STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015503	A. BUILDING: _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN INDEPENDENT & ASSISTED LIVING C(	5202 ST JOE ROAD FORT WAYNE, IN 46835

(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 the Investigation of Complaints IN00452119 & IN00450868. Complaint IN00452119 - No deficiencies related to the allegations are cited. Complaint IN00450868 - No deficiencies related to the allegations are cited. Survey date: January 31, 2025. Facility number: 015503 Residential Census: 99 Arbor Glen Independent & Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00452119 & IN00450868.	R 000		