

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RESIDENCES AT DEER CREEK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 EAST US 30</b> <b>SCHERERVILLE, IN 46375</b>		
(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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00433098.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the State Residential Licensure Survey and the Investigation of Complaint IN00424859 completed on 2/28/24.</p> <p>Complaint IN00433098 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00424859 - Corrected</p> <p>Survey date: April 24, 2024</p> <p>Facility number: 013069</p> <p>Residential Census: 106</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 IN00433098.</p> <p>Quality review completed on 4/26/24.</p>	R 000		

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

TITLE

(X6) DATE