

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 5829 116TH STREET EAST CARMEL, IN 46033
---	---

(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>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Initial State Residential Licensure Survey completed on 1/16/2015.</p> <p>Survey dates: February 24 & 25, 2015</p> <p>Facility number: 013217 Provider number: 013217 AIM number: N/A</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: Residential- 18 Total- 18</p> <p>Census payor type: Other- 18 Total- 18</p> <p>Sample: 7</p> <p>Bickford of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to PSR to the Initial State Residential Licensure Survey.</p> <p>Quality Review was completed by Tammy Alley RN on March 2, 2015.</p>	{R 000}		

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