| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 03/24/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000 | INITIAL COMMENTS<br><br>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaints IN00454829 and IN00454937 completed on March 6, 2025. This visit was inconjunction with the investigation of Complaint IN00455235.<br><br>Complaint IN00454829 - Corrected<br><br>Complaint IN00454937 - Corrected<br><br>Survey date: March 24, 2025<br><br>Facility number: 015503<br><br>Residential Census: 98<br><br>Arbor Glen Independent and Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaints IN00454829 and IN00454937. | R 0000 | | |

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|---|---|---|---|---|
| | Quality review complated March 24, 2025. | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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