							M APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C 06/28/2021		
		155857	B. WING	B. WING				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
TRANQUILITY NURSING AND REHAB				3640 N CENTRAL AVENUE				
TRANQUELTT NORSING AND REHAD				INDIANAPOLIS, IN 46205				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHO		LD BE COMPLETION		
F 000	INITIAL COMMENTS		F	000				
	Paper compliance to the Investigation of Complaint N00350882 completed on May 6, 2021.							
	Review Date: June 28, 2021							
	Facility number: 014265 Provider number: 155857 AIM number: 300029339 Tranquility was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper compliance review to the Complaint Investigation.							
I ABORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RF		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.

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