PRINTED: 07/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155631	A. BU B. WI		<del></del>		COMPLETED 06/17/2025	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD ENNY SIMPSON LN			
WHITE RIVER LODGE					DFORD, IN 47421			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5)	
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	COMPLETION DATE	
E 0000								
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 06/17/25		E 00	000				
	Facility Number: 001153 Provider Number: 155631 AIM Number: 200155900							
	At this Emergency Preparedness survey, White River Lodge was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.							
	certified beds and 1 facility had a total c visit. The entire fac lack of a 2 hour fire	otal capacity of 84 with 74 0 Assisted Living beds. The sensus of 41 at the time of this ility was surveyed due to the rated separation between the e Assisted Living Unit.						
	Quality Review cor	npleted on 06/23/25						
K 0000								
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 0	000				
	Survey Date: 06/17	/25						
	Facility Number: 0 Provider Number:							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

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

PRINTED: 07/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		01	COMPLETED		
		155631	B. WING			06/17/2025		
NAME OF PROVIDER OR SUPPLIER  WHITE RIVER LODGE				STREET ADDRESS, CITY, STATE, ZIP COD  3710 KENNY SIMPSON LN  BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEF		DEFICIENCY)	TCIENCY)		
TAG	AIM Number: 200  At this Life Safety C Lodge was found in Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa  This one story facilit Type II (000) constr sprinklered. The fac with hard wired sme spaces open to the c sleeping rooms. The 84 with 74 certified beds. The facility ha time of this visit. Th due to the lack of a between the Skilled Unit.  All areas where the	Code survey, White River compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  The was determined to be of ruction and was fully fully has a fire alarm system toke detectors in the corridors, corridors, and all resident for facility has a total capacity of beds and 10 Assisted Living and a total census of 41 at the fine entire facility was surveyed 2 hour fire-rated separation Unit and the Assisted Living residents have customary for each of the corridors for the cor		TAG	DEFICIENCY		DATE	
	Quality Review con	npleted on 06/23/25						

Event ID: Y89C21 Facility ID: 001153 If continuation sheet Page 2 of 2