

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 C 05/11/2015
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804
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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 IN00173025.</p> <p>Complaint IN00173025 - Substantiated, no deficiencies related to the allegations were cited.</p> <p>Survey Dates: May 7, 8 and 11, 2015</p> <p>Facility number: 005846 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 82 Total: 82</p> <p>Census payor type: Other: 82 Total: 82</p> <p>Sample: 3</p> <p>Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00173025.</p>	R 000		

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