STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155298			11/15/2016
	PROVIDER OR SUPPLIE D POINT POST-AC	R CUTE REHABILITATION CENTER	8530 To	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K 0000					
Bldg. 01	State Licensure the Indiana Stat accordance with Survey Date: 1 Facility Numbe Provider Numbe AIM Number: At this Life Safe	r: 000195 er: 155298 100267690 ety Code survey, Pyramid	K 0000	Plan of Correction for Life Safe recertification Craig A. Hestand, HFA Executive Director Pyramid Point Post-Acute Rehabilitation Center	ety
	At this Life Safety Code survey, Pyramid Point Post-Acute Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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. This three story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the				
	_	detectors in all resident The facility has a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 11/15/2016			ETED	
		155298	B. WI			11/15/	2016
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER		8530 TO	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	capacity of 135 the time of this v	and had a census of 32 at visit.					
	access were spri	residents have customary nklered. The facility has ildings providing facility which were not					
	Quality Review DA	completed on 11/22/16 -					
K 0211 SS=E Bldg. 01	discharges, exit lo in accordance wit means of egress i free of all obstruct	General ays, corridors, exit bocations, and accesses are h Chapter 7, and the s continuously maintained cions to full use in case of s modified by 18/19.2.2 1.					
	interview; the fa of 9 means of eg maintained free impediments to case of fire or of deficient practic residents, staff a	review, observation and cility failed to ensure 1 gress was continuously of all obstructions or full instant use in the her emergency. This e could affect 14 nd visitors if needing to using the corridor by	K 02	211	K 211 NFPA 101 Means of Egress-General This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely	n	12/12/2016
					because required by the provisions of the health and safety code		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet

Page 2 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED				
		155298	B. WI	NG		11/15/2016	;
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				DWNSHIP LINE RD		
PYRAMII	O POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
					7.11 02.10, 11.4 102.00		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	601	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPR		CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E	MPLETION DATE
TAG		of "Disaster Plan &		IAU	section 1280 and 42 CFR 483.	- '	DATE
					Section 1200 and 42 CFR 403.		
		edures" documentation			Compliance Date 12/15/2016		
		vith the Executive			Compilance Date 12, 13, 2010		
		5 p.m. on 11/15/16, the			Corrective actions accomplished for		
	written fire safet	y plan did not address			those residents found to be		
	the relocation of	wheeled equipment			affected by the alleged deficient		
	during a fire or s	imilar emergency.			practice:		
	Based on interview at the time of review, the Executive Director acknowledged the aforementioned written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with				1.) Area (means of egress) fire exi	t	
					was immediately cleared of wheel		
					chairs with in the affected area.		
					Identification of other residents having the potential to be affected		
					by the same alleged deficient		
					practice and corrective actions		
		Maintenance Assistant			taken: Director of Maintenance will		
		the facility from 12:45			audit exits (means of egress) with in		
	_	·			the facility to ensure exits are free		
		on 11/15/16, five			and clear of any equipment that		
	•	lifts and one chair			would affect the means of egress.		
		were stored at the south			Director of Maintenance will mark		
		loor corridor outside			off the means of egress area to ensure no obstructions. Staff will		
		to the south stairwell exit			be in-serviced by 12/12/2016.		
		stairwell exit on the			How the corrective measures will		
	third floor was n	narked as a facility exit			be monitored to ensure the alleged		
	with an exit sign	. Based on interview at			deficient practice does not recur:		
	the time of obser	vation, the Van			The following audits will be		
	Driver/Maintena	nce Assistant			conducted of Third floor exit areas		
	acknowledged th	ne aforementioned means			to ensure the areas are free and		
	of egress was no	t continuously			clear of any obstructions by the		
	_	of all obstructions or			Director of Maintenance or designed	II	
		full instant use in the			3 times per week times for 4 weeks, then monthly times 3 months to		
	case of fire or of				ensure compliance. Findings will be		
	1330 01 1110 01 01				reviewed/reported at our monthly		
	3.1-19(b)				QA meeting.		
