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	12/26/2024

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 36942 Based on interview and record review, the facility failed to ensure residents had access to personal funds for 2 of 2 residents reviewed for personal funds. (Resident K and Resident L) Findings include: An interview was conducted with the Business Office Manager (BOM) on 12/20/24 at 12:48 p.m. She indicated she started employment at the facility in October of 2024. Resident K and Resident L have been asking for money for the past week. The BOM notified the Former Administrator last week about the BOM's inability to cash checks from the resident's RFMS (Resident Fund Management Service) account. When the checks are printed, they have Former Administrator 2's name on the checks. He would be the only person who could cash the checks for the residents. The BOM informed the Director of Operations (DOO) on how the name on the RFMS account needed to be changed to the BOM's name. The DOO instructed the BOM to withdraw resident funds from the petty cash account. The BOM was conducting such but can no longer do so since the petty cash account was down to $12.00. A balance sheet for the residents' RFMS accounts was provided by the BOM on 12/20/24 at 1:30 p.m. The balance sheet indicated Resident K and Resident L had funds available in their RFMS account for use. An interview conducted with the Director of Operations (DOO), on 12/21/24 at 1:00 p.m., indicated he does not have access to the RFMS accounts. The BOM did not have the ability to print off checks so we cannot cash them. The DOO told the BOM to contact RFMS to ensure she was the person on the account to allow the ability to print and cash the residents' checks. The DOO indicated the facility was then waiting for RFMS to allow the BOM the access to print the checks. A document titled RESIDENT TRUST PETTY CASH was provided by the BOM on 12/26/24 at 3:40 p.m. The document indicated, on 11/1/24, there was $360.00 in the petty cash fund/account. After the withdrawals, from 11/1/24 through 12/9/24, there was only $12.00 remaining in the petty cash fund. The last withdrawal was, on 12/9/24, for Resident K. A document titled Resident Fund Management Service, undated, was provided by the DOO on 12/21/24 at 12:00 p.m. The document indicated when a resident withdraws money from their account, they are to acknowledge receipt of those funds by a signature. 3.1-6(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-6(c) 3.1-6(d) 3.1-6(e) 3.1-6(f)(1)

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

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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 0635

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide doctor's orders for the resident's immediate care at the time the resident was admitted.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36942

Based on interview and record review, the facility failed to ensure medication orders were inputted into the electronic health record (EHR) for administration for 1 of 5 residents reviewed for ventilator status (Resident B).

Findings include:

The clinical record for Resident B was reviewed on 12/18/24 at 3:50 p.m. The diagnoses included, but were not limited to, respiratory failure with tracheostomy, hypotension, and anemia. Resident B was admitted to the facility on [DATE].

A hospital discharge report, dated 12/12/24, included, but were not limited to, the following physician orders:

acetaminophen (Tylenol) 650 milligrams (mg) every six hours as needed,

ascorbic acid (vitamin C) 500 mg twice daily,

guaifenesin (medication for cough and congestion) 400 mg oral tablet three times daily,

hydroxyzine hydrochloride (antianxiety and antihistamine type medication) 25 mg every six hours as needed,

melatonin 3 mg at bedtime,

midodrine (medication for low blood pressure) 10 mg every eight hours,

oxycodone 5 mg every eight hours as needed, and

trazodone (antidepressant) 50 mg at bedtime.

The EHR did not contain orders inputted for all medications listed on the hospital discharge report for Resident B.

A progress note, dated 12/12/24, indicated Resident B admitted to the facility on [DATE] at 4:10 p.m.

An interview conducted with the DON, on 12/18/24 at 4:20 p.m., indicated Registered Nurse (RN) 3 was on shift on 12/12/24. RN 3 had a history of not inputting physician orders into the EHR for new admissions to the facility. The DON reviewed Resident B's clinical record and noted the electronic medication administration record (EMAR) consisting of two physician orders inputted onto the EHR and reflected on the EMAR. The two medications were oxycodone and acetaminophen.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Admissions, revised 11/28/16, was provided by the Administrator on 12/19/24 at 12:00 p.m. The policy indicated the following, .3. The objectives of our admission policies are to . b. Admit Residents who can be adequately cared for by the facility . e. Assure that appropriate medical and financial records are provided to the facility prior to or upon the Resident's admission A policy titled Liberalized Medication Pass, dated 11/28/17, was provided by the Nurse Consultant (NC) on 12/21/24 at 1:38 p.m. The policy indicated the following, .Policy . Medications which are ordered at a specific time by the physician will continue to be given as such. All others will be given as ordered per the Resident's desired schedule A policy titled Preparation and General Guidelines, undated, was provided by the NC on 12/21/24 at 1:38 p. m. The policy indicated the following, .B. Administration . 2) Medications are administered in accordance with written orders of the attending physician This citation relates to Complaint IN00449480. 3.1-30(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 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 observation, interview and record review, the facility failed to ensure 1 of 3 residents with gastric tube feedings received their feedings as ordered by the physician. Findings include: The clinical record of Resident E was reviewed on 12-20-24 at 12:48 p.m. Her diagnoses included, but were not limited to ventilator dependency, nontraumatic intracranial hemorrhage (brain bleed), cerebrovascular accident (stroke) and unspecified severe protein-calorie malnutrition. Her most recent Minimum Data Set (MDS) assessment, dated 10-25-24, indicated she is severely cognitively impaired and receives more than 500 milliliters (ml) of liquid nutrition via a feeding tube daily. A review of Resident E's weights indicated her weight has been stable during the two months she has been at the facility. A review of her physician orders indicated, effective 10-24-24, she was to receive Jevity 1.2 (liquid nutrition) at 65 ml per hour continuously. In an interview with Licensed Practical Nurse (LPN) 17 on 12-23-24 at 12:24 p.m., she indicated it was her first time caring for residents at this facility and she was unfamiliar with the residents, thus requiring her to verify their orders in the electronic health record (EHR) system. She indicated at this time; she was unable to access the EHR to verify the information for Resident E. In a second interview with LPN 17, on 12-23-24 at 1:17 p.m., she indicated she currently had EHR access and Resident E was ordered to receive Jevity 1.2 at 65 ml per hour. Observations of Resident E's feeding pump (device to monitor the infusion of the feeding) on 12-18-24 at 5:26 p.m., on 12-19-24 at 10:55 a.m., and 2:55 p.m., on 12-20-24 at 3:05 p.m., and on 12-23-24 at 12:20 p.m. , 1:17 p.m., and 2:50 p.m., indicated the Jevity 1.2 solution was infusing at a rate of 60 ml per hour. In an observation at 12-26-24 at 1:40 p.m., the infusion rate of the Jevity 1.2 continued at 60 ml per hour. On 12-18-24 at 10:43 a.m., the Nurse Consultant provided a copy of a policy entitled, Enteral Feedings-Safety Precautions. This policy had a revision date of November 2018. This policy indicated its purpose as, To ensure safe administration of enteral nutrition .Preventing errors in administration. Check the enteral nutrition label against the [physician's] order before administration. Check the following information . Rate of administration (ml/hour) [milliliters per hour]. On 12-18-24 at 10:43 a.m., the Nurse Consultant provided a copy of a procedure entitled, Enteral Tube Feeding via Continuous Pump. This procedure had a revision date of November 2018. Its indicated purpose is to provide a guideline for the use of a pump for enteral feedings. It indicated, Verify that there is a physician's order for this procedure .Check the enteral nutrition label against the order before administration. Check the following information .Rate of administration (ml/hour) [milliliters per hour]. This citation relates to Complaint IN00449362. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-44(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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on observation, interview, and record review, the facility failed to ensure adequate and competent staff were on duty to provide respiratory care and services for a resident admitted to the facility with a tracheostomy (surgical hole in the windpipe that helps with breathing) and was dependent on mechanical ventilation in accordance with physician orders. This resulted in a resident (Resident B) experiencing respiratory distress and subsequent death and a resident (Resident C) experiencing respiratory distress resulting in hospitalization for 2 of 5 residents reviewed for ventilator status. The facility also failed to ensure necessary respiratory and ventilator care supplies were available to provide quality of care to the residents on the ventilator unit. This had the potential to affect 11 of 11 residents who resided on the ventilator (Vent) unit. The Immediate Jeopardy began, on [DATE], when Resident B, with a tracheostomy and ventilator status, was in respiratory distress and the facility failed to ensure respiratory care and services were provided in accordance with physician orders that were listed on the hospital discharge paperwork that included, but were not limited to, provide scheduled nebulizer treatments, oxygen therapy, suctioning, tracheostomy care, and ventilator care and maintenance, and have competent nursing staff with knowledge regarding the utilization of a ventilator. This resulted in Resident B experiencing respiratory distress and subsequent death. The Director of Operations (DOO) and Administrator were notified of the Immediate Jeopardy on [DATE] at 4:29 p.m. The Immediate Jeopardy was not removed by the exit date of the survey. Findings include: 1. The clinical record for Resident B was reviewed on [DATE] at 3:50 p.m. The diagnoses from the hospital included, but were not limited to, respiratory failure with tracheostomy, hypotension, dependent on mechanical ventilation, pneumonia, history of stroke, hypothyroidism, and anxiety. Resident B was admitted to the facility on [DATE]. A hospital progress note, dated [DATE], indicated Resident B was on continuous mandatory ventilation (mode of mechanical ventilation in which the ventilator takes full control of the patient's breathing by delivering a present tidal volume at a specific, time-triggered frequency). The ventilator was set to administer 16 breaths per minute, a tidal volume (amount of air measured in milliliters that moves in or out of the lungs during every respiratory cycle) of 400 milliliters, ventilator PEEP (positive end-expiratory pressure) (setting that maintains a certain amount of pressure in the lungs at the end of expiration to improve oxygenation and gas exchange), an oxygen concentration of 30% (room air oxygen concentration is 21%), and ventilator I-time (the time of the inhalation phase of a breath; normal I-time is 0XXX,d+[DATE].2 seconds) of 0.75. A hospital discharge report, dated [DATE], indicated physician orders for albuterol (bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) inhalation solution every four hours and budesonide (steroid medication that helps prevent inflammation in the lungs) inhalation suspension twice a day. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility electronic health record (EHR) for Resident B was reviewed and included review of the face sheet, physician orders, electronic medication administration record, electronic treatment administration record, electronic ventilator flowsheet, progress notes, and care plans, dated from [DATE] to [DATE], and did not contain orders inputted for nebulizer treatments, oxygen therapy, tracheostomy care and suctioning, and/or ventilator care and maintenance. The EHR, under care plans, did not contain a plan of care for Resident B's utilization of a ventilator, tracheostomy care, oxygen therapy, and/or nebulizer treatments. A late entry progress note, dated [DATE] at 1:07 p.m., indicated Resident B admitted to the facility on [DATE] at 4:10 p.m. The next consecutive progress note, documented as a late entry, dated [DATE] at 1:08 p.m., indicated Resident B complained of pain to their coccyx and was administered oxycodone five milligrams (mg) through her gastrostomy (g-tube) (feeding tube) at 8:30 p.m. There was no further documentation regarding the pain Resident B was experiencing to their coccyx nor follow up to indicate if the medication was successful at relieving Resident B's pain. The next consecutive progress note, dated [DATE] at 5:20 p.m., indicated the following, .RESPIRATORY PROGRESS NOTE .at approximately 1720 [5:20 p.m.], This RT [respiratory therapist] came in to assess new admission resident. resident is awake, alert, and oriented .resident was received on these ordered settings: vt [tidal volume] 460 .R 14 [respirations of 14 breaths per minute] .FIO2 [fraction of inspired oxygen; concentration of oxygen] to KS [keep oxygen saturation] >90% [greater than 90%]. spo2 [oxygen saturation] . 86% with room air via ventilator. this RT increased FIO2 to 3 L [three liters] (32% FIO2) to KS >90% [keep oxygen saturation greater than 90%], at this time, spo2 [oxygen saturation] increased to 95%. ventilator round completed, patient assessment done, trach [tracheostomy] care done, BS: [breath sounds] course [sic; coarse] [harsh, low-pitched sounds that have a rough tone] upper Left Lobe and clear/diminished througout [sic]. suction set up and sx'd [suctioned] small pale secretions A progress note, dated [DATE] at 12:32 p.m., indicated the following, .Resident arrived via ambulance with 2 [two] attendants, daughter and grandson .Vent [ventilator] connected. Respiratory Therapy present .MD [medical director] notified of admission @ [at] approx. [approximately] 5:30 p.m. Ok to continue current orders per MD This was documented as a late entry from [DATE]. A wound observation tool, dated [DATE] at 6:05 p.m., indicated Awaiting MD [medical director] orders under the category of special equipment/preventative measures. Resident B had a stage III pressure ulcer (full-thickness skin loss) to her coccyx along with measurements and description of the wound. A nursing progress note, dated [DATE] at 10:42 a.m., indicated Resident B was alert and oriented. Their breathing was even and slightly labored (difficulty or impaired breathing). The oxygen saturation was 96%. There was no indication of a further assessment regarding Resident B's respiratory status. A nursing progress note, dated [DATE] at 10:53 a.m., indicated the following, .pt [patient] suctioned and air way [sic] made clear through out [sic] the night. @ [at] 4:04 am [sic] pt was observed in comatose state. after further assessment pts [patient's] respirations have ceased (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 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

