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	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tranquility Nursing and Rehab	3640 N Central Avenue Indianapolis, IN 46205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40287 Based on observation, interview, and record review, the facility failed to provide a shower and/or complete bed baths twice weekly for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/17/24 at 11:05 a.m. The diagnoses included, but were not limited to, traumatic brain injury. A Quarterly Minimum Data Set (MDS) assessment, dated 8/9/24, indicated he was moderately cognitively impaired and required substantial assistance of staff with showers. He was usually able to make himself understood and was usually able to understand what was said. On 9/17/24 at 11:00 a.m., Resident D was observed in his room, lying in bed wearing a hospital gown. He indicated he did not have a shower or had his hair washed in a while. He had his hand on his head and indicated his hair was feeling crunchy and needed washed. On 9/18/24 at 9:40 a.m., the Nurse Consultant (NC) provided a Shower Day Skin Inspection form for Resident D, dated 9/10/24, which indicated he had refused a shower. During an interview on 9/18/24 at 9:40 a.m., the NC indicated there were no other Shower Day forms and no documentation in the electronic health record (EHR) that Resident D had been offered other showers during the month of September 2024. He should have received a shower or bed bath twice weekly. On 9/18/24 at 1:45 p.m., the NC provided the Bath, Shower/Tub procedure, last revised February 2018, which read .Purpose The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .Documentation 1. The date and time the shower/tub bath was performed .5. If the resident refused the shower/ tub bath, the reason[s] why and the intervention taken . This citation relates to Complaints IN00441039 and IN00441964. 3.1-38(a)(3)(B) (continued on next page)

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.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(b)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34850 Based on interview and record review, the facility failed to ensure medications were administered as ordered for 2 of 3 residents reviewed for medications, and a wound treatment was completed as ordered for 1 of 3 residents reviewed for wounds. (Resident C, Resident F, and Resident K) Findings include: 1a. The clinical record for Resident C was reviewed on 9/17/24 at 11:30 a.m. The diagnoses included, but were not limited to, traumatic brain injury (TBI). A care plan, dated 7/25/22, indicated The resident has potential/for impairment in skin integrity due to at this time the resident has no pressure areas [sic], but dx [diagnosis] of TBI and hemiplegia [paralysis of one side of the body] may effect his risk .Interventions .Follow facility protocols for treatment of injury . A physician order, dated 8/28/24, indicated the staff was to clean with wound cleaner, pat dry, apply calcium alginate, skin prep periwound [area of skin around the wound] and cover with bordered dressing every day shift. The September 2024 treatment administration record (TAR) indicated the following days the wound treatment was not completed: 9/3/24, 9/4/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, 9/13/24, 9/14/24 and 9/16/24. The clinical record did not include a developed plan of care with interventions for refusal of care and/or treatments. An interview was conducted with the Nurse Consultant on 9/18/24 at 1:45 p.m. She indicated she was unable to provide documentation the treatments had been completed as ordered. 1b. A physician order, dated 8/22/24, indicated Resident C received 54 units of Lantus (long acting insulin) twice a day. The September 2024 medication administration record (MAR) indicated the following days the resident did not receive the 54 units of Lantus: 9/1/24 - 8:00 p.m., - documented as sleeping, 9/2/24 - 8:00 p.m., - documented as sleeping, 9/3/24 - 8:00 p.m., - documented as sleeping, 9/4/24 - 8:00 p.m., - documented as sleeping, 9/5/24 - 8:00 p.m., - documented as sleeping, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/7/24 - 8:00 a.m., 9/8/24 - 8:00 a.m., 9/10/24 - 8:00 p.m., 9/12/24 - 8:00 p.m., - documented as sleeping, 9/13/24 - 8:00 p.m., 9/16/24 - 8:00 a.m., and 8:00 p.m. 2. The clinical record for Resident F was reviewed on 9/17/24 at 1:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 2/7/24, indicated the staff was to administer Novolog insulin (fast acting insulin) utilizing a sliding scale to Resident F twice a day. The sliding scale was the following: 151- 200 blood sugar reading = 2 units of insulin, 201 - 250 blood sugar reading = 4 units of insulin, 251 - 300 blood sugar reading = 6 units of insulin, 301 - 350 blood sugar reading = 8 units of insulin, and 351 - 400 blood sugar reading = 10 units of insulin. The September 2024 MAR indicated the following days and times the resident did not receive the sliding scale of Novolog insulin as ordered: 9/7/24 - 8:00 a.m., 9/8/24 - 8:00 a.m., 9/9/24 - 8:00 a.m., and 9/16/24 - 8:00 a.m. An interview was conducted with the Nurse Consultant on 9/18/24 at 1:45 p.m. She indicated she was unable to provide documentation the medications were administered as ordered for Resident C and Resident F. 40287 3. The clinical record for Resident K was reviewed on 9/17/24 at 1:30 p.m. The diagnoses included, but were not limited to, diabetes and diabetic foot ulcer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 6/7/22, indicated he was to receive Exenatide ER (injectable diabetic medication) one vial injected one time every seven days. A Quarterly Minimum Data Set (MDS) assessment, dated 7/1/24, indicated he had moderately impaired cognition, and received insulin daily. A physician's order, dated 8/30/24, indicated he was to receive Humalog (fast acting insulin) four units injected with meals three times daily for diabetes. On 9/17/24 2:30 p.m., the traumatic brain injury (TBI) unit medication refrigerator was observed with Qualified Medication Aide (QMA) 4. A box of Exenatide ER injection, with a date received 6/11/24, was present in the refrigerator. There were two doses present in the box. QMA 4 indicated she did not administer the medication; it was administered by the licensed nurses. On 9/18/24 at 9:40 a.m., the Nurse Consultant (NC) provided the current diabetic care plan which indicated Resident K had diabetes. The goal was for him to be free from any signs or symptoms of hypoglycemia (low blood sugar). The interventions included, but were not limited to, administer diabetes medication as ordered by the doctor and monitor and document for side effects and effectiveness. The September 2024 MAR did not include documentation that the Exenatide ER injection had been administered on 9/3/24 or 9/10/24. The September 2024 MAR did not include documentation that the Humalog had been administered on the following date(s) and time(s): - 9/3/24 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., - 9/7/24 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., - 9/8/24 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., - 9/9/24 at 12:00 p.m. and 5:00 p.m., - 9/10/24 at 12:00 p.m. and 5:00 p.m., and - 9/16/24 at 8:00 a.m., 12:00 p.m., and 5:00 p.m. During an interview on 9/18/24 at 9:40 a.m., the NC indicated that the Exenatide ER injection and the Humalog insulin injection should have been given as ordered by the physician and documented as administered on the medication administration record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Documentation of Medication Administration policy was provided by the Nurse Consultant on 9/18/24 at 12:15 p.m. It indicated, .Policy Statement. The facility shall maintain a medication administration record to document all medications administration .1. A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include, as a minimum: a. name and strength of drug; b. dosage; c. Method of administration (e.g., oral, injection (and site), etc.); d. Date and time of administration; e. Reason(s) why a medication was withheld, not administered, or refused (as applicable); f. Signature and title of the person administering the medication; and g. Resident response to medication, if applicable (e.g., PRN [as needed], pain medication, etc.) . This citation relates to Complaint IN00441039. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40287 Based on interview and record review, the facility failed to ensure urine outputs were documented for a resident with a urinary catheter for 1 of 3 residents reviewed for urinary catheter. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/17/24 at 11:00 a.m. The diagnoses included, but were not limited to, traumatic brain injury and neuromuscular dysfunction of the bladder. A physician's order, dated 11/6/23, indicated to empty catheter drainage bag and record output of urine every shift. A Quarterly Minimum Data Set (MDS) assessment, dated 8/9/24, indicated he was moderately cognitively impaired and required substantial assistance of staff with showers. He was usually able to make himself understood and was usually able to understand what was said. He had an indwelling urinary catheter. On 9/17/24 at 11:00 a.m., Resident D was observed in his room, lying in bed wearing a hospital gown. He indicated he had concerns about his catheter. He had gone to the hospital to have it changed and did not think the staff were caring for his catheter correctly. His urinary catheter bag was hanging from his bed and had a small amount of light-yellow urine present in the drainage bag. On 9/18/24 at 9:40 a.m., the Nurse Consultant (NC) provided the current care plan addressing Resident D's urinary catheter. The care plan indicated that he had a suprapubic (urinary catheter that enters the bladder through the lower abdomen) catheter due to neuromuscular dysfunction of the bladder. The goal was for him to remain free from catheter- related trauma. The interventions included, but were not limited to, monitor and document intake and output per the facility policy. The September 2024 treatment administration record (TAR) did not include documentation on how much urine had been emptied from the urinary catheter drainage bag on the following days and shifts: - 9/1/24 - night shift, - 9/2/24 - night shift, - 9/3/24 - day and night shift, - 9/4/24- day shift, - 9/6/24 - day shift, - 9/7/24 through 9/10/24- day and night shift, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/13/24 - day and night shift, - 9/14/24 - night shift, and - 9/16/24- day and night shift. During an interview on 9/18/24 at 9:35 a.m., the NC indicated that the urinary catheter drainage bags should be emptied each shift, and the output should be recorded on the TAR. This citation relates to Complaint IN00441039. 3.1-41(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40287 Based on interview and record review, the facility failed to accurately document the administration of a diabetic ulcer treatment and to accurately document the administration of gastric tube feedings for 1 of 3 residents reviewed for wound care and 1 of 3 residents reviewed for gastric tube feedings. (Resident E and K) Findings include: 1. The clinical record for Resident E was reviewed on 9/18/24 at 9:15 a.m. The diagnosis included, but were not limited to, dysphagia (difficulty swallowing). A physician's order, dated 6/26/24, indicated he was to receive Jevity 1.5 (type of supplemental nutrition) 500 milliliter (mL) by gastric tube four times daily. A care plan, last revised on 9/11/24, indicated he received no food by mouth and required tube feedings daily. The goal was for him to be free of aspiration (inhaled food substances). The interventions included, but were not limited to, administer tube feeding as ordered by the physician. A nutrition note, dated 9/17/24, indicated Resident E's weight had been stable for 90 days. No significant weight changes had been noted and the tube feeding was meeting his estimated caloric needs. The September 2024 medication administration record (MAR) did not contain documentation that the Jevity 1.5 had been administered on the following date(s) and time(s): - 9/2/24 at 10:00 p.m., - 9/3/24 at 4:00 a.m., - 9/8/24 at 10:00 a.m. and 5:00 p.m., - 9/9/24 at 10:00 a.m. and 5:00 p.m., - 9/10/24 at 5:00 p.m. and 10:00 p.m., - 9/11/24 at 4:00 a.m., - 9/16/24 at 10:00 p.m., and - 9/17/24 at 4:00 a.m. During an interview on 9/18/24 at 11:30 a.m., the Nurse Consultant (NC) indicated she believed Resident E's tube feeding was being administered as ordered because his weight was stable. The nursing staff were not documenting the feedings were being completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident K was reviewed on 9/17/24 at 1:30 p.m. The diagnoses included, but were not limited to, diabetes and diabetic foot ulcer. A physician's order, dated 8/8/24, indicated he was to receive Medi honey (type of wound medication) to his right heel, covered with a border island dressing, each day. The order was discontinued on 9/10/24. The September 2024 treatment administration record (TAR) did not contain documentation that the Medi honey had been applied to the right heel on the following days: 9/3/24, 9/4/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, and 9/10/24. During an interview on 9/18/24 at 11:30 a.m., the NC indicated she believed the wound treatment had been completed, because the wound had gotten better and was almost healed. The staff were not documenting they had completed the treatment. This citation relates to Complaint IN00441039. 3.1-50(a)(1) 3.1-50(a)(2)