

Indiana Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004686 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF FORT WAYNE | STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815 |
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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 the Investigation of Complaints IN00434451 and IN00435003.</p> <p>Complaint IN00434451- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00435003- No deficiencies related to the allegations are cited.</p> <p>Survey date: June 18, 2024.</p> <p>Facility number: 004686</p> <p>Residential Census: 29</p> <p>Cedar Creek of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00434451 and IN00435003.</p> <p>Quality review completed June 19, 2024</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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