

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 06/18/2025	
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint IN00460591. Complaint IN00460591. No deficiencies related to the allegations are cited. Survey date: June 18, 2025 Facility number: 014576 Census Bed Type: Residential: 83 Cedarhurst of Fort Wayne was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00460591. Quality review completed June 18, 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	

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

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
---	--	--