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 _____	C 10/20/2021

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 the Investigation of Complaints IN00364289, IN00364311, IN00364818, IN00365007, IN00365014 and IN00365264. Complaint IN00364289 - Unsubstantiated due to lack of evidence. Complaint IN00364311 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00364818 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365007 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365014 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365264 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 18, 19 and 20, 2021 Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 6 Medicaid: 56 Other: 13 Total: 75	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 _____	C 10/20/2021

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 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 Investigation of Complaints IN00364289, IN00364311, IN00364818, IN00365007, IN00365014 and IN00365264. Quality review was completed on October 21, 2021.	F 000		