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	08/08/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34850 Based on observation, interview and record review, the facility failed to assess and determine if residents that resided on the traumatic brain injury unit were able to safely self-administer their own medications and/or treatments for 1 of 1 randomly observed resident and 1 of 10 residents reviewed for medication administration. (Resident 4 and Resident 8) Findings include: 1. The clinical record for Resident 4 was reviewed on 8/6/24 at 2:00 p.m. The diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage (brain bleed). An annual Minimum Data Set (MDS) assessment, dated 6/24/24, indicated Resident 4 was moderately impaired. A physician order, dated 6/27/24, indicated Resident 4 was to receive 5 milliliters of chlorhexidine mouth wash twice daily. A medication administration observation was conducted with Qualified Medication Aide (QMA) 7 on 8/6/24 at 8:14 a.m. A random observation was made of Resident 4 sitting in the dining room eating his breakfast. The resident's breakfast tray had a medication cup sitting on the tray containing a blue liquid. At that time, QMA 7 had indicated Resident 4 had an order for chlorhexidine mouth wash he chooses to administer after he ate breakfast. The resident did not have a self-administration of medication assessment in the clinical record that indicated he was able to safely administer the mouth wash himself. An interview was conducted with the Regional Nurse Consultant on 8/6/24 at 12:00 p.m. She indicated Resident 4 did not have a self-administration of medication assessment. She was unaware QMA 7 had left the chlorhexidine mouth rinse on Resident 4's tray for him to administer later. She would assess Resident 4's ability to self-administer the mouth wash. 36942 2. An observation was conducted, on 8/4/24 at 1:59 p.m., of a container of cream labeled triamcinolone on Resident 8's nightstand, next to his bed. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted, on 8/5/24 at 10:13 a.m., of a container of cream labeled triamcinolone on Resident 8's nightstand, next to his bed. An observation was conducted, on 8/5/24 at 3:25 p.m., of a container of cream labeled triamcinolone on Resident 8's nightstand, next to his bed. The clinical record for Resident 8 was reviewed on 8/6/24 at 11:01 a.m. The diagnoses included, but were not limited to, traumatic brain injury, muscle weakness, and need for assistance with personal care. A Quarterly Minimum Data Set assessment, dated 7/1/24, indicated severe cognitive impairment, impairment on one side of upper/lower extremity, and application of ointments/medications other than to feet. A current care plan indicated Resident 8 had impaired skin integrity due to eczema. An intervention was listed to administer topical medications as ordered. A physician order, dated 4/20/22, indicated triamcinolone acetonide cream 0.1%, apply to irritations on entire body topically every shift for eczema. The order did not indicate Resident 8 was to self-administer the topical cream. There were no physician orders and/or assessments to indicate Resident 8 was able to administer topical medications on his own. An interview conducted with the Regional Nurse Consultant, on 8/6/24 at 11:14 a.m., indicated Resident 8 did not have the ability to administer cream. The nursing staff were placing the cream on the nightstand for convenience. A policy titled Self-Administration of Medications, dated 5/2013, was provided by the Regional Nurse Consultant on 8/6/24 at 9:47 a.m. The policy indicated the following, .To assure each Resident who chooses to self medicate is properly assessed and provided with the opportunity if appropriate to administer own medications .Storage of Medication .1. When the determination has been made that it is safe for a resident to self administer their medication, the facility will obtain a locked bock [sic] with a key for the resident 3.1-11(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50826 Based on observation, interview and record review, the facility failed to ensure a resident was provided access to a call light system on a consistent basis for 1 of 1 resident reviewed for accommodation of needs. (Resident R) Findings include: The clinical record for Resident R was reviewed on 08/06/24 at 01:44 p.m. The diagnoses included, but were not limited to, respiratory failure with use of a tracheostomy (small surgical opening that is made through the front of the neck into the windpipe), diabetes mellitus, and quadriplegia (paralysis of all four limbs). Resident R was admitted to the facility on [DATE]. On 08/05/24 at 9:35 a.m., a random observation was conducted of Resident R's room. The call light (breath call light) was back over his head, and he could not utilize it. CNA 14, who was in the hall, moved the breath call light to a distance within the resident's mouth where he could reach it. On 08/06/24 at 10:30 a.m., an observation was conducted of Resident R's room. His breath call light was not within reach to be utilized. CNA 14, who was at the nurses' station, came into the room and moved the breath call light back within reaching distance . CNA 14 commented, We had just cleaned him up. On 08/06/24 at 12:00 p.m., an observation was conducted of Resident R's room. His breath call light was not in reach to be utilized. Registered Nurse (RN) 9 was approached and she went into the room and placed the breath call light back within Resident R's reach. On 08/06/24 at 01:30 p.m., an interview was conducted with RN 9 who cared for Resident R. She indicated the resident needed the breath call light near his mouth to utilize it. She indicated the call light was moved above the headboard when the staff came to assist Resident R and sometimes the staff forgot to place the breath call light in reach. RN 9 readjusted the breath call light for Resident R to utilize. A care plan, dated 7/16/24, indicated the following, Ensure/provide a safe environment .Call light in reach . Adequate low glare light .Bed in lowest position and wheels locked .Avoid isolation .Monitor/document frustration level .Wait 30 seconds before providing resident with word. A policy titled Call Lights, dated June of 2021, was provided on 8/6/24 at 2:40 p.m. The policy indicated the following, To assure each resident will have a readily accessible means to obtain needed assistance .the call light communication system will be a direct link to a centralized staff location .Each resident will be provided with a call light .Call lights will be kept within reach of residents .Breathe call lights will be provided for any residents that can not use a traditional call light. 3.1-3(v)(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41129 Based on interview and record review, the facility failed to take prompt efforts to resolve a grievance from a resident's representative regarding missing items for 1 of 2 closed records reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/6/24 at 2:43 p.m. The diagnoses included, but were not limited to, diffuse traumatic brain injury, generalized anxiety disorder, epilepsy (seizure disorder), and paraplegia (a chronic condition that impairs the motor or sensory function of the lower half of the body). Resident B was admitted to the facility for a respite (providing or being temporary care in relief of a primary caregiver) stay on 5/31/24 and was discharged to home on 6/10/24. An interview with Resident B's representative, conducted on 8/6/24 at 3:35 p.m., indicated the facility had stole his diamond earring, lost clothing, and had not returned his Xanax (a medication used to reduce anxiety) medication. Resident B's representative indicated she had contacted the facility and inquired about the missing items after his discharge. Resident B's representative indicated she had spoken to a woman, who she thought was the head nurse, and was described as a black woman who was pregnant about the missing items. Resident B's representative indicated she never heard back from the facility about the missing items. An interview with Admissions Manager (ADM), conducted on 8/7/24 at 2:46 p.m., indicated she had been contacted by Resident B's representative who had indicated to her via a phone call of the missing ring, a diamond ring. ADM indicated she called Resident B's representative back after reviewing Resident B's admission inventory sheet and explained the ring was not listed on the inventory sheet at the time of Resident B's admission. When asked if Resident B's representative had mentioned anything about missing clothing, ADM stated Resident B's representative did mention some clothing was missing as well as a medication but had indicated to ADM she would figure it out and call back. When asked if she had filled out a grievance form regarding the missing items, she indicated she had not. An interview conducted with the Regional Nurse Consultant (RNC), on 8/7/24 at 3:45 p.m., indicated ADM should have filled out a grievance form regarding the missing items. A Grievance - Resident Policy and Procedure was received, on 8/8/24 at 9:11 a.m., from the RNC. The policy indicated the following, A grievance form shall be initiated when a Resident, family, or Resident Representative verbalized the desire to file a grievance. Any employee may initiate a grievance form on behalf of the Resident, family, or Resident Representative .The Grievance Official shall review the grievance form and forward the grievance to the most applicable department for investigation and present further violations while under investigation. A complete investigation of the grievance shall be completed and documented on the grievance form. Steps to resolve the grievance should be determined and documented on the grievance form. The grievance form should then be returned to the Grievance Official for review and follow up with the Resident and/or responsible party .If resolution cannot be achieved at the facility level, the Resident may be offered additional resource information . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation is related to Complaint IN00436612. 3.1-7(b)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34850 Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse with a resident to resident altercation on the traumatic brain injury unit for 3 of 3 residents reviewed for abuse. (Resident 8, Resident C and Resident H) Findings include: 1. The clinical record for Resident H was reviewed on 8/4/24 at 2:05 p.m. The diagnoses included, but were not limited to, intracranial injury (traumatic brain injury). A quarterly Minimum Data Set (MDS) assessment, dated 6/24/24, indicated Resident H had moderate cognitive impairment. 2. The clinical record for Resident 8 was reviewed on 8/4/24 at 2:10 p.m. The diagnoses included, but were not limited to, brain injury. A quarterly MDS assessment, dated 7/1/24, indicated Resident 8 was cognitively impaired. 3. The clinical record for Resident C was reviewed on 8/4/24 at 2:20 p.m. The diagnoses included, but were not limited to, intracranial injury (traumatic brain injury). A quarterly MDS assessment, dated 5/30/24, indicated Resident C was cognitively impaired. The investigation for a reportable incident was provided by the Executive Director on 8/8/24 at 9:10 a.m. The investigation indicated the following, .Nurse on duty reported resident to resident altercation between Resident H and Resident 8. Per nurse, resident H struck resident 8 .Follow up .Investigation of incident involving resident to resident shows the following: Staff reports that Resident [8] was observed sitting in his motorized wheelchair at the dinner table, yelling and banging on his w/c [wheelchair] arms, when Resident [C] came over to see what was wrong. Resident [8] then turned his wheelchair and drove it toward Resident [C]. Resident [C] was able to move away and left the dining room. This incident occurred simultaneously as Resident [H] came from another table and tried to intervene. Resident [8] then drove his wheelchair towards Resident [H] and attempted to kick him. Both men were swinging their arms at each other with Resident [H] making contact with the side of Resident [8]'s face. Staff immediately responded and residents were separated from one another. Resident [8] was taken to his room for a head to toe assessment. No injuries were noted .[Resident 8] was placed on 15 minute checks for current behavior. Resident [8] has severe cognitive impairment and was unable to say what caused the outburst During incident a [Certified Nursing Assistant] CNA on duty entered the dining room called 911, which responded and Resident [H] was taken to [name of hospital] for psych eval [evaluation] and treatment. He is still currently admitted there. Resident [H] told nurse on duty, before he left he was just trying to help his friend [Resident C] when [Resident 8] came after him . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note by the Regional Nurse Consultant for Resident H, dated 5/27/24, indicated the following, [Resident H] was observed by QMA [Qualified Medication Aide] 12 making contact with pt [patient] several times. Authorities were notified and pt. was placed in emergent detention . A nursing note by Registered Nurse (RN) 10 for Resident 8, dated 5/27/24, indicated the following, [Resident 8] received contact from pt. [H] to the facial region. Pt. were redirected safely to calm environment and assessed for injury . An IDT (interdisciplinary team) note by Director of Nursing (DON) 15 for Resident 8, dated 5/28/24, indicated the following, .IDT reviewed incident on 5/27/24. Resident [8] was observed sitting in motorized wheelchair at the dinner table at [4:36 p.m.] yelling towards window and staff. Another resident [Resident C] walked over to see what was wrong. [Resident 8] turned wheelchair and drove wheelchair into resident [C] and tried to pin into wall. Resident was freed before any injury. Another Resident [Resident H] was triggered to respond to [Resident 8]'s actions, got up from chair and walked over to [Resident 8]. [Resident 8] then drove wheelchair towards resident with leg up trying to kick resident. [Resident 8] received physical contact from [Resident H]. Staff immediately responded to event and were separated from one another. [Resident 8] was assessed for injuries. Resident was taken to room for observations and assessing .Placed on 15 minute checks for current behavior . A nursing note, dated 6/27/24 at 11:05 a.m., indicated the following, The therapist spoke with [Resident 8's Representative] regarding safety in his power chair due to his recent agitation and emotional driving patterns. She agreed to keep [Resident 8] and other residents safe by immobilizing just the drive function of his chair once he is in his desired location in the dining room. Upon the request of the patient, his drive function will be resumed so he can drive back to his room or on the unit with supervision . An interview was conducted with the Executive Director (ED) and the Regional Nurse Consultant on 8/8/24 at 2:31 p.m. The ED indicated the incident was witnessed by CNA 12 and QMA 11. Staff responded to the residents as quickly as they could. It happened so fast. The abuse policy was provided by the Regional Nurse Consultant on 8/5/24 at 10:44 a.m. The policy indicated the following, .It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion .Policy statement. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse .1. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment . 3.1-27(a)(1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34850 Based on interview and record review, the facility failed to thoroughly investigate a reportable incident for 3 of 3 residents reviewed for abuse. (Resident 8, Resident C and Resident H) Findings include: 1. The clinical record for Resident H was reviewed on 8/4/24 at 2:05 p.m. The diagnoses included, but were not limited to, intracranial injury (traumatic brain injury) A quarterly Minimum Data Set (MDS) assessment, dated 6/24/24, indicated Resident H had moderate cognitive impairment. 2. The clinical record for Resident 8 was reviewed on 8/4/24 at 2:10 p.m. The diagnoses included, but were not limited to, brain injury. A quarterly MDS assessment, dated 7/1/24, indicated Resident 8 was cognitively impaired. 3. The clinical record for Resident C was reviewed on 8/4/24 at 2:20 p.m. The diagnoses included, but were not limited to, intracranial injury (traumatic brain injury) A quarterly MDS assessment, dated 5/30/24, indicated Resident C was cognitively impaired. An investigation for a reportable incident that had occurred on 5/27/24, between Resident C, Resident 8 and Resident H, was provided by the Executive Director on 8/8/24 at 9:10 a.m. The investigation included, but was not limited to, the following: A reportable incident, dated 5/27/24, indicated the following, .Nurse on duty reported resident to resident altercation between Resident H and Resident 8. Per nurse, resident H struck resident 8 .Follow up . Investigation of incident involving resident to resident shows the following: Staff reports that Resident [8] was observed sitting in his motorized wheelchair at the dinner table, yelling and banging on his w/c [wheelchair] arms, when Resident [C] came over to see what was wrong. Resident [8] then turned his wheelchair and drove it toward Resident [C]. Resident [C] was able to move away and left the dining room. This incident occurred simultaneously as Resident [H] came from another table and tried to intervene. Resident [8] then drove his wheelchair towards Resident [H] and attempted to kick him. Both men were swinging their arms at each other with Resident [H] making contact with the side of Resident [8]'s face. Staff immediately responded and residents were separated from one another. Resident [8] was taken to his room for a head to toe assessment. No injuries were noted .[Resident 8] was placed on 15 minute checks for current behavior. Resident [8] has severe cognitive impairment and was unable to say what caused the outburst During incident a [Certified Nursing Assistant] CNA on duty entered the dining room called 911, which responded and Resident [H] was taken to [name of hospital] for psych eval [evaluation] and treatment. He is still currently admitted there. Resident [H] told nurse on duty, before he left he was just trying to help his friend [Resident C] when [Resident 8] came after him . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note by the Regional Nurse Consultant for Resident H, dated 5/27/24, indicated the following, [Resident H] was observed by QMA [Qualified Medication Aide] 12 making contact with pt [patient] several times. Authorities were notified and pt. was placed in emergent detention . The investigation did not include statements from CNA 12 and QMA 11 that had witnessed the incident that had occurred, on 5/27/27, involving Resident 8, Resident H and Resident C. An interview was conducted with the Executive Director and Regional Nurse Consultant on 8/8/24 at 2:31 p. m. The ED indicated the incident was witnessed by CNA 12 and QMA 11. The ED did not have statements for either of them. The abuse policy was provided by the Regional Nurse Consultant on 8/5/24 at 10:44 a.m. The policy indicated the following, .It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion .Policy statement. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse .Policy Statement. All reports of resident abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management .2. The individual conducting the investigation will, at minimum .c. interview any witnesses to the incident .4. Witnesses will be interviewed by the investigator and their statements will be documented. Witnesses will then be required to sign and date such reports . 3.1-28(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41129 Based on interview and record review, the facility failed to develop a care plan for non-pharmacological interventions for a resident with behaviors (Resident 10) for 1 out of 5 residents reviewed for unnecessary medications; and failed to implement interventions for a resident with a suprapubic (a location above the pubis) urinary catheter per his care plan (Resident B) for 1 of 2 closed records reviewed. Findings include: 1. The clinical record for Resident 10 was reviewed on 8/6/24 at 9:59 a.m. The diagnoses included, but were not limited to, tracheostomy (a surgically created hole in the windpipe for breathing) and mood disorder. Resident 10 was prescribed Seroquel (an antipsychotic medication) for his mood disorder. A care plan, dated 4/2/24, indicated Resident 10 uses psychotropic medications (Seroquel) r/t [sic, related to] mood disorder. The interventions included, but were not limited to, the resident will be/remain free of psychotropic drug related complications, to administer psychotropic medications as ordered by the physician, and to monitor/document/report any adverse reactions. Resident 10's care plan did not contain a care plan/interventions for behavior management nor did it contain nonpharmacologic interventions to attempt when behaviors were present. An interview with the Regional Nurse Consultant (RNC), conducted on 8/8/24 at 2:52 p.m., indicated residents with known behaviors should have nonpharmacological interventions included in their plan of care. A Behavior Management policy was provided by the RNC on 8/8/24 at 1:03 p.m. The policy indicated the following, The facility will create, will provide or make referrals to provide appropriate intervention in establishing a plan of treatment for those Resident identified as needing Behavior Management. Behaviors/Mood Indicators may adversely affect the well-being of the Resident, other Residents, staff and visitors. Examples may include: physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care and wandering, and mood indicators .At least quarterly Interdisciplinary meeting will take place to discuss all Residents on the behavior management program as well as Residents receiving psychoactive medication who may be due for reduction .Interventions will be discussed and changed if necessary .Interventions will be implemented .Least restrictive interventions will be implemented initially in an attempt to alter the behavior .The use of drug management will only be considered if all additional less restrictive interventions have been tried and failed. 2. The clinical record for Resident B was reviewed on 8/6/24 at 2:43 p.m. The diagnoses included, but were not limited to, diffuse traumatic brain injury, generalized anxiety disorder, epilepsy (seizure disorder), and paraplegia (a chronic condition that impairs the motor or sensory function of the lower half of the body). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's care plan, created on 6/22/22, indicated Resident B had a suprapubic catheter due to the diagnosis of a neurogenic bladder (lack of bladder control due to brain, spinal or nerve issues). Interventions included, but were not limited to, monitor and document intake and output as per facility policy. A physician's order, dated 6/1/24, indicated to empty catheter drainage bag and record output of urine every 8 hours. Resident B's Treatment Administration Record (TAR) for June 2024 indicated, from 6/1/24 to 6/10/24 (date of discharge), the facility failed to record the urine output from the catheter drainage bag 8 out of 29 opportunities. An Interdisciplinary Team Care Planning policy received on 8/6/24 at 4:17 p.m., indicated the following, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . g. Incorporate identified problem areas . o. Reflect currently recognized standards of practice for problem areas and conditions .Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process .When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. This citation relates to Complaint IN00436612. 3.1-35(a) 3.1-35(b)(1)

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	08/08/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34850 Based on interview and record review, the facility failed to ensure care plan meetings were conducted for 2 of 2 residents reviewed for care plan meetings. (Resident 15 and Resident 30) Findings include: 1. The clinical record for Resident 15 was reviewed on 8/5/24 at 10:30 a.m. The diagnoses included, but were not limited to, paraplegia. A quarterly Minimum Data Set (MDS) assessment, dated 7/11/24, indicated Resident 15 was cognitively intact. A care plan conference note for Resident 15, dated 4/10/24, indicated a care plan meeting had been held. An interview was conducted with Resident 15 on 8/5/24 at 10:32 a.m. He indicated a care plan meeting had not been conducted for a while. The social services staff person had quit, so they had not been conducted. 2. The clinical record for Resident 30 was reviewed on 8/5/24 at 10:15 a.m. The diagnoses included, but were not limited to, intracranial injury (brain injury). A quarterly MDS assessment, dated 5/12/24, indicated Resident 30 was cognitively impaired. A care plan conference note for Resident 30, dated 3/18/24, indicated a care plan meeting was held with Resident 30's representative in attendance. An interview was conducted with Representative 22 on 8/5/24 at 10:15 a.m. She indicated there had been no care plan meetings for a long time. An interview was conducted with the Regional Nurse Consultant on 8/7/24 at 10:01 a.m. She indicated Resident 15 and Resident 30 should have care plan meetings conducted. Social Services Director (SSD) 35 had ended her employment with the facility. SSD 36 had attempted to set up care plan meetings to catch them up. A care planning policy was provided by the Regional Nurse Consultant on 8/6/24 at 4:17 p.m. The policy indicated the following, 3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family . 3.1-35(c)(2)(C)

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	155857	A. Building B. Wing	08/08/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 34850 Based on observation, interview, and record review, the facility failed to ensure showers and nail care were provided for 4 of 5 residents reviewed for activities of daily living (ADLs). (Resident 30, Resident B, Resident D and Resident E) Findings include: 1. The clinical record for Resident 30 was reviewed on 8/5/24 at 10:15 a.m. The diagnoses included, but were not limited to, intracranial injury (brain injury). A quarterly Minimum Data Set (MDS) assessment, dated 5/12/24, indicated Resident 30 was cognitively impaired. A skin care plan, dated 12/20/23, indicated the following, .The resident has potential/actual impairment to skin integrity of the right buttocks r/t [related to] moisture Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short .Keep skin clean and dry. Use lotion on dry skin . An interview was conducted with Representative 22 on 8/5/24 at 10:15 a.m. She indicated Resident 30 did not look like he had been bathed when she visited. The resident's fingernails and toenails were long in length and needed to be trimmed. An observation was made of Resident 30 with Qualified Medication Aide (QMA) 8 on 8/8/24 at 9:58 a.m. The resident's left hand fingernails were long in length and his toenails were chipped and long in length. The resident indicated the staff had finally trimmed his fingernails the other day, but they were still long. He was still waiting for his toenails to be trimmed. The July and August 2024 bathing sheets had been provided by the Regional Nurse Consultant on 8/8/24 at 1:00 p.m. The resident did not receive showers or bed baths on the following weeks: - shower nor bed bath provided the week of 6/30/24 - 7/6/24, - shower nor bed bath provided the week of 7/14/24 - 7/20/24, - shower provided week of 7/23/24 - 7/27/24, and - shower nor bed bath provided the week of 7/28/24 - 8/3/24. An interview was conducted with the Regional Nurse Consultant on 8/8/24 at 2:30 p.m. She indicated she was unable to provide any additional bathing sheets for Resident 30. The resident was supposed to receive bathing and/or showers twice a week. The resident was not diabetic, so the staff were able to trim his toenails. 36942 (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident D was reviewed on 8/6/24 at 11:53 a.m. The diagnoses included, but were not limited to, traumatic brain injury, major depressive disorder, and anxiety disorder. The annual MDS assessment, dated 6/12/24, indicated severe cognitive impairment and it was very important for Resident D to choose between a tub bath, shower, bed bath, or sponge bath. A state optional MDS assessment, dated 6/12/24, indicated extensive assistance with one staff person for bed mobility, transfers, and toileting. A current ADL care plan indicated Resident D required maximal assistance with one staff for showers and indicated often refuses that was revised on 8/5/24. An observation conducted of Resident D, on 8/4/24 at 1:57 p.m., indicated a long right thumb nail with brown substance underneath the nail. An observation conducted of Resident D, on 8/4/24 at 2:58 p.m., indicated a long right thumb nail with brown substance underneath the nail. Shower sheets and the plan of care (POC) charting task of bathing/shower documentation was provided. The documentation indicated Resident D last received nail care, on 7/9/24, and didn't receive showers, twice weekly, for the first two weeks in July 2024, nor the week of July 29, 2024. 