STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING _____ B. WING _____	R-C 07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HEALTHCARE CENTER	**14751 CAREY ROAD 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) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00353169, IN00353234, IN00353730, IN00354399, and IN00355536 completed on June 21, 2021. This visit was in conjunction with the PSR to the Investigation of Complaints IN00356459, IN00356621, and IN00356664 completed on July 9, 2021. Complaint IN00353169 - Corrected. Complaint IN00353234 - Corrected. Complaint IN00353730 - Corrected. Complaint IN00354399 - Corrected. Complaint IN00355536 - Corrected. Complaint IN00356459 - Corrected. Complaint IN00356621 - Corrected. Complaint IN00356664 - Corrected. Survey dates: July 26 and 27, 2021. Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type:	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING _____ B. WING _____	R-C 07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HEALTHCARE CENTER	**14751 CAREY ROAD 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) COMPLETION DATE
{F 000}	Continued From page 1 Medicare: 11 Medicaid: 57 Other: 9 Total: 77 Bridgewater Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00353169, IN00353234, IN00353730, IN00354399 and IN00355536. Quality review completed on August 4, 2021.	{F 000}		