

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003000</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/21/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINGSTON AT DUPONT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1716 E DUPONT RD</b> <b>FORT WAYNE, IN 46825</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 IN00406110.</p> <p>Complaint IN00406110 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 21, 2023</p> <p>Facility number: 003000</p> <p>Residential Census: 35</p> <p>Kingston At Dupont was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00406110.</p> <p>Quality review completed April 26, 2023</p>	R 000		

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

TITLE

(X6) DATE