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	02/06/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure a resident with an identified pressure ulcer received thorough and completed wound assessments and initiate recommendations from the wound provider when the pressure ulcer worsened and the resident (Resident J) later developed a fever and hospitalized with a wound infection that required ongoing intravenous (IV) antibiotics and surgical debridement (process of removing dead skin and foreign material from a wound) for 1 of 3 residents reviewed for pressure ulcers. Findings include: The clinical record for Resident J was reviewed on 2/6/25 at 2:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), pressure ulcer of other site, stage 4 ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) (the diagnosis was added on 9/18/24), gastrostomy (feeding tube) status, and dependence on a ventilator. A care plan for skin, initiated on 8/4/24 and revised on 10/26/24, indicated Resident J had the potential for impaired skin integrity. The interventions included, but were not limited to, evaluate skin integrity and provide skin care per facility guidelines and as needed. A care plan for the risk of pressure ulcer development, initiated on 8/4/24, indicated Resident J was at risk for pressure ulcer development related to immobility. The interventions included, but were not limited to, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report as needed of any changes in skin status pertaining to color, appearance, wound healing, signs and symptoms of infection, wound size, and/or stage, assistance to turn and reposition resident every two hours, and utilize a specialty mattress. A physician order, initiated on 9/10/24, indicated the use of Triad Hydrophilic Wound Dress External Paste to the right buttock every day shift for moisture associated skin dermatitis. This order was discontinued on 12/15/24. A Quarterly Minimum Data Set (MDS) assessment, dated 10/22/24, indicated Resident J had one stage 4 pressure ulcer, was dependent on staff for personal hygiene and bed mobility, and always incontinent of bowel. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 12/11/24 at 6:06 a.m., indicated Resident J was sent to the hospital, at 12:05 a.m., due to a fever, decreased blood pressure, and elevated heart rate. A progress note, dated 12/14/24 at 3:34 p.m., indicated Resident J returned from the hospital and didn't reflect any skin concerns to Resident J's coccyx. A Skin Check, dated 12/14/24, indicated a stage 3 pressure ulcer to Resident J's sacrum. There was no further assessment, description, and/or measurements of the wound. A progress note, dated 12/14/24 at 7:53 p.m., indicated a sacral wound was noted during perineal care. The wound nurse was to stage the wound, and the charge nurse was informed. A progress note, dated 12/15/24 at 7:36 a.m., indicated Resident J was provided with perineal care and the staff were awaiting the wound provider and/or wound nurse to review the sacral wound and to give plan of care. A physician order, dated 12/15/24, indicated to utilize Triad Hydrophilic Wound Dress External Paste to the bilateral buttocks daily for moisture associated skin dermatitis. A wound provider note, dated 12/18/24, indicated an unstageable wound (a type of wound that cannot be accurately assessed due to the presence of necrotic tissue or eschar, which obscures the depth of the ulcer) to Resident J's coccyx. The wound measured 10 centimeters (cm) x 12.5 cm x unmeasurable depth due to necrosis (dead tissue). The wound details indicated Resident J returned from the hospital with the coccyx wound. The dressing treatment plan was to apply Santyl ointment daily with calcium alginate, apply a gauze island dressing with a border, apply skin prep around the wound, and change the dressing daily. A surgical excisional debridement procedure (surgical removal or cutting away of such tissue, necrosis, or slough with the use of a scalpel) was conducted to Resident J's coccyx wound. A weekly skin/shower assessment, dated 12/19/24, indicated a stage 3 pressure ulcer to the sacrum measuring 2 cm x 2 cm x 2 cm in depth, a stage 3 pressure ulcer located to the left gluteal fold measuring 10 cm x 6 cm x 0 cm of depth, and a stage 3 pressure ulcer to the right gluteal fold measuring 10 cm x 6 cm x 0 cm of depth. There was no further assessment of the wounds that included the presence of infection, presence of pain, wound characteristics, and/or drainage. A Quarterly