STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/15/16 Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690 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 corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a	K 0000	Plan of Correction for Life Safety recertification Craig A. Hestand, HFA Executive Director Pyramid Point Post-Acute Rehabilitation Center	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	capacity of 135 and had a census of 32 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 11/22/16 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on record review, observation and interview; the facility failed to ensure 1 of 9 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 14 residents, staff and visitors if needing to exit the facility using the corridor by Room 321. Findings include:	K 0211	**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 because required by the provisions of the health and safety code**	12/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on review of " Disaster Plan & Evacuation Procedures" documentation dated 10/18/16 with the Executive Director at 12:45 p.m. on 11/15/16, the written fire safety plan did not address the relocation of wheeled equipment 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 the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3.1-19(b)		**section 1280 and 42 CFR 483.** **Compliance Date 12/15/2016** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1.) Area (means of egress) fire exit 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 taken:** Director of Maintenance will audit exits (means of egress) with in the facility to ensure exits are free and clear of any equipment that would affect the means of egress. Director of Maintenance will mark off the means of egress area to ensure no obstructions. Staff will be in-serviced by 12/12/2016. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted of Third floor exit areas to ensure the areas are free and clear of any obstructions by the Director of Maintenance or designee 3 times per week times for 4 weeks, then monthly times 3 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule	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.**	12/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on review of National Exhaust Cleaning "Job Work Order" documentation dated 08/10/15 and 04/08/16 with the Van		**K-324 NFPA 101 Cooking Facilities** **Compliance Date 12/15/2016** Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Hood System was scheduled to be cleaned with in the recommended timeframe, but unable to complete. Director of Maintenance immediately re-scheduled service visit and completed on 11/17/2016. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Director of Maintenance will schedule future semi anuualy service of Hood Cleaning services 4-6 weeks before recommending service date to ensure facility meets regulation requirements. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted monthly by the Director of Maintenance or designee 1 times per month x 3 months, then quarterly x 2 quarters to ensure compliance. Monitoring / auditing of this plan of correction will occur during the monthly QA&A meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Driver/Maintenance Assistant during record review from 9:20 a.m. to 12:45 p.m. on 11/15/16, documentation of semiannual kitchen exhaust system inspection six months after 04/08/16 was not available for review. Based on interview at the time of record review, the Van Driver/Maintenance Assistant stated National Exhaust Cleaning was under contract to perform semiannual kitchen exhaust systems' inspections and came October 2016 to perform the semiannual inspection but had to reschedule the inspection while on site. Based on observation with the Executive Director and 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, National Exhaust Cleaning had affixed a sticker to the range hood in the kitchen indicating the next scheduled inspection was due in October 2016 following the 04/08/16 inspection. Based on interview at the time of record review and of the observation, the Van Driver/Maintenance Assistant acknowledged documentation of semiannual kitchen exhaust system inspection six months after 04/08/16 was not available for review. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section	K 0353	**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.**	12/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients and staff in the facility. Findings include: Based on review of SafeCare's "Report of Inspection" documentation dated 06/02/16 and 09/12/16 and Direct Supply:TELS documentation dated 06/27/16 and 09/19/16 with the Van Driver/Maintenance Assistant during record review from 9:20 a.m. to 12:45 p.m. on 11/15/16, monthly sprinkler gauge inspection documentation for May, July, August and October 2016 was not available for review. In addition, weekly inspection documentation for all sprinkler system control valves for 22 of the 27 week period of 05/09/16 through 11/11/16 was also not available for review. Based on interview at the time of record review, the Van		**K-353 NFPA 101** **SPRINKLER SYSTEM-MAINTENANCE & TESTING** **Compliance Date 12/15/2016** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1.) Sprinkler Gauge system has been checked by the director of maintenance to ensure it is in good condition, with normal water supply pressure. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Director of Maintenance to in-service assistant Director of Maintenance on sprinkler gauge condition, water supply pressure. Assistant Director will be in-serviced by 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 of the sprinkler gauge to ensure the gauge is in good functional condition, and water supply reading. Director of Maintenance or designee will audit 3 times per week times for 4 weeks, then monthly times 3 months to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Driver/Maintenance Assistant stated both SafeCare and the facility document sprinkler gauge and control valve inspections on a quarterly basis. 