

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER BLOOM AT EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5045 W 52ND ST, INDIANAPOLIS, , 46254					
(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 the Post Survey Revisit (PSR) to the Investigation of Complaint IN00409427 completed on June 08, 2023. Complaint IN00409427 - Corrected. Survey date: July 17, 2023 Facility Number: 003915 Facility Census: 52 Bloom At Eagle Creek was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00409427. Quality review completed on July 19, 2023.	R 0000					
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	