

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE PARK COMMONS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2002 HERITAGE PARK DRIVE FORT WAYNE, IN 46805</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00420818</p> <p>Complaint IN00420818 - No deficiencies related to allegation are cited.</p> <p>Survey date: November 17, 2023.</p> <p>Facility number: 014113</p> <p>Residential Census: 31</p> <p>Heritage Park Commons was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00420818.</p> <p>Quality review completed November 17, 2023</p>	R 000		

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