A nursing progress note, dated [DATE] at 10:50 a.m., indicated the following, .Resident observed unresponsive. writer assessed pt [patient] and pt still not responding after attempts to wake pt. 911 called and medics arrived to attempt to stabalize [sic] pt. medics declared that pts [patient's] RHC'd [respirations have ceased]

An interview conducted with the Director of Nursing (DON), on [DATE] at 2:50 p.m., indicated she was off duty on [DATE]. When she returned to work, on [DATE], she was made aware of the facility not having the services of a Respiratory Therapist (RT) on night shift from, [DATE] at 7:00 p.m., through [DATE] at 7:00 a. m.

An interview conducted with the DON, on [DATE] at 4:20 p.m., indicated Registered Nurse (RN) 3 was on shift from 7:00 a.m. to 7:00 p.m. on [DATE]. RN 3 had a history of not inputting physician orders into the EHR for new admissions to the facility.

An interview conducted with Licensed Practical Nurse (LPN) 4, on [DATE] at 3:03 p.m., indicated she worked, on [DATE], in the evening until the morning on [DATE]. There was no RT in the facility for the 12-hour shift, starting on [DATE] at 7:00 p.m., through [DATE] at 7:00 a.m. So, LPN 4 was responsible for conducting respiratory care for the residents on the Ventilator (Vent) unit. LPN 4 would conduct rounds of the residents with a tracheostomy in need of suctioning. LPN 4 went into some rooms more often based on the frequency of visits RT would make. Resident B had no changes to her condition and appeared stable. Vital signs were obtained for Resident B and were good. Resident B's blood pressure was a little low but for the most part she was stable. Resident B's ventilator kept going off during the shift and it went off several times. On one occasion, the alarms sounded, and it appeared Resident B fumbled with their call light, and it came out of the wall, causing the alarm to sound. The call light was connected and the alarm cleared. The last time the vent alarm sounded LPN 4 knew it was a problem. The vent alarm would not stop sounding. LPN 4 checked Resident B and noticed she wasn't breathing, and the ventilator was breathing for her. LPN 4 proceeded to suction Resident B with no improvement. LPN 4 called [DATE] and called for other facility staff for assistance. LPN 4 was getting ready to conduct CPR (cardiopulmonary resuscitation) but upon review of Resident B's hospital paperwork, it mentioned no CPR. LPN 4 indicated she worked at the facility about two years prior and then returned to work at the facility in March of 2024. LPN 4 was familiar with the respiratory part with suctioning, but Resident B was a new resident the facility staff were not familiar with. LPN 4 stated she was shown a little bit about respiratory, related to tracheostomy care and suctioning, but mainly RT was responsible for the portion of the residents' care pertaining to the care/maintenance of the mechanical ventilators. The nursing staff receive basic training over ventilators but all the technical parts of the ventilators, RT was responsible for. There was always an RT in the facility. The RT would conduct tracheostomy care, suctioning, oxygen therapy, and maintain the ventilators. The ventilator alarms and ventilator settings were more in the purview of RT. The RT scheduled for the night of [DATE], RT 6, was not present and LPN 4 attempted to contact RT 6 the evening, on [DATE], but they did not respond. LPN 4 wanted the opinion of RT 6 for the management of the ventilator.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview conducted with the DOO, on [DATE] at 2:04 p.m., indicated he received a call from the facility staff, on [DATE] around 7:00 p.m., about not having an RT in the facility. The DOO contacted Contracted Agency Provider 1 with the indication the agency would attempt to find coverage for an RT. The DOO didn't receive a call back from Contracted Agency Provider 1 nor did the DOO contact the agency to follow up with the availability of an RT to cover on [DATE] 7:00 p.m. to [DATE] 7:00 a.m. The DOO was unable to provide information pertaining to the attempts made contacting Contracted Agency Provider 1. A document titled TEMPORARY STAFFING AGREEMENT indicated Contracted Agency Provider 1 was initiated with an effective date of [DATE]. The contract indicated the following, .Services shall be provided at the request of the facility and under the direction of the Facility departmental supervisor An interview conducted with RN 3, on [DATE] at 11:44 a.m., indicated she had worked at the facility since February of 2024. She was the nurse that admitted Resident B to the facility. Resident B appeared fine but was a little slow to respond. She admitted to the facility on a ventilator and transferred to the facility ventilator machine. RN 3 indicated she put all her attention to Resident B when she admitted . RN 3 conducted a skin assessment of Resident B and anticipated the needs of the resident with doing an overall assessment. The Respiratory Therapy Staff inputted physician orders pertaining to respiratory and the nursing staff would input physician orders pertaining to medications and/or treatments. If one shift couldn't input all the physician orders, there would be communication with the next shift to ensure the inputting of physician orders were completed. RN 3 indicated she had returned the following day to finish inputting physician orders for newly admitted residents in the past. When RN 3 was hired by the facility, orientation was conducted that consisted of a checklist. The checklist was pertaining to the job and the RT showed her how to conduct the process of suctioning. The facility nurses do not conduct tracheostomy care, suctioning, and ventilator maintenance. That was conducted by the RT department. An interview conducted with Certified Nurse Aide (CNA) 5, on [DATE] at 3:00 p.m., indicated she worked day shift, on [DATE], when Resident B was admitted to the facility. Resident B appeared alert and able to answer questions, but she was slower to respond. Resident B was pleasant and didn't appear to be in distress from when she admitted until CNA 5 left the facility at the end of her shift on [DATE] around 7:00 p.m. There was no RT that showed up to work on the shift starting at [DATE] from 7:00 p.m. to [DATE] at 7:00 a.m. An interview conducted with the Former Administrator, on [DATE] at 12:27 p.m., indicated she was the acting Administrator on [DATE]. The DOO was responsible for the RT schedules. The Former Administrator indicated there was a RT on site when she left the faciity on [DATE] at approximately 5:00 p.m. If RT staff were to call in, they would contact the DOO. The Former Administrator worked at the facility for 60 days and the whole time she worked there was no active RT Manager. The nursing staff were trained in suctioning and if there were an emergency, the nursing staff were trained to call [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview conducted with RT 9, on [DATE] at 1:30 p.m., indicated she was working day shift (7:00 a.m. to 7:00 p.m.) for [DATE]. This was her first day working at the facility as a RT. She indicated Vent rounds were conducted every four hours for all residents on a ventilator. If there was a new admission to the facility on a ventilator, the RT Manager would be the one to input orders for the ventilator, tracheostomy care, suctioning, oxygen, etc. She had conducted training with the facility staff regarding suctioning and tracheostomy care. She noticed, on [DATE], a nursing staff member was attempting to suction a resident who had a tracheostomy and was capped but not on a ventilator at that time. The nursing staff was attempting to suction the resident with a [NAME] (closed suction catheter system to suction residents on mechanical ventilation) for a resident with a tracheostomy who was not on a ventilator. So, RT 9 educated the nursing staff on utilizing a suction catheter to suction a resident with a tracheostomy who was not on a ventilator. An interview conducted with Former RT 8, on [DATE] at 3:09 p.m., indicated Vent rounds were conducted every four hours and as needed. As a standard of practice for RT, you would make a note in the Vent round log for documentation and look at the ventilator settings. The standard of the facility was to have an RT 24 hours a day and seven days a week. The goal was to have an RT Manager who would be responsible for the RT schedule along with being a safety net for when there was a call off of a RT. When Former RT 8 worked at the facility, there was never agency staff utilized for the RT department. There was a discussion about checking off the nursing staff for tracheostomy care and suctioning, but the demand was not high enough with the census of the Vent unit being low. RTs would be responsible for any care pertaining to tracheostomy care and ventilator status. The census of the facility reflected the need for 24 hours a day, seven days a week RT coverage. An interview conducted with RT 10, on [DATE] at 11:45 a.m., indicated she started as an RT of the facility on [DATE]. She was instructed to come to the facility, on [DATE] at 9:00 a.m., for orientation. RT 10 arrived at the facility, on [DATE] at 9:00 a.m., and there was no other RT in the facility. RT 10 was not sure how long the facility went without an RT prior to RT 10 entering the facility. RT 10 didn't have access to the electronic health records (EHR). RT 10 left the facility, on [DATE] around 3:00 p.m., since she was instructed to only be there for orientation for those date(s) and time(s). RT 10 received a call from the facility about a new admission on a Vent. So, RT 10 returned to the facility to conduct an initial RT assessment on [DATE] around 5:30 p.m. After the assessment, RT 10 left the facility and returned on [DATE] at 9:00 a.m. There was no other RT in the facility on [DATE] at 9:00 a.m. RT 10 still didn't have access to the EHR on [DATE]. RT 10 commented on how the other RTs seem to be defending [sic] for themselves. RT 10 had handwritten notes from her Vent rounds that included vital signs, treatments provided, ventilator settings, and assessment findings. RT 10 was in the process of inputting such documentation since RT 10 did not have access to document in the electronic health record, on [DATE] and [DATE]. Upon reviewing the RT schedule and staff interviews, it was determined there was no RT in the facility on the following occasions: [DATE] from 7:00 a.m. until 9:00 a.m., [DATE] from 3:00 p.m. until 5:20 p.m., [DATE] from 7:00 p.m. until [DATE] at 9:00 a.m., and [DATE] from 3:00 p.m. until 7:00 p.m. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There were 10 out of 11 residents on the Vent unit that were dependent on the utilization of a ventilator. An interview conducted with Family Member 20, on [DATE] at 3:05 p.m., indicated her mother, Resident B, was admitted to the facility on [DATE] on a Vent. There was no RT on site during the evening, on [DATE], through the night and early morning of [DATE]. LPN 4 was the only nurse there and no RT was present. There was no wall suction. She was not a fan of that. The facility utilized the old, primitive suction machines. There were no monitors or a code blue button. If Family Member 20 knew there was no RT on site, she would have contacted [DATE] and have her mother sent out to the hospital. Resident B was supposed to be admitted to the facility, on Wednesday [DATE], but didn't admit on that day due to the facility not having adequate staff. Family Member 20 spoke with the DON and the DON apologized and indicated there was no staff. The DON had been working on the floor most of the time due to not having staff. 2. The clinical record for Resident C was reviewed on [DATE] at 5:15 p.m. The diagnoses included, but were not limited to, chronic respiratory failure, neurofibromatosis (genetic disease caused by mutations in genes that lead to increased risk of developing tumors), and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident C was cognitively intact, utilized oxygen, was provided suctioning, tracheostomy care, and utilized a ventilator. A care plan for the utilization of a ventilator, revised [DATE], included, but were not limited to, the following interventions, suction as needed and routine trach change by resident to be monitored by respiratory. An interview conducted with Resident C, on [DATE] at 5:20 p.m., indicated last Thursday, [DATE], she had a mucus plug (buildup of mucus in the airways) and there was no RT. The nurse working that evening would not change the tracheostomy tube by commenting on how they were not allowed to. Resident C's mother lived six minutes away. So, Resident C contacted their mother, and the mother came to the facility to change Resident C's tracheostomy tube. Resident C indicated she then had an asthma attack and ended up being admitted to the hospital and stayed there for five days. The hospital administered steroids and albuterol nebulizer treatments every four hours. The incident happened on [DATE], around 8:00 p.m. A progress note, dated [DATE] at 9:42 p.m., indicated the following, .Resident transferred to [name of hospital] @ [at] approx. [approximately] 8:24 p.m. for respiratory distress, trach replacement. Resident taken to hospital per ambulance A hospital document, dated [DATE], indicated the following, .was well until yesterday when patient's mother who is a pediatrician .went to visit her and found that she was in respiratory distress. As usual it was felt to be due to mucous plug; therefore patient tracheostomy was appropriately suctioned and she began to feel better .She was brought to the ED [emergency department] on account of respiratory distress and was found to be wheezing and hypoxic, requiring several doses of albuterol .Patient herself is also able to communicate quite well and did state that since receiving the treatments she is about 95% better (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview conducted with RN 3, on [DATE] at 11:44 a.m., indicated Resident C was having difficulty breathing. Resident C had contacted her mother, who came into change out Resident C's tracheostomy tube. RN 3 later sent Resident C out to the hospital. An interview conducted with the Medical Director (MD), on [DATE] at 3:42 p.m., indicated he had been the MD for approximately two years. The expectations included the facility to have 24 hours a day, seven days a week RT coverage. A policy titled ADMISSIONS, dated [DATE], was provided by the Administrator on [DATE] at 12:00 p.m. The policy indicated the objective to admit residents who can be adequately cared for by the facility. The admission checklist indicated to input a progress note in the electronic health record, input admission set orders in the computer, input medication orders in the computer with correct diagnosis, and complete admission assessment before the end of shift. A document titled Adult Respiratory Therapy Protocols, undated, was provided by the DOO on [DATE] at 3:10 p.m. The document indicated the following, .Policy .A. Respiratory Therapy will be administered by protocol when physician ordered as . 1. Evaluate and treat . 2. RT protocol . 3. Physician has a standing order for Respiratory Therapy protocols . F . 2. Medications/Modalities will be administered based on the patient's acuity and/or by physician's order . Modalities/Interactions . A. Modalities included in the respiratory therapy protocol are . Bronchial Hygiene Therapy - nasotracheal, endotracheal, or tracheal suctioning. Aerosol therapy, deep breath/cough, incentive spirometry . Oxygen Therapy/Sp02 monitoring . B. Medications/Oxygen . Medication - Indications and suggested dosages/frequencies per home use, or physicians order . C. Physician Interactions . Respiratory Therapy will inform the ordering and/or primary physician of: adverse response .significant increase in Oxygen requirements . Worsening of ventilator status . F. Modalities started per Respiratory Therapy Protocol shall be written as physician orders. Order should include modality, medication (if pertinent), and frequency. Orders shall be signed, dated, timed, and include Per Respiratory Therapy Protocol/Physician name/Respiratory Therapist . G. Documentation/Communication . When a patient is transferred to this facility Respiratory Therapy orders need to be re-written per Respiratory Therapy Protocol, or physicians order. Respiratory Therapy must check the EMAR to see if medications have been re-ordered from transfer hospital, or prior stay at this facility . Initial evaluation will be done upon arrival .and will consist of the following . 1. Respiratory Therapy Protocol/Physicians orders/Standing orders . 2. Clinical assessment done on admission . 3. RT indicated and/or Physician ordered . 5. Continue with ordered Respiratory Therapy care plan . 6. Re-evaluate per policy A document titled Tracheal bronchial suctioning, undated, was provided by the DOO on [DATE] at 3:10 p.m. The document indicated tracheal bronchial suctioning was an effective way to maintain a clear airway and to aid in the removal of secretions for patients who are unable to clear their secretions when coughing. The procedure was to review physician's order on the chart for completeness and should include the frequency and signature of the physician. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. An interview conducted with RT 10, on [DATE] at 1:50 p.m., indicated there was only one HME (heat and moisture exchange filter) available for resident use currently. There were no backup supplies for the HME. Some of the RTs have substituted a bacterial filter, for the HME but that was not ideal. RT 10 indicated, in her opinion, each resident on a ventilator should have their HME changed daily, if not more often, plus need a few more just in case there would be a problem, and we would need to change the HME. Additionally, HME's may be changed when the RTs visually inspect the HME and see fluids or secretions present. She added it was a matter of troubleshooting the change of the HME when a resident had increased levels of peak inspiratory pressure (PIP) to possibly improve the resident's ventilation status. An interview conducted with the Administrator, on [DATE] at 2:18 p.m., indicated she did not have access to order supplies. She indicated she couldn't order a resident's brief, let alone an HME. An interview conducted with the DOO, on [DATE] at 2:42 p.m., indicated the RTs have the bacterial filters to replace the HMEs. The RT indicated they could be utilized but they would need changed more often. The DOO indicated the supply shipment should be in tomorrow from the shipment that the DOO submitted last week. An interview conducted with Former RT 8, on [DATE] at 4:02 p.m., indicated the HME stands for heat and moisture exchange. It's a humidification device that acts like one's nose for humidification. It tracks the exhale moisture, and the patient can breathe the moisture like they would through their nose. For the most part, HMEs are changed daily and, at times, every shift, for some residents. It's a very vital piece of the ventilator circuit. A bacterial filter would be changed monthly and was not an appropriate substitute for an HME. The bacterial filters cannot trap the moisture. You were basically filtering the air twice and going without humidification. Not changing the HME would allow water to build up and cause a situation to where the air wouldn't flow properly. The ventilator would not stop alarming due to high pressure, and you would not be able to ventilate someone properly. An interview conducted with the DOO, on [DATE] at 3:40 p.m. indicated he had an invoice for the HME's, on his phone with the planned delivery for the HME's of tomorrow, [DATE]. He indicated he had been working with the new RT, RT 10, with locating RT supplies and he had found several supplies that he was not sure the facility had. The DOO indicated, himself, and RT 10 found a bunch of bacterial filters that can be substituted for the HME's if needed, but I'm not an RT. The DOO indicated he had no RT manager at all. The previous Administrator was overseeing RT. The senior RT, RT 6, was kind of overseeing the RTs, because he was the senior RT. The DOO indicated RT 6 was aware of this responsibility. The DOO was unaware of any policies or procedures for the RT department and reiterated he was not an RT and unfamiliar with respiratory care or services. During the interview, the DOO displayed the supplies of bacterial filters, estimated at over 50, three boxes of small gloves, two boxes of medium gloves, and two boxes of large/extra-large exam gloves as the current supplies available, apart from current boxes in use for the Vent unit. The DOO indicated glove orders were normally received on Thursdays, but due to the holiday, they may be delivered on a different day this week. RT 10 was present and indicated she was new to the facility and was unaware of the last three locations on the Vent unit in which RT 10 and the DOO had been able to locate various RT-related supplies that afternoon. An invoice from the Medical Supply Company indicated an order was placed, on [DATE] at 10:56 a.m., for facility supplies. The invoice did not have HMEs listed as supplies that were ordered. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview conducted with RT 10, on [DATE] at 11:05 a.m., indicated additional HMEs were brought into the facility on night shift. There were approximately 250 of them. A policy titled Ventilator Management: General Policies and Guidelines, dated [DATE], was provided by the DOO on [DATE] at 1:38 p.m. The policy indicated the following, .Purpose: To describe general polices and guidelines to assist in the care of ventilator dependent residents in skilled nursing facilities . Scope . All administrative, Nursing and Respiratory Therapists, and Pulmonologists/Pulmonary Medicine Board Certified Physician and his or her practitioners . Policy . Physician orders for mechanical ventilation must be clear. Physician orders will be written for each ventilator-dependent resident and are to contain the mode of ventilation, tidal volume, respiratory rate oxygen percentage or liter flow [sic], PEEP .Respiratory therapists will adjust and set sensitivity levels, flow rate controls, and all internal and external alarm systems. All adjustments in ventilator settings will be made by the respiratory therapists when so prescribed by the attending pulmonologist/PulmonaryCertified Physician [sic] .3. Selection of Ventilator . The ventilator-dependent resident must be able to be supported by a ventilator that is utilized in the facility and in which the staff have been trained on utilizing . B. Respiratory Therapy Department Personnel Function with Ventilator-dependent residents . 1. Respiratory Therapy staffing in a Skilled Nursing Facility for ventilator-dependent residents can vary depending on the acuity of the residents. Minimum coverage by respiratory therapy for ventilator-dependent patients will be 24 hours a day. A respiratory therapist must be on the facility grounds at all times. A respiratory therapist or licensed nurse must be present on the ventilator unit at all times . 2. Respiratory Therapy Services . b. Tracheostomy care per policy . c. Oral and tracheal suction (shared function with nurse service) .d. Monitoring of mechanical ventilators and remote external alarm systems . 