STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING _____ B. WING _____	R-C 07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	**8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00230239 completed on May 22, 2017. This visit was in conjunction with a PSR to the Investigation of Complaints IN00232194 and IN00232406 completed on June 14, 2017. Complaint IN00230239 - Corrected Complaint IN00232194 - Corrected Complaint IN00232406 - Corrected Survey date: July 17, 2017 Facility number: 000195 Provider number: 155298 AIMS: 100267690 Census bed type: SNF/NF: 32 Total: 32 Census payor type: Medicare: 1 Medicaid: 26 Other: 5 Total: 32 Pyramid Point Post-Acute 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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00230239. Quality review completed on July 18, 2017	{F 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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