

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/13/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>SILVER BIRCH OF FORT WAYNE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7125 S HANNA STREET</b> <b>FORT WAYNE, IN 46816</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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Residential Complaint IN00415255 and Complaint IN00416469.</p> <p>Complaint IN00415255 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00416469 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 13, 2023</p> <p>Facility number: 014316</p> <p>Residential Census: 109</p> <p>Silver Birch of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00415255 and Complaint IN00416469.</p> <p>Quality review completed September 14, 2023</p>	R 000		

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

TITLE

(X6) DATE