

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014576</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF FORT WAYNE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9210 MAYSVILLE ROAD</b> <b>FORT WAYNE, IN 46815</b>		
(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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00423811 and IN00426368.</p> <p>Complaint IN00423811 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00426368 - No deficiencies related to the allegations are cited.</p> <p>Survey date: January 17, 2024</p> <p>Facility number: 014576</p> <p>Residential Census: 66</p> <p>Cedarhurst of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00423811 and IN00426368.</p> <p>Quality reivew completed January 18, 2024</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE