

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/21/2023	
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 Investigation of Complaints IN00404925, IN00405594 and IN00406602. Complaint IN00404925 - No deficiencies related to the allegations are cited. Complaint IN00405594 - No deficiencies related to the allegations are cited. Complaint IN00406602 - No deficiencies related to the allegations are cited. Survey date: April 21, 2023. Facility number: 014316 Residential Census: 95 Silver Birch of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00404925, IN00405594 and IN00406602. Quality review completed April	R 0000					

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	21, 2023			
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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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