

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 This visit was for the Investigation of Complaint IN00455235. This visit was in conjunction with the Investigation of Complaints IN00454829 and IN00454937. Complaint IN00455235 - No deficiencies related to the allegations are cited. Survey date: March 24, 2025 Facility number: 015503 Residential Census: 98 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 IN00455235. Quality review completed March 25, 2025	R 0000			

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.)

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