

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 08/12/2026
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD, FORT WAYNE, , 46815			
(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 Intake 471102. Intake 471102- No deficiencies related to the allegations are cited. Survey date: August 12, 2026 Facility number: 004686 Census Bed Type: Residential: 34 Total: 34 Census Payor Type: Medicaid: 6 Other: 28 Total: 34	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

Cedar Creek was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Intake 471102.			
Quality review completed August 12, 2026			

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 SIGNATURE	TITLE	(X6) DATE
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