PRINTED: 08/01/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED 07/07/2023	
		155857	B. WI	NG			
			_	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R		3640 N	I CENTRAL AVENUE		
TRANQI	JILITY NURSING A	ND REHAB		INDIAN	IAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN O			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 00	000	By submitting the enclosed		
	conducted by the Indiana Department of Health in				material, we are not admitting	the	
	accordance with 42	2 CFR 483.73.			truth or accuracy of any speci	fic	
					findings or allegations. We res	serve	
	Survey Date(s): 07	7/06/23 & 07/07/23			the right to contest the finding	s or	
					allegations as part of any		
	Facility Number: (proceedings and submit these)	
	Provider Number:	155857			responses pursuant to our		
	AIM Number: 300	0029339			regulatory obligations. The fac	-	
					request the plan of correction	be	
		Preparedness survey,			considered our allegation of		
		g and Rehab was found not in			compliance effective July 27,	2023	
	_	mergency Preparedness			to the Life Safety Survey		
	1 -	Medicare and Medicaid			completed on July 7, 2023. The		
	1 -	ders and Suppliers, 42 CFR			facility request that the plan of		
	483.73.				correction be considered effect	ctive	
	The facility has 70	contified hade At the time of			August 7, 2023 the survey	200	
	the survey, the cens	certified beds. At the time of			completed on July 7, 2023, 20		
	the survey, the cent	sus was 31.			The facility also requests that		
	Quality Paviany co	mpleted on 07/11/23			plan of correction be consider for paper review. The facility was		
	Quality Review co.	impleted on 07/11/23			be happy to submit to you any		
	The requirement at	42 CFR, Subpart 483.73 is NOT			additional paperwork that you		
	MET as evidenced	•			would need for review.		
	WIET as evidenced	oy.			would need for review.		
E 0037	403.748(d)(1), 41	6.54(d)(1), 418.113(d)(1),					
SS=F	1 ' ' ' '	22.15(d)(1), 483.475(d)(1),					
Bldg	, , , ,	.102(d)(1), 485.625(d)(1),					
Ŭ		5.727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 49						
	EP Training Prog	. , . ,					
		416.54(d)(1), §418.113(d)(1),					
		460.84(d)(1), §482.15(d)(1),					
	1 - ' ' ' ' -	83.475(d)(1), §484.102(d)(1),					
		485.625(d)(1), §485.727(d)					

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

(1), §485.920(d)(1), §486.360(d)(1),

TITLE (X6) DATE

Heather Kesler **Executive Director** 07/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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§491.12(d)(1).

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	ľ í	UILDING	NSTRUCTION	(X3) DATE COMPL 07/07/	ETED	
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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	
	Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training ir policies and proce existing staff, indivender arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docurpreparedness train (iv) Demonstrate semergency proced (v) If the emergen and procedures at [facility] must concupdated policies at The hospice must (i) Initial training ir policies and proceexisting hospice existing hospice existing hospice existing hospice existing hospice existent with the (ii) Demonstrate semergency proced (iii) Provide emergat least every 2 ye (iv) Periodically reemergency preparemployees (including with special emph	n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness training ears. mentation of all emergency ning. staff knowledge of dures. cy preparedness policies re significantly updated, the duct training on the and procedures. §418.113(d):] (1) Training. do all of the following: a emergency preparedness edures to all new and employees, and individuals a under arrangement, eir expected roles. taff knowledge of dures. gency preparedness training						

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	NT OF DEFICIENCIES OF CORRECTION			COME	(X3) DATE SURVEY COMPLETED 07/07/2023	
	PROVIDER OR SUPPLIEI		364	EET ADDRESS, CITY, STATE, ZIP COD 0 N CENTRAL AVENUE VIANAPOLIS, IN 46205	•	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY.)		LD BE	(X5) COMPLETION
TAG	and others. (v) Maintain docul preparedness trait (vi) If the emerger and procedures a hospice must contupdated policies a procedures. *[For PRTFs at §4 program. The PR following: (i) Initial training in policies and procedures and procedures arrangement consistent with the (ii) After initial trait preparedness trait (iii) Demonstrate emergency procedure) Maintain docul preparedness trait (v) If the emergency procedures and procedures	mentation of all emergency ining. Incy preparedness policies re significantly updated, the duct training on the and 441.184(d):] (1) Training TF must do all of the In emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected roles. Ining, provide emergency ining every 2 years. Istaff knowledge of dures. Immentation of all emergency ining. Incy preparedness policies re significantly updated, the fuct training on the updated edures. 60.84(d):] (1) The PACE to do all of the following: In emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with ess. Igency preparedness training	TAG			DATE
	emergency proce	dures, including informing				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED.
		155857	B. W	ING		07/07/2023	
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		3640 N	CENTRAL AVENUE		
TRANQL	JILITY NURSING A	ND REHAB			APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		at to do, where to go, and					
		n case of an emergency. mentation of all training.					
	` '	ncy preparedness policies					
		re significantly updated, the					
	-	- · · · · · · · · · · · · · · · · · · ·					
	PACE must conduct training on the updated policies and procedures.						
	*[For LTC Facilitie	es at §483.73(d):] (1)					
	_	. The LTC facility must do all					
	of the following:						
		n emergency preparedness					
		edures to all new and					
		viduals providing services					
	under arrangemer						
	consistent with the						
		ency preparedness training					
	at least annually.						
	' '	mentation of all emergency					
	preparedness trai	_					
	, ,	staff knowledge of					
	emergency proced	dures.					
		485.68(d):](1) Training. The					
	CORF must do all	<u> </u>					
	, ,	raining in emergency					
	1 ' ' '	icies and procedures to all					
		staff, individuals providing					
		rangement, and volunteers,					
	consistent with the	ency preparedness training					
	at least every 2 ye						
		mentation of the training.					
	(iv) Demonstrate	_					
	' '	dures. All new personnel					
		and assigned specific					
		garding the CORF's					
		vithin 2 weeks of their first					
		ning program must include					
	-	ocation and use of alarm	1				