3. Ventilator monitoring schedule (ventilator checks): All residents who are ventilator-dependent will be routinely monitored as ordered, no less than every 4 hours .5. Respiratory therapy documentation . a. All ventilator checks will be documented on the ventilator flow sheet .b. All respiratory therapy treatments and services will be documented . 9. Equipment cleaning and change out schedule . b. If a Heat and Moisture Exchange System (HME) is used for humidification, the HME will be changed three (3) times a week. The HME will be changed more frequently if it becomes saturated and adversely effects ventilator system pressures This citation relates to Complaints IN00449362 and IN00449480. 3XXX,d+[DATE](a)(4) 3XXX,d+[DATE](a)(5) 3XXX,d+[DATE](a)(6)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36942 1. Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to provide competent nursing services during two random observations when no licensed nurse was at the facility. This affected 11 of 11 residents on the ventilator (Vent) unit and 21 of 21 residents with traumatic brain injuries (TBI) who resided in the facility. 2. Based on interviews and record review, the facility failed to ensure sufficient nurse staffing regarding having a plan for staff call-offs and filling open positions in a timely manner. This had the potential to affect 32 of 32 residents who reside in the facility. The Immediate Jeopardy began, on 12/22/24, when the facility had no licensed nurse available for 24 hours a day with the potential for serious injury, harm, impairment or death for all residents. The Director of Operations (DOO) and Chief Financial Officer (CFO) were notified of the Immediate Jeopardy, on 12/25/24 at 1:49 p.m., via e-mail. The Immediate Jeopardy was not removed by the exit date of the survey. Findings include: 1.a. An observation was conducted, on 12/22/24 at 10:35 a.m., of a black car pulling out of the parking lot. An interview conducted with Certified Nurse Aide (CNA) 14 on the TBI unit, on 12/22/24 at 10:40 a.m., indicated she was unsure who was working as the nurse and had not seen the nurse on the TBI unit. An interview conducted with Qualified Medication Aide (QMA) 16 on the TBI unit, on 12/22/24 at 10:53 a.m., indicated the nurses spent a good amount of their time on the Vent unit. Normally, the nurse does not leave the property when there's only one nurse working at the facility. An observation was conducted, on 12/22/24 at 10:55 a.m., of the black car pulling back into the parking lot. Two people got out of the black car and proceeded to go inside of the facility. The two staff were later identified as Licensed Practical Nurse (LPN) 4 and LPN 15. An interview conducted with LPN 4, on 12/22/24 at 11:00 a.m., indicated she left the facility to take a break and LPN 15 was in the black car with her. LPN 4 indicated she was not aware, as being the only nurse, that she could not leave the facility. The daily staffing sheet, dated 12/22/24, indicated LPN 4 was working day shift (7:00 a.m. to 7:00 p.m.), and LPN 15 was working night shift (7:00 p.m. to 7:00 a.m.). The day shift consisted of LPN 4 and QMA 16 working as the licensed nurse or QMA. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	There was no licensed nursing staff observed in the facility between 10:35 a.m. to 10:55 a.m. to ensure effective and competent services were provided to 10 of 11 residents dependent on the utilization of a ventilator and 21 TBI residents. There was no administrative staff observed in the facility on 12/22/24 from 10:35 a.m. to 12:00 p.m. 1b. An observation was conducted of the Vent unit on 12/25/24 at 11:30 a.m. Respiratory Therapist (RT) 18 was working and indicated the agency nurse (Nurse 19) was on break. An observation was conducted of the TBI unit, on 12/25/24 at 11:40 a.m., of lunch service. There were 13 residents located in the TBI dining room consuming lunch. The staff present were QMA 16, CNA 22, and CNA 23. An observation and interview were conducted on the Vent unit, on 12/25/24 at 11:57 a.m., and RT 18 indicated Nurse 19 was still on break and attempted to contact them. An observation and interview were conducted, on 12/25/24 at 12:00 p.m., of Nurse 19 returning to the Vent unit. Nurse 19 indicated she left the facility to get a coffee. Nurse 19 was not aware she could not leave the facility with being the only nurse working at the facility. The daily staffing sheet, dated 12/25/24, indicated the day shift consisted of Nurse 19 and QMA 16 working as the licensed nurse or QMA. There was no licensed nursing staff observed in the facility between 11:30 a.m. to 11:57 a.m. to ensure effective and competent services were provided to 10 of 11 residents dependent on the utilization of a ventilator and 21 TBI residents. There was no administrative staff observed in the facility on 12/25/24 from 11:30 a.m. through 2:00 p.m. An interview conducted with Agency Nurse 20, on 12/26/24 at 2:11 p.m., indicated most of the residents have some type of feeding tube, regarding residents on the Vent unit. Ten out of the 11 residents on the Vent unit receive nutrition through a feeding tube and one resident takes food by mouth but their medications through the feeding tube. An interview conducted with CNA 21, on 12/26/24 at 11:36 a.m., indicated they have worked at the facility for five months and primarily worked on the TBI unit. The current census was 20 residents with three residents out of the building. There was one resident who was nothing by mouth and received all nutrition through a feeding tube. There were two residents who were dependent on staff for eating and four residents who required supervision/monitoring from staff during mealtimes. A facility user agreement for Contracted Agency Provider 2, dated 5/16/23, did not include documentation to determine in which the provider or the facility was responsible to ensure the agency nurse met the criteria to serve as a charge nurse. The contract indicated the facility should provide adequate and timely orientation to the facility's policies and procedures. 2. An interview conducted with the Activity Director, on 12/20/24 at 10:14 a.m., indicated the facility staff does not get paid on time. They were supposed to be paid, on 12/9/24, but the staff did not get paid until 12/11/24. So, that resulted in some staff quitting. It appeared the facility did not have a nurse to work on the weekend, 12/21/24 and 12/22/24. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with the Business Office Manager (BOM), on 12/20/24 at 12:48 p.m., indicated she had worked at the facility since October of 2024. She was also the role of Human Resources. The BOM indicated there were times payroll would be late getting into employee accounts. The payroll processing company would show the balance of their check, then go into the negative, and post days later. This most recent pay date, 12/9/24, the pay was delayed by three days. The facility had a receptionist quit, two Licensed Practical Nurses (LPNs) quit, a Certified Nurse Aide (CNA) quit, and the only Minimum Data Set (MDS) nurse quit. An interview conducted with the DON, on 12/20/24 at 7:30 p.m., indicated she was sick and not able to come to work on 12/20/24 and 12/21/24. She was the only full-time nurse for day shift. The facility had three night shift nurses and only herself and Registered Nurse (RN) 3 for day shift but RN 3 works part time, day shift, on Tuesdays and Thursdays. The DON indicated she was exhausted and only had time to work on a cart as a floor nurse. She worked six days a week, 12-hour shifts, and did not have the ability to complete tasks such as auditing charts, reviewing employee files, in-services, and conduct plans for improvement. The DON had worked at the facility, since October of 2024, and there had never been agency in the facility. The DON was under the impression the facility could not have agency because the staffing agencies utilized prior would not come to the facility since the DOO had not paid them for past services. An anonymous interview was conducted on 12/20/24 at 1:27 p.m. They indicated payroll deposits were late. It will take up to two days, at times, for the money to deposit into employee accounts. That had resulted in staff quitting. It used to be every other paycheck, but it seems to be occurring with every paycheck recently. The facility had utilized multiple staffing agencies, but they ended up terminating the contracts due to non-payment. The DOO would pay them enough to get through a weekend and then back to the same problem. An interview conducted with the Scheduler, on 12/21/24 at 12:25 p.m., indicated due to losing so many employees, this last week had been staffed with only one nurse and one QMA on day shift. She used to schedule two CNAs on each side of the facility, two on the Vent unit and two on the TBI unit. The DOO said she was not allowed to schedule two CNAs on each unit. The DOO wanted a CNA on each unit and one float CNA to go back and forth from the Vent and TBI unit. The DOO instructed the Scheduler to staff the facility with only three CNAs on 12/16/24. When it comes to day shift nurses, I don't really have any. I had the DON and LPN 12, who just started employment, but LPN 12 doesn't work on the weekends. Last week there were four day shift nurses but when the payroll was late, some nurses quit. On 12/20/24, the Scheduler was told the facility had signed a contract for another nurse staffing agency, but no one had picked up. We have the night shift nurse, LPN 4, who was still working on the floor since we cannot find a nurse to come in and replace LPN 4. The DON was on the schedule to work day shift, 7:00 a.m. to 7:00 p.m., on 12/21/24, but she called off sick. An interview conducted with the DOO, on 12/21/24 at 1:00 p.m., indicated the payroll funds were sent out late and that resulted in a delay of the facility staff, who were under direct deposit, from obtaining their pay checks. The day(s) the facility staff get paid are on the 9th and 24th of every month. This last pay period, pay date of 12/9/24, was late and one nurse and two CNAs quit. During an interview conducted with the DOO on 12/21/24 at 1:50 p.m., he stated we are looking related to finding a nurse to relieve LPN 4. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/21/24 at 2:55 p.m., a nurse from a staffing agency arrived at the facility to provide relief to LPN 4, who had been working at the facility since 12/20/24 at 7:00 p.m. LPN 4 had demonstrated working for 19 hours and 55 minutes before another nurse came to relieve her. An interview conducted with the DOO, on 12/19/24 at 1:55 p.m., indicated he had a facility assessment, but it was blank, and he needed to fill it out. At 2:04 p.m., he provided the facility assessment, consisting of three pages, dated 12/19/24, and it consisted of the information of the facility units, population of residents, and resident census. The assessment did not include sufficient information to determine the resident care requirements or the necessary staff competencies and skills set required to provide care to residents on the ventilator and traumatic brain injury units. A policy titled Competency of Nursing Staff, revised May 2019, was provided by the Nurse Consultant (NC), on 12/21/24 at 10:43 a.m. The policy indicated the following, .Policy statement . 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law . 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will . a. participate in a facility-specific, competency-based staff development and training program . b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care This citation relates to Complaints IN00449362 and IN00449480. 3.1-17(a) 3.1-17(b)(2) 3.1-17(c)(1) 3.1-17(c)(2) 3.1-17(c)(3)

