

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 10/22/2025	
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 Intakes IN00465424 and IN00465519. Intake IN00465424 - No deficiencies related to the allegations are cited. Intake IN00465519 - No deficiencies related to the allegations are cited. Survey date: October 22, 2025 Facility number: 014576 Residential Census: 86 Cedarhurst of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes IN00465424 and IN00465519. Quality Review completed on October 23, 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.)							

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------