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A. BUILDING B. WING	COMPLETED 07/07/2023
STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205	
PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION
CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION DATE
	STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205 ID PROVIDER'S PLAN OF CORRECTIVE (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVI

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		A. BU	A. BUILDING B. WING			COMPLETED 07/07/2023	
	F PROVIDER OR SUPPLIEF QUILITY NURSING A			3640 N	ADDRESS, CITY, STATE, ZIP COD I CENTRAL AVENUE JAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
	Based on record review of failed to ensure the training and testing program. The LTC following: (i) Initia preparedness polici and existing staff, in under arrangement, with their expected preparedness training Maintain document Demonstrate staff is procedures in accord (1). This deficient occupants. Findings include: Based on review of Manual" documents Executive Director during record review on 07/06/23 and frou 07/07/23, document emergency prepared twelve month period Review of "General documentation for spreparedness policient most recent twelve. These findings were findings we	ning at least every 2 years. view and interview, the facility emergency preparedness program includes a training facility must do all of the I training in emergency es and procedures to all new individuals providing services and volunteers, consistent roles; (ii) Provide emergency ing at least annually; (iii) ation of the training; (iv) mowledge of emergency dance with 42 CFR 483.73(d) practice could affect all "Emergency Preparedness ation dated 02/08/23 with the and the Maintenance Director w from 10:05 a.m. to 2:30 p.m. im 9:00 a.m. to 9:20 a.m. on tation for staff training on dness within the most recent d was not available for review. I Orientation Checklist" staff training on emergency es and procedures did not a staff training on emergency es and procedures within the	E 00	037	It is the practice of this facilit to provide Emergency Preparedness training to all staff upon hire and annually thereafter. The correction action taken is the resident found to be affer by the deficient practice include: No resident was identified as being affected. All staff have received required in servicing Emergency Preparedness. Other residents that have the potential to be affected have been identified by: All residents residing at the fact have the potential to be affected Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude Emergency Preparedness trait is included in all new hire train The General Orientation Checken.	for cted on cility ed. into ecur ning ing.	08/07/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155857	B. W	ING	_	07/07/2023	
NAME OF T	ADOLUDED OF CLUBY			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .	3640 N CENTRAL AVENUE				
TRANQU	IILITY NURSING A	ND REHAB	INDIANAPOLIS, IN 46205				
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TE	COMPLETION	
TAG	KEGULATUKY OF	R LSC IDENTIFYING INFORMATION	+	TAG	has been updated to include		DATE
					Emergency Preparedness. A	JI	
					new hires will receive emerge		
					preparedness training upon hi	-	
					and annually thereafter. All st		
					have received in-servicing to		
					include facility Emergency		
					Preparedness.		
					The corrective action taken	to	
					monitor performance to ass		
					compliance through the qua		
					assurance is:		
					A Performance Improvement	Tool	
					has been initiated that reviews		
					Emergency Preparedness Tra		
					and ensures all staff have rec	-	
					the required training. The		
					Maintenance Director, or		
					designee, will complete this to	ol	
					weekly x3, monthly thereafter.		
					Any issues identified will be		
					immediately corrected. The		
					Quality Assurance Committee		
					review the tools at the schedu		
					meetings with recommendation		
					as needed based on the outco	omes	
					or the tools.		
					The date the systemic chang	ges	
					will be completed: 8/7/23		
E 0041	482.15(e), 483.73	(e), 485.625(e)					
SS=F	` , ,	LTC Emergency Power					
Bldg	· ·	tion for Participation:					
	` '	d standby power systems.					
	` '	implement emergency and					
	•	stems based on the					
		et forth in paragraph (a) of					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	 JILDING	NSTRUCTION	(X3) DATE COMPL 07/07/	ETED
	PROVIDER OR SUPPLIER		3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	this section and in procedures plan s (i) and (ii) of this s	et forth in paragraphs (b)(1)				
	The [LTC facility a implement emerge systems based on	625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.				
	Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, an Code (NFPA 101 Amendments TIA	e located in accordance with ements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA ad TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing				
	Emergency gener The [hospital, CAI implement the em inspection, testing requirements foun	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] id in the Health Care FPA 110, and Life Safety				
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency perational during the sit evacuates.				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	ì	UILDING	NSTRUCTION	(X3) DATE COMPL 07/07/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	§483.73(g), and O The standards incomplete the section are apprehensed by the E Federal Register in 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information Reson Boulevard, Baltim Archives and Rec (NARA). For information Reson this material at NA go to: http://www.archive_of_federal_regul. If any changes in incorporated by redocument in the Fannounce the characteristic (1) National Fire Fatterymarch Par Quincy, MA 021691.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) Tla 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012						