	J.1-17(0)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 3 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/15/2016	
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0324 SS=D Bldg. 01	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used limited cooking in 18.3.2.5.2, 19.3.2. * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer p conditions under 1 Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazal be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on record interview; the fa of 1 kitchen exha- inspected semiar Edition, Standard and Fire Protecti Cooking Operati the entire exhaus inspected for gre properly trained, person(s) accept having jurisdicti-	IFPA 96, Standard for and Fire Protection of ing Operations, unless: an equipment (i.e., small smicrowaves, hot plates, for food warming or accordance with 5.2 open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1 is, 9.2.3, TIA 12-2 review, observation and cility failed to ensure 1 aust systems was annually. NFPA 96, 2011 d for Ventilation Control on of Commercial ons, Section 11.4 states at system shall be	K 0324	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 4 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155298	B. WI	NG		11/15/	2016
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			8530 TO	OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	*	r Grease Buildup,			,		
	1 2	serving moderate			K-324 NFPA 101 Cooking Facilities	•	
	volume cooking operations shall be				Compliance Date 12/15/2016		
	inspected semiar	nnually. NFPA 96,		Compliance Date 12/15/2016			
	11.6.1 states, upo	on inspection, if the			Corrective actions accomplished for		
	exhaust system i	s found to be			those residents found to be affected		
	contaminated with deposits from grease				by the alleged deficient practice:		
		e contaminated portions			1.) Hood System was scheduled t	0	
	•	estem shall be cleaned by			be cleaned with in the		
	a properly traine	•			recommended timeframe, but		
		• •			unable to complete. Director of		
	certified person(s) acceptable to the authority having jurisdiction. Hoods,				Maintenance immediately		
		•			re-scheduled service visit and		
		levices, fans, ducts, and			completed on 11/17/2016.		
		ices shall be cleaned to			Identification of other residents		
		ible contaminants prior			having the potential to be affected		
	to surfaces become	ning heavily			by the same alleged deficient		
	contaminated wi	th grease or oily sludge.			practice and corrective actions		
	After the exhaus	t system is cleaned, it			taken: Director of Maintenance will		
	shall not be coat	ed with powder or other			schedule future semi anuualy		
	substance. When	n an exhaust cleaning			service of Hood Cleaning services		
		certificate showing the			4-6 weeks before recommending		
	· ·	icing company, the name			service date to ensure facility meets		
		forming the work, and			regulation requirements.		
		ction or cleaning shall be					
	•	the premises. This			How the corrective measures will		
		e could affect five staff			be monitored to ensure the alleged		
					deficient practice does not recur:		
	and visitors in th	е киспеп.			The following audits will be		
					conducted monthly by the Director		
	Findings include				of Maintenance or designee 1 times		
					per month x 3 months, then		
		of National Exhaust			quarterly x 2 quarters to ensure		
	Cleaning "Job W	ork Order"			compliance. Monitoring / auditing		
	documentation d	ated 08/10/15 and			of this plan of correction will occur during the monthly QA&A meeting.		
	04/08/16 with th	e Van			daming the monthly QAQA meeting.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet

Page 5 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/15/2016
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	record review from p.m. on 11/15/16 semiannual kitch inspection six menot available for interview at the the Van Driver/N stated National Euroder contract to kitchen exhaust scame October 20 semiannual inspereschedule the im Based on observ Director and the Assistant during from 12:45 p.m. 11/15/16, Nationaffixed a sticker kitchen indicatin inspection was defollowing the 04 on interview at the and of the observer/Maintena acknowledged desemiannual kitch	spection while on site. ation with the Executive Van Driver/Maintenance a tour of the facility to 2:30 p.m. on all Exhaust Cleaning had to the range hood in the g the next scheduled ue in October 2016 /08/16 inspection. Based the time of record review vation, the Van nnce Assistant ocumentation of ten exhaust system onths after 04/08/16 was			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet

Page 6 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		A. BU	A. BUILDING <u>01</u> C			DATE SURVEY COMPLETED 11/15/2016	
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			<u> </u>	8530 TO	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of systen inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record interview; the fa sprinkler system accordance with Standard for the Maintenance of Protection Syste Section 5.2.4.1 s sprinkler system monthly to ensur condition and th	supply source RKS information on non-required or partial er system. , and NFPA 25 review, observation and cility failed to document	K 0.	353	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	n	12/12/2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 7 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155298 B. WING 11/15/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD PYRAMID POINT POST-ACUTE REHABILITATION CENTER INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with K-353 **NFPA 101** Chapter 13. Section 13.1.1.2 states Table SPRINKLER SYSTEM-MAINTENANCE 13.1.1.2 shall be utilized for inspection, & TESTING testing and maintenance of valves, valve components and trim. Section 4.3.1 Compliance Date 12/15/2016 states records shall be made for all Corrective actions accomplished for inspections, tests, and maintenance of the those residents found to be system and its components and shall be affected by the alleged deficient made available to the authority having practice: jurisdiction upon request. This deficient 1.) Sprinkler Gauge system has practice could affect all clients and staff been checked by the director of maintenance to ensure it is in good in the facility. condition, with normal water supply pressure. Findings include: Identification of other residents Based on review of SafeCare's "Report of having the potential to be affected Inspection" documentation dated by the same alleged deficient practice and corrective actions 06/02/16 and 09/12/16 and Direct taken: Director of Maintenance to Supply: TELS documentation dated in-service assistant Director of 06/27/16 and 09/19/16 with the Van Maintenance on sprinkler gauge Driver/Maintenance Assistant during condition, water supply pressure. record review from 9:20 a.m. to 12:45 Assistant Director will be in-serviced p.m. on 11/15/16, monthly sprinkler by 12/1/2016. How the corrective measures will gauge inspection documentation for May, be monitored to ensure the alleged July, August and October 2016 was not deficient practice does not recur: available for review. In addition, weekly The following audits will be inspection documentation for all conducted of the sprinkler gauge to sprinkler system control valves for 22 of ensure the gauge is in good functional condition, and water the 27 week period of 05/09/16 through supply reading. Director of 11/11/16 was also not available for Maintenance or designee will audit 3 review. Based on interview at the time of times per week times for 4 weeks, record review, the Van

then monthly times 3 months to

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155298	B. WING		11/15/2016
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DOLUBER OF STARTS		STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		8530 T	OWNSHIP LINE RD	
		UTE REHABILITATION CENTER	INDIAN	IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		nce Assistant stated both		ensure compliance. Findings will be	!
	SafeCare and the	e facility document		reviewed/reported at our monthly	
	sprinkler gauge a	and control valve		QA meeting.	
	inspections on a	quarterly basis. Based			
	on observation w	vith the Van			
	Driver/Maintena	nce Assistant during a			
		ry from 12:45 p.m. to			
		15/16, the facility has a			
	wet sprinkler sys	•			
		water pressure gauge			
		osi. Based on interview			
	at the time of rec				
		Van Driver/Maintenance			
		vledged monthly and			
	, ,	system gauge and			
		pection documentation			
		tioned periods was not			
	available for revi	iew.			
	3.1-19(b)				
K 0711	NFPA 101				
SS=C	Evacuation and Re	elocation Plan			
Bldg. 01	Evacuation and Re				
		plan for the protection of			
		their evacuation in the			
	event of an emerg	ency. riodically instructed and			
		their duties under the			
	1	of the plan is readily			
	· · · · · · · · · · · · · · · · · · ·	phone operator or with			
		addresses the basic			
		of staff per 18/19.7.2.1.2 Il of the fire safety plan			
	components per 1	· · · · · · · · · · · · · · · · · · ·			
		8.7.1.3, 18.7.2.1.2,			
		19.7.1.1 through 19.7.1.3,			
	19.7.2.1.2, 19.7.2.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 9 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPL	ETED
		155298	B. WING 11/15/2016			2016	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			OWNSHIP LINE RD		
DVDAMI	D DOINT DOST AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
					AI OLIS, IIV 40200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		review, observation and	K 0'	711	This plan of correction constitutes		12/12/2016
	interview; the fa	cility failed to provide a			the facility's written credible		
	written plan that	addressed all			allegation of compliance.		
	components in 1	of 1 written fire plans.			Preparation and/or execution of		
	LSC 19.7.2.2 red	quires a written health			this Plan of Correction does not constitute admission or agreement		
	care occupancy fire safety plan that shall				by the provider of the truth of the		
	provide for the following:				facts alleged or the conclusion set		
	(1) Use of alarms				forth on the Statement of		
	` ′				Deficiencies. This plan of correction	n	
	(2) Transmission	1 of alarm to life			is prepared and/or executed solely		
	department				because required by the provisions		
	(3) Emergency phone call to fire				of the health and safety code		
	department				section 1280 and 42 CFR 483.		
