

Indiana Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014576 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 06/18/2025 |
| NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE | | STREET ADDRESS, CITY, STATE, ZIP CODE 9210 MAYSVILLE ROAD 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) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00460591.</p> <p>Complaint IN00460591. No deficiencies related to the allegations are cited.</p> <p>Survey date: June 18, 2025</p> <p>Facility number: 014576</p> <p>Census Bed Type: Residential: 83</p> <p>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.</p> <p>Quality review completed June 18, 2025</p> | R 000 | | |

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

TITLE

(X6) DATE