Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001135	A. BUILDING: ______ B. WING ______	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON RESIDENCE OF FORT WAYNE	**7515 WINCHESTER RD** **FORT WAYNE, IN 46819**

(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 This visit was for the Investigation of Complaint IN00453406. Complaint IN00453406-No deficiencies related to the allegations are cited. Survey date: March 4, 2025 Facility number: 001135 Residential census: 55 Kingston Residence of Fort Wayne was found to be compliant with 42 CFR Parts 483.10, 483.12, 483.25 and 483.35 in regard to the Investigation of Complaint IN00453406. Quality review completed March 4, 2025.	R 000		

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