

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 02/05/2025	
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS, L.L.C.		STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD, FORT WAYNE, , 46804					
(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 Complaints IN00451427 and IN00451823. Complaint IN00451427 - No deficiencies related to the allegations are cited. Complaint IN00451823 - No deficiencies related to the allegations are cited. Survey date: February 5, 2025 Facility number: 005846 Residential Census: 76 Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00451427 and IN00451823. Quality review completed February 5, 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

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE