| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER BIRCH OF HAMMOND | 5620 SOHL AVENUE, HAMMOND, , 46320 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00446352, IN00447572, and IN00448582.<br><br>Complaint IN00446352 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00447572 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00448582 - No deficiencies related to the allegations are cited.<br><br>Survey date: April 10, 2025<br><br>Facility number: 013801<br><br>Residential Census: 111<br><br>Silver Birch of Hammond was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00446352, IN00447572, and IN00448582.<br><br>Quality review completed on | R 0000 | April 24, 2025<br><br>Suzanne Williams, Director of Long-Term Care<br><br>Indiana Department of Health<br><br>2 North Meridian Street<br><br>Sec 4-B<br><br>Indianapolis,<br>In 46204-3006<br><br>Dear Ms. Williams:<br><br>Please reference the enclosed 2567L as “Plan of Correction” for the | |

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| | 4/11/25. | | April 10, 2025 Complaint Survey (IN00446352, IN00447572, IN00448582) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools April 24,2025. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.<br><br>The Plan of Correction submitted on April 24,2025 serves as our allegation of compliance. Should you have any questions or concerns regarding the Plan of Corrections, please contact me. | |

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| | | | Respectfully,<br><br>Neysa Holman Stewart, HFA | |

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 |
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