of 100 ml while running continuously every 2 hours every shift for nutritional supplement.In an interview, on April 12, 2026, at 1:39 PM, the Assistant Director of Nursing (ADON) indicated she watched the nurse hang the tube feeding otherwise, she would not have known when it was hung. The ADON indicated the facility labeled and dated the tube feeding. The ADON indicated the nurse may have been busy and forgot to make a label for the feeding.Vital 1.5 cal instructions for use were provided by the Director of Nursing (DON) on April 15, 2026, at 11:41 AM. The instructions indicated, once opened, reclose, refrigerate, and use within 48 hours.A current policy, titled General Guidelines for Administering Medication Via Enteral Tube, dated 10/2024, was provided by the Administrator on April 13, 2026, at 10:04 AM. The policy indicated the manufacturer's written recommendations regarding suggested time period for hanging of the product are consulted when determining the schedule for enteral feeding administration.410 IAC (Indiana Administrative Code) 3.1-44(a)(2)