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

PRINTED: 01/27/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47/170 PREPIX ISAMIANARY STRILMAND OF DEPICIPATIONS ISAMIANARY STRILMAND OF DEPICIPATION OF PREPIX ISAMIANARY STRILMAND OF DEPICIPATION OF PREPIX ISAMIAND OF THE OFFICE OF THE OFFI OF THE OFFI OF THE OFFI OFFI OFFI OFFI OFFI OFFI OFFI OFF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES TAGGED BY FULL								R-C
HICKORY CREEK AT SCOTTSBURG (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDE PREFIX TAG PROVIDE PROPERTY (PACK) PROVIDE PROPERTY (PACK) PROVIDE PROPERTY (PACK) PROVIDE PROPERTY (PACK) PROVIDE PREFIX TAG PROVIDE PROPERTY (PACK) PA			155417	B. WING			01/	/24/2025
SCOTTSBURG, IN 47170	NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) INITIAL COMMENTS Paper compliance to the Investigation of Complaints IN00447339 and IN00447152 completed on December 6, 2024. Complaint IN00447339 - corrected. Complaint IN00447152 - corrected. Review Date: January 24, 2025 Facility Number: 000421 Provider Number: 155417 AlM Number: 100288340 Hickory Creek at Scottsburg was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper review to the Investigation of Complaints IN00447339 and IN00447152.	HICKUDA	CDEEK AT SCOTTSBILE	26		110	0 N GARDNER AVE		
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.