	(4) Response to	alarms					
	(5) Isolation of f	ire					
	(6) Evacuation o	of immediate area					
	` '	of smoke compartment			K-711 NFPA 101 EVACUATION		
		of floors and building for			AND RELOCATION PLAN		
	evacuation	or moore with currently for			Compliance Date 12/15/2016		
	(9) Extinguishm	ant of fire			Compliance Date 12/13/2010		
		(4) states any required			Corrective actions accomplished for	r l	
					those residents found to be		
		shall not be less than 48			affected by the alleged deficient		
		vidth where serving as			practice:		
	1	from patient sleeping			1.) ED and Director of		
		ons into the required			Maintenance revised Disaster		
	width shall be pe	ermitted for wheeled			Manual for facility on 11/22/2016		
	equipment provi	ded the relocation of			to include smoke compartment		
	wheeled equipm	ent during a fire or			evacuations.		
		cy is addressed in the			Identification of the China		
		ry plan and training			Identification of other residents		
		facility. The wheeled			having the potential to be affected		
		-			by the same alleged deficient practice and corrective actions		
	equipment is lim				taken: Staff in-serviced on		
		use and carts in use			11/22/2016 on new Disaster Manua	n	
	11. Medical emer	gency equipment not in			with smoke compartment		
	use				evacuation plan. New Disaster		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPL	ETED
		155298	B. WI	NG		11/15/	/2016
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			OWNSHIP LINE RD		
DVDAMII		UTE REHABILITATION CENTER			APOLIS, IN 46260		
	J FOINT FOST-AC	OTE REHABILITATION CENTER		INDIAN	AFOLIS, IN 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
		nd transport equipment			manuals have been placed through		
	This deficient pr	actice could affect all			out the facility to ensure they are accessible. Director of Maintenance	•	
	occupants.				will audit all exits (means of egress)		
					with in the facility to ensure all exits		
	Findings include	:			are free and clear of any equipment		
	-				that would affect the means of		
	1. Based on rev	iew of "Disaster Plan &			egress. Director of Maintenance wi	ill	
	Evacuation Procedures" documentation dated 10/18/16 with the Executive Director at 12:45 p.m. on 11/15/16, the				mark off the means of egress area t	:0	
					ensure no obstructions. Staff will		
					be in-serviced by 12/12/2016.		
	written fire safety plan did not address internal evacuation of smoke				How the corrective measures will		
					be monitored to ensure the alleged	d	
	-	rithin the facility. The			deficient practice does not recur: The following audits questionnaire		
		ed specific procedures to			will be conducted with staff by the		
	evacuate the bui	lding in the event of fire.			Director of Maintenance or designe	ıe.	
	The "Fire Policy	& Procedure" section of			relating to smoke compartment		
	the aforemention	ned written fire safety			evacuations 3 times per week times	5	
	plan stated to "cl	lose all fire doors" but			x 4 weeks, then monthly x 4 month		
	did not provide t	the location of fire doors			to ensure compliance. Findings will		
	in the plan. Base	ed on interview at the			be reviewed/reported at our		
	-	he Executive Director			monthly QA meeting. The following		
		ne aforementioned			audits will be conducted of all Third	l	
	_	y plan did not address			floor exit areas to ensure the areas		
		on procedures in the			are free and clear of any		
		and did not include the			obstructions by the Director of Maintenance or designee 3 times		
		d fire doors in the			per week x 4 weeks, then monthly		
		a fire doors in the			times 3 months to ensure		
	facility.				compliance. Findings will be		
					reviewed/reported at our monthly		
		iew of "Disaster Plan &			QA meeting.		
