

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER KINGSTON RESIDENCE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 7515 WINCHESTER RD, FORT WAYNE, , 46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00453406. Complaint IN00453406-No deficiencies related to the allegations are cited. Survey date: March 4, 2025 Facility number: 001135 Residential census: 55 Kingston Residence of Fort Wayne was found to be compliant with 42 CFR Parts 483.10, 483.12, 483.25 and 483.35 in regard to the Investigation of Complaint IN00453406. Quality review completed March 4, 2025.	R 0000			
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S			TITLE	(X6) DATE	

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FORM APPROVED

OMB NO. 0938-0391

SIGNATURE		
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