

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2016
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NAME OF PROVIDER OR SUPPLIER WOODVIEW ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3320 E STATE BLVD FORT WAYNE, IN 46805
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(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 the Investigation of Complaint IN00203741.</p> <p>Complaint IN00203741 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 1, and 2, 2016</p> <p>Facility number: 012107 Provider number: 012107 AIM number: NA</p> <p>Census bed type: Residential: 84 Total: 84</p> <p>Census payor type: Other: 84 Total: 84</p> <p>Sample: 3</p> <p>Woodview Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00203741.</p> <p>QR was completed by 99993 on 08/03/16.</p>	R 000		

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