

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/03/2023
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(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 IN00396669.</p> <p>Complaint IN00396669 - Unsubstantiated due to lack of evidence</p> <p>Survey date: January 3, 2023</p> <p>Facility number: 005846</p> <p>Residential Census: 78</p> <p>Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00396669.</p> <p>Quality review completed January 3, 2023</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE