

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 03/21/2024	
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 7125 S HANNA STREET, FORT WAYNE, , 46816					
(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 Residential Investigation of Complaint IN00428098, IN00429332, IN00430308, and IN00430683. Complaint IN00428098 - No deficiencies related to the allegations are cited. Complaint IN00429332 - No deficiencies related to the allegations are cited. Complaint IN00430308 - No deficiencies related to the allegations are cited. Complaint IN00430683 - No deficiencies related to the allegations are cited. Survey date: March 21, 2024. Facility number: 014316 Residential Census: 99 Silver Birch of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

IN00428098, IN00429332, IN00430308, and IN00430683.				
Quality review completed March 22, 2024				

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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