

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012706</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>08/03/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF BLOOMINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401</b>
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(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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00411516 completed on June 26, 2023.</p> <p>Complaint IN00411516 - Corrected</p> <p>Survey date: August 3, 2023</p> <p>Facility number: 012706</p> <p>Residential Census: 29</p> <p>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.</p> <p>Quality review completed August 7, 2023.</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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