

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2012
NAME OF PROVIDER OR SUPPLIER HARBOUR ASSISTED LIVING OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805		
(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 Complaints IN00103273, IN00103928, and IN00103886.</p> <p>Complaint IN00103273 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00103928 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00103886 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 6 & 7, 2012</p> <p>Facility number: 010235 Provider number: 010235 AIM number: N/A</p> <p>Survey team: Rick Blain, RN TC Sue Brooker, RD Angela Strass, RN</p> <p>Census bed type: Residential: 50 Total: 50</p> <p>Census payor type: Other: 50 Total: 50</p> <p>Sample: 7</p> <p>Harbour Assisted Living of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaints IN00103273, IN00103928, and IN00103886.</p> <p>Quality review 3/07/12 by Suzanne Williams, RN</p>	R 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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