	Evacuation Procedures" documentation						
	dated 10/18/16 v	vith the Executive					
	Director at 12:45	5 p.m. on 11/15/16, the					
	written fire safet	y plan did not address					
		wheeled equipment					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 11 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED
	155298	B. WING		11/15/2016
	PROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	8530 To	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	during a fire or similar emergency. Based on interview at the time of review, the Executive Director acknowledged the aforementioned written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Van Driver/Maintenance Assistant during a tour of the facility from 12:45 p.m. to 2:30 p.m. on 11/15/16, five wheelchairs, two lifts and one chair weighing station were stored at the south end of the third floor corridor outside Room 321 next to the south stairwell exit door. The south stairwell exit on the third floor was marked as a facility exit with an exit sign. Based on interview at the time of observation, the Van Driver/Maintenance Assistant acknowledged wheeled equipment was stored in the aforementioned means of egress. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet

Page 12 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED			ETED	
		155298	B. WI	NG		11/15/2016	
				CTD FFT A	ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
	DOINT DOOT AG	LITE DELIABILITATION CENTED			OWNSHIP LINE RD		
PYRAMIL	J POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the patient care vi	cinity may not be used for					
	non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet						
		ls. All power strips are					
		precautions. Extension d as a substitute for fixed					
		re. Extension cords used					
	_	moved immediately upon					
		purpose for which it was					
	•	ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99),					
		590.3(D) (NFPA 70), TIA					
	12-5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Based on observ	ration and interview, the	K 09	920	This plan of correction constitutes		12/12/2016
		ensure 1 of 1 extension			the facility's written credible		
	_	power strips were not			allegation of compliance.		
		•			Preparation and/or execution of this Plan of Correction does not constitute admission or agreement		
		ute for fixed wiring. ires utilities to comply					
	•	1 2					
		. LSC 9.1.2 requires			by the provider of the truth of the		
	_	and equipment to			facts alleged or the conclusion set		
	comply with NF				forth on the Statement of		
	Electrical Code,	2011 Edition. NFPA 70,			Deficiencies. This plan of correction		
	Article 400.8 red	quires that, unless			is prepared and/or executed solely		
		nitted, flexible cords and			because required by the provisions		
		be used as a substitute for			of the health and safety code		
					section 1280 and 42 CFR 483. K-920 NFPA 101 ELECTRIC		
	_	structure. This deficient					
	•	ffect three residents, staff			EQUIPMENT-POWER CORDS AND EXTENS		
	and visitors in th	ne northwest Therapy			LATENS		
	Room on the firs	st floor.			Compliance Date 12/15/2016		
	Findings include	ş•			Corrective actions accomplished for	•	
	- mamgo merade				those residents found to be	•	
					affected by the alleged deficient		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 13 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u>			COMPLETED		
155298			B. WING 11/			11/15/	2016
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 ID PROVIDER'S PLAN OF CORRECTION (X5)				
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	Based on observ Driver/Maintena tour of the facilit 2:30 p.m. on 11/ general purpose plugged into a po- northwest Thera floor. The power documentation in Based on intervi- observation, the Assistant acknow was being used a	ation with the Van ance Assistant during a ty from 12:45 p.m. to 15/16, one electric tumbling panel mat was ower strip in the py Room on the first or strip had no affixed indicating its UL listing. ew at the time of Van Driver/Maintenance wledged a power strip as a substitute for fixed rementioned location.		TAG	practice: 1.) ED and Director of Maintenance revised Disaster Manual for facility on 11/22/2016 to include smoke compartment evacuations. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Staff in-serviced on 11/22/2016 on regulations relating to power cords and uses. Director of Maintenance completed audit of facility to ensure proper use completed 12/1/2016. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the Director of Maintenance or designee relating to of power strips with in common areas and resident areas 3 times per week x 4 weeks, then monthly x 4 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.	;	DATE
K 0923 SS=E Bldg. 01	Storag Gas Equipment - O Storage Greater than or ec Storage locations	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet

