STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/17/2025

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 Intake 464114 completed on August 22 and 25, 2025. Intake 464114- Corrected Survey date: November 17, 2025 Facility number: 011804 Residential Census: 110 Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Intake 464114. Quality reivew completed November 18, 2025 This visit was for a Post Survey Revisit (PSR) to Investigation of Intake 464114 completed on August 22 and 25, 2025. Intake 464114- Corrected Survey date: November 17,	R 0000		

	2025 Facility number: 011804 Residential Census: 110 Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Intake 464114. Quality reivew completed November 18, 2025			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.	R 0214		11/20/2025
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be	R 0241		11/20/2025

	administered by licensed nursing personnel or qualified medication aides.			

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