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 10/19/2021

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 Complaints IN00364495. Complaint IN00364495 - Substantiated. No deficiencies related to the allegations are cited. Survey date: October 19, 2021 Facility number: 000498 Provider number: 155654 AIM number: 1002666110 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 3 Medicaid: 39 Other: 13 Total: 55 Englewood Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00364495. Quality review completed October 19, 2021.	F 000		

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