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 02/16/2022

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	F 000		

This visit was for Investigation of Complaint IN00363220

Complaint IN00363220-Unsubstantiated due to lack of evidence.

Survey date: February 16, 2022

Facility number: 000498
Provider number:155654
AIM number:100266110

Census Bed Type:
SNF/NF:54
Total:54

Census Payor Type:
Medicare:6
Medicaid:37
Other:11
Total:54

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 IN00363220.

Quality review completed February 17, 2022

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