

Indiana Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011804 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/13/2025 |
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| NAME OF PROVIDER OR SUPPLIER STORYPOINT FORT WAYNE WEST | STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814 |
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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 |
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| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 12, and 13 2025.</p> <p>Facility number: 011804</p> <p>Residential Census: 106</p> <p>Story Point Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed February 13, 2025</p> | R 000 | | |

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