

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014316	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER SILVER BIRCH OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 7125 S HANNA STREET FORT WAYNE, IN 46816		
(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 Complaint IN00447117 and IN00447352..</p> <p>Complaint IN00447117- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00447352- No deficiencies related to the allegations are cited.</p> <p>Survey date: December 11, 2024</p> <p>Facility number: 014316</p> <p>Residential Census: 78</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 Complaint IN00447117 and IN00447352.</p> <p>Quality review completed December 11, 2024</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE