STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING **01** B. WING _____	R **10/28/2021**

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
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 09/07/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/28/21 Facility Number: 014265 Provider Number: 155857 AIM Number: 300029339 At this PSR survey to the Emergency Preparedness survey, Tranquility Nursing and Rehab was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 78 certified beds. At the time of the survey, the census was 27. Quality Review completed on 10/28/21	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Certification and State Licensure Survey conducted on 09/07/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/28/21 Facility Number: 014265 Provider Number: 155857 AIM Number: 300029339 At this PSR survey, Tranquility Nursing and	{K 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 **01** B. WING _____	R **10/28/2021**

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
{K 000}	Continued From page 1 Rehab was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor with smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 78 and had a census of 27 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage building. Quality Review completed on 10/28/21	{K 000}		