STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	**6006 BRANDY CHASE COVE FORT WAYNE, IN 46815**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00349575. Complaint IN00349575 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: March 31 and April 1, 2021 Facility number: 000153 Provider number: 155249 AIM number: 10026690 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 5 Medicaid: 69 Other: 16 Total: 90 (Name of Facility) 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 IN00349575. Quality review completed April 1, 2021	F 000		

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