STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/01/2026

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 Intake 469358. Intake 469358 - State deficiencies related to the allegations are cited at R29. Survey date: May 1, 2026 Facility number: 012706 Residential Census: 34 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 6, 2026.	R 0000		
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.	R 0029	*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*	05/18/2026

Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and individuality for 1 of 1 days of the survey. Residents did not have access to their apartments and personal belongings. This had the potential to affect 34 out of 34 residents residing in the facility.

Finding includes:

During an observation on 5/1/26 at 11:30 a.m., 12 residents' apartment doors were closed and locked.

During an interview on 5/1/26 at 11:55 a.m., Resident Assistant 1 indicated a resident who was more cognitively intact was offered and provided a room key. Most residents were not cognitively or physically able to go to their apartment without assistance. When a resident asked to go to their room or demonstrated a desire to do so by their behavior, staff assisted them to their room.

During an interview on 5/1/26 at 12:30 a.m., the Executive Director (ED) indicated the apartment doors were locked to provide privacy, to prevent residents from wandering into other residents' rooms, and families were informed of this at admission. If a resident wanted to go to their room, staff would

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 273 410 IAC 7-26

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

34 residents were directly affected by deficient practice.
The facility failed to ensure residents were treated with dignity and individuality as residents did not have access to their apartments and personal belongings.

	help them get to their room. All the apartment doors were locked unless a family or resident requested their apartment door to be left unlocked. On 5/1/26 at 2:10 p.m., the ED provided the facility policy, "410 INDIANA ADMINISTRATIVE CODE 16.2-5-1.2 RESIDENTS' RIGHTS," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... (b) Residents have the right to a dignified existence, self-determination ..." During an interview on 5/1/26 at 2:12 p.m., the ED indicated the facility did not have a policy in regard to the locked residents' apartment doors.		**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:** This had the potential to affect 34 out of 34 residents residing in the facility. A one-time re-education has been completed regarding resident rights by all care staff. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All staff will receive re-education on resident rights and allowing resident access to apartments by leaving resident apartments unlocked unless the resident, family or POA has indicated otherwise in writing. The Administrator/designee will be responsible for auditing this daily for the first 30 days and twice a week for the following 30 days. Any issues identified will be	

			immediately corrected, 1:1 re-education completed with staff and personnel as identified, with disciplinary action completed as determined by the Administrator and 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:** The Administrator is responsible for sustained compliance. The Administrator/designee will complete audits per the schedule above. Re-education, frequency and/or duration of reviews will be increased if any areas of noncompliance are identified during the auditing process until ensuring compliance with this plan of correction. **5. By what date will the systemic changes be completed?**	

			05/18/2026	

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 SIGNATUREMaurice Woolfolk	TITLEExecutive Director	(X6) DATE05/14/2026