

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/10/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>EVERGREEN VILLAGE AT BLOOMINGTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3607 SOUTH HEIRLOOM DRIVE BLOOMINGTON, IN 47401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00407573.</p> <p>Complaint IN00407573 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 10, 2023</p> <p>Facility number: 014002</p> <p>Residential Census: 115</p> <p>Evergreen Village at Bloomington was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00407573.</p> <p>Quality review completed May 12, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE