

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/03/2024	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF LOGANSFORT		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD, LOGANSFORT, , 46947					
(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 a State Residential Licensure Survey. Survey dates: July 2 and 3, 2024. Facility number: 004441 Residential Census: 44 Cedar Creek of Logansport was found to be in compliance with 410 IAC 16.2-5. in regards to the State Residential Licensure Survey. Quality review was completed on July 8, 2024.	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		