

Indiana State Department of Health

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 07/27/2022
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 IN00385862.</p> <p>Complaint IN00385862- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: July 27, 2022</p> <p>Facility number: 014576</p> <p>Residential Census: 56</p> <p>Cedarhurst of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00385862.</p> <p>Quality review completed July 28, 2022</p>	R 000		

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

TITLE

(X6) DATE