

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 04/11/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>SILVER BIRCH OF MISHAWAKA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3630 HICKORY ROAD MISHAWAKA, IN 46545</b>		
(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) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey and Investigation of Complaint IN00399126 completed on 1/26/2023.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00402391 and IN00402722 completed on 3/2/2023.</p> <p>Complaint IN00399126 - Corrected</p> <p>Survey dates: April 10 &amp; 11, 2023</p> <p>Facility number: 014260</p> <p>Residential Census: 113</p> <p>Silver Birch of Mishawaka was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey and the Investigation of Complaint IN00399126.</p> <p>Quality review completed 4/21/23.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE