

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 12/02/2025	
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 Intakes 465514, 465820, and 466333. Intake 465514 - No deficiencies related to the allegations are cited. Intake 465820 - No deficiencies related to the allegations are cited. Intake 466333 - No deficiencies related to the allegations are cited. Survey dates: December 1 and 2, 2025 Facility number: 011804 Residential Census: 108 Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 465514, 465820, and 466333.	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

	Quality review completed December 3, 2025			
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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
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