STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY NURSING AND REHAB	**3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205**

(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 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of Complaint IN00374192.

Complaint IN00374192: Substantiated. No deficiencies related to the allegations are cited.

Survey dates: March 8 and 9, 2022

Facility number: 014265
Provider number: 155857
AIM number: 300029339

Census Bed Type:
SNF/NF: 24
Total: 24

Census Payor Type:
Medicare: 2
Medicaid: 18
Other: 4
Total: 24

Tranquility Nursing and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00374192.

Quality review completed on March 10, 2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE