PRINTED: 07/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	<u> </u>				
55298	D. WII			06/14/	2017
REHABILITATION CENTER					
EMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
MUST BE PRECEDED BY FULL]		CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
e Investigation of 2194 and 194 - Substantiated. encies related to the at F257. 406 - Substantiated. encies related to the at F257. 13-14, 2017 20195 55298 67690 ects State findings with 410 IAC	F 00	00	the facility's written credible allegation of compliance. Preparation and/or the executi of this Plan of Correction does constitute admission or agreement of 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	ion not ne e s	
	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION) e Investigation of 2194 and 194 - Substantiated. encies related to the at F257. 406 - Substantiated. encies related to the at F257. 13-14, 2017 0195 55298 57690	EREHABILITATION CENTER MENT OF DEFICIENCIES (IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION) F 000 194 - Substantiated. Incies related to the at F257. 406 - Substantiated. Incies related to the at F257. 13-14, 2017 0195 55298 57690	EREHABILITATION CENTER MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL IDENTIFYING INFORMATION) TAG F 0000	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 MENT OF DEFICIENCIES RUST BE PRECEDED BY FULL IDENTIFYING INFORMATION) E Investigation of 2194 and PAGE Investigation of 2194 - Substantiated. Incies related to the at F257. 406 - Substantiated. Incies related to the at F257. 13-14, 2017 10195 555298 67690	STREET ADDRESS, CTIY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 WE REHABILITATION CENTER INDIANAPOLIS, IN 46260 PREFIX TAG PREFIX TAG TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or the execution of this Plan of Correction does not constitute admission or agreement of 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 PREFIX TAG This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or the execution of this Plan of Correction does not constitute admission or agreement of 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 PREFIX TAG This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or the execution of this Plan of Correction to agreement of 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

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

(X6) DATE

TITLE

Any defiencystatement 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.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 06/14/2017
	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) Quality review completed June 16, 2017.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0257 SS=F Bldg. 00	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. Based on observation, interview and record review, the facility failed to maintain comfortable temperatures between 71 and 81 degrees Fahrenheit (F) for 28 of 28 resident rooms observed affecting 37 of 37 residents residing in the building. (Resident B, C, D, E, F, G, H, Z, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, BB, CC, DD, EE, FF, GG, HH, JJ, KK, LL, MM, NN, and OO) Findings include: Upon entrance to the facility on 6/13/17 at 9:41 a.m., the temperature outside was 80 degrees Fahrenheit (F). A mobile air unit was located outside the facility and running.	F 0257	F 257 1. Staff education provided on 6/13/17 and 6/14/17 by ED/designee regarding extreme heat policy and procedure/rise in facility temperature. 2. Revised facility staffing to accommodate the delivery of heat protocols. Nursing rounds were increased in order to observe residents, ensure comfort levels, and monitor for	

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	PROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, 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 an interview with the Executive Director at this time, he indicated the facility had two compressors that were not working on the facility air conditioning unit. He indicated this had first started on 5/24/17. At that time until this past weekend the temperatures in the building were maintained in the acceptable range with the rental and purchase or portable air units and fans for resident rooms. He indicated the past weekend was hot and as the temperatures rose, so did the temperature inside the building. On Sunday, June 11, 2017, two 1.5 ton air units were installed and two 5 ton units were installed on Monday, 6/12/17, finishing around 8 p.m. He also indicated during this process, hydration carts were utilized and additional		heat-related illness. Cool compresses/washcloths were provided for resident comfort (forehead, axilla, back of neck). Portable fans/portable AC units provided to assist in controlling room temperatures/increase ai flow. Some residents were relocated to cooler areas of the facility as needed with proper notifications.		
	hydration was given. He indicated estimates had been received to replace the compressors and they were waiting on the parts. A timeline and receipt of purchases was received on 6/13/17 by the Payable clerk. The form and receipts indicated a 5 ton air conditioning unit was rented on 6/5/17, and 6/7/17, then on 6/11/17 two 1.5 ton air conditioning units were delivered and on 6/12/17 two 25 ton air conditioning units were delivered. The therapy room was 77 degrees F on		3. Facility provided additional fluids on all meal trays. Hydration carts/stations were also maintained by facility staff. In addition, fresh ice water pitchers were delivered every shift. Additional fluids also offered during med pass, activities, and during therapy.		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155298	B. WI	ING		06/14/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			OWNSHIP LINE RD	
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			IAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT 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	IATE CONTENT
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		2 a.m. During an				
	interview at this time, Certified				4. Facility rented a	
	_	Occupational Therapy Assistant 1			chiller and installed on	
		erapy room had been cool			6/22/17. Facility staff	
	through the trou				monitored temperatures	
	conditioning sys	tem.			to ensure that the unit is	
	During a tour of the 3rd floor where				effectively operational in	
	-	on 6/13/17 at 9:54 a.m.,			regards to maintaining	
	the following was observed: South Hall				regulatory temperatures	
					and ensuring the comfor	
	There was a "Mo	ovincool" air			of our patients. All	
		t in the hall way set at 70			·	
		a temperature reading of			resident's returned to th	e
	_	his unit was blowing			third floor on 6/23/17.	
	forceful cold air	. Another air				
	conditioning uni	t was located on south			5. Maintenance or	
		emperature reading on			designee to will continue	2
		and was blowing cold			to monitor temperatures	S
	air.				throughout the facility	
	Nursing Station				3x/week for 2 months,	
		table air conditioning unit			weekly for 2 months and	
	_	ation set on 65 degrees F,			monthly for 2 months.	
	_	are reading of 75 degrees			Results will be forwarded	d
		residents at the nursing			to the Executive	
	station. There was a hydration cart filled with ice, bottled water and Gatorade.				Director/designee for	
					further follow up if	
	North Hall				· ·	
	There was a "Movincool" air				required.	
	_	t at the end of the hall set with a temperature				

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	PROVIDER OR SUPPLIED D POINT POST-AC	R CUTE REHABILITATION CENTER	85	30 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	reading of 78 de blowing cold air	egrees F. The unit was					
	entry way set or	it at the North Hall dining a 70 degrees F, with a ding of 86 degrees F. The					
		r conditioning unit at the II with a temperature egrees F.					
		r conditioning unit in 3rd m, with a temperature egrees F.					
	_	ws between 10 a.m. and 1/13/17, the following was					
	but she was mar	cated her room was hot, naging. She indicated she and plenty of					
		icated the heat was not nd he had plenty of					
		cated she had just ne hospital and she was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/14/2017
	PROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	8530 T	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
	concerned the heat would affect her breathing. She had a fan and oxygen was in use.			
	Resident DD indicated it had been hot for about a week and the fan in his room helped at night but through the day it just blew hot air. He indicated the Executive Director (ED) had talked with him about the air conditioning problem and the time frame it might get fixed. He indicated he had plenty of liquids and could move to a cooler place in or outside the building as he pleased.			
	The family member of Resident O indicated the air conditioning system had been working "off and on" for a while now and it really needed to get fixed. He indicated his loved one had no ill effects from the heat.			
	A review of the facility temperature log received from the ED on June 14, 2017 at 10:30 a.m., indicated during sporadic room and common area temperature checks between June 9-12, 2017, temperatures were maintained between 74-84 degrees F on the third floor. On the following dates and times, the temperature was above the 81 degree F acceptable temperature:			
	6/9/17: 12 p.m., west hall was 82 degrees			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	LETED
		155298	B. WII	NG		06/14/	/2017
	n oxympun o			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C			OWNSHIP LINE RD		
		UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAU		LSC IDENTIFYING INFORMATION)		TAG	DES TOTAL OF		DATE
		hall was 82 degrees F,					
		4 degrees F, West hall					
	_	F, and the common area					
	was 82 degrees I	۲.					
	6/11/17: 8 a.m.,	North hall was 82					
	· · · · · · · · · · · · · · · · · · ·	m., North hall was 82					
		., North hall was 84					
		hall was 82 degrees F; 4					
		was 82 degrees F.					
	p.iii., rvotti nuir was 62 degrees 1.						
	6/12/17: 8 a.m.,	North, South, and West					
	· ·	grees F; 10 a.m. North					
		rees F. 12 p.m., North and					
		34 degrees F and South					
		rees F. 2 p.m., North hall					
		F, South and West hall					
	_	F. 4 p.m., North hall was					
	82 degrees F.	2 p, 1.0101 11011 1100					
	02 40510001.						
	During the envir	conmental tour of the 3rd					
	_	dents resided, with the					
		rector, on 6/13/17 at					
		following was observed:					
	,	-					
	3 North						
	Room was 86 de	egrees Fahrenheit (F).					
	Resident B occur	pied this room, but was					
		x fan was running.					
	Room was 87 degrees F. Resident C and						
	•	n the room. A box fan					
	_	esident D indicated					
during interview at this time, the room							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		155298	B. W		<u></u>	06/14	
	PROVIDER OR SUPPLIER	L THE REHABILITATION CENTER	₹	8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	<u> </u>	
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Room was 86 de F were present in was running. Re	egrees F. Resident E and in the room. A box fan esident F indicated during time, the room was too					
	Room was 88 de H were present i	egrees F. Resident G and n the room.					
	in the room and	egrees F. Resident Z was indicated at this time, the ot. A box fan was					
		egrees F. Resident J om, but was not present. unning.					
		egrees F. Resident K was om and a fan was					
		egrees F. Resident L om but was not present nning.					
		egrees F. Resident M and room but was not present nning.					
		egrees F. Resident O and oom, were present and a					

