| DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>CENTERS FOR MEDICARE & MEDICAID SERVICES                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FORM APPROVED                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| DF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED<br>R-C<br>05/05/2022                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                               | 155790                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
| ROVIDER OR SUPPLIER                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
| BRIDGEWATER HEALTHCARE CENTER                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 14751 CAREY ROAD<br>CARMEL, IN 46033                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
| ID SUMMARY STATEMENT OF DEFICIENCIES<br>FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>G REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (EACH CORRECTIVE ACTION SH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | PROVIDER'S PLAN OF CORRECTION (X5)<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                         |  |
| INITIAL COMMENTS                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                             | {F 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 00}                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
| Complaints IN003733<br>IN00374098, IN00374<br>completed on March<br>Review Date: May 5,<br>Facility Number: 012<br>Provider Number: 012<br>Provider Number: 15<br>Aim Number: 201023<br>Bridgewater Healthca<br>in compliance with 42<br>and 410 IAC 16.2-3.1 | <ul> <li>322, IN00373790,</li> <li>4619 ad IN00374610</li> <li>10, 2022.</li> <li>2022.</li> <li>548</li> <li>5790</li> <li>3760</li> <li>are Center was found to be</li> <li>2 CFR part 483, Subpart B</li> <li>, in regard to the Paper</li> </ul>                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
|                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |  |
|                                                                                                                                                                                                                                                               | PF DEFICIENCIES<br>CORRECTION<br>ROVIDER OR SUPPLIER<br>ATER HEALTHCARE CE<br>SUMMARY ST.<br>(EACH DEFICIENC<br>REGULATORY OR I<br>INITIAL COMMENTS<br>Paper compliance to<br>Complaints IN003743<br>IN00374098, IN00374<br>completed on March<br>Review Date: May 5,<br>Facility Number: 012<br>Provider Number: 15<br>Aim Number: 201023<br>Bridgewater Healthca<br>in compliance with 42<br>and 410 IAC 16.2-3.1<br>compliance to the Co | OF DEFICIENCIES<br>CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         ISUMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         Paper compliance to the Investigation of<br>Complaints IN00373322, IN00373790,<br>IN00374098, IN00374619 ad IN00374610<br>completed on March 10, 2022.         Review Date: May 5, 2022.         Facility Number: 012548<br>Provider Number: 155790<br>Aim Number: 201023760         Bridgewater Healthcare Center was found to be<br>in compliance with 42 CFR part 483, Subpart B<br>and 410 IAC 16.2-3.1, in regard to the Paper<br>compliance to the Complaint Investigations. | OF DEFICIENCIES<br>CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTI<br>A. BUILDIN         NUMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG         INITIAL COMMENTS       {F 00<br>Paper compliance to the Investigation of<br>Complaints IN00373322, IN00373790,<br>IN00374098, IN00374619 ad IN00374610<br>completed on March 10, 2022.       {F 00<br>Paper: 012548<br>Provider Number: 012548<br>Provider Number: 155790<br>Aim Number: 201023760         Bridgewater Healthcare Center was found to be<br>in compliance with 42 CFR part 483, Subpart B<br>and 410 IAC 16.2-3.1, in regard to the Paper | FERCIENCIES<br>CORRECTION       (X1) PROVIDERSUPPLIERCUA<br>IDENTIFICATION NUMBER:<br>155790       (X2) MULTIPLE CONSTRUCTION<br>A BUILDING<br>BUILDING<br>INTEL         ATER HEALTHCARE CENTER       STREET ADDRESS, CITY, STATE, 2IP CODE<br>14751 CAREY ROAD<br>CARMEL, IN 46033         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR US: DENTIFIYING INFORMATION)       IP<br>PREPX<br>TAG       PROVIDER'S PLAN OF CORR<br>(EACH ORRECTIVE ACTION S)<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR US: DENTIFIYING INFORMATION)       IP<br>PREPX<br>TAG       PROVIDER'S PLAN OF CORR<br>(EACH ORRECTIVE ACTION S)<br>(EACH ORRECT | predencements       [X1] PROVIDERGUMPLERCUM       [X2] MULTIPLE CONSTRUCTION       [X3] OND         155790       #.WING |  |

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.

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