

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

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                  |                                                                 |  |                                                 |  |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------|--|-------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                    |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>08/17/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RESIDENCES AT DEER CREEK |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>401 EAST US 30, SCHERERVILLE, ,<br>46375 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                        | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                       | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Intakes 470106<br/>and 471142.</p> <p>Intake 470106 - No deficiencies<br/>related to the allegations are<br/>cited.</p> <p>Intake 471142 - No deficiencies<br/>related to the allegations are<br/>cited.</p> <p>Survey date: August 17, 2026</p> <p>Facility number: 013069</p> <p>Residential Census: 103</p> <p>Residences at Deer Creek was<br/>found to be in compliance with<br/>410 IAC (Indiana Administrative<br/>Code) 16.2-5 in regard to the<br/>Investigation of Intakes 470106<br/>and 471142.</p> <p>Quality review completed on<br/>8/21/26.</p> | R 0000                                                                                   |                                  |                                                                 |  |                                                 |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from

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

FORM APPROVED

OMB NO. 0938-0391

|                                                                                                                               |       |           |
|-------------------------------------------------------------------------------------------------------------------------------|-------|-----------|
| correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) |       |           |
| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                   | TITLE | (X6) DATE |