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	10/10/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36942 Based on interview and record review, the facility failed to ensure a dependent resident did not experience a fall from bed during activities of daily living (ADLs) care for 1 of 3 residents reviewed for feeding tubes. (Resident R) Findings include: The clinical record for Resident R was reviewed on 10/10/24 at 1:30 p.m. The diagnoses included, but were not limited to, attention to gastrostomy (feeding tube), anoxic brain damage, contracture of muscle, and dependence on ventilator status. A Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated impairment on both sides of the upper and lower extremities and dependent on staff for personal hygiene and bed mobility. A communication care plan, dated 6/22/22, indicated Resident R was nonresponsive and had a communication problem. A care plan for ADLs, revised 10/7/24, indicated Resident R was dependent for staff for ADL care, a mechanical lift with two staff for transfers, and dependent with two staff for bed mobility. A care plan for fall risk, revised 10/8/24, indicated Resident R had a witnessed fall from the bed on 10/5/24. The interventions included, but were not limited to, two staff person assistance for all ADLs and follow facility fall protocol. An incident note, dated 10/5/24, indicated the following, .pt. [patient/resident] had a witnessed fall this morning while aide was administering care. aide stated she was cleaning pt. up when she began to roll over on the side of bed. pt. was witnessed lying on right side of her body on the floor when nurse came in to access pt. after assessment nurse did see minor bruising on R [right] side of face .aide educated on the importance of using another staff member while administering care as safety precaution (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Licensed Practical Nurse (LPN) 2, on 10/10/24 at 2:05 p.m., indicated a nurse and an aide usually conduct ADL care for Resident R together. The aide stated Resident R started sliding while performing perineal care. The aide had worked at the facility for a couple of months but did not usually work on the Ventilator Unit. LPN 2 was unsure why the aide didn't call me to come and assist with ADL care for Resident R. Resident R required two staff assistance with ADL care. An interview conducted with Family Member 2, on 10/10/24 at 1:55 p.m., indicated they come to visit Resident R daily. There were usually two staff members to conduct ADL care for Resident R but if they were short staffed they would only utilize one staff member for ADL care. An interview conducted with the Director of Nursing (DON), on 10/10/24 at 2:40 p.m., indicated she asked the aide why they didn't request help to care for Resident R and they commented on how they were unable to find any other staff to come and help. 3.1-45(a)(1) 3.1-45(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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 36942 Based on interview and record review, the facility failed to ensure gastrostomy tube (g-tube) feedings were administered per the physician orders upon discharge from the hospital for 1 of 3 residents reviewed for g-tubes. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/10/24 at 10:00 a.m. The diagnoses included, but were not limited to, cerebral infarction (stroke), diabetes mellitus, and dysphagia (difficulty swallowing). A Quarterly Minimum Data Set (MDS) assessment, dated 9/22/24, indicated Resident B had a feeding tube for greater than 51% of nutritional needs. A hospital discharge instruction document, dated 9/15/24, indicated nutritional orders for continuous tube feeding at 25 milliliters (mLs) per hour through feeding tube. Resident B's diet was nothing by mouth (NPO). A physician order, start date of 8/16/24 and discontinuation date of 9/18/24, indicated continuous tube feeding at 75 mLs per hour. The electronic medication administration record (EMAR), dated September 2024, indicated the tube feeding at 75 mLs per hour was signed off, as administered, from the evening of 9/15/24 through day shift on 9/18/24. A progress note, dated 9/18/24, indicated the following, .It appears that hospital made error about feeding rate - it was lowered to 25ml/h [milliliters/hour], as pt [patient] wasn't tolerating anything faster. Pt [patient] with projectile vomiting per family overnight. Pt with several episodes of vomiting after this. Feeding was held A physician order, dated 9/18/24, indicated continuous tube feeding at 25 mLs per hour. A policy titled Enteral Nutrition, revised January 2014, was provided by the Administrator on 10/10/24 at 3:05 p.m. The policy indicated the following, .4. Enteral nutrition will be ordered by the Physician based on the recommendations of the Dietitian .Preventing errors in administration .1. Check the enteral nutrition label against the order before administration. Check the following information .b. Type of formula .f. Method (pump, gravity, syringe) .g. Rate of administration (mL/hour) This citation relates to Complaint IN00444010. 3.1-44(a)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40287 Based on interview and record review, the facility failed to ensure a resident was free of a significant medication error by not administering an anti-anxiety medication as ordered by the physician for 1 of 4 residents reviewed for pharmacy services (Resident 8). Findings include: The clinical record for Resident 8 was reviewed on 10/10/24 at 11:11 a.m. The diagnoses included, but were not limited to, traumatic brain injury and generalized anxiety disorder. A physician's order, dated 6/26/24, indicated Resident 8 was to receive lorazepam (anti-anxiety medication) 0.5 milligram (mg) one tablet daily, at 8:00 a.m., for generalized anxiety disorder. The clinical record for Resident 8 did not contain a physician's order for Resident 8 to receive as needed (PRN) lorazepam 0.5 mg. Order administration notes, dated 10/4/24, 10/7/24, 10/8/24, and 10/9/24 indicated the lorazepam 0.5 mg was on order. The lorazepam 0.5 mg Controlled Drug Record indicated 30 tablets was delivered from the pharmacy on 9/11/24. Resident 8 had received a lorazepam 0.5 mg, at 8:00 p.m., on the following days: 9/12/24, 9/18/24, 9/24/24, 9/25/24, 9/26/24, 9/29/24, and 10/2/24. During an interview on 10/10/24 at 2:42 p.m., the Director of Nursing (DON) indicated Resident 8 had ran out of lorazepam before it was time for it to be reordered. Upon investigation it was discovered that a Qualified Medication Aide (QMA) had been administering the lorazepam in the evenings as a PRN medication. The QMA was unaware that he did not have a PRN order for lorazepam. On 10/10/24 at 5:08 p.m., the Facility Owner provided the Incident Note, dated 10/1/24 at 10:50 a.m., which read .QMA gave narcotic without MD [sic] order in place. Resident does have order for medication in questions [sic] however not at time administered. MD [sic] notified, No new orders given. Resident assessment completed by RN [sic]. Resident at baseline, No adverse reactions noted at this time . 3.1-48(c)(2)