STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF BLOOMINGTON MEMORY CARE	3203 MOORES PIKE ROAD, BLOOMINGTON, , 47401

(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 Investigation of Complaints IN00461506 and IN00463539. Complaint IN00461506 - State deficiencies related to the allegations are cited at R0151. Complaint IN00463539 - State deficiencies related to the allegations are cited at R0052, R0090, and R0214. Survey date: July 28 and 29, 2025 Facility number: 012706 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 30, 2025.	R 0000	***Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.***	

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect the residents right to be free from sexual abuse by another resident for 1 of 3 residents reviewed for abuse. (Resident F, Resident E) Findings include: Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia. The resident admitted to the facility on 7/19/25. Resident E's observation notes, dated, 7/19/25 at 4:00 p.m., indicated Resident E was discovered by the Director of Nursing (DON) to be sitting on the side of a female residents bed in her apartment, Resident F. Resident E was lying back across Resident F's stomach	R 0052	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident who was demonstrating inappropriate sexual behavior was removed from the communityon 7/23/25. All staff have been re-educated on the Abuse, Neglect, and Exploitation policy, and Resident Rights and Communication policies. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. All staff have been re-educated on the Abuse, Neglect, and Exploitation policy, Resident Rights and Communication policies. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not**	08/15/2025

	and was observed to have his left hand on Resident F's right breast while his left hand was observed to be on his penis. The DON separated the residents and proceeded to redirect Resident E from Resident F's apartment. Resident E was placed with CNA 1 for one to one observation. Qualified Medication Aide 1 (QMA) accompanied the DON back into Resident F's apartment where Resident F was assessed for injury. No injuries noted. The Executive Director (ED) was informed of the above incident. The Admission Assessment, dated, 7/19/25, indicated yes to inappropriate expressions or behaviors present. A Service Plan, dated 7/19/25, for Resident E lacked documentation of the resident having had behaviors. Resident E's clinical record lacked documentation of a Pre-Admission evaluation having been completed prior to the resident's admission date. Resident F's clinical record was reviewed on 7/29/25 at 10:15 a.m. The diagnosis included, but was not limited to, dementia. During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated she had gone into Resident F's		**reoccur:** The Executive Director's employment was terminated on 7/23/25 based on her failure to protect her residents. All staff have been re-educated on the Abuse, Neglect and Exploitation Policy, Resident Rights and Timely Reporting/Communication Policy. Preadmission assessments will be reviewed by the Regional Director of Nursing or designee for 6 months. This audit will be discussed at monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on going. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director, or designee is responsible for	

	room to pass medication on 7/19/25 at approximately 3:45 p.m., when she observed Resident E sitting on Resident F's bed with his left hand on Resident F's right breast and Resident E's right hand on his penis. Resident E's left hand was under Resident F's clothing with her shift pulled up and his penis was outside of his clothing. The DON was able to assist Resident E from Resident F's room and asked Qualified Medication Aide 1 (QMA) to stay with Resident E. The DON then assessed Resident F for injuries and asked if Resident E had touched her. Resident F said several times, "I don't know that man, I don't know that man," but did confirm Resident E had touched Resident F's breast and had been touching himself while in the room. Resident E was placed on one to one observation and was discharged from the facility on 7/23/25. On 7/29/25 at 9:18 a.m., the Executive Director (ED) filling in from another facility provided the facility policy, "Abuse, Neglect and Exploitation Prevention, Prohibition and Investigation" dated, 12/15/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Abuse means ... sexual contact including fondling of a resident by ... other resident by force, threat, duress, or		sustained compliance. The ED/designee will complete audits of pre-hire training documents as well as monthly in-servicing documents monthly for 6 months. The audit wil be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on going. **5. By what date will the systemic changes be completed?** August 15, 2025	

coercion, or sexual contact with a resident who has no ability to consent ... "

On 7/29/25 at 9:18 a.m., the ED filling in from another facility provided the document "Resident Rights" and indicated it was given to each resident upon admission. The document indicated, "... v. Residents have the right to be free from 1. sexual abuse 2. physical abuse ..."

This citation relates to Complaint IN00463539.

Based on interview and record review, the facility failed to protect the residents right to be free from sexual abuse by another resident for 1 of 3 residents reviewed for abuse. (Resident F, Resident E)

Findings include:

Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia. The resident admitted to the facility on 7/19/25.

Resident E's observation notes, dated, 7/19/25 at 4:00 p.m., indicated Resident E was discovered by the Director of Nursing (DON) to be sitting on the side of a female residents bed in her apartment, Resident F. Resident E was lying back across Resident F's stomach

and was observed to have his left hand on Resident F's right breast while his left hand was observed to be on his penis. The DON separated the residents and proceeded to redirect Resident E from Resident F's apartment. Resident E was placed with CNA 1 for one to one observation. Qualified Medication Aide 1 (QMA) accompanied the DON back into Resident F's apartment where Resident F was assessed for injury. No injuries noted. The Executive Director (ED) was informed of the above incident.

The Admission Assessment, dated, 7/19/25, indicated yes to inappropriate expressions or behaviors present.

A Service Plan, dated 7/19/25, for Resident E lacked documentation of the resident having had behaviors.

Resident E's clinical record lacked documentation of a Pre-Admission evaluation having been completed prior to the resident's admission date.

Resident F's clinical record was reviewed on 7/29/25 at 10:15 a.m. The diagnosis included, but was not limited to, dementia.

During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated she had gone into Resident F's

	room to pass medication on 7/19/25 at approximately 3:45 p.m., when she observed Resident E sitting on Resident F's bed with his left hand on Resident F's right breast and Resident E's right hand on his penis. Resident E's left hand was under Resident F's clothing with her shift pulled up and his penis was outside of his clothing. The DON was able to assist Resident E from Resident F's room and asked Qualified Medication Aide 1 (QMA) to stay with Resident E. The DON then assessed Resident F for injuries and asked if Resident E had touched her. Resident F said several times, "I don't know that man, I don't know that man," but did confirm Resident E had touched Resident F's breast and had been touching himself while in the room. Resident E was placed on one to one observation and was discharged from the facility on 7/23/25. On 7/29/25 at 9:18 a.m., the Executive Director (ED) filling in from another facility provided the facility policy, "Abuse, Neglect and Exploitation Prevention, Prohibition and Investigation" dated, 12/15/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Abuse means ... sexual contact including fondling of a resident by ... other resident by force, threat, duress, or			

	coercion, or sexual contact with a resident who has no ability to consent ... " On 7/29/25 at 9:18 a.m., the ED filling in from another facility provided the document "Resident Rights" and indicated it was given to each resident upon admission. The document indicated, "... v. Residents have the right to be free from 1. sexual abuse 2. physical abuse ..." This citation relates to Complaint IN00463539.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;	R 0090	**R -090 410IAC 16.2-5-1.3(g) (1-6)** **Administration and Management** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident who was demonstrating inappropriate sexual behavior was removed from the community on 7/23/25. All staff have been re-educated on	08/15/2025

	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years		the Abuse, Neglect, and Exploitation policy, Resident Rights and Communication policies on 7/25/25 and again on 8/13/25. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. All staff have been re-educated on the Abuse, Neglect, and Exploitation policy, Resident Rights and Communication policies. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director’s employment was terminated on 7/23/25 based on her failure to report an incident to the State survey agency as well as her regional team. All staff have	

	and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to report an incident of unusual occurrence to the State survey agency for 2 of 2 residents reviewed for an unusual occurrence. (Resident E, Resident F) Findings include: Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia. Resident E's observation notes, dated 7/19/25 at 4:00 p.m., indicated Resident E was discovered by the Director of Nursing (DON) to be sitting on the side of a female residents bed in her apartment, Resident F. Resident E was lying back across Resident F's stomach and was observed to have his left hand on Resident F's right breast while his left hand was observed to be on his penis. The DON separated the residents and proceeded to redirect Resident E from Resident F's apartment. Resident E was placed with CNA 1 for one to one observation. Qualified Medication Aide 1 (QMA) accompanied the DON back into Resident F's apartment where		been re-educated on the Abuse, Neglect and Exploitation Policy, Resident Rights and Timely Reporting/Communication Policy. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director (Licensed Administrator) is responsible for sustained compliance. The Communication Policy will be reviewed on a weekly basis with the Executive Director and Director of Nursing by the Regional Director of Operations, The Regional Director of Nursing or designee.	

	Resident F was assessed for injury. No injuries noted. The Executive Director (ED) was informed of the above incident. Resident F's clinical record was reviewed on 7/29/25 at 10:15 a.m. The diagnosis included, but was not limited to, dementia. A review of the State Reportable on the above incident indicated it was reported on, 7/21/25, which was outside of the 24 hour time frame required for reporting of an unusual occurrence. During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated the above incident was reported to the ED on 7/19/25 at 3:58 p.m. The DON indicated she informed the ED that the event needed to be reported to the State, however, the ED stated it was not a reportable and she had no plans to report it to the State. The DON reported the incident to the State herself on 7/21/25. On 7/29/25 at 9:18 a.m., the ED filling in from another facility provided the policy titled, "Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation" dated, 12/15/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...		The continued training will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going. **5. By what date will the systemic changes be completed?** August 15, 2025	

	Witnessed or Suspected Abuse, Neglect, and Exploitation Procedures: 3. Immediately report the alleged abuse to your supervisor and ED by phone call. Your state agency will be notified by the ED or designee per State guidelines ..." This citation relates to Complaint IN00463539. Based on interview and record review, the facility failed to report an incident of unusual occurrence to the State survey agency for 2 of 2 residents reviewed for an unusual occurrence. (Resident E, Resident F) Findings include: Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia. Resident E's observation notes, dated 7/19/25 at 4:00 p.m., indicated Resident E was discovered by the Director of Nursing (DON) to be sitting on the side of a female residents bed in her apartment, Resident F. Resident E was lying back across Resident F's stomach and was observed to have his left hand on Resident F's right breast while his left hand was observed to be on his penis. The DON separated the residents and proceeded to redirect Resident E from			

	Resident F's apartment. Resident E was placed with CNA 1 for one to one observation. Qualified Medication Aide 1 (QMA) accompanied the DON back into Resident F's apartment where Resident F was assessed for injury. No injuries noted. The Executive Director (ED) was informed of the above incident. Resident F's clinical record was reviewed on 7/29/25 at 10:15 a.m. The diagnosis included, but was not limited to, dementia. A review of the State Reportable on the above incident indicated it was reported on, 7/21/25, which was outside of the 24 hour time frame required for reporting of an unusual occurrence. During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated the above incident was reported to the ED on 7/19/25 at 3:58 p.m. The DON indicated she informed the ED that the event needed to be reported to the State, however, the ED stated it was not a reportable and she had no plans to report it to the State. The DON reported the incident to the State herself on 7/21/25. On 7/29/25 at 9:18 a.m., the ED filling in from another facility provided the policy titled,			

	"Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation" dated, 12/15/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Witnessed or Suspected Abuse, Neglect, and Exploitation Procedures: 3. Immediately report the alleged abuse to your supervisor and ED by phone call. Your state agency will be notified by the ED or designee per State guidelines ..." This citation relates to Complaint IN00463539.			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure an annual veterinary examination was completed in a timely manner for 1 of 2 residents who housed pets in the facility. (Resident D) Findings include:	R 0151	**R -151 410IAC 16.2-5-1.5(h) Sanitation & Safety Standards** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to have been affected by the deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action**	08/15/2025

	On 7/28/25 at 11:30 a.m., Resident D was observed to be walking in the hallway pushing a dog in a stroller. On 7/28/25 at 11:45 a.m., the Executive Director (ED) filling in from another facility provided a list of pets housed inside the facility. A review of the animal vaccinations indicated Resident D housed a dog. The last veterinary examination, which included a rabies booster, had expired on 5/6/23. During an interview on 7/28/25 at 12:00 p.m., the ED filling in from another facility indicated the dog for Resident D had not had a recent veterinary examination and rabies booster. The last one was on 5/6/23. On 7/28/25 at 3:15 p.m., the ED filling in from another facility provided the policy titled, "Pet Agreement Addendum" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 4. The resident shall maintain and provide evidence to the Community of current and proper immunizations and licenses of the pet in accordance with the laws, regulations and health customs of the city/county in the which the Community is located ..." This citation relates to		**will be taken:** All residents had the potential to be affected by this deficient practice. The pet without proper immunizations was removed from the community on 7/30/25. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** All pet vaccination records were audited to ensure compliance on 7/30/25. Prior to admission to the community vaccination records for all pets will be collected and verified by the Executive Director or designee. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