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155857	B. WI	NG	.	07/07	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			CENTRAL AVENUE		
TRANQL	JILITY NURSING A	ND REHAB			IAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	, ,	IFPA 101, issued August					
	11, 2011.						
	, ,	FPA 101, issued October					
	30, 2012.	-DA 404 : 10 1 1					
		FPA 101, issued October					
	22, 2013.	CDA 101 issued October					
	, ,	FPA 101, issued October					
	22, 2013.						
	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,						
	including TIAs to chapter 7, issued August 6,						
	2009	oriaptor 1, locada 1 tagadt 0,					
	Based on record review, observation and		E 00)41	E041		08/07/2023
	interview; the facility failed to implement the			,			00.07.2025
		system inspection, testing and			It is the practice of this facili	ty	
	maintenance requir	ements found in the Health			to conduct Generator Load	•	
	Care Facilities Cod	e, NFPA 110, and Life Safety			Testing and labeling in		
	Code in accordance	e with 42 CFR 483.73(e)(2).			accordance with current		
	This deficient pract	ice could affect all occupants.			regulation.		
	Findings include:						
					The correction action taken		
		view on 07/06/23 and			the resident found to be affe	cted	
		/07/23, the following was		by the deficient practice			
	noted:				include:		
	a. Based on review	of Direct Supply TELS			No resident was identified as		
		Generators: Test generator			being affected. Generator Lo	ad	
		entation with the Maintenance			Testing has been completed t		
		ord review from 10:05 a.m. to			meets the stated requirements		
		/23, monthly load testing			The emergency stop has bee		
	_	the facility's diesel fuel fired			labeled. The Tels system has		
	emergency generate	or for six months of the most			been updated to included time	es for	
	recent twelve mont	h period was incomplete. The			both processes.		
	run time was docum	nented as less than 30 minutes					
	-	sting conducted on 01/26/23,			Other residents that have the	Ð	
	02/28/23, 03/30/23, 04/26/23, 05/31/23 and 06/30/23.				potential to be affected have		
	Based on interview at the time of record review,				been identified by:		
		irector agreed monthly load					
	testing documentati	ion for the six month period of			All residents residing at the fa	cility	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	(X2) MULTIPLE C A. BUILDING B. WING	construction 	(X3) DATE SURVEY COMPLETED 07/07/2023
	PROVIDER OR SUPPLIEI		3640 N	ADDRESS, CITY, STATE, ZIP COI N CENTRAL AVENUE NAPOLIS, IN 46205	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ŒACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE COMPLETION PROPRIATE DATE
	January 2023 throu time was less than 3	gh June 2023 indicated the run 30 minutes.		have the potential to be a Please see system chan below to prevent reoccur	iges
	b. Based on review "Emergency Power under load" docum Director during rec 2:30 p.m. on 07/06, documented as "4 r testing conducted of 04/26/23, 05/31/23 interview at the time Maintenance Director for monthly load te facility's emergency less than 5 minutes c. Based on observation Director during a to to 11:40 a.m. on 07 manual stop which the weatherproof sl generator located of side of the property Manufacturer's nan the diesel fired eme was manufactured to kW. Based on inte observations, the Mo	of Direct Supply TELS Generators: Test generator entation with the Maintenance ord review from 10:05 a.m. to /23, the cool down time was minutes" for monthly load m 01/26/23, 02/28/23, 03/30/23, and 06/30/23. Based on the of record review, the tor agreed the cool down time sting documentation for the sy generator was documented as ations with the Maintenance our of the facility from 9:20 a.m. //07/23, the facility's remote was affixed to the exterior of mell for the emergency utside the facility on the west		1	matic n put into n put into not recur or and ed on Testing Generator completed rgency The Tels ed to processes. aken to processure ne quality ment Tool
	the remote manual These findings wer	stop station was not labeled. e reviewed with the Executive aintenance Director during the		processes. The Maintenant Director, or designee, with complete this tool month issues identified will be immediately corrected. The Quality Assurance Compreview the tools at the sound meetings with recomment as needed based on the of the tools.	III III III III III III III III III II

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED		
111.212.11	or comments.	155857	B. WING	07/07/2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date(s): 07/2 Facility Number: 0 Provider Number: 3000 At this Life Safety O Nursing and Rehab with Requirements Medicare/Medicaid Life Safety From Fi National Fire Protec Life Safety Code (L Health Care Occupa This one story facility Type V (000) const: The facility has a findetection in the corr corridor with smoke fire alarm system in rooms. Resident sle and 206 through 21 bedrooms with a tot	14265 155857 029339 Code survey, Tranquility was found not in compliance	K 0000	By submitting the enclosed material, we are not admitting truth or accuracy of any spefindings or allegations. We the right to contest the findiallegations as part of any proceedings and submit the responses pursuant to our regulatory obligations. The request the plan of correct considered our allegation of compliance effective July 2 to the Life Safety Survey completed on July 7, 2023. facility request that the plan correction be considered exaugust 7, 2023 the survey completed on July 7, 2023. The facility also requests the plan of correction be considered for paper review. The facility be happy to submit to you additional paperwork that y would need for review.	ing the ecific reserve ings or ese facility ion be if 7, 2023 The in of ffective 2023. Inat our dered by would gany

