

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005846</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COVENTRY MEADOWS ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7833 W JEFFERSON BLVD FORT WAYNE, IN 46804</b>		
(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 a State Residential Licensure survey. This visit included the Investigation of Complaint IN00099611.</p> <p>Complaint IN00099611- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 7 and 8, 2011</p> <p>Facility number: 005846 Provider number: 005846 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC Tim Long, RN Julie Wagoner, RN (November 7, 2011)</p> <p>Census bed type: Residential: 78 Total: 78</p> <p>Census payor type: Other: 78 Total: 78</p> <p>Sample: 10</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 and the Investigation of Complaint IN00099611.</p> <p>Quality review completed 11/15/11 by Jennie Bartelt, RN.</p>	R 000		

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TITLE

(X6) DATE

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