

Indiana Department of Health

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 C 09/11/2023
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		
(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 IN00416172.</p> <p>Complaint IN00416172- No deficiencies related to the allegations are cited.</p> <p>Survey date: September 11, 2023</p> <p>Facility number: 011804</p> <p>Residential Census: 96</p> <p>Story Pointe Fort Wayne West was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00416172.</p> <p>Quality review completed September 11, 2023.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE