STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING _____ B. WING _____	R-C 12/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the PSR completed on November 10, 2021 to the Recertification and State Licensure Survey completed on August 19, 2021. This visit was in conjunction with a PSR to the PSR completed on November 10, 2021 to the Investigation of Complaint IN00361924 completed on September 17, 2021. This visit was in conjunction with a PSR to the PSR completed on November 10, 2021 to the Investigation of Complaint IN00363933 completed on October 5, 2021. Complaint IN00361924 - Corrected. Complaint IN00363933 - Corrected. Survey date: December 9, 2021 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 24 Total: 24 Census Payor Type: Medicaid: 22 Other: 2 Total: 24 Tranquility Nursing and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the PSR to Recertification and State Licensure Survey.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING _____ B. WING _____	R-C 12/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed on December 14, 2021	{F 000}		