3. The clinical record for Resident E was reviewed on 8/6/24 at 11:36 a.m. The diagnoses included, but were not limited to, traumatic subdural hemorrhage, paranoid schizophrenia, and diabetes mellitus. A state optional MDS assessment, dated 7/24/24, indicated Resident E was independent with transfers and extensive assistance with one staff person for toilet use. A current ADL care plan indicated Resident E required supervision/occasional limited assistance by staff for bathing/showering. An observation conducted of Resident E, on 8/4/24 at 3:05 p.m., noted his hair was greasy. Shower sheets and the plan of care (POC) charting task of bathing/shower documentation was provided. The documentation indicated Resident E did not receive, nor was offered bathing/showers twice weekly from 7/8/24 until 7/17/24. An interview conducted with the Regional Nurse Consultant, on 8/6/24 at 11:14 a.m., indicated the expectations were for residents to be bathed twice weekly or according to the plan of care. Bathing includes nail care being provided. 41129 (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The clinical record for Resident B was reviewed on 8/6/24 at 2:43 p.m. The diagnoses included, but were not limited to, diffuse traumatic brain injury, generalized anxiety disorder, epilepsy (seizure disorder), and paraplegia (a chronic condition that impairs the motor or sensory function of the lower half of the body). Resident B was admitted to the facility for a respite (providing or being temporary care in relief of a primary caregiver) stay on 5/31/24 and was discharged to home on 6/10/24. An interview with Resident B's representative, conducted on 8/6/24 at 3:35 p.m., indicated Resident B was discharged home on 6/10/24. She indicated when he arrived from the facility, he stunk like he hadn't been bathed for the 11 days he was in the care of the facility. A physician's progress note, dated 5/31/24, indicated Resident B was a paraplegic that had contractures to both hands and flaccid (limp) legs. Resident B had a severe cognitive deficit, his ability to communicate was limited, and his mobility was very limited making him wheelchair bound. Resident B's care plan, created on 6/17/24, indicated he had an ADL self-care performance deficit and was totally dependent on the assistance of one staff member to provide bathing/showering. A resident shower sheet, dated 6/4/24, was provided by Regional Nurse Consultant (RNC) on 8/7/24 at 12:56 p.m. It indicated, Resident B received a shower, and a shampoo was provided. An interview with the RNC, conducted at the same time as when the shower sheet was received, indicated she was unable to locate any other shower sheets for Resident B's stay between 5/31/24 and 6/10/24. This citation relates to Complaint IN00436612. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(E)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 36942 Based on observation, interview, and record review, the facility failed to ensure individualized activities were provided for 1 of 2 residents reviewed for activities. (Resident D) Findings include: The clinical record for Resident D was reviewed on 8/6/24 at 11:53 a.m. The diagnoses included, but were not limited to, traumatic brain injury, major depressive disorder, and anxiety disorder. The annual Minimum Data Set assessment, dated 6/12/24, indicated severe cognitive impairment and very important for Resident D to keep up with the news. An activities care plan, revised 3/12/24, indicated to inform resident of daily activities, encourage resident to take his meals in the dining room for socialization, and invite resident to each activity of interest daily. An activities review document, dated 7/2/24, indicated Resident D's favorite activities were going outside, BINGO, and independently watching television in his room. An observation was conducted of Resident D, on 8/4/24 at 1:57 p.m., of him laying in bed with his eyes open and the television was off. An observation was conducted of Resident D, on 8/4/24 at 2:58 p.m., of him laying in bed with his eyes open and the television was off. An observation was conducted of Resident D, on 8/5/24 at 3:26 p.m., of him laying in bed with his eyes open and the television was off. He was looking around his room while facing towards the window. A policy titled Activities Programs, revised June of 2018, was provided by the Regional Nurse Consultant on 8/6/24 at 9:47 a.m. The policy indicated the following, .2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident .3. The Activities Program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities 3.1-33(a)

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	155857	A. Building B. Wing	08/08/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34850 Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered; effectively administer eye medications, and timely initiate a treatment for a diabetic ulcer for 1 of 1 resident reviewed for skin impairment, 1 of 10 residents observed for medication administration, and 1 of 1 resident reviewed for antibiotic usage. (Resident 30, Resident D and Resident J) Findings include: 1. The clinical record for Resident 30 was reviewed on 8/5/24 at 10:15 a.m. The diagnoses included, but were not limited to, intracranial injury (brain injury). A quarterly Minimum Data Set (MDS) assessment, dated 5/12/24, indicated Resident 30 was cognitively impaired. A care plan for Resident 30, dated 5/29/24, indicated the following, The resident is on antibiotic therapy for chronic urinary tract infection with catheter. MD [medical doctor] to be notified q [every] 3 m [months] to change antibiotic .Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness . A physician order, dated 5/31/24, indicated staff should administer 875-125 milligrams of amoxicillin-pot clavulanate daily for bacterial infection for 69 days. The order was discontinued on 8/4/24. A physician order, dated 8/5/24, indicated staff should administer 875-125 milligrams of amoxicillin-pot clavulanate daily for bacterial infection for 69 days. The July 2024 Medication Administration Record (MAR) indicated the 875-125 milligrams of amoxicillin-pot clavulanate was not administered as ordered on 7/10/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/20/24, 7/21/24, 7/22/24, 7/26/24, 7/27/24, 7/28/24, 7/29/24 and 7/31/24. The August 2024 MAR indicated the 875-125 milligrams of amoxicillin-pot clavulanate was not administered as ordered on 8/1/24, 8/2/24, 8/3/24 and 8/5/24. The July 2024 and August 2024 nursing notes indicated the 875-125 milligrams of amoxicillin-pot clavulanate was not administered, on the dates listed above, because the medication was on order. An interview was conducted with the Regional Nurse Consultant on 8/7/24 at 2:30 p.m. She indicated she was unsure why Resident 30's amoxicillin-pot clavulanate was not available to be administered. 2. The clinical record for Resident J was reviewed on 8/5/24 at 1:00 p.m. The diagnoses included, but were not limited to, stroke. A physician order, dated 5/7/24, indicated the resident was to receive one drop of Atropine 1% eye drops twice a day in his right eye. (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 4/22/24, indicated the resident was to receive one drop of dorzolamide 2-0.5% twice a day in his right eye. A physician order, dated 5/7/24, indicated the resident was to receive one drop of Vigamox eye drops in his right eye every four hours. A physician order, dated 5/7/24, indicated the resident was to receive one application of 5 milligrams of erythromycin ointment twice a day in his right eye. An observation was conducted of a medication administration for Resident J with Registered Nurse (RN) 9 on 8/6/24 at 10:18 a.m. During the administration, RN 9 was observed administering eye drops to the resident's right eye. She administered one drop of dorzolamide to his right eye. Immediately after, RN 9 administered one drop of Atropine to his right eye. She then administered one drop of Vigamox to his right eye. RN 9 concluded by applying erythromycin ointment to his right eye. There was no delay in the administration of eye drops or the erythromycin application. During an interview with the Regional Nurse Consultant, on 8/6/24 at 12:00 p.m., she indicated she was unsure the wait times in between multiple eye drop administrations. An eye drop administration policy was provided by the Regional Nurse Consultant on 8/6/24 at 1:55 p.m. The policy indicated the following, .to administer ophthalmic solution into and around the eye in a safe and accurate manner .Wait at least five (5) minutes before applying additional medications to the eye . An Ordering and Receiving Medications policy was provided by the Regional Nurse Consultant on 8/6/24 at 1:55 p.m. The policy indicated the following, .Policy: Medications and related products are received from the pharmacy in a timely manner . 