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/07/2023			
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB		364	EET ADDRESS, CITY, STATE, ZIP COD O N CENTRAL AVENUE DIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPR	DBE COMPLETION
K 0345 SS=F Bldg. 01	All areas where resist were sprinklered and services were sprinklered and system Maintenance Fire Alarm System Maintenance A fire alarm system Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are ready 1.1. Based on record of facility failed to enswas maintained in a 9.6.1.3 requires a firested, and maintain 70, National Electric National Fire Alarm Section 14.4.5 requires a firequencies. NFPA alarm systems, indicappliances shall be section 14.6.2.4 statesting and mainten includes all applications.	dents have customary access d all areas providing facility clered except for one detached inpleted on 07/11/23 In - Testing and in - Testing and in - Testing and in - Testing and in a proved program is requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 Teview and interview, the sure 1 of 1 fire alarm systems accordance with 9.6.1.3. LSC are alarm system to be installed, and in accordance with NFPA cal Code and NFPA 72, in Code. NFPA 72, 2010 Edition, irrest testing shall be performed and notification functional tested annually. Ites a record of all inspections, ance shall be provided that the information requested in its deficient practice could	K 0345	K345 It is the practice of this f to maintain the facility fir alarm and sprinkler syst accordance with current regulations. The correction action take the resident found to be by the deficient practice include: No resident was identified being affected. The required quarterly inspection of the sprinkler system and semi	acility re em in ken for affected

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				ОМ	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			ETED
		155857	B. W	ING		07/07/	/2023
							-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					CENTRAL AVENUE		
TRANQU	IILITY NURSING AI	ND REHAB		INDIAN	IAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID DOWNSON WAS CONTRACTED			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
		CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	
TAG		LSC IDENTIFYING INFORMATION	+	TAG			DATE
	Findings include:				inspection on the fire alarm ha		
					been scheduled to occur befor	е	
		riew with the Maintenance			8/7/23.		
		a.m. to 2:30 p.m. on 07/06/23,					
	-	n documentation for the most					
		n period was not available for			Other residents that have the)	
	review. Based on in	nterview at the time of record			potential to be affected have		
	review, the Mainten	ance Director stated the			been identified by:		
	facility switched fire	e alarm system inspection			_		
	contractors within the	he last year and agreed fire			All residents residing at the fac	cility	
	alarm system testing	g documentation within the			have the potential to be affected	-	
	,	month period was not			Please see system changes		
	available for review	•			below to prevent reoccurrence	1	
	available for review	•			below to prevent recodulitence	•	
	These findings were	e reviewed with the Executive					
		nintenance Director during the			The measures or systematic		
	exit conference.	antenance Director during the			changes that have been put		
	CAR COMETENCE.				_	iiito	
	2.1.10/%)				place to ensure that the		
	3.1-19(b)				deficient practice does not re	ecur	
	0 D 1 1				include		
		review and interview, the					
	-	intain 1 of 1 fire alarm systems			The facility updated its contract		
		NFPA 72, National Fire Alarm			with the fire alarm and sprinkle		
		LSC Sections 19.3.4.5.1 and			system service provider and it		
	,	tion 14.3.1 states that unless			includes all required services.		
	-	by 14.3.2, visual inspections			required quarterly inspection of	f the	
	_	in accordance with the			sprinkler system and semi- an	nual	
	schedules in Table 1	14.3.1, or more often if required			inspection on the fire alarm ha	ve	
	by the authority hav	ring jurisdiction. Table 14.3.1			been scheduled to occur befor	е	
	states that the follow	ving must be visually			8/7/23.		
	inspected semi-annu	ally:					
	a. Control unit troub	-			The corrective action taken t	0	
	b. Remote annuncia	_			monitor performance to assu		
		(e.g. duct detectors, manual			compliance through the qual		
	_	at detectors, smoke detectors,			assurance is:		
	etc.)	ar arrectors, smoke detectors,			accuration is.		
	d. Notification appli	iances			A Porformance Improvement	Tool .	
					A Performance Improvement		
	e. Magnetic hold-op				has been initiated that reviews	TIre	
	This deficient practice could affect all residents,				alarm and sprinkler system		

staff and visitors.

