

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>07/13/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>CROSSINGS AT COVINGTON COMMONS                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>2601 COVINGTON COMMONS DRIVE,<br>FORT WAYNE, , 46804 |                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                             | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION... | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                                                                                                                                                                                                            | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Intake 470777.</p> <p>Intake 470777: No deficiencies<br/>related to the allegations are<br/>cited.</p> <p>Survey date: July 13, 2026</p> <p>Facility number: 014017</p> <p>Residential Census: 73</p> <p>Crossings at Covington<br/>Commons was found to be in<br/>compliance with 410 IAC 16.2-5<br/>in regard to the Investigation of<br/>Intake 470777.</p> <p>Quality review completed July<br/>14, 2026</p> | 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<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      | TITLE                            | (X6) DATE                                                       |                                                 |