36942 3. The clinical record for Resident D was reviewed on 8/6/24 at 1:26 p.m. The diagnoses included, but were not limited to, traumatic brain injury, type 2 diabetes mellitus, and malnutrition. A progress note, dated 7/25/24 at 9:07 p.m., indicated Resident D returned to the facility from a hospitalization and his skin was intact. A weekly wound observation tool, dated 7/26/24, indicated a diabetic ulcer to the left heel that was acquired on 7/25/24. A weekly skin assessment, dated 7/31/24, indicated a diabetic ulcer to Resident D's left heel. A current care plan indicated Resident D had a diabetic ulcer to the left heel. The interventions included to administer treatment as ordered by the physician. (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 7/31/24 at 9:45 p.m., indicated to cleanse to right heel (sic) with wound cleanser, pat dry, cover with calcium alginate, apply skin prep to the peri wound, wrap with gauze, and secure with tape daily and as needed. The order indicated to apply a treatment to the right heel, but the left heel was documented to have a diabetic ulcer on the weekly skin assessment, dated 7/31/24, and the wound observation tool, dated 7/26/24. There were no previous physician orders for the treatment of Resident D's diabetic ulcer prior to 7/31/24. The treatment administration record (TAR), dated August of 2024, indicated the treatment to Resident D's heel was initially signed off on 8/1/24. A policy titled Weekly Skin Check, dated 11/2011, was provided by Regional Nurse Consultant on 8/6/24 at 9:47 a.m. The policy indicated the following, .2. If skin impairment has been identified the nurse shall complete the Weekly Skin Assessment form indicating any new areas of abnormality .and obtain a treatment order from the attending MD (Medical Director) immediately This citation relates to Complaint IN00438800. 3.1-37(a)

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	155857	A. Building B. Wing	08/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34850 Based on interview and record review, the facility failed to ensure wound dressings were completed as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 8/4/24 at 11:30 a.m. The diagnoses included, but were not limited to, stage 4 sacral pressure ulcer (the most severe type of pressure ulcer and occurs when the hypodermis and underlying fascia are breached, exposing muscle and bone). A quarterly Minimum Data Set assessment, dated 7/11/24, indicated Resident 15 was cognitively intact. A physician order, dated 7/7/24, indicated the staff were to cleanse all open areas with vashe wound wash, dry area thoroughly, cover with calcium alginate with silver to all open areas, cover with ABD [abdominal] pads, secure with tape. The staff were to change the wound dressing on day shift and night shift. The July 2024 Medication/Treatment Administration Record (MAR/TAR) indicated the following date(s) and shifts the resident's wound treatments were not completed as ordered: 7/4/24 - day shift, 7/10/24 - day shift, 7/11/24 - day shift and night shift, 7/12/24 - day shift, 7/13/24 - night shift, 7/15/24 - day shift, 7/16/24 - day shift, 7/17/24 - day shift, 7/18/24 day shift, 7/19/24 - night shift, 7/20/24 - day shift, 7/22/24 - day shift and night shift, (continued on next page)

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	08/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/24/24 - night shift, 7/25/24 - day shift, 7/26/24 - day shift and night shift, 7/27/24 - day shift and night shift, 7/28/24 - day shift and night shift, 7/29/24 - day shift, 7/30/24 - day shift, and 7/31/24 - day shift. The August 2024 MAR/TAR indicated the resident's wound treatments were not completed as ordered on 8/1/24 during day shift. The resident's clinical record did not have documentation the resident refused the wound treatment on those days. An interview was conducted with Resident 15 on 8/5/24 at 10:29 a.m. He indicated the staff did not change the dressings twice daily as they should be. An interview was conducted with the Regional Nurse Consultant on 8/6/24 at 12:00 p.m. She indicated the resident was not compliant with his wound dressings, but the staff should be documenting if he refused. 3.1-40(a)(2)

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	08/08/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50826 Based on observation, interview and record review, the facility failed to manage a feeding pump resulting in a miscalculated amount of tube feeding and water flushes for 1 of 5 residents reviewed for feeding tubes. (Resident R) Findings include: The clinical record for Resident R was reviewed on 08/06/24 at 1:44 p.m. The diagnoses included, but were not limited to, respiratory failure with use of a tracheostomy, diabetes mellitus, and quadriplegia. Resident R was admitted to the facility on [DATE]. An observation was conducted of Resident R on 08/05/24 at 09:19 a.m. The label attached to the enteral feeding bag indicated to infuse Glucerna at 60ml/hr (milliliters/hour) and 30ml/hr for water flush. The feeding pump was programmed and infused enteral feeding at 65 ml/hr and 40ml/hr for water flush. On 08/05/24 at 02:35 p.m., an observation of the feeding pump for Resident R indicated the feeding pump was infusing Glucerna at 65ml/hr and 40ml/hr for water flush. On 08/06/24 at 01:25 p.m., an observation of Resident R's room indicated the label attached to the enteral feeding bag hanging read Glucerna at 60ml/hr and 30ml/hr for water flush. The feeding pump was programmed and infused feed at 65ml/hr and 40ml/hr for water flush. An interview was conducted with RN 9 on 08/06/24 at 01:35 p.m. RN 9 indicated the feeding pump was programmed differently than the label on the enteral feeding bag. She indicated she would stop the pump and review the orders for Resident R. A physician order, dated 07/19/24 at 06:43 a.m., indicated the following, every shift Glucerna 1.5 at 60ml/hr and 30ml/hr water flush. A care plan, dated 07/16/24, indicated The resident is dependent with tube feeding and water flushes. See MD [medical director] orders for current feeding orders. On 08/06/24 at 01:55 p.m., a policy titled Best Practices for Administering Tube Feeding and Management/Treatment was provided by the Regional Nurse Consultant. The policy indicated, Review the individual's tube feeding orders and nutritional care plan. 3.1-44(a)(2)

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	08/08/2024

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Tranquility Nursing and Rehab	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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50826 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) had worked a minimum of 8 hours (in each 24-hour day) in the facility during the time frame of January 1, 2024 - March 31, 2024. This had a potential to affect 35 of 35 residents that resided in the facility. The PBJ (Payroll-Based Journal) Staffing Data Report that was generated, from January 1, 2024 - March 31, 2024, indicated the facility failed to have an RN working in the building for 25 out of the 91 days in the first quarter. An interview was conducted with the Executive Director (ED) on 8/8/24 at 10:30 a.m. He indicated that the facility had no RN's working in the building for the following dates: 01/27/24, 01/28/24, 02/11/24, 02/17/24, 02/18/24, 03/02/24, 03/03/24, 03/17/24, and 03/30/24. On 8/8/24 at 02:49 p.m., a policy titled Staffing Policy was provided by the Regional Nurse Consultant. The policy indicated the following, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. 3.1-17(b)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on observation, interview and record review, the facility failed to ensure a routine anti-convulsant medication was available for administration (Resident M), admission orders were received for a newly admitted resident with an insulin pump and utilized an outside pharmacy (Resident C), and an effective system for disposition of medications was effectively implemented (Resident B and Resident C) for 2 of 2 closed records reviewed and 1 of 10 residents reviewed for medication administration. (Resident B, Resident C, and Resident M) Findings include: 1. The clinical record for Resident M was reviewed on 8/4/24 at 12:00 p.m. The diagnoses included, but were not limited to, seizures. A physician order, dated 6/15/24, indicated Resident M should receive 375 milligrams of Depakote once a day. The August 2024 Medication Administration Record (MAR) indicated Resident M did not receive his 375 milligrams of Depakote as ordered on 8/5/24. During an observation of medication administration with Qualified Medication Aide (QMA) 7 on 8/6/24 at 8:34 a.m., QMA 7 was observed preparing Resident M's medications for administration. QMA 7 indicated the resident's 375 milligrams of Depakote was not available for administration. The last dosage he received was on 8/4/24. An interview was conducted with the Regional Nurse Consultant on 8/6/24 at 12:00 p.m. She indicated she was unsure why Resident M's Depakote was not available for administration. The staff should be ordering approximately one week prior to running out. Some staff are not consistently popping pills out of the card numerically. They sporadically pop the medications out of the cards, so it was difficult to recognize when the medications were running low to reorder the medications. Valproic Acid medication at MedlinePlus drug information at website www.medlineplus.gov, dated 4/15/19, was retrieved on 8/15/24. The website indicated the following, .Valproic acid is used alone or with other medications to treat certain types of seizures .Take valproic acid at around the same time(s) every day. Take valproic acid with food to help prevent the medication from upsetting your stomach. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take valproic acid exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor . 2. The clinical record for Resident C was reviewed on 8/4/24 at 1:30 p.m. The diagnoses included, but were not limited to, Type 1 diabetes mellitus (pancreas makes little or no insulin; also known as insulin dependent diabetes). The resident was admitted on [DATE]. An admission Minimum Data Set assessment, dated 5/30/24, indicated Resident C did not receive insulin injections in the past seven days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 5/23/24, indicated Resident C had type 1 diabetes and utilized an insulin pump. Interventions included, but were not limited to, provide diabetic medications as ordered by physician. An admission note, dated 5/24/24, indicated Resident C had an insulin pump. The resident's blood sugar was monitored with a Dexcom (continuous glucose monitoring system) that was connected to a personal phone. Resident C's clinical record did not include physician orders on how to address the resident's insulin pump, nor physician orders for the administration of insulin. A physician order, dated 5/23/24, indicated insulin pump is monitor [sic] by spouse phone, when sugar is too low an alarm will sound. Give resident a soda or orange juice immediately. A physician order, dated 5/28/24, indicated the staff was to check the resident's blood sugar four times a day. If the blood sugar was less than 70 or greater than 400 notify the medical provider. The staff was to check resident's phone for diabetic application. A physician order, dated 5/28/24, indicated the staff was to change insulin dexcom C6 receiver on ABD [abdomen] region every 10 days. A physician order, dated 5/28/24, indicated the staff was to change insulin dexcom C6 receiver [a wearable device that continuously tracks blood sugar levels] on upper arm extremity every three days. The resident's clinical record did not include the staff had administered insulin; changed out insulin pods for an insulin pump, nor pharmacy review of medications such as insulin. 2b. A physician order, dated 6/17/24, indicated Resident C was to receive 100 milligrams of trazadone at night. A medical provider visit note from Nurse Practitioner 30, dated 7/5/24, indicated the following, .Patient [Resident C] is seen today for acute visit related to alert critical glucose. Follow up related to alert critical high glucose. Patient glucose was 302 today; patient's [Resident C's Representative] manages his insulin pump for sliding scale that is connected to her phone. Patient has been stable and no new complaint or concerns. A nursing progress note, dated 7/9/24, indicated Spoke with resident [Representative], regarding her wishes to take resident home with her. She has some concerns with resident's diabetic pump and monitoring of sugars via resident's and her phones only. Resident broke his phone within the last 24 hours and notification of sugars not available at facility. Manual sugars [staff obtain blood sugar readings by glucometer] being taken and insulin given. Wife voiced she had no other complaints with resident's care while he was at the facility . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a confidential interview, they indicated Resident C's representative discharged Resident C to home due to the staff was not appropriately caring for the resident's diabetes that utilized an insulin pump. Resident C's representative had provided the facility insulin pods and vials of insulin utilizing an outside pharmacy. Resident C's representative came in for a visit, on 7/7/24, and observed the insulin pump had been alarming and had run out of insulin. The resident's blood sugar had been elevated. The staff had not replaced the pod in the pump. Resident C's representative provided education to two different Directors of Nursing on how to manage the pump throughout Resident C's stay at the facility. Resident C's representative decided to discharge the resident home after Resident C's representative had observed the insulin pump pod had not been changed. Later, it was recognized the resident did not receive all his medications at discharge. Resident C's representative contacted the facility and returned a few days later to pick up a medication card of trazadone. All personal information and medication information was removed from the medication card. The resident's name was handwritten. Registered Nurse (RN) 6 had taken the medication out of the medication cart and gave the trazadone medication card to Resident C's representative. They indicated Resident C's representative was unsure if the trazadone belonged to the resident. She did accept the trazadone medication. An interview was conducted with RN 6 on 8/7/24 at 3:04 p.m. He indicated Resident C's representative had provided the insulin pods for the insulin pump and insulin vials to be used if needed. The resident's insulin pump would alarm all the time. The resident and the resident's representative had phone applications to provide the blood sugar readings and how much, if needed, of the insulin administration utilizing the vials she provided. The staff would change out the insulin pods and administer the insulin vials using a sliding scale at times. During his stay, the resident broke his phone, so the staff had to conduct the blood sugar readings by pricking his finger and utilizing a glucometer. After the resident's discharge, Resident C's representative did return to the facility and RN 6 gave a bubble pack of trazadone medication to them. The trazadone medication did belong to Resident C. He could not recall if the medication card was torn, or ripped, or without labeling of personal and/or medication information. An interview was conducted with the Regional Nurse Consultant on 8/8/24 at 9:20 a.m. She indicated upon admission through mid-part of his stay Resident C's representative managed the insulin pump for a while. The staff proceeded to take over the care of his insulin pump later during his stay. The former Director of Nursing would change the insulin pods herself. There was an insulin sliding scale the staff would utilize at times, but the resident used an application on his phone to indicate the dosage of the insulin to administer. The resident's representative had a lot of control how the staff was to manage his insulin. She wanted the trazadone supply, but it had not arrived from the pharmacy at the time of discharge. She returned to the facility a few days after Resident C had discharged , and RN 6 had given the supply of trazodone to her. RN 6 did not have Resident C's representative sign anything to indicate she had received the trazadone medication supply as anticipated. An interview was conducted with Nurse Practitioner 30 on 8/8/24 at 11:26 a.m. She indicated Resident C's representative wanted a lot of control over the management of Resident C's insulin medication. The resident and his representative utilized an application on their phones for blood sugar readings, and the administration of the insulin coverage. The phone application would indicate how much insulin the staff was to administer depending on his blood sugar reading. The staff used a Novolog insulin medication sliding scale that was on the phone application. She was fine with the staff using the sliding scale on the phone application due to the preference of Resident C and his representative. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41129 3. The clinical record for Resident B was reviewed on 8/6/24 at 2:43 p.m. The diagnoses included, but were not limited to, diffuse traumatic brain injury, generalized anxiety disorder, epilepsy (seizure disorder), and paraplegia (a chronic condition that impairs the motor or sensory function of the lower half of the body). Resident B was admitted to the facility on [DATE] and discharged on [DATE]. He did not have an admission Minimum Data Set assessment completed. Resident B's physician's orders for June 2024 did not contain an order for Xanax (an anti-anxiety medication, also known as alprazolam). Resident B's care plan, created on 6/16/22, indicated he utilized anti-anxiety medications related to a diagnosis of anxiety. Interventions included, but were not limited to, administer anti-anxiety medications as ordered by physician and monitor for side effects. An interview with Resident B's representative, conducted on 8/6/24 at 3:35 p.m., indicated Resident B was to receive Xanax 0.25 mg (milligrams) three times a day, daily. When Resident B was discharged from the facility, she did not receive any of his Xanax pills from the facility and wanted to know where they went. An interview with the facility's pharmacy was conducted on 8/8/24 at 8:30 a.m. The pharmacy representative indicated the facility had received 18 alprazolam tablets, on 5/31/24, for Resident B. The pharmacy representative indicated they had not received any returned alprazolam tablets back at the pharmacy. They indicated the pharmacy does not accept returns of controlled medications and they must be destroyed at the facility if not given to the resident upon discharge. When asked if they had record of who signed for the alprazolam delivery, they indicated no signature was obtained upon delivery only a check mark to indicate it was delivered. A pharmacy's Prior Authorization fax, dated 5/31/24, indicated Resident B's alprazolam (an anti-anxiety medication; also known as, Xanax) had been initially dosed and delivered as a short supply because the medication required a prior authorization from the insurance plan for reimbursement. The form was signed and dated 6/3/24. Resident B's clinical record did not contain a physician's order for Xanax 0.25 mg to be given three times a day, nor did it indicate the disposition of the alprazolam tablets upon discharge from the facility. A controlled medication count sheet for alprazolam was not in the clinical record. Resident B's Medication Administration Record (MAR), for July 2024, did not indicate any of the 18 tablets of alprazolam had been administered to Resident B during his stay at the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Regional Nurse Consultant (RNC), conducted on 8/8/24 at 8:52 a.m., indicated she had searched for Resident B's alprazolam tablets within the facility and was not able to locate any of the tablets. The RNC indicated she was unable to find an order for the alprazolam and was confused as to why the pharmacy delivered a medication to for a resident without a current order for the medication. She indicated, she attempted to reach the consultant pharmacist concerning the matter, but was unsuccessful. The facility did not have evidence to indicate Resident B received any of the alprazolam doses; were not able to provide a controlled medication count sheet for the alprazolam; nor did they have evidence to prove the alprazolam had been destroyed at the facility. RNC was unable to locate and provide the pharmacy delivery inventory sheet from the day the alprazolam for Resident B was delivered. RNC indicated the Director of Nursing had changed, in July 2024, and she was having trouble finding paperwork from that time period. The RNC indicated she did not believe the facility's pharmacy had recognized the discrepancy. An Ordering and Receiving Controlled Medications policy received on 8/8/24 at 9:11 a.m., from RNC, indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substance by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations .New and refill order for controlled medications other than those in Schedule II are ordered as detailed as follows: a. Ordering nurse must be a designated agent of the physician .3. The pharmacy dispenses medications listed in Schedule II, III, IV, and V in readily accountable quantities and containers designed for easy counting of contents .4. An individual resident's controlled substance record is prepared by the pharmacy or the facility for each controlled substance medication prescribed for the resident The following information is completed: a. Name of resident b. Prescription number c. Drug name, strength .and dosage form of medication d. Date received e. Quantity received f. Name of person receiving the medication supply . This citation relates to Complaints IN00436612 and IN00438800. 3.1-25(a) 3.1-25(b)(3) 3.1-25(e)(2) 3.1-25(p) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50826 Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when unattended, failed to date medications when opened, failed to destroy expired medications, failed to ensure food items were not stored in the medication refrigerator and failed to ensure medication carts were free from loose pills in 2 of 2 medication carts and 1 of 1 medication storage rooms. ((Ventilator unit (Vent) and Traumatic Brain Injury (TBI) medication carts and storage rooms)) Findings include: 1. On 8/8/24 at 2:47 p.m., an observation was conducted of QMA 8 standing in the hall entryway of the TBI unit. The medication cart was located around the corner from Qualified Medication Aide 8 (QMA), behind a separation wall taller than the cart. Upon approach to the medication cart, it was observed to be unlocked with no licensed nursing staff within sight of the cart. During an interview on 8/8/24 at 2:48 p.m., QMA 8 indicated the cart should have been locked. 2. During a medication storage observation on the TBI medication cart, on 8/8/24 at 2:50 p.m., the following was observed: an opened/undated vial of Humalog insulin; an opened/undated vial of Humulin R insulin; and three loose pills in the third drawer. During an interview on 8/8/24 at 2:51 p.m. with QMA 8, she indicated the loose pills should not be in the cart. 3. On 8/8/24 at 2:35 p.m., the medication cart for the Vent unit was observed with a container of Miralax on the top of the medication cart with no licensed nursing staff within sight of the cart. During an interview, on 8/8/24 at 2:35 p.m., Registered Nurse (RN) 9 indicated the medication should not be left out on the medication cart. 4. On 8/8/24 at 2:40 p.m., an observation was conducted of the Medication Storage room on the Vent unit. An opened container of Clorpactin 500mg (milligrams) bladder irrigation with a use by date of 12/29/23 by 14:30, and without a resident identifier or label was shelved in the cabinet labeled wound care, alongside the wound care supplies. During an interview, on 8/8/24 at 2:40 p.m., RN 9 indicated the medication should not be in the cabinet that housed wound care supplies. The items should have resident information on it and expired medications should be destroyed. 5. On 8/8/24 at 2:41 p.m., an observation was conducted of the refrigerator in the Medication Storage room on the Vent unit. Located on the top shelf in the refrigerator was an unopened individual container of applesauce, an unopened individual container of Jello, and an unopened individual container of chocolate pudding. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/8/24 at 2:41 p.m., RN 9 indicated she was unaware that food items for the residents should not be stored in the medication refrigerator. During an interview, on 8/8/24 at 4:13 p.m., the Regional Nurse Consultant (RNC) indicated that no food items of any kind are to be stored in the medication refrigerator located in the medication storage room. 6. On 8/8/24 at 2:41 p.m., an observation was conducted of the medication storage room on the Vent unit. Located on the storage shelf for enteral feeding were 15 containers of TwoCal 2.0 475ml (milliliters), all with an expiration date of 7/30/24, and 3 containers of Promote with fiber 1.0 475ml, all with an expiration date of 7/30/24. During an interview, on 8/8/24 at 2:41 p.m., RN 9 indicated expired enteral feeding product should be destroyed. 7. During a medication storage observation of the Vent unit medication cart on 8/8/24 at 2:45 p.m., an opened/undated Kwikpen with Humalog insulin was observed in the top drawer. During an interview, on 8/8/24 at 2:45 p.m., RN 9 indicated the insulin pen should have been dated when it was pulled from refrigerator for use with both the open date and use by/expiration date. On 8/8/24 at 4:13 p.m., the RNC provided the policy titled Storage of Medications and Biologicals, dated 5/21/18, and indicated the policy was currently used by the facility. The policy indicated the following, The facility is required to secure all medications in a locked storage area and to limit access to only authorized or licensed personnel .Storage areas may include, but are not limited to, drawers cabinets, medication rooms, refrigerators and carts .Store medication(s) separately from fruit juices, applesauce, and other foods used for administering medication(s) .No employee or personal food items should be stored in the medication refrigerator .Disposal of medication(s) should be completed for medication(s) that are without secure closure, outdated, contaminated or deteriorated .Disposal needs to be timely. 3.1-25(j) 3.1-25(k)(6) 3.1-25(m) 3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on observation, interview, and record review, the facility failed to ensure proper food storage related to undated/expired food, boxes stacked on the floor, and dishwasher temperatures not monitored and/or documented to determine when the dishwasher was not functioning properly. This had the potential to affect 30 out of 35 residents who receive food from the kitchen. (Facility) Findings include: a. An initial tour of the kitchen was conducted, on [DATE] at 11:08 a.m., with [NAME] 6. The dishwasher appeared to have a label to indicate it was a high temperature dishwasher to reach 150 degrees Fahrenheit (F) for wash and 180 degrees F for rinse. [NAME] 6 ran the dishwasher through 3 cycles with the following temperatures noted: First round was 154 degrees F for wash and 120 degrees F for rinse, Second round was 152 degrees F for wash and 123 degrees F for rinse, & Third round was 154 degrees F for wash and 127 degrees F for rinse. An interview with [NAME] 6, on [DATE] at 11:10 a.m., indicated the Maintenance Director had been working on the dishwasher for the past couple of days. The Maintenance Director did not instruct them to not utilize the dishwasher. There were two carts that contained dishes that were located on the end of the dishwasher to indicate they have been ran through the machine. [NAME] 6 indicated they did have a supply of paper products, and she would utilize such for lunch service. The Dishwasher Temperature Worksheet was taped to the wall by the dishwasher, dated [DATE]. The worksheet was completely blank for the month of August. The [DATE] Dishwasher Temperature Worksheet was provided by the DM on [DATE] at 1:17 p.m. The document indicated the temperature was to be checked for breakfast, lunch, and dinner for all 31 days of the month. There were 13 instances for breakfast, 12 instances for lunch, and 15 instances for dinner where the dish machine did not meet 180 degrees F for the month of [DATE]. b. The dry storage room was noted with two sets of boxes that had a total of three boxes stacked on each set and located on the floor. The main refrigerator was noted with the following: A cantaloupe noted with a black substance and what appeared to be mold on the core, A bag of wilted lettuce, opened, and a best by date of [DATE], Another bag of lettuce, unopened, and a best by date of [DATE], A Ziploc bag of parmesan cheese, left open, and not sealed, A jar of pickle ranch with no indication of a use by date, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A jar of relish with a use by date of ,d+[DATE], A container of