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	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER		8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	occupied the roo was running. Room was 88 de occupied the roo fans were running portable air unit Room was 90.4 doccupied the roo and a fan was run Room was 92 de U occupied the roo was running. Room was 89.2 doccupied the roo was running. Shinterview at this returned from the utilizing oxygen. Room was 90.6 doccupied the roo and a fan was run. Room was 90.6 doccupied the roo and a fan was run. Room was 90.5 dand Y occupied the roo and y occupied the y occ	egrees F. Resident Q m, was present and a fan egrees F. Resident R m, was present and 2 eg. There was also a in the room. degrees F. Resident S m but was not present nning. egrees F. Resident T and coom, were present and eg. degrees F. Resident V m, was present and a fan e indicated during time, she had just e hospital and was degrees F. Resident W m but was not present					

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	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER	8530 TO	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)	ATE	(X5) COMPLETION DATE
	running. Room was 90 de and CC occupied and a fan was run indicated at this the fan only help Room was 89.9 doccupied the roo fan was running. Room was 91 de occupied the roo and a fan was run Room was 89.8 doccupied the roo was running. Room was 89.8 doccupied the roo was running. Room was 88 de occupied the roo and a fan was run af fan was fan	grees F. Resident BB I the room, were present nning. Resident CC time during interview, red a little with the heat. I degrees F. Resident DD m, was not present and a grees F. Resident EE m but was not present nning. I degrees F. Resident FF m, was present and a fan grees F. Resident GG m but was not present nning. grees F. Resident HH m, was present and no		CROSS-REFERENCED TO THE APPROPRIA	ATE C	
	Room was 86 de KK occupied the	grees F. Resident JJ and room. Resident JJ was om and a fan was				

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			DDDEGG CUTY CT LTD ZID CODE	06/14/	2017		
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
		grees F. Resident LL om but was not present					
	and a fan was ru	-					
		egrees F. Resident MM					
	•	om. She indicated at					
	that time during	interview, she would like					
	a fan.						
	Room was 84 degrees F. Resident NN						
	-	m but was not present					
	and a fan was ru	nning.					
	Room was 85.7	degrees F. Resident OO					
	occupied the roo was running.	m, was present and a fan					
	_	ion was 78 degrees F and					
	_	was 79 degrees F. There s in the dining room and					
	2 at the nurses' s	_					
	_	vs between 11 a.m., and					
	indicated:	/13/17 the following was					
	Housekeeper 2 in been working for	ndicated the air had not r about a week.					
		indicated the air had not					
	been working in	the last week.					
		ant 4 indicated she came nost daily through the					

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	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	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
	started about a w	conditioning problem reek ago. She indicated any medical problems at.			
	and she was wor	vas hot in the facility then king on Sunday 6/11/17 was here installing air			
	Maintenance Dir p.m., the ED ind process of movir residents from th floor since it was acceptable tempe be closing the So compressors wer he had acquired	iew with the ED and the sector on 6/13/17 at 1:10 icated they were in the ag the South Hall se third floor to the 2nd scooler and within the erature range and would both hall until the se replaced. He indicated agency staffing to help the residents during this			
	"Extreme Rise in Facility Tempera 6/14/17 at 10 a.n deemed as currer "Policy To antici respond immedia in environmental	order to attain and/or			

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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 STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG				PREFIX TAG			COMPLETION DATE
	Temperature: is farenheight [sic] reasonable and repreventing and response to the control of the	between 71 -81 degreesPurpose To set a necessary standard for esponding to facility excess of 85 degrees"					

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

Event ID:

635I11

Facility ID: 000195

If continuation sheet

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