

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005616</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 12/08/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIDGE AT GARDEN PLAZA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8614 W 10TH ST INDIANAPOLIS, IN 46234</b>		
(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 IN00417988 completed on October 2, 2023.</p> <p>Complaint IN00417988 - Corrected</p> <p>Survey dates: December 7 and 8, 2023</p> <p>Facility number: 005616</p> <p>Residential Census: 74</p> <p>Bridge At Garden Plaza was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00417988.</p> <p>Quality review completed on December 15, 2023.</p>	{R 000}		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE