

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 03/17/2026	
NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR, FORT WAYNE, , 46845					
(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 Intake 468430. Intake 468430 - No deficiencies related to the allegations are cited. Survey date: March 17, 2025 Facility number: 012582 Residential Census: 168 Park Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake 468430. Quality review completed on March 18, 2026.	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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE		