STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER BIRCH OF HAMMOND	5620 SOHL AVENUE HAMMOND, IN 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00446352, IN00447572, and IN00448582. Complaint IN00446352 - No deficiencies related to the allegations are cited. Complaint IN00447572 - No deficiencies related to the allegations are cited. Complaint IN00448582 - No deficiencies related to the allegations are cited. Survey date: April 10, 2025 Facility number: 013801 Residential Census: 111 Silver Birch of Hammond was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00446352, IN00447572, and IN00448582. Quality review completed on 4/11/25.	R 0000	April 24, 2025 Suzanne Williams, Director of Long-Term Care Indiana Department of Health 2 North Meridian Street Sec 4-B Indianapolis, In 46204-3006 Dear Ms. Williams: Please reference the enclosed 2567L as “Plan of Correction” for the April 10, 2025 Complaint Survey (IN00446352, IN00447572, IN00448582) that was conducted at Silver Birch of Hammond. I will submit signature sheets of the in-servicing, content of in-service and audit tools April 24,2025. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on April 24,2025 serves as our allegation of compliance. Should you have any questions or concerns regarding the Plan of Corrections, please contact me. Respectfully, Neysa Holman Stewart, HFA	