

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014512</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>EVERGREEN VILLAGE AT FORT WAYNE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12523 AUBURN ROAD</b> <b>FORT WAYNE, IN 46845</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 IN00430720.</p> <p>Complaint IN00430720- No deficiencies related to the allegations are cited.</p> <p>Survey date: April 26, 2024.</p> <p>Facility number: 014512</p> <p>Residential Census: 126</p> <p>Evergreen Village at Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00430720.</p> <p>Quality review completed April 29, 2024</p>	R 000		

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