Indiana State 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 _____	06/14/2012

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 a State Residential Licensure Survey. Survey dates: June 13 & 14, 2012 Facility number: 001135 Provider number: 001135 AIM number: N/A Survey team: Sue Brooker RD TC Rick Blain RN Angie Strass RN Census bed type: Residential: 60 Total: 60 Census payor type: Other: 60 Total: 60 Residential sample: 7 Kingston Residence of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality review 6/14/12 by Suzanne Williams, RN	R 000		