

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 06/02/2026
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 Investigation of Intake 469666. Intake 469666- No deficiencies related to the allegations are cited. Survey date: June 2, 2026 Facility number:15503 Census Bed Type: Residential: 104 Total: 104 Census Payor Type: Medicaid: 55 Other: 49 Total: 104 Arbor Glen Retirement Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

Investigation of Intake 469666.

Quality review completed June 2, 2026

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