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	12/26/2024

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

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 36942 1. Based on observation, interview, and record review, the facility failed to be administered in a manner to ensure the wellbeing of residents. The facility failed to ensure adequate and competent staff were on duty at all times to provide respiratory services and failed to have adequate respiratory supplies on hand to effectively provide respiratory care and services for 11 of 11 residents who resided on the ventilator unit. This resulted in a resident (Resident B) experiencing respiratory distress and subsequent death and a resident (Resident C) experiencing respiratory distress resulting in hospitalization for 2 of 5 residents reviewed for ventilator status. The facility failed to ensure licensed nursing staff were on duty at all times to provide routine and emergency nursing services during two random observations, failed to ensure money was available upon request for 2 of 2 residents (Resident K and Resident L) reviewed for personal fund accounts, and failed to ensure the facility assessment was completed annually and accurately to identify the necessary resources required to provide competent care to 32 of 32 residents who resided in the facility. 2. Based on interview and record review, the facility failed to ensure consistent administrative staff were in place to provide continuity of care, prevent system breakdown, and prevent repeat deficiencies, affecting 32 of 32 residents who resided in the facility. The Immediate Jeopardy began, on 12/12/24, when the facility had no respiratory therapist (RT) available for 24 hours a day on the Ventilator (Vent) unit, supplies were not available to ensure adequate utilization of the ventilator, a nurse was not in the facility for 24 hours a day, and residents could not access their personal funds with the potential for psychosocial harm and the potential for serious outcome for all residents. The Administrator was notified of the Immediate Jeopardy on 12/23/24 at 4:30 p.m. The Immediate Jeopardy was not removed by the exit date of the survey. Findings include: 1.a. An interview conducted with the Director of Nursing (DON), on 12/18/24 at 2:50 p.m., indicated she worked six days a week, 12-hour shifts, but was off duty on 12/12/24. When she returned to work, on 12/13/24, she discovered there was no RT staff from 12/12/24 at 7:00 p.m. through the following morning, 12/13/24. The DON indicated the Administrator was responsible for the RT schedules. An interview conducted with the Director of Operations (DOO), on 12/18/24 at 3:00 p.m., indicated the facility had their own RT staff and utilized agency staff to fulfill the RT schedule. He believed someone from RT came in around 10:00 p.m., on 12/12/24, but the DOO could not provide any documentation to confirm this statement. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with Licensed Practical Nurse (LPN) 4, on 12/18/24 at 3:03 p.m., indicated she worked from 7:00 p.m., on 12/12/24, to 7:00 a.m., on 12/13/24. There were no RT staff for the night shift, on 12/12/24 from 7:00 p.m., until 12/13/24 at 7:00 a.m. LPN 4 indicated she worked at the facility about two years prior and then returned to work at the facility in March of 2024. LPN 4 was familiar with the respiratory part with suctioning, and she was shown a little bit about respiratory but mainly RT was responsible for that portion of their care. The RT covered the bases regarding care for the ventilators. The nursing staff received basic training over ventilators but all the technical parts of the ventilators, RT was responsible for. There was always supposed to be an RT in the facility. The RT would conduct tracheostomy care, suctioning, oxygen therapy, and maintain the ventilators. The ventilator alarms and ventilator settings were more in the purview of RT. An interview conducted with Certified Nurse Aide (CNA) 5, on 12/19/24 at 3:00 p.m., indicated there were two occasions to where the facility did not have an RT present. No RT showed up to work night shift, 7:00 p. m. to 7:00 a.m., on 12/12/24. An interview conducted with the Former RT 8, on 12/19/24 at 3:09 p.m., indicated there should always be RT staff for the ventilator (Vent) unit 24 hours a day, seven days a week. The facility did not have an RT director when they worked there this past year. The RT staff were policing themselves. An interview conducted with RT 9, on 12/19/24 at 1:30 p.m., indicated she worked as needed at the facility and, 12/19/24, was her first day as an RT at the facility. RT 9 didn't do any onboarding. She came to the facility and there was no other RT for this shift. So, she just started working and conducted resident care for ventilated residents per what she knew as an RT. An interview conducted with RT 10, on 12/20/24 at 11:45 a.m., indicated she started as an RT of the facility on 12/12/24. She was instructed to come to the facility, on 12/12/24 at 9:00 a.m., for orientation. RT 10 arrived at the facility, on 12/12/24 at 9:00 a.m., and there was no other RT in the facility. RT 10 was not sure how long the facility went without an RT prior to RT 10 entering the facility. RT 10 didn't have access to the electronic health records (EHR). So, she found a sheet of paper that had a list of resident names, room numbers, code status, the size and type of tracheostomy tube, instructions as to if they were on a ventilator or not, and respiratory treatments for each resident on the Vent unit. RT 10 left the facility, on 12/12/24 around 3:00 p.m., since she was instructed to only be there for orientation for those date(s) and time(s). RT 10 received a call from the facility about a new admission on a Vent. So, RT 10 returned to the facility to conduct an initial RT assessment on 12/12/24 around 5:30 p.m. After the assessment, RT 10 left the facility and returned on 12/13/24 at 9:00 a.m. There was no other RT in the facility on 12/13/24 at 9:00 a.m. RT 10 still didn't have access to the EHR. So, RT 10 utilized the sheet of paper with resident specific information to conduct the Vent rounds. RT 10 worked on 12/13/24, from 9:00 a.m. to 3:00 p.m. She didn't see another RT when she came in at 9:00 a.m. or when she left at 3:00 p.m. RT 10 returned to work her first 12-hour shift on 12/17/24. There was no RT manager in the facility. So, it appeared the RT department was defending [sic] for themselves. An interview was conducted with the Administrator, the DOO, and Nurse Consultant on 12/20/24 at 4:52 p.m. The DOO indicated the Administrator was previously responsible for the management of the RT schedule. The DOO indicated he was not responsible to manage the RT schedule in the past but would begin the oversight of the RT schedule. The DOO named the Administrator as the one to oversee the RT schedule. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with RT 10, on 12/23/24 at 9:00 a.m., indicated the RT department was attempting to work out the schedule as a department. RT 6 will put together a supply order pertaining to RT supplies, but he cannot input those orders for delivery. It appeared the DOO was attempting to get more organized with the budget and supplies. RT 10 spoke with the DOO regarding RT supplies and the DOO commented on how they ordered supplies last week and the items should be coming. The RT department has no HMEs (humidification and moisture exchange; devices used in mechanically ventilated patients intended to help prevent complications due to drying of the respiratory mucosa, such as mucus plugging). RT 10 indicated the HMEs are changed out daily, usually. If moisture builds up on the HMEs and they are not changed, it could affect the ability for the air to move through the ventilator as effective as it could. There were only four suction canisters and those are changed out weekly, usually. So, if the Vent residents need their suction canisters changed out, that's all we got. An interview conducted with RT 10, on 12/23/24 at 1:50 p.m., indicated there was only one HME available for resident use currently. There were no backup supplies for the HME. Some of the RTs have substituted a bacterial filter, for the HME but that was not ideal. RT 10 indicated in her opinion, each resident on a ventilator should have their HME changed daily, if not more often, plus need a few more just in case there would be a problem, and we would need to change the HME. Additionally, HME's may be changed when the RTs visually inspect the HME and sees fluids or secretions present. She added it was a matter of troubleshooting to change the HME when a resident had increased levels of peak inspiratory pressure (PIP) to possibly improve the resident's ventilation status. An interview conducted with the Administrator, on 12/23/24 at 2:18 p.m., indicated she still did not have access to order supplies. She indicated she couldn't order a resident's brief, let alone an HME. An interview conducted with the DOO, on 12/23/24 at 2:42 p.m., indicated the RTs have the bacterial filters to replace the HMEs. The RT indicated they could be utilized but they would need changed more often. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with Former RT 8, on 12/23/24 at 4:02 p.m., indicated the HME stands for heat and moisture exchange. It's a humidification device that acts like one's nose for humidification. It tracks the exhale moisture, and the patient can breathe the moisture like they would through their nose. For the most part, HMEs are changed daily and, at times, every shift, for some residents. It's a very vital piece of the ventilator circuit. A bacterial filter would be changed monthly and was not an appropriate substitute for an HME. The bacterial filters cannot trap the moisture. You were basically filtering the air twice and going without humidification. Not changing the HME would allow water to build up and cause a situation to where the air wouldn't flow properly. The ventilator would not stop alarming due to high pressure, and you would not be able to ventilate someone properly. Former RT 8 indicated when he worked at the facility, Medical Supply Company #1 was the best place for RT supplies. The facility's RT supplies were being fulfilled by this company until the bill wasn't paid and the facility account was put on hold. Medical Supply Company #2 was the next choice but there was an issue with paying this company as well. So, that account was put on hold. Former RT 8 was able to find a third company, but they didn't have all the RT supplies that were needed for day-to-day RT operation/management. He told the DOO we could not operate without [Medical Supply Company #2] on board. Medical Supply Company #3 wasn't the best with all the RT supplies needed. You wouldn't be able to order tracheostomy care kits, inner cannulas, suction kits, and HMEs. Former RT 8 would communicate with the DOO about the lack of RT supplies with Medical Supply Company #3, but the DOO would still want to operate the way he wanted to. It didn't seem to faze the DOO about the consequences pertaining to his actions. The DOO was ultimately the money man and didn't want the Administrator involved with scheduling and ordering of supplies. When Former RT 8 left, the first week of October 2024, the DOO tried to involve himself in the RT schedule and ordering of supplies because he had no one else to do it. The DOO would just say no or refuse to discuss items such as nonpayment of agency and not having the proper staff because they (the staff) knew the reputation of the facility or the staff not wanting to work in an environment that wasn't staffed. The facility was not able to retain staff due to the DOO, nonpayment of vendors, and the payroll checks not being given timely. Former RT 8 conducted the RT schedules during their time at the facility as well as the ordering of supplies. The DOO was involved in the payment of such services. An interview conducted with the DOO, on 12/23/24 at 3:40 p.m. indicated he had an invoice for the HME's, on his phone with the planned delivery for the HME's of tomorrow, 12/24/24. He indicated he had been working with the new RT, RT 10, with locating RT supplies and he had found several supplies that he was not sure the facility had. The DOO indicated, himself, and RT 10 found a bunch of bacterial filters that can be substituted for the HME's if needed, but I'm not an RT. The DOO indicated he had no RT manager at all. The previous Administrator was overseeing RT. The senior RT, RT 6, was kind of overseeing the RTs, because he was the senior RT. The DOO indicated RT 6 was aware of this responsibility. The DOO was unaware of any policies or procedures for the RT department and reiterated he was not an RT and unfamiliar with respiratory care or services. During the interview, the DOO displayed the supplies of bacterial filters, estimated at over 50, three boxes of small gloves, two boxes of medium gloves, and two boxes of large/extra-large exam gloves as the current supplies available, apart from current boxes in use for the Vent unit. The DOO indicated glove orders were normally received on Thursdays, but due to the holiday, they may be delivered on a different day this week. RT 10 was present and indicated she was new to the facility and was unaware of the last three locations on the Vent unit in which RT 10 and the DOO had been able to locate various RT-related supplies that afternoon. An invoice from a Medical Supply Company indicated an order was placed, on 12/23/24 at 10:56 a.m., for facility supplies. The invoice did not have HMEs listed as supplies that were ordered. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Cross reference F695 related to the facility failing to ensure adequate and competent staff were on duty to provide respiratory care and services for a resident admitted to the facility with a tracheostomy and dependent on mechanical ventilation in accordance with physician orders. This resulted in a resident (Resident B) experiencing respiratory distress and subsequent death and a resident (Resident C) experiencing respiratory distress resulting in hospitalization for 2 of 5 residents reviewed for ventilator status. 1.b. An interview conducted with the Nurse Consultant (NC), on 12/18/24 at 3:32 p.m., indicated she does not come to the facility in person but does conduct chart audits, plan of correction (POC) initiation, and various items off site. There were employees that were upset, due to not getting their paychecks on time, and some of them quit. Payroll dates are on the 9th and the 24th of every month. This most recent payroll date, 12/9/24, resulted in employees not getting access to their paychecks until 12/11/24. An interview conducted with the DON, on 12/18/24 at 5:22 p.m., indicated she worked at the facility a couple of years ago but recently was rehired approximately three months ago. The facility ran her license and did a background check. She conducted the onboarding for new employees, but the orientation was all online. There was no orientation checklist compared to when she was initially hired a couple of years ago. The DON indicated she came to work and went straight to working the medication cart by herself. She indicated she was constantly on the medication cart, working six days a week, 12-hour shifts. She wanted to conduct chart reviews, audit employee files, but had no time to do such with always being on the medication cart to work on the floor as the nurse. There was an issue with the facility staff not receiving their paychecks. Some staff threatened to not show up for work if they didn't get paid. The facility staff were supposed to get paid, on 12/9/24, but they didn't receive their paychecks until 12/11/24. So, a lot of staff quit after the delay in receiving their paychecks. There was no staff member identified as the Administrator on 12/18/24. On 12/18/24 at 4:30 p.m., the DOO indicated he hired a new Administrator and expected them to start on 12/19/24. An interview conducted with the Administrator, on 12/19/24, at 10:00 a.m., indicated she was the new Administrator of the facility. The Administrator received an offer to work on 12/18/24, and 12/19/24 was her first day as the Administrator. An interview conducted with the Former Administrator, on 12/19/24 at 12:27 p.m., indicated the DOO was responsible for the RT schedules. The RT schedules were not under her area of management/operations. She did not receive a notification about an RT staff member calling off to work nor the facility having an RT available, until she returned to work, on 12/13/24. There were delays in the staff obtaining their paychecks. There were some staff that didn't show up to work after that, but she wasn't sure of the exact number. She indicated she was the Administrator for 60 days and there was no RT manager during her time spent there as the Administrator. There was no control here. The DOO was over the RT schedule and any new employees he would hire and interview without consulting her. She would reach out to the DOO and inquire about information pertaining to newly hired employees and he would comment I will take care of it. The Former Administrator indicated the DOO was acting as the Administrator without having the license of the Administrator. The Former Administrator's last day of employment was 12/13/24. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A confidential interview conducted, on 12/20/24 at 10:14 a.m., indicated she had worked at the facility since the middle of October of 2024. The DOO does not pay us on time. The last pay day was 12/9/24, and the staff did not receive their paychecks until 12/11/24 around 6:00 p.m. The staff received their paychecks after the staff member reached out to the Chief Financial Officer (CFO) regarding the delay in pay and the staff received their pay checks that evening. The Former Administrator left, and the facility didn't have an Administrator for four days. Resident K was requesting money out of his personal funds account, and he still hasn't received it. Resident K commented I wonder if that man [the DOO] stole my money. The staff member reached out to the DOO about Resident K's request for his personal funds and the DOO stated I don't know, I will figure it out. It made Resident K feel intimidated. The DOO always wants to be at a lower budget. The staff member worked, on 12/12/24, and they had seen an RT leave around 3:00 p.m. to 4:00 p.m. and she asked them when they left, and they responded with there's another RT coming. That RT did not show up on 12/12/24 in the evening. An interview conducted with the Business Office Manager (BOM), on 12/20/24 at 12:48 p.m., indicated they started employment on 10/19/24. She had two residents asking for money, Resident K and Resident L. The BOM had informed the Former Administrator about the lack of funds in the petty cash account to withdraw money for resident funds. The Former Administrator requested the DOO to add money to the petty cash account, but that did not occur yet. The BOM indicated she can print checks from the RFMS (Resident Fund Management Service) accounts, but the checks had Former Administrator 2's name (the Administrator that worked as the Administrator prior to the Former Administrator) on them. He (Former Administrator 2) would be the only one who could cash the checks from the residents' accounts and a system was not implemented by Administration staff to remedy the conflict. That money would go into the petty cash account and then the BOM could withdraw those funds for the residents. It's been over a week of Resident K asking for money for Christmas. The BOM asked the DOO to either add money to the petty cash account or switch the name on the RFMS account checks to the BOM. The DOO keeps telling the BOM to take the money out of the RFMS accounts but the BOM cannot since their name wasn't on the checks to be able to cash them. The facility has been relying on the petty cash account for resident funds and other expenses, like haircuts, and now the petty cash account is down to only $12.00. Payroll has been an ongoing issue. The payroll will be processed, added to the payroll account, then goes into the negative, and it appears there are not sufficient funds to process payroll. Payroll was delayed for approximately three days for the most recent payroll date of 12/9/24. We had the following staff quit last week: Receptionist, Two LPNs, One CNA, and The only Minimum Data Set (MDS) nurse. A document titled RESIDENT TRUST PETTY CASH was provided by the BOM on 12/26/24 at 3:40 p.m. The document indicated, on 11/1/24, there was $360.00 in the petty cash fund/account. After the withdrawals, from 11/1/24 through 12/9/24, there was only $12.00 remaining in the petty cash fund. The last withdrawal was, on 12/9/24, for Resident K. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The BOM indicated they have been receiving collection notices for bills not being paid. The BOM indicated the Former Administrator gave them the invoices and instructed the BOM to keep a paper trail. It included, but was not limited to, the following vendors: - A fire protection company in the amount of $838.79, - A collection statement from a health equipment company, dated from 4/9/24, - Laboratory services company for dates from 1/3/24 to 11/4/24 for a total of $2,105.95, - An e-mail from the pest control company regarding an outstanding balance of $737.00 for 90 days, and - An electric contractor for generator services related to past due balances from 3/1/24, 5/9/24, and 9/27/24. A confidential interview was conducted on 12/27/24 at 1:27 p.m. They indicated the biggest concern was with one of the medical supply companies. All the equipment such as ventilator equipment and specialty beds are rented from this supplier. Apparently, the facility owes them over $100,000.00 and the facility is on a payment hold. That meant the company will not be supplying anymore specialty beds or ventilator equipment until there was a payment made. There was a new admission the week of 12/8/24 and they had to borrow a bed from a resident who was out to the hospital for the newly admitted resident. The staff member ensured the bed was disinfected prior to utilization for another resident. A follow-up interview was conducted on 12/26/24 at 2:55 p.m., and indicated the staff member received a phone call from the supply company about the facility being on a payment hold due to the lack of payment for their services. The confidential interview on 12/20/24 at 1:27 p.m. indicated they were not sure who was responsible for ordering supplies for the facility. The previous person was the Former Administrator. There was no RT manager, and the DOO had been overseeing the RT schedule for the past couple months. An interview conducted with the Medical Director (MD), on 12/20/24 at 3:43 p.m., indicated he's been coming to the facility for approximately two years. The expectations were to have RT coverage 24 hours a day, seven days a week. Over the two years he has been working with the facility, he had encountered eight different DONs. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/20/24 at 7:00 p.m., a telephone interview was conducted with the DON. She indicated she had been the DON since the beginning of December 2024 and was a floor nurse for the couple of months prior. There have been issues with payroll and facility staff receiving their paychecks timely. That resulted in multiple staff members quitting the week of 12/8/24, when payroll, that was due on 12/9/24, was delayed until 12/11/24. The facility staff would come and go. It was a revolving door with staffing. The DOO does not do cash bonuses, the pay wasn't the best, and there's no control regarding the nurses' schedule. The DOO will comment on how he wants the nursing schedule to reflect, regarding number of staff, and wants to oversee the nurse staff agency application for when nurses pick up open shifts at the facility. When it comes to the facility supplies, the facility cannot order medical supplies from certain vendors due to nonpayment. The Former Administrator was the one who ordered supplies in the past. Her last day was 12/13/24. The DON was afraid that if she left, no one would be able to care for the residents. The DON was under the impression no nurse agency staff would come to the facility due to nonpayment. The DON indicated she was the only full-time day shift staff member. There was another Registered Nurse (RN), but she only worked every Tuesday and Thursday. The DOO was aware about the DON's status of working on the floor for most of the time but would not inquire about utilizing nurse staffing agencies. The DON indicated she was not able to fulfill her duties as a DON with her working on a medication cart most of the time. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with the Scheduler, on 12/21/24 at 12:25 p.m., indicated due to losing so many employees, this last week we have staffed the facility with one nurse and one qualified medication aide (QMA) on day shift. They used to schedule two CNAs on each side of the facility. Two CNAs on Vent Unit and two CNAs for the Traumatic Brain Injury (TBI) unit. The DOO instructed the Scheduler, on 12/16/24, to only schedule one CNA for each unit and one CNA as a float to go back and forth from the Vent and TBI units. The Scheduler indicated the facility would benefit from two CNAs on the TBI unit due to them having behaviors. The DOO commented we cannot afford four aides. The Scheduler attempts to respond and come to a conclusion with the nursing schedule and the DOO just walks away. When it comes to day shift nurses, she doesn't really have any. The DON and LPN 12, 12/20/24 was LPN 12's second day of employment and LPN 12 doesn't work on the weekends, were the only full-time nurses. The prior week, 12/8/24, the facility had four day shift nurses. One left due to the pay being delayed and one left because they mentioned how chaotic it was. For 12/21/24, there were no nurses for day shift. We have LPN 4, who worked night shift, stay over while we find someone to come in to relieve LPN 4. There were two nurse staffing agencies that have the day shift nurse position posted, for 12/21/24, but no one had signed up yet. Unfortunately, the pay is low and there's been a delay in receiving paychecks, more frequently. The facility staff was paid on the 9th and 24th of every month. The most recent pay, on 12/9/24, was late and given on 12/11/24. The pay before that, on 11/24/24, was also delayed until 11/26/24. When the pay was late, some staff got their utilities shut off and some ended up quitting after the delay of the 12/9/24 paycheck. When it comes to facility supplies, the Scheduler believed the DOO conducted the ordering of supplies since the Former Administrator, who ordered supplies previously, was no longer employed by the facility. The DOO wants to handle everything, even the nursing schedule. The facility usually had enough briefs, but the supplies were running late. If you come into the facility in the morning and do not see any beds made, that's because the linen isn't out yet. The linen has been an issue when it comes to availability. Sometimes there might not be enough washcloths to wash anyone. The facility staff will conduct showers later in the afternoon just so there's enough linen for bathing/showers. The Former Administrator did not place a supply order before she left, on 12/13/24. This past Wednesday, 12/8/24, we only received one pallet of supplies, and we usually received four pallets. There were some COVID tests, gloves, and big briefs. The DOO has his hands in everything. The Administrator attempted to contact six different staffing agencies, and five out of the six staffing agencies, indicated they would not provide nurse staffing with them being owed money. The Scheduler indicated she had worked at the facility for approximately four months. When she initially started employment, she came to the facility on her first day and saw RN 3. RN 3 stated well, I guess it's just me and you. So, the Scheduler worked by herself on her first day of employment and by her third day of employment, she was orientating new employees to work at the facility. Two weeks ago, the Scheduler had one nurse on each unit and the DON didn't have to work on a medication cart. The DOO let the Scheduler staff the facility like that for a while and the DOO stated it was a lot of overtime. So, the DOO wanted the Scheduler to cut back. The Scheduler asked, why would you cut back if there's a lot of overtime? (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024