monitoring required services. The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155857		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY LETED 7/2023	
	PROVIDER OR SUPPLIER		3640 N	ADDRESS, CITY, STATE, ZIP C I CENTRAL AVENUE NAPOLIS, IN 46205	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
V 0354	Director from 10:05 semi-annual fire ala within the most reconstruction of record reviet facility switched fir contractors within the semi-annual inspect facility's fire alarm review. These findings were Director and the Material conference. 3.1-19(b)	riew with the Maintenance a.m. to 2:30 p.m. on 07/06/23, rm system documentation ent twelve month period was riew. Based on interview at the w, the Maintenance stated the e alarm system inspection he last year and agreed ion documentation for the system was not available for e reviewed with the Executive eintenance Director during the		Maintenance Director, designee, will complet monthly. Any issues id be immediately correct Quality Assurance Correview the tools at the meetings with recommas needed based on the first of the tools. The date the systemic will be completed: 8/1	e this tool lentified will ted. The mmittee will scheduled nendations ne outcomes c changes	
K 0351 SS=E Bldg. 01	by construction tyl throughout by an a sprinkler system ir 13, Standard for th Systems. In Type I and II co protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of	Installation nd hospitals where required				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155857	B. W	ING		07/07/2023	
NAME OF	PROVIDER OR SUPPLIEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF	PROVIDER OR SUPPLIED			3640 N	CENTRAL AVENUE		
TRANQUILITY NURSING AND REHAB			INDIAN	IAPOLIS, IN 46205			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	BETCHENCT	DATE	
	· · · · · · · · · · · · · · · · · · ·	it as required by NFPA 13, illation of Sprinkler					
	Systems.	mation of Spirikler					
	,	, 19.3.5.3, 19.3.5.4,					
		19.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	K351	08/07/2023	
		he ceiling construction in 1 of					
	_	ms in accordance with NFPA			It is the practice of this facili	ty	
		e Installation of Sprinkler			to maintain the facility		
	1 -	3, 2010 edition, Section 6.2.7.1			sprinkler system in accorda	nce	
	_	cheons, or other devices used r space around a sprinkler shall			with current regulations.		
		be listed for use around a					
		cient practice could affect staff			The correction action taken	for	
	_	the vicinity of the storage			the resident found to be affe		
		oms by the main entrance			by the deficient practice		
	lobby.				include:		
	Findings include:				No resident was identified as		
					being affected. The two ceilin	ng	
		ons with the Maintenance			mounted sprinkler heads loca	ted	
	_	our of the facility from 9:20 a.m.			in the storage area now have		
		7/07/23, each of the two ceiling			properly fitting escutcheon rin	gs.	
	_	in the storage room by the ain entrance lobby were			Other residents that have the	_	
		eon. Based on interview at the			potential to be affected have		
		tions, the Maintenance			been identified by:		
		ch of the two sprinklers were					
	missing its escutche				Residents residing in the vicin	nity of	
					the storage area have the pot	ential	
	_	e reviewed with the Executive			to be affected. Please see sys	stem	
		aintenance Director during the			changes below to prevent		
	exit conference.				reoccurrence.		
	3.1-19(b)						
					The measures or systematic		
					changes that have been put	into	
					place to ensure that the		
					deficient practice does not r include	ecur	

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER 155857	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/07/2023
	ROVIDER OR SUPPLIER ILITY NURSING AND REHAB	3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE JAPOLIS, IN 46205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
			The two ceiling mounted sprin heads located in the storage now have properly fitting escutcheon rings. The facility Maintenance Director has addithe two sprinkler heads to his rounding list. The corrective action taken monitor performance to assist compliance through the quasiurance is: A Performance Improvement has been initiated that review sprinkler head escutcheon ring. The Maintenance Director, or designee, will complete this to monthly. Any issues identified be immediately corrected. The Quality Assurance Committee review the tools at the scheduling meetings with recommendation as needed based on the outcometings with recommendation as needed based on the outcometings with recommendation as needed based on the outcometings with recommendation as needed based on the outcometing will be completed: 8/7/23	ded to to ture ality Tool s to to ture ality Tool s to ture ture ture ture ture ture ture ture
K 0353 SS=F 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.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/07/2023 155857 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVENUE TRANQUILITY NURSING AND REHAB INDIANAPOLIS, IN 46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE shall be tested semiannually. This deficient All residents residing at the facility practice could affect all residents, staff, and have the potential to be affected. visitors in the facility. Please see system changes below to prevent reoccurrence. Findings include: Based on record review with the Maintenance The measures or systematic Director from 10:05 a.m. to 2:30 p.m. on 07/06/23, changes that have been put into sprinkler system inspection and testing place to ensure that the documentation for the most recent twelve month deficient practice does not recur period was not available for review. Based on include interview at the time of record review, the Maintenance Director stated the facility switched The facility updated its contract sprinkler system contractors within the most with the fire alarm and sprinkler recent twelve month period and agreed sprinkler system service provider and it now system inspection and testing documentation for includes all required services. The the most recent twelve month period was not required quarterly inspection of the available for review. Based on observations with sprinkler system and semi- annual the Maintenance Director during a tour of the inspection on the fire alarm have facility from 9:20 a.m. to 11:40 a.m. on 07/07/23, been scheduled to occur before sprinkler system contractors had affixed hanging 8/7/23. tags to the sprinkler system riser indicating sprinkler system inspection and testing was The corrective action taken to conducted by the contractor in September 2022 monitor performance to assure and in December 2022. compliance through the quality assurance is: These findings were reviewed with the Executive Director and the Maintenance Director during the A Performance Improvement Tool exit conference. has been initiated that reviews fire alarm and sprinkler system 3.1-19(b) monitoring required services. The Maintenance Director, or designee, will complete this tool monthly. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 07/07/2023			
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB		3640	T ADDRESS, CITY, STATE, ZIP COD N CENTRAL AVENUE NAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0500 SS=F Bldg. 01	Section 18.5 and requirements that provided K-tags, information, along Safety Code or N should be include Based on record re interview; the facil heaters which requithe State of Indiana certificates to ensure safe operating conductive minimizes the possion requiring the evacute deficient practice a visitors. Findings include: Based on record re Director from 10:0 current inspection of Indiana for all water require inspection of for review. Based Maintenance Director from 9:20 a.m. to 1 following water he		K 0500	K500 It is the practice of this facility to maintain the proper Certificates of Inspection for facility water heaters. The correction action taken the resident found to be affectly the deficient practice include: No resident was identified as being affected. Inspections we completed on August 1st, 202. Other residents that have the potential to be affected have been identified by: All residents residing at the factor have the potential to be affected have been identified by:	ity r for ected ill be 23. ie e

