

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2023
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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE PLACE - FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 11911 DIEBOLD ROAD FORT WAYNE, IN 46845
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(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 IN00IN00422318 and IN00423222.</p> <p>Complaint IN00422318- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00423222 - No deficiencies related to the allegations are cited.</p> <p>Survey date:: December 11, 2023.</p> <p>Facility number: 013687</p> <p>Residential Census: 33</p> <p>Lincolnshire Place - Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00422318, and IN00423222.</p> <p>Quality review completed December 11, 2023.</p>	R 000		

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