

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 15 & 16, 2013</p> <p>Facility number: 005846 Provider number: N/A AIM number: N/A</p> <p>Survey team: Virginia Terveer, RN, TC Sue Brooker, RD Angela Strass, RN Martha Saull, RN (October 16, 2013)</p> <p>Census bed type: Residential: 75 Total: 75</p> <p>Census payor type: Other: 75 Total: 75</p> <p>Sample: 9</p> <p>Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 10/16/13 by Lisa McColly</p>	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____