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/07/2023
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB		3640 N	ADDRESS, CITY, STATE, ZIP COD I CENTRAL AVENUE NAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	b. the water heater is c. the water heater is Based on interview observations, the Mathematical three different Certificate of from the State of Interview of of Int	faintenance Director agreed water heaters did not have of Inspection documentation		The measures or systematic changes that have been put place to ensure that the deficient practice does not include Inspections will be completed August 1st, 2023. The facility post Certificates of Inspection upon receipt. The Director of Maintenance will audit The corrective action taken monitor performance to assistance through the quassurance is: A Performance Improvement has been initiated that review Certificates of Inspection for the heaters. The Maintenance Director, or designee, will complete this tool monthly. A issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedimeetings with recommendatings needed based on the outdoof the tools. The date the systemic chanwill be completed: 8/7/23	to cure cality Tool con water a will culed consciones
K 0712 SS=F	NFPA 101 Fire Drills				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLET			ETED	
		155857	B. WING 07/07/2023				
	PROVIDER OR SUPPLIER			3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE IAPOLIS, IN 46205		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
Bldg. 01	alarm signal and seconditions. Fire drand unexpected tile conditions, at least The staff is familia aware that drills are routine. Where draware that drills are routine. The second record reversities and record reversities and record reversities and visitors. Findings include: Based on review of Drills" and "Fire Draware that the drills" and "Fire Draware the Maintenance Diffrom 10:05 a.m. to 2 documentation of a second shift in the the September) 2022 with drill documentation 07/18/22 at 2:00 p.m. fire drill. Fire drill conducted on 09/02 was a "2nd shift" find documented as bein second shift time of the time of record rec	ay be used instead of	K 0	712	It is the practice of this facilit to conduct and document fir drills in accordance with regulation. The correction action taken is the resident found to be affe by the deficient practice include: No residents have been identified as being affected by this pract. A fire drill was performed and documented on July 28, 2023 calendar was adjusted to indict when fire drills are scheduled. Other residents that have the potential to be affected have been identified by: All residents residing at the fact have the potential to be affected. Please see system changes	for cted fied ice. d A cate	08/07/2023