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, the facility has a wet sprinkler system and had one sprinkler system water pressure gauge which read 100 psi. Based on interview at the time of record review and observation, the Van Driver/Maintenance Assistant acknowledged monthly and weekly sprinkler system gauge and control valve inspection documentation for the aforementioned periods was not available for review. 3.1-19(b)		ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use	K 0711	**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.** **K-711 NFPA 101 EVACUATION AND RELOCATION PLAN** **Compliance Date 12/15/2016** **Corrective actions accomplished for those residents found to be affected by the alleged deficient 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 new Disaster Manual with smoke compartment evacuation plan. New Disaster	12/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: 1. Based on review of "Disaster Plan & Evacuation Procedures" documentation dated 10/18/16 with the Executive Director at 12:45 p.m. on 11/15/16, the written fire safety plan did not address internal evacuation of smoke compartments within the facility. The plan only provided specific procedures to evacuate the building in the event of fire. The "Fire Policy & Procedure" section of the aforementioned written fire safety plan stated to "close all fire doors" but did not provide the location of fire doors in the plan. Based on interview at the time of review, the Executive Director acknowledged the aforementioned written fire safety plan did not address internal evacuation procedures in the event of a fire and did not include the location of stated fire doors in the facility. 2. Based on review of "Disaster Plan & Evacuation Procedures" documentation dated 10/18/16 with the Executive Director at 12:45 p.m. on 11/15/16, the written fire safety plan did not address the relocation of wheeled equipment		manuals have been placed through out the facility to ensure they are accessible. Director of Maintenance will audit all exits (means of egress) with in the facility to ensure all exits are free and clear of any equipment that would affect the means of egress. Director of Maintenance will mark off the means of egress area to ensure no obstructions. Staff will be in-serviced by 12/12/2016. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits questionnaire will be conducted with staff by the Director of Maintenance or designee relating to smoke compartment evacuations 3 times per week times x 4 weeks, then monthly x 4 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting. The following audits will be conducted of all Third floor exit areas to ensure the areas are free and clear of any obstructions by the Director of Maintenance or designee 3 times per week x 4 weeks, then monthly times 3 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the patient care vicinity 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 other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect three residents, staff and visitors in the northwest Therapy Room on the first floor. Findings include:	K 0920	**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.** **K-920 NFPA 101 ELECTRIC EQUIPMENT-POWER CORDS AND EXTENS** **Compliance Date 12/15/2016** **Corrective actions accomplished for those residents found to be affected by the alleged deficient**	12/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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, one electric general purpose tumbling panel mat was plugged into a power strip in the northwest Therapy Room on the first floor. The power strip had no affixed documentation indicating its UL listing. Based on interview at the time of observation, the Van Driver/Maintenance Assistant acknowledged a power strip was being used as a substitute for fixed wiring in the aforementioned location. 3.1-19(b)		**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.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 staff and visitors in the vicinity of the third floor oxygen storage and transfilling room. Findings include: 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, one of two 'E' type oxygen cylinders was standing upright on the floor of the oxygen storage and transfilling room next to the nurse's station on the third floor and was not properly chained or supported in a proper cylinder stand or cart. One liquid oxygen container was also observed stored in the room. Based on interview at the time of observation, the Van Driver/Maintenance Assistant acknowledged one of two 'E' type oxygen cylinders in the aforementioned oxygen storage and transfilling room was not properly		**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.** **K-923 NFPA 101 Gas Equipment-Cylinder and Container storage** **Compliance Date 12/15/2016** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** **1.) Director of Maintenance placed signage to ensure cylinders are secured behind the safety chains. Nursing staff will be in-serviced/educated on proper Gas equipment storage.** **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Sign placed with in Gas Equipment storage area by Director of Maintenance with in-service/education completed by 12/12/2016** **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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chained or supported in a proper cylinder stand or cart. 3.1-19(b)		**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.**	