STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012107	A. BUILDING: _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE ASSISTED LIVING	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	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00425707. Complaint IN00425707- No deficiencies related to allegations are cited. Survey date: Feburary 16, 2024. Facility number: 012107 Residential Census: 17 Magnolia Village Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00425707. Quality review completed February 19, 2024	R 000		