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	f í		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING ()1 COMPLE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155857	A. BUII B. WIN		01	COMPLETED 07/07/2023
		100001	D. WIN	_		0110112023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE	
TRANQU	IILITY NURSING A	ND REHAB			APOLIS, IN 46205	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	+	TAG		DATE
drill was conducted was not during the second shift and agreed documentation of a fire drill				below to prevent reoccurrence	^{‡.}	
	-	econd shift in the third quarter				
	2022 was not availa	able for review.			The measures or systematic	:
					changes that have been put	into
		e reviewed with the Executive			place to ensure that the	
	exit conference.	nintenance Director during the			deficient practice does not re include	ecur
	3.1-19(b)				The Director of Maintenance a	and
					his assistant were in-serviced	on
					fire drill documentation and the	
					development of the calendar.	I
					calendar listing which dates fir drills are due has been put int	
					use.	
					466.	
					The corrective action taken t	
					monitor performance to assi	
					compliance through the qua assurance is:	Inty
					A Performance Improvement	Tool
					has been initiated that reviews	s the
					dates fire drills are due. The	
					Maintenance Director, or	.ol
					designee, will complete this to monthly. Any issues identified	I
					be immediately corrected. The	
					Quality Assurance Committee	I
					review the tools at the schedu	
					meetings with recommendation	I
					as needed based on the outco	omes
					or the tools.	
					The date the systemic chang	ges
					will be completed: 8/7/23	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 07/07/2023	
	PROVIDER OR SUPPLIER JILITY NURSING AI		3640 N	ADDRESS, CITY, STATE, ZIP COD I CENTRAL AVENUE NAPOLIS, IN 46205	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0907 SS=E Bldg. 01	systems have door programs. The proof all source systemanufactured ass Inspection and matestablished through considering manual Inspection proceds are established the Persons maintain demonstrated by the credentialing to the 6030 or 6040. 5.1.14.2.1, 5.1.14. 5.3.13.4.2 (NFPA Based on record revinterview; the facility's piped gas and NFPA 99, Health Control Edition. This deficition when the control the control that the control that the control that the control that the facility from 9:45 and three master alarms of the control that the control th	Piped Systems - gram um, WAGD, or support gas umented maintenance ogram includes an inventory ms, control valves, alarms, emblies, and outlets. sintenance schedules are gh risk assessment facturer recommendations. ures and testing methods rough risk assessment. ng systems are qualified as raining and certification or re requirements of AASE 2.2, 5.1.15, 5.2.14, 99) riew, observation and ty failed to maintain the systems in accordance with are Facilities Code, 2012 tent practice could affect 34 ints should the facility's pipe	K 0907	K907 It is the practice of this facility to maintain gas and vacuum piped systems in accordance with regulation. The correction action taken for the resident found to be affect by the deficient practice include: No resident has been identified being affected by this practice. The system was evaluated by th	or ted as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ì í	JLTIPLE CO IILDING	NSTRUCTION 01	(X3) DATE : COMPL	
		155857	B. WI	NG		07/07/	2023
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
PREFIX TAG	red at the wall mour location at the recep lobby and at the wall control panel location. The alarm warning Emergency Reserve Reserve in Use" and Maintenance Requirithe time of the obset through, the Mainte facility has a work of gas system but is away that vent unit reside concentrators but he Based on review of inspection contractor Vacuum System" in November 2022 with the Maintenance Diffrom 10:05 a.m. to 2 inspection document gas systems conduct twelve month period deficiencies with the piped gas system "Service Repair" do indicated "Med Vac quote for PM service manifold". Based or record review, the Efacility relies on the unit bed locations by as the back up oxyginterview at the time Maintenance Direct alarm warning light 05/01/23 contractor the same issues. Ba 1:30 p.m. on 07/06/25.	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Inted master alarm control panel brion desk at the main entrance Ill mounted master alarm on at the south nurse's station. Ilights were labeled "Oxygen of CY Low", "Oxygen Cylinder I "Medical Air Compressor red". Based on interview at rivations during the initial walk nance Director stated the order in for repair of the piped vaiting approval for repair and ints have been using oxygen or would have to check on that the piped gas system or's "Annual Medical Gas & ispection documentation dated the the Executive Director and rector during record review 2:30 p.m. on 07/06/23, the annual tation for the facility's piped ted within the most recent didid not indicate any re piped gas system. Review of in inspection contractor's cumentation dated 05/01/23 or in Alarm" and "Please send refor Med Vac + Med Air + O2 or interview at the time of executive Director stated the piped gas system for 34 vent at uses oxygen concentrators ren supply. Based on reforecord review, the restated the current master trouble indicator lights and the documentation are related to restated the current master trouble indicator lights and the documentation are related to restated the facility switched		PREFIX TAG	Service provider and made operational. The indicator light are now green indicating norm operation. Other residents that have the potential to be affected have been identified by: All residents residing on the verification of the potential to be affected. Residents requiring oxygen and/or the use of nebulizers have the potential to be affected. Residents requiring oxygen we provided with concentrators are those requiring nebulizers were provided with portable air compressor units until piped graystem was operational. The measures or systematic changes that have been put place to ensure that the deficient practice does not resinclude The Respiratory Therapists has been in-serviced regarding monitoring the Pipe Gas System added to the Respiratory Therapist's assignment as it relates to Pipe Gas Systems oxygen level and pressure in to oxygen tanks. Additionally, surveillance of the Pipe Gas Systems indicator panel was added to the TELS Program. Identified issues will be brought.	ent ere end e er	COMPLETION DATE

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Ť.		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		onstruction 01	(X3) DATE SURVEY COMPLETED	
155857					07/07/		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE				
TRANQUILITY NURSING AND REHAB				INDIAN	APOLIS, IN 46205		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION out the reserve oxygen supply last Tuesday, the warning lights should have cleared within an hour depending on the air pressure settings and stated they have a service call in for repair. The Director of Respiratory Therapy also stated they have a service call in for the medical air compressor maintenance required indicator light. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
					The corrective action taken to monitor performance to assure		
					compliance through the quality assurance is:		
					A Performance Improvement Tool has been initiated regarding the Pipe Gas System. The Maintenance Director, or designee, will complete this weekly x 4, monthly x3 quarterly x 2 Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: 8/7/23		
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro-	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life					

