

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER COMMONS AT JACKSON CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 SARE RD, BLOOMINGTON, , 47401					
(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 a State Residential Licensure Survey. Survey dates: August 5 and 6, 2026 Facility number: 011076 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 11, 2026.	R 0000	The following is the plan of correction for Commons at Jackson Creek regarding the statement of deficiencies dated 8/6/26. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document we have outlined specific actions to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigation factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective				
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure	R 0092	1. No residents were affected 2. All residents have the potential for being affected 3. The Executive Director collaborated with the	08/12/2026			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure staff documented attempts to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. Findings include: On 8/5/26 at 11:30 a.m., the Executive Director (ED) provided the facility's Fire and Emergency Drill reports for the	Maintenance director and established a plan to ensure all communications are done via email and/or regular postal service so a record of communication can be maintained. Said communications to be placed in the emergency binder for record of communication. 4. The maintenance Director to review planned evacuation during safety meeting held quarterly, if applicable. Communication between the Maintenance Director and the fire department personnel will be placed in the emergency binder along with the record of community fire drills. Emailed communication to also include Executive Director. Audits will be reviewed in Quarterly Quality Meetings and any suggestions will be acted on promptly 5. Completion date 8/10/26	
--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	last 12 months. A review of the facility's fire and emergency drills indicated none of the drills involved the local fire department. During an interview with the ED on 8/6/26 at 10:00 a.m., he indicated the maintenance director had attempted to contact the fire department for drills but there was no documentation that showed when they were contacted. On 8/6/26 at 10:20 a.m., the ED provided a copy of the facility policy labeled "Disaster and Emergency Drills," review date 1/10/24, and indicated this was a current policy used by the facility. A review of the policy indicated, "...Total Evacuation Drill (or simulation of) will be performed bi-yearly in conjunction with the local fire department. a. All attempts to schedule with the Fire Department will be kept in writing in the Emergency Book."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:	R 0217	1. Resident 5 was affected, concern was taken care of immediately 2. All residents have the potential to be affected 3. Director of Nursing and/or designee to audit 15 charts	08/12/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

(1) The services offered to the individual resident shall be appropriate to the:

- (A) scope;
 - (B) frequency;
 - (C) need; and
 - (D) preference;
- of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on record review and interview, the facility failed to

monthly for 2 months, then 10 charts monthly for 2 months, then 5 charts monthly for 2 months. Service plans in an electronic record will be checked weekly for completion. Nursing Director to bring results to stand up meeting held Monday thru Friday.

4. Executive Director and Director of nursing will collaborate on a completion form for new admissions and will review daily in stand-up meetings held Monday thru Friday as applicable. This form will be signed by Director of nursing when completed. Audits will be reviewed in Quarterly Quality Meetings and any suggestions will be acted on promptly

5. Completion date 8/15/26

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

ensure service plans were signed and dated by the resident or resident's representative for 1 of 7 residents reviewed for service plans. (Resident 5)

Findings include:

On 8/6/26 at 9:15 a.m., Resident 5's clinical record was reviewed. The diagnosis included, but was not limited to, was macular degeneration.

The Personal Service Plan, dated 6/7/26, was not signed or dated by the resident or resident's representative.

During an interview on 8/6/26 at 9:30 a.m., the Administrator indicated the resident's Personal Service Plan had not been signed by the resident or the resident's representative.

On 8/6/26 at 10:15 a.m., the Administrator provided the Assistance Service Plan policy with a review date of 1/10/24 and indicated this was the policy currently used by the facility. A review of the policy indicated, "...all components of the assistance/service plan form must be completed..."

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

TITLEExecutive Director

(X6) DATE08/13/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREChad Mashburn		
--	--	--