

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011804</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STORYPOINT FORT WAYNE WEST</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814</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 Complaints IN00413112, IN00413260 and IN00413410.</p> <p>Complaint IN00413112 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00413260 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00413410 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 24 and 25, 2023.</p> <p>Facility number: 011804</p> <p>Residential Census: 96</p> <p>Storypoint Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00413112, IN00413260 and IN00413410.</p> <p>Quality review completed July 26, 2023.</p>	R 000		

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