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

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with the Director of Operations (DOO), on 12/21/24 at 1:00 p.m., indicated he conducts review of any new admissions, supplies, and involved in the day-to-day operations. There was a representative from the supply company coming out next week to show the Administrator how to place orders in their system and let the Administrator have access to the system for ordering supplies. The DOO indicated he does not have access to order supplies from one of the medical supply companies at all, but the facility had been utilizing this company for medical supplies a lot more. The Administrator does the inventory and ordering of facility supplies. When it comes to payroll, the payroll company was based out of Oklahoma and in a different time zone. The money for payroll was wired to a bank located in New York. The DOO called the bank and the bank indicated the payroll funds were not transferred timely to ensure payroll funds were covered for 12/9/24. So, moving forward, the DOO will ensure the funds are transferred prior to 3:00 p. m. This pay period, pay date of 12/24/24, will be paid early so the staff wouldn't be upset. When it comes to onboarding of new employees, the DOO stated he reaches out to staff that have applied to work at the facility and talks to them. He will then send the job offer letter. Once that was signed, we move forward with hiring that staff member within 24-hours. When it comes to personal funds, the items were in the BOM's name. RFMS only wants one person to handle the money. The DOO instructed the BOM to contact RFMS to the BOM would have access to print and cash the checks. There was $53.00 in the petty cash fund at that time. The DOO indicated he doesn't have access to the RFMS accounts. The activities staff indicated they needed money for supplies and decorations. So, I just gave them (activities staff) cash. The DOO will write a check from the facility to the Administrator, the Administrator cashes the check and puts such funds into the petty cash account. The DOO brought the Administrator money, on 12/21/24, to put into the petty cash account. When it comes to Governing Body, it's just myself. When asked about Quality Assurance and Improvement Plan (QAPI), the DOO indicated he had not attended the last three QAPI meetings. They are usually conducted on Wednesdays, where the MD can attend. The meetings are held every three months. The last QAPI meeting was right before Former Administrator 2 left, on 9/25/24. There was one scheduled for Monday, 12/23/24. On 12/21/24 at 1:50 p.m., the DOO indicated we're looking, regarding for a nurse to relieve LPN 4 who had been working since 7:00 p.m., on 12/20/24. An interview conducted with the Nurse Consultant (NC), on 12/21/24 at 2:03 p.m., indicated the DOO conducted the hiring of new employees. When the administrative staff would attempt to hire, terminate, or write up employees, the DOO would retract and allow that person to continue working. Everything had to go through the DOO. There was the Scheduler, but the DOO was involved with the nursing schedule and indicated how he wanted staffing to be. The DOO would make decisions about the day-to-day operations including the schedules and hiring of staff but would not say anything to the Administrator or the DON. The newly hired staff would just show up. On 12/21/24 at 2:55 p.m., an RN from a nurse staffing agency showed up to work and relieve LPN 4, who had been working at the facility since 12/20/24 at 7:00 p.m. 2.a. An observation was conducted, on 12/22/24 at 10:35 a.m., of a black car pulling out of the parking lot. An interview conducted with CNA 14, on 12/22/24 at 10:40 a.m., indicated she was unsure who was working as the nurse. (continued on next page)

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	155857	A. Building B. Wing	12/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview conducted with Qualified Medication Aide (QMA) 16, on 12/22/24 at 10:53 a.m., indicated the nurses spend a good amount of their time on the Vent unit. Normally, the nurse does not leave the property when there's only one nurse working at the facility. [TRUNCATED]

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 36942 Based on interview and record review, the facility failed to ensure a complete and accurate facility assessment based on the resident population and identification of resources needed to provide the necessary care and services required for 32 of 32 residents that reside in the facility with a Ventilator (Vent) and Traumatic Brain Injury (TBI) unit. Findings include: An interview conducted with the Director of Operations (DOO), on 12/19/24 at 1:55 p.m., indicated he had a facility assessment, but it was blank, and he needed to fill it out. At 2:04 p.m., he provided the facility assessment, consisting of three pages, dated 12/19/24. The document indicated the date of 12/19/24, the census information, admission and discharges, and reflected having a Vent unit and a TBI unit. There was no further information that reflected staffing, acuity of care, or resources provided by the facility. Another Facility Assessment Tool, undated, was provided by the DOO on 12/21/24 at 3:48 p.m. The document reflected the Administrator, DON, Governing Body as the DOO, and the Medical Director (MD). There were nine residents requiring the need for tracheostomy care, suctioning, and oxygen therapy. The document did not reflect the needs of residents on a ventilator or included the need for respiratory therapy (RT) staff. One medical supply company was listed. The Operational Standards indicated yes to the practice being met for budgetary guidelines for nursing staffing, non-nursing staffing, and medical supplies. The list of contracts/agreements of third-party providers were blank regarding laboratory services, radiology services, psych services, and oxygen vendor. The assessment did not include sufficient information to determine the resident care requirements or the necessary staff competencies, and skill set required to provide care. A policy titled Ventilator Management, dated 1/1/19, was provided by the DOO on 12/21/24 at 1:38 p.m. The policy indicated minimum coverage by respiratory therapy for ventilator-dependent residents will be 24 hours a day and a respiratory therapist must be on the facility grounds at all times. A policy titled Competency of Nursing Staff, revised May 2019, was provided by the Nurse Consultant (NC) on 12/21/24 at 10:43 a.m. The policy indicated the following, .2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will . b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care . 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 36942 Based on interview and record review, the facility failed to ensure a complete Quality Assurance and Performance Improvement (QAPI) program that addressed the full range of services the facility provided related to lack of a QAPI plan and lack of an ongoing Performance Improvement Project (PIP). This had the potential to affect 32 of 32 residents that resided in the facility. Findings include: A QAPI Action Plan form, dated 9/25/24, indicated the Medical Director (MD), Administrator, Director of Nursing (DON), Nurse Consultant (NC), Social Worker, Admissions Coordinator, Physical Therapist, Dietary Manager, and Housekeeping Manager were in attendance. The goal was left blank, and the responsible member item was left blank. There was nothing marked under start date, completion date, or any comments related to the QAPI plan for designation of staff member(s), establish goals, investigate and track, identify barriers to meet goals, create plan to address barriers, and/or re-assess. The form was the most recent QAPI meeting conducted. Performance Improvement Tool documents were provided by the Administrator on 12/26/24 at 1:08 p.m. The documents indicated the following topics and audits conducted: Medication Errors dated 10/28/24, 11/4/24, and 11/11/24. There were no documents for December of 2024. Resident Call System dated 10/28/24, 11/4/24, and 11/11/24. There were no documents for December of 2024. Quality of Care dated 10/27/24. There were no documents for November of 2024 or December of 2024. Resident Records dated 10/28/24, 11/4/24, and 11/11/24. There were no documents for December of 2024. Tube Feeding Management dated 10/27/24, 11/4/24, and 11/11/24. There were no documents for December of 2024. Free of Accidents dated 10/28/24, 11/4/24, and 11/11/24. There were no documents for December of 2024. An interview conducted with the Director of Operations (DOO), on 12/21/24 at 1:00 p.m., indicated he conducts review of any new admissions, supplies, and involved in the day-to-day operations. When it comes to Governing Body, it's just myself. When asked about Quality Assurance and Improvement Plan (QAPI), the DOO indicated he had not attended the last three QAPI meetings. They are usually conducted on Wednesdays, where the Medical Director (MD) can attend. The meetings are held every three months. The last QAPI meeting was right before Former Administrator 2 left, on 9/25/24. There was one scheduled for Monday, 12/23/24. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A document titled Quality Assurance & Performance Improvement (QAPI) Plan, revised 6/2024, was provided by the Nurse Consultant (NC), on 12/21/24 at 10:43 a.m. The document indicated the following, . [Name of facility] provides specialized care to people with brain injury and advanced pulmonary disease . Purpose . The administrator will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee . Services . QAPI activities will be integrated across all the care and service areas. Each area of concern will have a representative on the committee .Our service areas will work together whenever possible to integrate care and services across our continuum of care to better meet the needs of the residents living in our facility. Our QAPI activities will cross service areas and departments and we will work together to assure we address all concerns and strive to continuously improve the provided services . Our service areas include . Long Term Care for Male Traumatic Brain Injury . Post Acute Ventilator Care . Trach [tracheostomy] Collar Services . Plan . Our QAPI plan includes the policies and procedures used to . Identify and use data to monitor our performance . Identify and prioritize problems and opportunities for improvement . Systematically analyze underlying causes of systemic problems and adverse events . Develop corrective action or performance improvement activities . Responsibility and Accountability . The administrator has responsibility and is accountable for ensuring that QAPI is implemented throughout our organization . The administrator is responsible for assuring that all QAPI activities and required documentation is provided as needed . Performance Improvement Projects (PIPS) .Our facility will conduct Performance Improvement Projects that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention .We will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident, and family satisfaction. An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained .The QAA committee will review data and input on a monthly basis to look for potential topics for PIPs .In addition, we will consider . Measures that can be used to monitor progress .Projects that require systemic changes . Projects affecting staff . The QAA committee will provide guidance on how to address issues that arise and need immediate corrective action . To implement planned changes, many organizations choose the following courses of action . Clearly define roles and responsibilities for new actions . Communicate the change(s) and its purpose to all those needing to carry out the new actions . Identify and correct barriers/roadblocks that may be in the way of doing things the new way . Integrate the new change(s) into new employee orientation and training . Ensure that there is adequate funding to support the change . Effectiveness . our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and is performed consistently 3.1-52(b)(2)