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
155857		B. WING	07/07/2023			
NAME OF I	DROVIDED OD STIDDLIEE		STRE	ET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				N CENTRAL AVENUE		
TRANQL	JILITY NURSING A	ND REHAB	INDI	ANAPOLIS, IN 46205		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
		branches. Maintenance				
		generator and transfer				
	NFPA 110.	ormed in accordance with				
		e inspected weekly,				
		pad 30 minutes 12 times a				
		intervals, and exercised				
	, ,	nths for 4 continuous hours.				
	1	ider load conditions include				
	a complete simula					
	•	ual transfer of all EES				
		nducted by competent				
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in					
	accordance with N	NFPA 111. Main and feeder				
	circuit breakers are inspected annually, and a					
	program for period	dically exercising the				
	components is est	tablished according to				
	manufacturer requ	uirements. Written records				
	of maintenance ar	nd testing are maintained				
	and readily availal	ble. EES electrical panels				
	and circuits are marked, readily identifiable,					
	•	n normal power circuits.				
		ssibility of damage of the				
		source is a design				
	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 6 months of the most recent 12 month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once monthly, for a					
			17.0010	1,, 0,0	00/05/2022	
			K 0918	K 918	08/07/2023	
				It is the man-time of the first	114	
				It is the practice of this faci	lity	
				to conduct Generator Load		
				Testing in accordance with current regulation.		
				Current regulation.		
		•		The correction action taken	for	
	minimum of 30 minutes, using one of the following methods:			the resident found to be aff	-	
		untains the minimum exhaust		by the deficient practice		
	(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the			include:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/07/2023 155857 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205 TRANQUILITY NURSING AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE manufacturer (2) Under operating temperature conditions and at No resident was identified as not less than 30 percent of the EPS (Emergency being affected. Generator Load Power Supply) nameplate kW rating. Testing has been completed that Section 8.4.2.3 states diesel-powered EPS meets the stated requirements. installations that do not meet the requirements of The emergency stop has been 8.4.2 shall be exercised monthly with the available labeled. The Tels system has EPSS (Emergency Power Supply System) load and been updated to included times for shall be exercised annually with supplemental both processes. loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes Other residents that have the and at not less than 75 percent of the EPS potential to be affected have nameplate kW rating for 1 continuous hour for a been identified by: total test duration of not less than 1.5 continuous hours. This deficient practice could affect all All residents residing at the facility residents, staff and visitors. have the potential to be affected. Please see system changes Findings include: below to prevent reoccurrence. Based on review of Direct Supply TELS "Emergency Power Generators: Test generator The measures or systematic under load" documentation with the Maintenance changes that have been put into Director during record review from 10:05 a.m. to place to ensure that the 2:30 p.m. on 07/06/23, monthly load testing deficient practice does not recur documentation for the facility's diesel fuel fired include emergency generator for six months of the most recent twelve month period was incomplete. The The Maintenance Director and run time for the monthly load test was Assistant were in-serviced on documented as less than 30 minutes for monthly Generator Monthly Load Testing load testing conducted on 01/26/23, 02/28/23, and time requirements. Generator 03/30/23, 04/26/23, 05/31/23 and 06/30/23. Based Load Testing has been completed on interview at the time of record review, the that meets the stated Maintenance Director agreed monthly load testing requirements. The emergency documentation for the six month period of January stop has been labeled. The Tels 2023 through June 2023 indicated the run time was system has been updated to less than 30 minutes. included times for both processes. These findings were reviewed with the Executive The corrective action taken to Director and the Maintenance Director during the monitor performance to assure exit conference. compliance through the quality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/07/2023					
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			3640 N	STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE					
TAG	3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for six months of the most recent twelve month period. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.5(4) requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency Power Generators: Test generator under load" documentation with the Maintenance Director during record review from 10:05 a.m. to 2:30 p.m. on 07/06/23, the cool down time was documented as "4 minutes" for monthly load testing conducted on 01/26/23, 02/28/23, 03/30/23, 04/26/23, 05/31/23 and 06/30/23. Based on interview at the time of record review, the Maintenance Director agreed the cool down time for monthly load testing documentation for the facility's emergency generator was documented as less than 5 minutes. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility		TAG	assurance is: A Performance Improvement has been initiated that review Generator Load Testing processes. The Maintenance Director, or designee, will complete this tool monthly. A issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the scheduler meetings with recommendate as needed based on the out of the tools. The date the systemic chain	t Tool ws e Any ee will duled tions comes				
				will be completed: 8/7/23					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		A. BUILDING 01 B. WING		COMPLETED 07/07/2023				
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
	SUMMARY S (EACH DEFICIEN REGULATORY OR failed to ensure 1 of facility's emergency accordance with NF Facilities Code, 201 states emergency ge system, where required, shall be instal accordance with NF Emergency and Star 110, 2010 edition, 5 shall have a remote to prevent inadverte located outside the mover, where so inspremises where the the building. The reshall be labeled. The affect all residents, shall be labeled. The affect all residents, shall be labeled and to 11:40 a.m. on 07/manual stop which weatherproof sh generator located outside of the property Manufacturer's name the diesel fired emergement was manufactured J kW. Based on inter observations, the M the location of the rethe remote manual stop which we the remote manual stop which was manufactured or side of the property Manufacturer's name the diesel fired emergement of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the location of the remote manual stop which was manufactured by the remote manufactured by the remote manual stop which was manufactured by the remote manufactured by the rem	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION To remote manual stops for the generator was labeled in PA 99. NFPA 99, Health Care 2 Edition, Section 15.5.1.3 merators and standby power red for compliance with this led, tested, and maintained in PA 110, Standard for ndby Power Systems. NFPA .6.5.6 states all installations manual stop station of a type int or unintentional operation room housing the prime stalled, or elsewhere on the prime mover is located outside emote manual stop station its deficient practice could staff and visitors. ons with the Maintenance are of the facility from 9:20 a.m. 107/23, the facility's remote was affixed to the exterior of sell for the emergency intside the facility on the west			(X5) COMPLETION DATE			
	exit conference.	intenance Director during the						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
		155857	B. WING			07/07/2023	
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	PREFIX (EACH CORRECT CROSS-REFEREN		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				·· =	DATE
	3.1-19(b)						

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