MDS assessment, dated 12/20/24, indicated Resident J had one stage 3 pressure ulcer, was dependent on staff for personal hygiene and bed mobility, and always incontinent of bowel. There were no physician orders, for December of 2024, for the utilization of Santyl ointment and calcium alginate to Resident J's coccyx. The medication administration record (MAR), dated December of 2024, reflected the utilization of Triad Hydrophilic Wound Dress External Paste to Resident J's bilateral buttocks daily that was initiated on 12/15/24. A wound provider note, dated 12/23/24, indicated an unstageable wound to Resident J's coccyx that measured 11 cm x 11 cm x unmeasurable depth due to necrosis. The dressing treatment plan was to apply Santyl ointment daily with calcium alginate, apply a gauze island dressing with a border, apply skin prep around the wound, and change the dressing daily. A surgical excisional debridement procedure was conducted to Resident J's coccyx wound. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	The December 2024 MAR did not reflect utilization of Santyl ointment with calcium alginate for Resident J's coccyx wound. A progress note, dated 12/24/24 at 10:21 p.m., indicated Resident J requested to be sent out to the hospital due to not feeling well. Resident J's temperature was elevated to 102.3 degrees, he was shaking, felt cold, and had goosebumps on his skin. Resident J's sacral wound had a foul smell and increased drainage. Hospital records for Resident J's hospitalization from [DATE] to 1/9/25 were reviewed. Resident J presented to the emergency room with a sacral wound with drainage and fever. The sacral ulcer was identified with osteomyelitis (infection of bone) and underwent surgical debridement on 12/25/24. A wound care note, dated 1/3/25, indicated the sacrum and bilateral buttocks wound continued to have a significant amount of bone exposed in the base of the wound. The resident would need continued sharp debridement, continued wound vacuum (type of therapy to assist in wound closure) utilization, and would benefit from a diverting colostomy (surgical procedure that brings one end of the large intestine out through the abdominal wall to create a stoma; to keep fecal matter out of a certain section of your body that needs to rest and heal). Resident J was discharged from the hospital, on 1/9/25, and returned to the facility on intravenous (IV) antibiotics and oral antibiotics until 2/5/25. A Quarterly MDS assessment, dated 1/29/25, indicated Resident J had two stage 4 pressure ulcers, was dependent on staff for personal hygiene and bed mobility, and always incontinent of bowel. An interview conducted with the Interim Director of Nursing (DON), on 2/6/25 at 2:05 p.m., indicated she was unable to find documentation to show Resident J received Santyl and calcium alginate, for December of 2024, in accordance with the wound provider's treatment plan/recommendations. It didn't appear the recommendations for Santyl and calcium alginate were followed by the facility staff as written on the 12/18/24 wound note. A policy titled Wound Care, revised October 2010, was provided by the Interim DON on 2/6/25 at 2:15 p.m. The policy indicated the following, .Documentation . The following information should be recorded in the resident's medical record . 5. Any change in the resident's condition . 6. All assessment data (i.e., wound bed color, size, draining, etc.) obtained when inspecting the wound . Reporting . 2. Report other information in accordance with facility policy and professional standards of practice An interview conducted with the Interim DON, on 2/6/25 at 4:22 p.m., indicated she did not have any additional policies pertaining to wounds and/or pressure ulcers. Resident J's sacral wound had developed, and he was in and out of the hospital prior to her starting as the Interim DON. There were different DONs residing in the facility in December of 2024. So, the overall management of Resident J's coccyx wound must have fell through the cracks. This citation relates to Complaint IN00449893. 3.1-40(a)(1) 3.1-40(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36942 Based on interview and record review, the facility failed to ensure a resident was supervised in the shower per the plan of care for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/6/25 at 10:45 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, obesity, and intellectual disabilities. A Quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, indicated Resident B was cognitively intact, he required partial/moderate assistance with personal hygiene, supervision for tub/shower transfer, and supervision with walking. A care plan for fall risk, dated 5/10/24, indicated Resident B was at risk for falls and had an actual fall. The interventions included, but were not limited to, Resident B to be supervised during showers, dated 5/5/24. A care plan for activities of daily living (ADLs), dated 12/6/23 and revised 1/8/25, indicated Resident B had an ADL performance deficit related to limited mobility. The interventions included, but were not limited to, limited assistance with one staff person for bathing and touching assistance by staff for transferring. A progress note, dated 1/7/25 at 3:35 p.m., indicated the following, .Resident came out of shower c/o [complaints of] shortness of breath. RT and nurses lowered resident to the floor begin bagging resident via trach with 6-25 LPM [liters per minute] of 02 [oxygen]. Resident O2 sat [oxygen saturation] were 50% then increased to 97%. 911 [emergency medical services] was called A progress note, dated 1/7/25 at 4:37 p.m., indicated the following, .Res [resident] came out the shower room and started to mouth 'I can't breathe'. RT [Respiratory Therapist] was notified. Res was naked and wet from shower, and fell to the floor, but didn't hit head An investigative file regarding Resident B was provided by the Interim Director of Nursing (DON) on 2/6/25 at 11:55 a.m. The incident report, dated 1/7/25, indicated the following, .Brief Description of Incident . Resident requested a shower . [Name of Certified Nurse Aide 2] pre-set up the shower room with two full portable oxygen tanks. [Name of Certified Nurse Aide 2] took the resident to the shower room, where he then told her to get out of the shower room. He, however told her to come back in 10 minutes . Resident came out of the shower room stating he couldn't breath [sic] . [Name of Resident B] exited into the hallway and slipped on the floor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by Certified Nurse Aide (CNA) 2, undated, indicated the following, . [Name of Resident B] asked me if I could give him a shower. I told him yes I can after I do my rounds. I got his clothes towels [symbol for and] wash clothes [sic]. I told [name of Resident B] I wanted to leave the door open he said get out come and check on me in 10 min [minutes] [sic]. I said ok I went and made his bed up . he ran out of the shower room less than 10 min saying he couldn't breath [sic] so the RT [Respiratory Therapist] [symbol for and] Nursing was hear [sic]. I made sure that his oxygen tanks were full before I took him to the shower There were no care plans to indicate Resident B preferred to bathe by himself nor that he was able to do bathing tasks by himself. An interview conducted with the Interim DON, on 2/6/25 at 11:49 a.m., indicated the plan of care should reflect a resident's preferences pertaining to conducting ADL tasks by themselves and follow the plan of care as written. A policy titled Fall Prevention and Assessment, undated, was provided by the Interim DON on 2/6/25 at 2:05 p.m. The policy indicated the following, .Treatment/Management . 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling . 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . Monitoring and Follow-Up . 2. The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling This citation relates to Complaints IN00449893 and IN00451822. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36942 Based on interview and record review, the facility failed to ensure a discharged resident (Resident C) received medications consistent with the physician orders that resulted in Resident C receiving medications that belonged to two different residents (Resident L and Resident M) upon discharge from the facility. The facility also failed to ensure narcotic medication was signed off as ordered for 1 of 3 residents reviewed for medication administration. (Resident C) Findings include: 1a. The clinical record for Resident C was reviewed on 2/6/25 at 12:36 p.m. The diagnoses included, but were not limited to, traumatic brain injury, anxiety disorder, and post traumatic seizures. A care plan related to activities of daily living (ADLs), revised 1/11/25, indicated Resident C was resistive to ADL care related to a diagnosis of anxiety. The interventions included, but were not limited to, administer medications and treatments as ordered. A physician order, dated 6/25/24, was noted for lorazepam (narcotic antianxiety medication) 0.5 milligrams (mg) daily related to anxiety disorder. A controlled drug record, dated from 11/10/24 to 12/9/24, indicated the following date(s) when the lorazepam 0.5 mg was not administered per physician order(s): 11/15/24, 11/20/24 - signed off twice, 12/3/24, and 12/5/24. A controlled drug record, dated from 12/10/24 to 1/9/25, indicated the following date(s) when the lorazepam 0.5 mg was not administered per physician order(s): 12/12/24, 12/20/24- signed off twice, 12/30/24, 1/2/25, and 1/7/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication administration record (MAR), dated December 2024 and January 2025, was reviewed and indicated Resident C's lorazepam 0.5 mg was signed off, as ordered, daily, from 12/1/24 to 1/9/25. 1b. An interview was conducted with Family Member of Resident C on 2/6/25 at 11:34 a.m. She indicated when Resident C discharged home, on 1/11/25, the nursing staff didn't send all of Resident C's medications home with him. Resident C didn't receive all his medications, and he was having behavioral issues. Resident C's behavioral issues were due to the fact the nursing staff were not administering his medications. Now that Resident C returned home and started receiving his medications, as ordered, his behaviors are gone. The Family Member indicated upon review of the medications sent home with Resident C, there were medications from two other residents that were included with Resident C's medications. A total of three pictures were reviewed that showed a card of medication that contained gabapentin 100 mg capsules for Resident L. In the background of the picture of the card containing gabapentin 100 mg capsules, there was a face sheet that had Resident C's name on it. Another picture showed a card of medication that contained trazodone 50 mg tablets, half tablets, for Resident M. The third picture showed a card of medication that contained buspirone 10 mg tablets for Resident M. 1c. The clinical record for Resident L was reviewed on 2/6/25 at 3:55 p.m. The diagnoses included, but were not limited to, traumatic brain injury, diabetes mellitus, and epilepsy. A current physician order, dated 1/21/25, was noted for gabapentin 100 mg; give two capsules by mouth three times a day for neuropathy. 1d. The clinical record for Resident M was reviewed on 2/6/25 at 4:00 p.m. The diagnoses included, but were not limited to, traumatic brain injury, post-traumatic stress disorder, schizophrenia, psychotic disorder, anxiety disorder, and insomnia. A current physician order, dated 9/14/23, was noted for buspirone 20 mg by mouth three times a day for anxiety. A current physician order, dated 6/24/24, was noted for trazodone 25 mg by mouth at bedtime for insomnia. An interview conducted with the Interim Director of Nursing (DON), on 2/6/25 at 11:49 a.m., indicated the Family Member of Resident C came to pick him up to go home on 1/11/25. The Interim DON instructed the nurse working on 1/11/25, to send all of Resident C's medications home with the family along with a discharge summary. The Family Member called the Interim DON back and stated they didn't have all of Resident C's medications. The Interim DON indicated she went through the medication cart and found the remaining medications belonging to Resident C in the bottom drawer where the overflow was located. The Family Member stated they also received cards of medications that did not belong to Resident C. The Family Member brought the cards of medications, not belonging to Resident C, back to the facility the following Monday. It was an agency nurse who conducted the discharge of Resident C. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy entitled Discharge Medications, reviewed 5/12/21, was provided by the Interim DON on 2/6/25 at 2:05 p.m. The policy indicated the following, . Procedure . 2. The labels of discharge medications are verified for completeness and accuracy by checking them against the most recent physician orders A policy entitled Medication Administration General Guidelines, reviewed 5/12/21, was provided by the Interim DON on 2/6/25 at 2:05 p.m. The policy indicated the following, .q. Medication(s) are to be administered no sooner than 60 minutes prior and no later than 60 minutes after scheduled time . r. Medications supplied for one resident cannot be administered to any other resident This citation relates to Complaint IN00449893. 3.1-25(a) 3.1-25(b)(3) 3.1-25(b)(9) 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(p)