

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005846</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/03/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>COVENTRY MEADOWS ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7833 W JEFFERSON BLVD</b> <b>FORT WAYNE, IN 46804</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 Complaint IN00405599.</p> <p>Complaint IN00405599 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 3, 2023</p> <p>Facility number: 005846</p> <p>Residential Census: 80</p> <p>Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00405599.</p> <p>Quality review completed May 3, 2023.</p>	R 000		

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

TITLE

(X6) DATE