

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 08/03/2023	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF BLOOMINGTON MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00411516 completed on June 26, 2023. Complaint IN00411516 - Corrected Survey date: August 3, 2023 Facility number: 012706 Residential Census: 29 Cedarhurst of Bloomington was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00411516. Quality review completed August 7, 2023. This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00411516 completed on June 26, 2023. Complaint IN00411516 - Corrected	R 0000					

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Survey date: August 3, 2023

Facility number: 012706

Residential Census: 29

Cedarhurst of Bloomington was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00411516.

Quality review completed August 7, 2023.

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