

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014017 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/27/2023 |
| NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF FORT WAYNE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2601 COVINGTON COMMONS DRIVE FORT WAYNE, IN 46804 | | |
| (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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00404110.</p> <p>Complaint IN00404110 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 27, 2023</p> <p>Facility number: 014017</p> <p>Residential Census: 71</p> <p>Five Star Residences of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00404110.</p> <p>Quality review completed March 28, ,2023</p> | R 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE