

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 06/16/2025	
NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD SOUTH, FORT WAYNE, , 46814					
(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 IN00460774 and IN00460778. This survey also included a Post Survey Revist (PSR) to Complaint IN00458856. Complaint IN00460774 - No deficiencies related to the allegations are cited. Complaint IN00460778- No deficiencies related to the allegations are cited. Survey date: June 16, 2025 Facility number: 011804 Residential Census: 102 Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00460774 and IN00460778. Quality review completed June 17, 2025	R 0000					

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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