STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FORT WAYNE	9210 MAYSVILLE ROAD, FORT WAYNE, , 46815

(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 Complaints IN00438817 and IN00439651. Complaint IN00438817-No Federal/State deficiencies related to the allegations are cited. Complaint IN00439651-No Federal/State deficiencies related to the allegations are cited. Survey date: August 21, 2024 Facility number: 014576 Residential Census: 72 Cedarhurst of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00438817 and IN00439651. Quality review completed August 23, 2024.	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