

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2025
NAME OF PROVIDER OR SUPPLIER RESIDENCES AT DEER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST US 30 SCHERERVILLE, IN 46375		
(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 IN00451183.</p> <p>Complaint IN00451183 - No deficiencies related to the allegations are cited.</p> <p>Survey date: January 30, 2025</p> <p>Facility number: 013069</p> <p>Residential Census: 97</p> <p>Residences at Deer Creek was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00451183.</p> <p>Quality review completed on 2/3/25.</p>	R 000		

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

TITLE

(X6) DATE