

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|                        |  |        |  |  |
|------------------------|--|--------|--|--|
| F 0000<br><br>Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00185578.</p> <p>Complaint IN00185578 Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F250.</p> <p>Survey date:<br/>November 16, 2015</p> <p>Facility Number: 000195<br/>Provider Number: 155298<br/>AIM Number: 100267690</p> <p>Census Bed Type:<br/>SNF/NF: 36<br/>Total: 36</p> <p>Census Payor Type:<br/>Medicare: 0<br/>Medicaid: 34<br/>Other: 2<br/>Total: 36</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on</p> | F 0000 |  |  |
|------------------------|--|--------|--|--|

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.

|  |   |   |   |  |  |   |  |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                             |  | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |  |   |  |
| (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   |  |   |  |
| F 0157<br>SS=D<br>Bldg. 00   | <p>November 18, 2015.</p> <p>483.10(b)(11)<br/>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br/>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the</p> | F 0157  | 1.Residents B and E were  | 12/01/2015   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>facility failed to ensure interested parties were notified at impending Guardianship appointment and transfer/discharge for 2 of 4 sampled residents. (Resident's "B" and "E").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 11-16-15 at 10:30 a.m. Diagnoses included, but were not limited to, adult failure to thrive, impaired vision, history of falls, hypertension and communication deficit. These diagnoses remained current at the time of the record review.</p> <p>At the time of admission to the facility, two individuals were identified as "contact's" for the resident. The resident's face sheet also contained the telephone numbers of the individuals.</p> <p>A review of the admission paperwork, business office paperwork in regard to representative payee, and hospital records contained the signature of one of the two individuals, listed on the resident's face sheet.</p> <p>Although the resident had these two individuals involved in her personal care and financial interest's, the facility "filed" for Guardianship on 02-17-15 and a State</p> |               | <p>discharged.</p> <p>2.No other residents were affected. No other residents currently have guardians.</p> <p>3.Any request for guardianship will be made by theSocial Service Director after verification from the business office managerthat the resident has no interested party. ED will review final verification prior to starting the guardianshipprocess.</p> <p>4.Any residents requiring guardianship will havetheir documents reviewed at the monthly QA committee meeting, on going.</p> |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|  |   |  |  |  |
|--|---|--|--|--|
|  | <p>appointed Guardian was named on 04-01-15.</p> <p>During an interview on 11-16-15 at 10:52 a.m., the one individual listed on the face sheet indicated, the resident had been a "girlfriend to my husband's father for 20 years. They never got married, and when my husband's father died, we assumed her care. She lived with us for awhile and then we were able to get her a place of her own. We were her caregiver's. When we noticed she started to go down hill and not take care of herself, we took her to [name of local area hospital]. The Doctor at the hospital agreed with us that she could no longer live on her own, and that's when we admitted her to Pyramid Point. They got a hold of us for all kinds of things, but never told us anything about Guardianship. We went there for her birthday and my then ex-husband went to visit her in August and that's when we found out she wasn't there anymore. They were reluctant to tell us where she had been sent but one of the nurses who knew us, told us she was at [name of facility]. I got the telephone number for the Guardian and called her. She said she was unaware there was anyone involved in [name of resident] life. Someone decided she needed a Guardian and a move to another facility without letting us know."</p> |  |  |  |
|--|---|--|--|--|

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|                    | <p>During an interview on 11-16-15 at 12:30 p.m., the State appointed Guardian verified the individual's recollection of the events as noted above. "Typically the information is provided by the Social Worker. The Social Worker and the facility Attorney work on these cases, and before I will accept I inquire if anyone is named in the record. The Attorney would need to also check to see if family or friends were involved. I questioned the Social Worker to make sure there was no one else in the resident's life who would be willing to assume Guardianship. The Social Worker assured me there was no one else involved. The Social Worker called me and informed me the Census at the facility was low and the facility would probably be closing. I had three resident's residing at Pyramid Point and if I needed to transfer them I wanted to make sure I got appropriate placement."</p> <p>2. The record for Resident "E" was reviewed on 11-16-15 at 11:20 a.m. Diagnoses included, but were not limited to, schzoaffective disorder, history of urinary tract infections, hypertension, convulsions, senile dementia and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|----------------------------|---|---------------|---|----------------------|
| F 0250<br>SS=D<br>Bldg. 00 | <p>At the time of admission to the facility, two individuals were identified as "contacts" for the resident. The resident's face sheet also contained multiple telephone numbers of the two individuals.</p> <p>During interview on 11-16-15 at 12:30 p.m., the State appointed Guardian identified Resident "E" as having the same issues as [name of Resident "B"], where she had friends involved in her care, and for whatever reason, the Social Worker felt the resident needed a Guardian. After I became Guardian for [name of Resident "E"], is when I found out she had two friends involved in her care. In both cases the resident's had friends who cared about them and the facility should have attempted to notify them of the possibility of Guardianship and transfer."</p> <p>This Federal tag relates to Complaint IN00185578.</p> <p>3.1-5(a)(4)</p> <p>483.15(g)(1)<br/>PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br/>The facility must provide medically-related social services to attain or maintain the</p> |               |   |                      |

