STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU REHABILITATION AND HEALTHCARE CENTER	**6006 BRANDY CHASE COVE FORT WAYNE, IN 46815**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00395119, IN00395278, IN00396353, IN00396484, and IN00397060. Complaint IN00395119 - Unsubstantiated, due to lack of evidence. Complaint IN00395278 - Unsubstantiated, due to lack of evidence, Complaint IN00396353 - Unsubstantiated, due to lack of evidence, Complaint IN00396484 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00397060 - Unsubstantiated, due to lack of evidence. Survey dates: January 3, 4, 5, and 9, 2023 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 10 Medicaid: 62 Other: 11 Total: 83 Chateau Rehabilitation And Healthcare Center was found to be in compliance with 42 CFR Part	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU REHABILITATION AND HEALTHCARE CENTER	**6006 BRANDY CHASE COVE FORT WAYNE, IN 46815**

(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) COMPLETION DATE
F 000	Continued From page 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigations of Complaints IN00395119, IN00395278, IN00396353, IN00396484 and IN00397060. Quality review completed January 11, 2023	F 000		