

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 COVINGTON COMMONS DRIVE FORT WAYNE, IN 46804		
(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 IN00453556.</p> <p>Complaint IN00453556- No deficiencies related to the allegations are cited.</p> <p>Survey date: February 25, 2025.</p> <p>Facility number: 014017</p> <p>Residential Census: 68</p> <p>Five Star Residences of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00453556.</p> <p>Quality Review completed on February 26, 2025.</p>	R 000		

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

TITLE

(X6) DATE