

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015503</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/18/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ARBOR GLEN INDEPENDENT &amp; ASSISTED LIVING CC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5202 ST JOE ROAD</b> <b>FORT WAYNE, IN 46835</b>
--	---

(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 Complaint IN00459674.</p> <p>Complaint IN00459674 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 18, 2025</p> <p>Facility number: 015503</p> <p>Residential Census: 90</p> <p>Arbor Glen Independent and Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00459674.</p> <p>Quality review completed June 18, 2025</p>	R 000		

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