

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>07/26/2024</b>
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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>
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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
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00439516 and IN00439619.</p> <p>Complaint IN00439516 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00439619 - No deficiencies related to the allegations are cited.</p> <p>Survey date: July 26, 2024</p> <p>Facility number: 015503</p> <p>Residential Census: 101</p> <p>Arbor Glen Independent &amp; Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00439516 and IN00439619.</p> <p>Quality review completed July 30, 2023.</p>	R 000		

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