

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003924</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/05/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STONEBRIDGE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3100 SHAWNEE DR S BEDFORD, IN 47421</b>
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(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 the Investigation of Complaint IN00429896.</p> <p>Complaint IN00429896 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 5, 2024</p> <p>Facility number: 003924</p> <p>Residential Census: 25</p> <p>Stonebridge Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00429896.</p> <p>Quality review completed April 9, 2024.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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