

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2022
FORM APPROVED
OMB NO. 0938-0391

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|--|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/28/2022 |
| NAME OF PROVIDER OR SUPPLIER BRIDGEWATER HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
| K 000 | <p>INITIAL COMMENTS</p> <p>An investigation of Complaint Number IN00373879 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Complaint Number IN00373879 was not substantiated due to lack of evidence.</p> <p>Survey Date: 02/28/22</p> <p>Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760</p> <p>At this Complaint survey, Bridgewater Healthcare Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 74 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building for medical gas storage and the generator transfer switch which was sprinklered.</p> | K 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.

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| K 000 | Continued From page 1 Quality Review completed on 03/02/22 | K 000 | | | |