

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>001135</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/16/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINGSTON RESIDENCE OF FORT WAYNE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7515 WINCHESTER RD</b> <b>FORT WAYNE, IN 46819</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00207870.</p> <p>Complaint IN00207870 - Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey Dates: September 15 &amp; 16, 2016</p> <p>Facility number: 001135 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 49 Total: 49</p> <p>Census payor type: Other: 49 Total: 49</p> <p>Sample: 3</p> <p>Kingston Residence of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00207870.</p> <p>QR was completed by 99993 on 09/16/16.</p>	R 000		

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