STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2024

NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR 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) COMPLETION DATE
F 000	**INITIAL COMMENTS** This visit was for the Investigation of Complaint IN00441330. Complaint IN00441330- No deficiencies related to the allegations are cited. Survey date: September 9, 2024 Facility number: 000240 Provider number: 155349 AIM number: 100274960 Census Bed Type: SNF/NF: 109 SNF: 6 Residential: 81 Total: 196 Census Payor Type: Medicare: 8 Medicaid: 59 Other: 129 Total: 196 Saint Anne Home 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 IN00441330. Quality review completed September 9, 2024	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE