STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
			A. BUILDING 01 COMPLETE B. WING 04/28/20				
133230			D. 111			04/20/	2017
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	CUTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG K 0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 01	. T.O. O. O O.		17.04	200	Dian of Correction for Dynamic	1	
	_	ode Recertification and	K 00)00	Plan of Correction for Pyramic Point Post Acute Rehabilitatio		
		Survey was conducted by			We respectfully request Paper		
		e Department of Health in			Compliance with submission of		
	accordance with	42 CFR 483.70(a).			this plan of correction for our most recent Life Safety		
	Survey Date: 04	4/28/17			recertification survey on 4/28/2017.		
	Facility Number	r: 000195			Craig Hestand, HFA		
	Provider Number				Executive Director		
	AIM Number:						
	At this Life Safe	ety Code survey, Pyramid					
		e Rehabilitation Center					
		n compliance with					
		or Participation in					
	•	eaid, 42 CFR Subpart					
		Safety from Fire and the					
	* / *	the National Fire					
		ciation (NFPA) 101, Life					
	,	SC), Chapter 19, Existing					
		cupancies and 410 IAC					
	16.2.						
	This three star	facility was determined					
		facility was determined					
	• •	(222) construction and					
		I. The facility has a fire					
		ith smoke detection in the					
		all areas open to the					
		icility has battery					
	-	detectors in all resident					
	sleeping rooms.	The facility has a					

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

TITLE

(X6) DATE

Any defiency statement 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.

000195

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/28/2017	
	PROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP 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
	capacity of 135 and had a census of 37 at the time of this visit.			
	All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.			
	Quality Review completed on 05/03/17 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on record review, observation and interview; the facility failed to ensure 1 of 9 means of egress was continuously maintained free of all obstructions or	K 0211	K 211 NFPA 101 Means of Egress-General Compliance Date 05/26/17	05/26/2017
	impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility using the stairwell exit by Room 320. Findings include:		Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Area (means of egress) fire exist was immediately cleared of wheel chairs with in the affected area. Identification of other residents having the potential to be affected.	t
			by the same alleged deficient practice and corrective actions	

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 2 of 10

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION O O O O O O O O O O O O	(X3) DATE SURVEY COMPLETED 04/28/2017			
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 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	Document" and Procedure" with Driver/Maintena record review from a.m. on 04/28/17 plan did not addit wheeled equipm similar emergency observations with Driver/Maintena tour of the facility 12:35 p.m. on 04 was noted: a. A wheeled we in the corridor of outside Room 32 b. A wheeled characteristic and the corridor outside c. A Hoyer lift, wheeled characteristic and the corridor outside corridor outside corridor by the same same same same same same same sam	the Van nce Assistant during om 9:30 a.m. to 11:30 If, the written fire safety ress the relocation of ent during a fire or ey. Based on the Van nce Assistant during a ty from 11:30 a.m. to 12/28/17, the following igh scale was unattended tuside Room 306 and 20. The air was unattended in the Room 320. The air was unattended in the Room 320. The air was unattended in the train and a wheeled fucted of PVC piping was stored at the end of the tairwell exit by Room wheel chair and a wheeled fucted of PVC piping was stored at the end of the tairwell exit by Room wheel chair and a wheeled fucted of PVC piping was stored at the end of the tairwell exit by Room wheel chair and a wheeled fucted of PVC piping was stored at the end of the tairwell exit by Room full obstructions or full instant use in the		taken: Director of Maintenance waudit exits (means of egress) with the facility to ensure exits are free and clear of any equipment that would affect the means of egress. Director of Maintenance will mark off the means of egress area to ensure no obstructions. Staff will be in-serviced by 5/19/2016. How the corrective measures will be monitored to ensure the allege deficient practice does not recur: The following audits will be conducted of Third floor exit areas to ensure the areas are free and clear of any obstructions by the Director of Maintenance or design 3 times per week times for 4 week then monthly times 3 months to ensure compliance. Disaster Manupdated to reflect relocation of wheel equipment. Findings will be reviewed/reported at our monthly QA meeting.	ee ee s, ual		

