STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY, SHELBYVILLE, , 46176

(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 Post Survey Revisit (PSR) to the Investigation of Investigation of Complaints IN00360152 and IN00369290 completed on 8-20-2021. This visit was conducted in conjunction with a PSR to the Residential Covid-19 Quality Assurance Walk Through Survey completed on 9-8-2021. Complaint IN00360152 -- Not corrected. Complaint IN00369290 -- Not corrected. The Residential Covid-19 Quality Assurance Walk Through Survey-R407 Survey date: October 15, 2021 Facility number: 014548 Residential census: 29 These State Residential Findings are cited in accordance	R 0000		

	with 410 IAC 16.2-5. Quality review completed on October 26, 2021			

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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE