STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT FORT WAYNE WEST	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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00458856 completed on May 15, 2025. This visit was in conjunction with an investigation of Complaints IN00460774 and IN00460778. Complaint IN00458856 - Corrected 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 PSR to Investigation of Complaint IN00458856. Quality review completed June 17, 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	TITLE	(X6) DATE

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		