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 3 of 10

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (X3) DATE SURVI COMPLETED 04/28/2017				ETED	
	PROVIDER OR SUPPLIER D POINT POST-AC	UTE REHABILITATION CENTER		8530 TC	DDRESS, CIT DWNSHIP APOLIS, IN	LINE RD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH COI	IDER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0500 SS=C Bldg. 01	Section 18.5 and requirements that provided K-tags, b information, along Safety Code or NF should be included	- Other LKS section any LSC 19.5 Building Services are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.		500				05/04/0017
	the facility failed service equipment certificates to en safe operating consection 19.1.1.3. facilities to be demaintained and opossibility of a fit the evacuation of	review and interview, I to ensure 5 of 5 facility int had current inspection sure the units were in ondition. NFPA 101, 1 requires all health esigned constructed, operated to minimize the ire emergency requiring f occupants. This e affects all residents,	K 0.	500	Corrective at those resid affected by practice: 1.) Din followed up company for completed	Building Services - Date 05/26/2017 actions accomplished for ents found to be the alleged deficient rector of Maintenance powith insurance or inspection certs 5/15/2017, Certification is sent to state to process in records.	r	05/26/2017
	Driver/Maintena a.m. to 11:30 a.n. Certificate of Ins from the State of service equipment review. The equal the water tube	review with the Van nce Assistant from 9:30 n. on 04/28/17, current spection documentation Findiana for facility nt was not available for ipment is identified as: boilers identified as			be monitor deficient properties of the The following conducted Maintenant to certificate but Pyramical audits ever compliance inspection company we certification	rective measures will red to ensure the alleged rectice does not recur: ng audits will be by the Director of ce or designee relating tion of boilers is annual, d Point will conduct y 6 months to ensure in timely fashion. request for insurance will be made prior to n expirations. Findings ewed/reported at our A meeting.		

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 4 of 10

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/28/2017
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TO	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP 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
	IN252654 and IN Certificate of Insexpiration date of the chiller ider a Certificate of Insexpiration date of Based on intervior review, the Van Assistant stated of inspection performs company to proceed Inspections' documentation were view and acknowledge and acknowledge and certificate of Indianal documentation were view and acknowledge acknowledge and acknowledge and acknowledge and acknowledge and acknowledge and acknowledge and acknowledge acknowledge and acknowledge and acknowledge and acknowledge and acknowledge and acknowledge and acknowledge acknowledge acknowledge and acknowledge acknowledge and acknowledge acknowledge and acknowledge acknowledge acknowledge acknowledge acknowledge and acknowledge ac	ter heaters identified as N254996 each had a spection with an f 02/06/17. Intified as IN254997 had inspection with an f 02/06/17. Interest the time of record Driver/Maintenance each unit had a recent remed by their insurance turn new Certificate of amentation from the but inspection was not available for owledged the service equipment had			
K 0711 SS=C Bldg. 01	all patients and for event of an emerg Employees are pe kept informed with plan, and a copy of available with telep security. The plan response required	elocation Plan plan for the protection of their evacuation in the ency. riodically instructed and their duties under the of the plan is readily phone operator or with addresses the basic of staff per 18/19.7.2.1.2 Il of the fire safety plan			

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 5 of 10

	TE OF DEFICIENCIES		(3/2) 3.77	H TIDLE C	ONGTRUGTION		GHDVEY
				ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> B. WING			ETED (2047
						04/28	/201/
NAME OF I	PROVIDER OR SUPPLIE	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
					OWNSHIP LINE RD		
PYRAMID POINT POST-ACUTE REHABILITATION CENTER			INDIAN	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 APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		18.7.1.3, 18.7.2.1.2,					
	19.7.2.1.2, 19.7.2	, 19.7.1.1 through 19.7.1.3,					
		review, observation and	K 07	711	K 711 Evacuation and Relocation		05/26/2017
		cility failed to provide a	110		Plan		05/20/2017
	written plan that	•					
	_	of 1 written fire plans.			Compliance Date 05/26/17		
		quires a written health			Corrective actions accomplished for		
		fire safety plan that shall			those residents found to be affecte		
	provide for the f	J 1			by the alleged deficient practice:	u	
	(1) Use of alarm	•			1.) Area (means of egress) fire	!	
	` /	n of alarm to fire			exit was immediately cleared of		
	department	1 of diariii to fife			wheel chairs with in the affected		
	(3) Emergency p	phone call to fire			area. Disaster Manual updated		
		mone can to me			5/15/17 to reflect wheeled		
	department	alamaa			equipment relocation plan. Identification of other residents		
	(4) Response to				having the potential to be affected		
	(5) Isolation of f				by the same alleged deficient		
	` ′	of immediate area			practice and corrective actions		
	` ′	of smoke compartment			taken: Director of Maintenance wil	I	
	` ' -	of floors and building for			audit exits (means of egress) with in	1	
	evacuation				the facility to ensure exits are free		
	(9) Extinguishm				and clear of any equipment that		
	Section 19.2.3.4	(4) states any required			would affect the means of egress.		
	aisle or corridor	shall not be less than 48			Director of Maintenance will mark		
	inches in clear w	vidth where serving as			off the means of egress area to ensure no obstructions. Staff will		
	means of egress	from patient sleeping			be in-serviced by 5/19/2016.		
	_	ons into the required			How the corrective measures will b	e	
	1	ermitted for wheeled			monitored to ensure the alleged		
	_	ded the relocation of			deficient practice does not recur:		
		ent during a fire or			The following audits will be		
		cy is addressed in the			conducted of Third floor exit areas		
	_	ty plan and training			to ensure the areas are free and		
		facility. The wheeled			clear of any obstructions by the Director of Maintenance or designe	Α	
	equipment is lim				3 times per week times for 4 weeks		
	equipment is iiii	nica io.	ı		5 miles per week times for 4 weeks	,	1