Page 14 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/15/2016				
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	enclosure or within space of non- or liconstruction, with that can be secure stored with flamma from combustibles sprinklered) or enconcombustible or minimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas of less than or equanot required to be Cylinders must be as specified in 11. A precautionary sion each door or groom, where the sas a minimum "CAGAS(ES) STORE SMOKING." Storage is planned order of which the supplier. Empty of from full cylinders. cylinders with intee threshold pressure established. Empavoid confusion. Copen are protected 11.3.1, 11.3.2, 11.99)	ign readable from 5 feet is ate of a cylinder storage sign includes the wording AUTION: OXIDIZING D WITHIN NO d so cylinders are used in y are received from the cylinders are segregated. When facility employs gral pressure gauge, a econsidered empty is ty cylinders are marked to Cylinders stored in the d from weather. 3.3, 11.3.4, 11.6.5 (NFPA)	V 0022		12/12/2016			
	facility failed to nonflammable g properly secured Health Care Fac	ation and interview, the ensure 1 of 2 cylinders of ases such as oxygen were I from falling. NFPA 99, illities Code, 2012 11.3.2 states storage for	K 0923	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the	12/12/2016			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 15 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>			COMPLETED		
155298		155298	B. WING			11/15/2016		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					OWNSHIP LINE RD			
PYRAMID POINT POST-ACUTE REHABILITATION CENTER								
			1					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
1710				1710	facts alleged or the conclusion set		DITTE	
	_	ases greater than 8.5			forth on the Statement of			
	,	00 cubic feet) but less			Deficiencies. This plan of correction	n		
		eters (3000 cubic feet)			is prepared and/or executed solely			
	shall comply wit	th 11.3.2.1 through		because required by the provisions				
	11.3.2.3. NFPA	99, Section 11.3.2.6			of the health and safety code			
	states cylinder of	r container restraints			section 1280 and 42 CFR 483.			
	shall comply wit	th 11.6.2.3. Section						
	11.6.2.3(11) stat	es freestanding cylinders			K-923 NFPA 101 Gas			
	` ′	chained or supported in			Equipment-Cylinder and Container			
	1	* *			storage			
	a proper cylinder stand or cart. This							
	deficient practice could affect 10 staff				Compliance Date 12/15/2016			
	and visitors in the vicinity of the third							
	floor oxygen storage and transfilling				Corrective actions accomplished for	r		
	room.				those residents found to be			
					affected by the alleged deficient			
	Findings include:				practice: 1.) Director of Maintenance			
					placed signage to ensure cylinders			
	Based on observ	ration with the Van			are secured behind the safety			
	Driver/Maintenance Assistant during a				chains. Nursing staff will be			
	tour of the facility from 12:45 p.m. to				in-serviced/educated on proper Ga	s		
	2:30 p.m. on 11/15/16, one of two 'E'				equipment storage.			
	•				Identification of other residents			
	type oxygen cylinders was standing				having the potential to be affected			
	upright on the floor of the oxygen storage and transfilling room next to the nurse's				by the same alleged deficient			
	1				practice and corrective actions			
		ird floor and was not			taken: Sign placed with in Gas	_		
	1 ^ ^ -	l or supported in a proper			Equipment storage area by Director of Maintenance with	r		
	cylinder stand or	r cart. One liquid oxygen			in-service/education completed by			
	container was al	so observed stored in the			12/12/2016			
	room. Based on	interview at the time of			,,,			
	observation, the	Van Driver/Maintenance			How the corrective measures will			
	Assistant acknowledged one of two 'E'				be monitored to ensure the alleged	ı		
		•			deficient practice does not recur:			
	type oxygen cylinders in the				The following audits will be			
	aforementioned oxygen storage and				conducted by the Director of			
transfilling room was not properly			1		Maintenance or designee relating			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2UI521

Facility ID: 000195

If continuation sheet Page 16 of 17

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	r ´	ILDING	onstruction 01	(X3) DATE COMPI 11/15.	LETED
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUNCE CROSS-REFERENCED TO THE APP			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	chained or suppostand or cart. 3.1-19(b)	orted in a proper cylinder			to of Gas Equipment storage 3 times per week x 4 weeks, then monthly x 4 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2UI521 Facility ID: 000195 If continuation sheet Page 17 of 17