

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015122</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/27/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIDGEPOINTE GARDENS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3100 UTICA SELLERSBURG ROAD</b> <b>JEFFERSONVILLE, IN 47130</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 IN00404004.</p> <p>Complaint IN00404004 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 26 and 27, 2023</p> <p>Facility number: 015122</p> <p>Residential Census: 32</p> <p>Bridgepointe Gardens was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00404004.</p> <p>Quality review completed on April 28, 2023.</p>	R 000		

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