

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011804	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/20/2023
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NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814
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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 IN00405516.</p> <p>Complaint IN00405516 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 20, 2023.</p> <p>Facility number: 011804</p> <p>Residential Census: 93</p> <p>Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00405516.</p> <p>Quality review completed April 21. 2023</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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