|  |   |   |  |                      |   |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260   |                      |   |
| (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 |   |
|  | <p>highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure medically related social services were provided to residents and involved interested parties when decisions of Guardianship were made for 2 of 4 sampled residents. (Resident's "B" and "E").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 11-16-15 at 10:30 a.m. Diagnoses included, but were not limited to, adult failure to thrive, impaired vision, history of falls, hypertension and communication deficit. These diagnoses remained current at the time of the record review.</p> <p>At the time of admission to the facility, two individuals were identified as "contact's" for the resident. The resident's face sheet also contained the telephone numbers of the individuals.</p> <p>A review of the admission paperwork, business office paperwork in regard to representative payee, and hospital records contained the signature of one of the two individuals, listed on the resident's face sheet.</p> | F 0250  | <p>1.Residents B and E were discharged.</p> <p>2.No other residents were affected. No other residents currently have guardians.</p> <p>3.Any request for guardianship will be made by theSocial Service Director after verification from the business office managerthat the resident has no interested party. ED will review final verification prior to starting the guardianshipprocess.</p> <p>4.Any residents requiring guardianship will havetheir documents reviewed at the monthly QA committee meeting, on going.</p> | 12/01/2015           |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|                    | <p>A review of the Business office file, contained a "handwritten" entry which indicated, "needs Guardian."</p> <p>Although the resident had these two individuals involved in her personal care and financial interest's, the facility "filed" for Guardianship on 02-17-15 and a State appointed Guardian was named on 04-01-15.</p> <p>During an interview on 11-16-15 at 10:52 a.m., the one individual listed on the face sheet indicated, the resident had been a "girlfriend to my husband's father for 20 years. They never got married, and when my husband's father died, we assumed her care. She lived with us for awhile and then we were able to get her a place of her own. We were her caregiver's. When we noticed she started to go down hill and not take care of herself, we took her to [name of local area hospital]. The Doctor there agreed with us that she could no longer live on her own, and that's when we admitted her to Pyramid Point. They got a hold of us for all kinds of things, but never told us anything about Guardianship. We went there for her birthday and my then ex-husband went to visit her in August and that's when we found out she wasn't there anymore. They were reluctant to tell us where she had been sent but one of the</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|                    | <p>nurses who knew us, told us she was at [name of facility]. I got the telephone number for the Guardian and called her. She said she was unaware there was anyone involved in [name of resident] life. Someone decided she needed a Guardian and a move to another facility without letting us know."</p> <p>During an interview on 11-16-15 at 12:30 p.m., the State appointed Guardian verified the individual's recollection of the events as noted above. "Typically the information is provided by the Social Worker. The Social Worker and the facility Attorney work on these cases, and before I will accept I inquire if anyone [emphatic] is named in the record. The Attorney would need to also check to see if family or friends were involved. I questioned the Social Worker to make sure there was no one else in the resident's life who would be willing to assume Guardianship. The Social Worker assured me there was no one else involved. The Social Worker called me and informed me the Census at the facility was low and the facility would probably be closing. I had three resident's residing at Pyramid Point and if I needed to transfer them I wanted to make sure I got appropriate placement."</p> <p>2. The record for Resident "E" was</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |
|--|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>reviewed on 11-16-15 at 11:20 a.m. Diagnoses included, but were not limited to, schzoaffective disorder, history of urinary tract infections, hypertension, convulsions, senile dementia and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p> <p>At the time of admission to the facility, two individuals were identified as "contacts" for the resident. The resident's face sheet also contained multiple telephone numbers of the two individuals.</p> <p>During further interview on 11-16-15 at 12:30 p.m., the State appointed Guardian identified Resident "E" as having the same issues as [name of Resident "B"], where she had friends involved in her care, and for whatever reason, the Social Worker felt the resident needed a Guardian. After I became Guardian for [name of Resident "E"], is when I found out she had two friends involved in her care. In both cases the resident's had friends who cared about them and the facility should have attempted to notify them of the possibility of Guardianship."</p> <p>This Federal tag relates to Complaint IN00185578.</p> |               |   |                      |

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155298 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>11/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PYRAMID POINT POST-ACUTE REHABILITATION CENTER |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8530 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260                        |                      |   |
| (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 |   |
|  | 3.1-34(a)<br>3.1-34(a)(4)<br>3.1-34(a)(5)  |   |   |                      |   |