

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/16/2024	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 3630 HICKORY ROAD, MISHAWAKA, , 46545					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00447799, IN00446380, IN00444499 and IN00444094. Complaint IN00447799 - No deficiencies related to the allegations are cited. Complaint IN00446380 - No deficiencies related to the allegations are cited. Complaint IN00444499 - No deficiencies related to the allegations are cited. Complaint IN00444094 - No deficiencies related to the allegations are cited. Survey date: December 16, 2024 Facility number: 014260 Residential Census: 89 Silver Birch Of Mishawaka was found to be in compliance with 410 IAC 16.2-5 in regard to the	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

Investigation of Complaints IN00447799, IN00446380, IN00444499 and IN00444094. Quality Review completed on 12/18/2024			
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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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