Indiana Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **011804** | A. BUILDING: ______<br>B. WING ______ | C<br>**12/15/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STORYPOINT FORT WAYNE WEST** | **611 W COUNTY LINE RD SOUTH**<br>**FORT WAYNE, IN 46814** |

| (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<br><br>This visit was for the Investigation of Complaint IN00422205.<br><br>Complaint IN00422205 - No deficiencies related to the allegations are cited.<br><br>Survey date: Dacember 15, 2023<br><br>Facility number: 011804<br><br>Residential Census: 90<br><br>Story Point Fort wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00422205<br><br>Quality review completed December 15, 2023. | R 000 | | |

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