	Complaint IN00461506. Based on observation, interview, and record review, the facility failed to ensure an annual veterinary examination was completed in a timely manner for 1 of 2 residents who housed pets in the facility. (Resident D) Findings include: On 7/28/25 at 11:30 a.m., Resident D was observed to be walking in the hallway pushing a dog in a stroller. On 7/28/25 at 11:45 a.m., the Executive Director (ED) filling in from another facility provided a list of pets housed inside the facility. A review of the animal vaccinations indicated Resident D housed a dog. The last veterinary examination, which included a rabies booster, had expired on 5/6/23. During an interview on 7/28/25 at 12:00 p.m., the ED filling in from another facility indicated the dog for Resident D had not had a recent veterinary examination and rabies booster. The last one was on 5/6/23. On 7/28/25 at 3:15 p.m., the ED filling in from another facility provided the policy titled, "Pet Agreement Addendum" undated, and indicated it was the policy currently being used by the facility. A review of the		The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by checking vaccination records 1 time per week for 6 months. The audit wil be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going. **5. By what date will the systemic changes be completed?** August 15, 2025	

	policy indicated, "... 4. The resident shall maintain and provide evidence to the Community of current and proper immunizations and licenses of the pet in accordance with the laws, regulations and health customs of the city/county in the which the Community is located ..." This citation relates to Complaint IN00461506.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a resident received an evaluation prior to admission for 1 of 3 residents reviewed for Pre-Admission Evaluation. (Resident E) Findings include: Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia.	R 0214	**R -214 410IAC 16.2-5-2(a) Evaluation** **1** **What corrective action(s) will be accomplished** **for those residents found to have been affected by the deficient practice:** The resident who was demonstrating inappropriate sexual behavior was removed from the community on 7/23/25. All staff have been re-educated on the Abuse, Neglect, and Exploitation policy, Resident Rights and Communication policies on 7/25/25 and again on 8/13/25. **2. How the facility will identify other residents**	08/15/2025

The resident admitted to the facility on 7/19/25.

During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated Resident E's family toured the facility on 7/17/25, however, the DON had told the Executive Director (ED) she needed to complete a Pre-Admission Evaluation prior to the resident being admitted. On 7/19/25 at 9:11 a.m., Resident E and family arrived at the facility and indicated to the DON they were told the ED had given them the okay to admit that morning. The clinical record lacked documentation of a Pre-Admission Evaluation having been completed prior to Resident E admitting to the facility.

During an interview on 7/29/25 at 10:25 a.m., the ED filling in from another facility indicated the facility did not have a policy related to Pre-Admission Evaluations. The facility followed the State guidelines.

This citation relates to Complaint IN00463539.

Based on interview and record review, the facility failed to ensure a resident received an evaluation prior to admission for 1 of 3 residents reviewed for Pre-Admission Evaluation. (Resident E)

having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents had the potential to be affected by this deficient practice.

3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:

Prior to admission all potential residents will be assessed for appropriateness by the Director of Nursing or a designee who is a nurse. This assessment will be discussed with the Executive Director prior to admission to the community.

Preadmission assessments will be reviewed by the Regional Director of Nursing or designee for 6 months. This audit will be discussed at monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 6 consecutive months of

Findings include:

Resident E's clinical record was reviewed on 7/29/25 at 10:00 a.m. The diagnosis included, but was not limited to, dementia. The resident admitted to the facility on 7/19/25.

During an interview on 7/28/25 at 2:30 p.m., the Director of Nursing (DON) indicated Resident E's family toured the facility on 7/17/25, however, the DON had told the Executive Director (ED) she needed to complete a Pre-Admission Evaluation prior to the resident being admitted. On 7/19/25 at 9:11 a.m., Resident E and family arrived at the facility and indicated to the DON they were told the ED had given them the okay to admit that morning. The clinical record lacked documentation of a Pre-Admission Evaluation having been completed prior to Resident E admitting to the facility.

During an interview on 7/29/25 at 10:25 a.m., the ED filling in from another facility indicated the facility did not have a policy related to Pre-Admission Evaluations. The facility followed the State guidelines.

This citation relates to Complaint IN00463539.

compliance. Monitoring will be on going.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director is responsible for sustained compliance.

Preadmission assessments will be reviewed by the Regional Director of Nursing or designee for 6 months. This audit will be discussed at monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on going.

The QI Committee will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on going.

5. By what date will the

			systemic changes be completed? August 15, 2025	

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