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

then monthly times 3 months to

Page 6 of 10

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/28/2017	
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD NAPOLIS, 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
	ii. Medical emerguse iii. Patient lift an	use and carts in use gency equipment not in d transport equipment actice could affect all and visitors.		ensure compliance. 2.) Disaster Manual updated to reflect relocation of wheel equipment with staff education by 5/19/2017 Findings will be reviewed/reported at our monthly QA meeting.	
	Findings include: Based on review of "Disaster Planning				
	Document" and 'Procedure" with Driver/Maintena record review fro a.m. on 04/28/17 plan did not addr	'Fire Policy and the Van nee Assistant during om 9:30 a.m. to 11:30 f, the written fire safety ress the relocation of the ent during a fire or by. Based on			
	Driver/Maintena tour of the facilit 12:35 p.m. on 04 was noted: a. A wheeled we	nce Assistant during a sy from 11:30 a.m. to 128/17, the following sigh scale was unattended atside Room 306 and			
	corridor outside c. A Hoyer lift, v bed frame construnattended and s corridor by the st 320.	air was unattended in the			

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 7 of 10

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU			(X2) MULTIPLE CO A. BUILDING B. WING	nstruction 01	(X3) DATE SURVEY COMPLETED 04/28/2017
	PROVIDER OR SUPPLIER	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
K 0920	_				
SS=E Bldg. 01	Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a proper strips in assembled by quanthe conditions of 1 the patient care vianon-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or strips for non-PCR rooms (outside of non-patient care roother UL standard used with general cords are not used with general cords are not used wiring of a structure temporarily are recompletion of the prinstalled and meet 10.2.3.6 (NFPA 98 400-8 (NFPA 70), 12-5	lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE OLL 60601-1. Power EEE in the patient care vicinity) meet UL 1363. In coms, power strips meet is. All power strips are precautions. Extension if as a substitute for fixed ite. Extension cords used moved immediately upon curpose for which it was is the conditions of 10.2.4. (NFPA 99), 590.3(D) (NFPA 70), TIA	K 0920	K-920 Electrical	05/26/2017
		review, observation and cility failed to ensure 2	K 0920	K-920 Electrical Equipment - Power Cords and	05/26/2017

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet

Page 8 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED		
155298		B. WING 04/28/201			2017		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
DVDAMI		UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID		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 APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		ords including power			Extens		
	_	sed as a substitute for			Canadian as Data Of 126 147		
	fixed wiring. LS	SC 19.5.1 requires			Compliance Date 05/26/17		
	utilities to comp	ly with Section 9.1. LSC			Corrective actions accomplished fo	.	
	9.1.2 requires ele	ectrical wiring and			those residents found to be	'	
	equipment to con	mply with NFPA 70,			affected by the alleged deficient		
	1 * *	cal Code, 2011 Edition.			practice:		
		le 400.8 requires that,			1.) All Power Cords were		
	· · · · · · · · · · · · · · · · · · ·	ly permitted, flexible			immediately removed from service.		
	_				Audit conducted through out facility	,	
		shall not be used as a			on 5/15/17 to ensure no other		
		ed wiring of a structure.			power cords in use per		
	1	ractice could affect 13			regulation.		
	residents, staff a	nd visitors in the vicinity					
	of Room 303.				Identification of other residents		
					having the potential to be affected		
	Findings include	2.			by the same alleged deficient		
					practice and corrective actions taken: Director of Maintenance to		
	Based on observ	rations with the Van			in-service staff on power cord strip		
		ince Assistant during a			usage. Staff will be in-serviced by		
		ty from 11:30 a.m. to			05/19/2017.		
		4/28/17, the following			How the corrective measures will		
	_	4/28/17, the following			be monitored to ensure the alleged	ı	
	was noted:	1			deficient practice does not recur:		
		oven was plugged into a			The following audits will be		
		e Maintenance Office on			conducted of the facility to ensure		
		ne UL listing of the power	1		proper usage of power strips.		
	strip could not b	e determined.			Director of Maintenance or designe		
	b. a refrigerator	was plugged into a power			will audit 3 times per week times fo	r	
	strip in Room 30	3. The UL listing of the			4 weeks, then monthly times 3		
	_	d not be determined.			months to ensure compliance. Findings will be reviewed/reported		
	-	ew at the time of the			at our monthly QA meeting.		
	observations, the				acour monthly warmeeting.		
	1	knowledged a power strip					
	_	as a substitute for fixed					
	wiring at the afo	rementioned locations.					

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

Event ID:

RE3621

Facility ID: 000195

If continuation sheet Page 9 of 10

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPLETED	
		155298	B. WING		04/28/2017		
	PROVIDER OR SUPPLIE D POINT POST-AC	R CUTE REHABILITATION CENTER		8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN (PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RE3621 Facility ID: 000195 If continuation sheet Page 10 of 10