

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/10/2022
NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 3320 EAST STATE BOULEVARD FORT WAYNE, IN 46805		
(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 IN00373409.</p> <p>Complaint IN00373409 - Unsubstantiated due to lack of evidence .</p> <p>Survey date: March 10, 2022</p> <p>Facility number: 012107</p> <p>Residential Census: 29</p> <p>Cedar Ridge of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00373409.</p> <p>Quality review completed March 10, 2022</p>	R 000		

Indiana State Department of Health

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

TITLE

(X6) DATE