STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	**2237 ENGLE RD FORT WAYNE, IN 46809**

(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 Complaint IN00377861. Complaints IN00377861 - Unsubstantiated due to lack of evidence. Survey dates: May 12, 2022 Facility number: 000498 Provider number: 155654 AIM number: 100266110 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 17 Total: 54 Englewood Health and Rehab Center was found to be in compliance with 42 CFR Parts 483.12 and 483.25 in regard to the Investigation of Complaint IN00377861. Quality review completed May 16, 2022	F 000		

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