cooking wine with a use by date of ,d+[DATE], & A jar of French dressing with a use by date of [DATE]. Cook 6 proceeded to go into the refrigerator and discard the items that were expired, outdated, and/or unlabeled. [NAME] 6 indicated she believed the other staff checked the refrigerator the previous day. An interview conducted with the Dietary Manager (DM), on [DATE] at 1:17 p.m., indicated the dishwasher has been up and down and they had utilized paper products for August. The Maintenance Director was in the kitchen Friday, [DATE], when the DM made him aware of the issue. They were serving on paper products during that time. The Maintenance Director left the kitchen and didn't comment further about the dishwasher. The kitchen staff would continue to utilize paper products until they heard otherwise. The dietary staff knew to pull items that are expired, outdated, and/or unlabeled out of the refrigerator. The DM indicated she was the primary one to check and audit the food. An interview conducted with the Maintenance Director, on [DATE] at 3:30 p.m., indicated he was notified, last Wednesday or Thursday, about the dishwasher not reaching the proper temperature. He ordered a booster heater to heat the water during the rinse cycle to ensure it would reach 180 degrees F. He attempted to install the booster heater, on [DATE], but it wasn't the correct one. So, he ordered another one and it was due to arrive on [DATE]. A policy titled Food Receiving and Storage, revised [DATE], was provided by Regional Nurse Consultant on [DATE] at 9:47 a.m. The policy indicated the following, .1. Food Services, or other designated staff, will maintain clean food storage areas at all times .5. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean .6. Food in designated dry storage areas shall be kept off the floor (at least 18 inches) .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) A policy titled Dishwashing Machine Use, revised [DATE], was provided by Regional Nurse Consultant on [DATE] at 9:47 a.m. The policy indicated the following, .2. Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures .a. 150 [degrees] F for stationary rack .3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 [degrees] F, or less than .b. 180 [degrees] F for all other machines 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(3)

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	155857	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36942 Based on interview and record review, the facility failed to ensure accurate and complete documentation of the medication administration record (MAR) for 2 of 5 residents reviewed for unnecessary medications. (Resident D and Resident N) Findings include: The clinical record for Resident D was reviewed on 8/6/24 at 11:53 a.m. The diagnoses included, but were not limited to, traumatic brain injury, major depressive disorder, and anxiety disorder. A physician order, dated 3/23/23, indicated to check Resident D's blood glucose before meals and at bedtime. The August 2024 MAR indicated the 12:00 p.m. and 4:00 p.m. blood glucose check, for 8/5/24, was blank. A physician order, dated 3/23/23, indicated Humalog (short acting insulin) per sliding scale before meals and at bedtime. The August 2024 MAR indicated the following date(s)/time(s) where the Humalog was left blank: 8/1/24 at 12:00 p.m., 8/1/24 at 6:00 p.m., 8/5/24 at 12:00 p.m., & 8/5/24 at 6:00 p.m. The August 2024 MAR indicated the following date(s)/time(s) where the Humalog was not signed off, as administered, due to Resident D sleeping: 8/1/24 at 9:00 p.m., 8/2/24 at 7:00 a.m., 8/3/24 at 9:00 p.m., 8/4/24 at 7:00 a.m., 8/4/24 at 9:00 p.m., & 8/5/24 at 7:00 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no progress notes to indicate that the nursing staff attempted to reapproach or awaken Resident D to administer his Humalog insulin. 41129 2. The clinical record for Resident N was reviewed on 8/6/24 at 1:48 p.m. The diagnoses included, but were not limited to, traumatic brain injury, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, schizophrenia, and psychotic disorder with delusions. Resident N's census record did not indicate Resident N was out of the facility on 7/26/24 nor 7/27/24. Resident N's clinical record indicated the physician's orders included, but were not limited to: A physician's order, dated 12/12/23, indicated to give 7.5 mg (milligrams) of olanzapine (antipsychotic medication) by mouth one time a day related to schizophrenia. A physician's order, dated 6/24/24, indicated to give 25 mg of trazodone (antidepressant) by mouth at bedtime for insomnia. A physician's order, dated 9/14/23, indicated to give 20 mg of Buspar (antianxiety medication) by mouth three times a day for anxiety. A physician's order, dated 5/31/23, to give 15 mg of olanzapine by mouth at bedtime related to schizophrenia. A physician's order, dated 9/14/23, indicated to give Zoloft (antidepressant) 50 mg; 1.5 tablets to equal 75 mg by mouth one time a day related to major depressive disorder. A physician's order, dated 4/18/23, indicated to give 50 mg of tramadol every 8 hours as needed for pain. A review of Resident N's July 2024 Medication Administration Record, conducted on 8/6/24 at 1:37 p.m., indicated on 7/26/24 and 7/27/24, Resident N either did not receive many of his daily medications or the administration/denial of the medications were not documented in the MAR or in his progress notes. The medications not documented on 7/26/24 were: olanzapine 7.5 mg; once a day; Zoloft 50 mg; one and a half tabs once a day; & Buspar 20 mg; for 2 out of 3 doses. The medications not documented on 7/27/24 were: olanzapine 7.5 mg; once a day; olanzapine 15 mg; at bedtime; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trazodone 25 mg; at bedtime; Zoloft 50 mg; one and a half tabs once a day; & Buspar 20 mg; for 3 out of 3 doses. An interview with the Regional Nurse Consultant (RNC), conducted on 8/8/24 at 9:11 a.m., indicated she was unable to determine the reason why Resident N's July 2024 MAR, for the previously mentioned medications, was blank. The RNC indicated she was unable to indicate, if or if not, Resident N received the aforementioned medications on 7/26/24 and/or 7/27/24. A Medication Administration policy was received on 8/8/24 at 9:11 a.m. The policy indicated, Qualified staff will administer medication to residents only per physicians[sic] orders and facility policy .All medications administered will be documented .6. Administer the medication. IF the resident refuses medication, indicated failure to administer medication sheet and in the nurses' notes .record the medication given on the medication sheet. 3.1-50(a)(1) 3.1-50(a)(2)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 41129 Based on interview and record review, the facility failed to ensure a binding arbitration agreement was explained to the resident and his/her representatives in a form and manner that he/she acknowledged as being understood for 2 of 2 residents reviewed for arbitration agreements. (Resident H and N) Findings include: 1. The clinical record for Resident H was reviewed on 8/8/24 at 1:07 p.m. The diagnoses included, but were not limited to, schizophrenia and traumatic brain injury. Resident H had a temporary appointed guardian, as of 4/17/24, related to being incapable of managing their person and property because of their schizoaffective disorder and a traumatic brain injury which rendered Resident H unable to make health care decisions on their own and was found to be an incapacitated person under Indiana law. Resident H's admission agreement, dated 5/13/24, included, but was not limited to, a [NAME] Trial waiver. The waiver stated, Each party Hereby irrevocably waives any right it may have, and agrees not to request, a jury trial for the adjudication of any dispute hereunder, or in connection with or arising out of this agreement, including any injury or alleged injury to resident while residing at the facility. This waiver was signed and dated by Resident H after he was already appointed a temporary guardian related to incapacity to make health care decisions on his own and after being found as an incapacitated person. 2. The clinical record for Resident N was reviewed on 8/6/24 at 1:48 p.m. Resident N's diagnoses included, but were not limited to, traumatic brain injury, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, schizophrenia, and psychotic disorder with delusions. A quarterly Minimum Data Set assessment, dated 6/24/24, indicated Resident N was found to have moderate cognitive impairment. Resident N's admission agreement, dated 4/14/23, included, but was not limited to, a [NAME] Trial waiver in which it is stated, Each party Hereby irrevocably waives any right it may have, and agrees not to request, a jury trial for the adjudication of any dispute hereunder, or in connection with or arising out of this agreement, including any injury or alleged injury to resident while residing at the facility. Resident N's sister/representative had signed and dated the [NAME] Trial waiver. An interview with Resident N's sister/representative, at the time of admission, was conducted on 8/9/24 at 2:28 p.m. Resident N's sister/representative indicated, she did not understand that by signing the [NAME] Trial waiver, they were waiving their rights to (if needed) have allegations, including any injury or alleged injury while residing at the facility, heard by a jury of their peers. Resident N's sister indicated, had the waiver been explained to her, she would have never signed such an agreement. (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Admissions Manager (ADM), conducted on 8/8/24 at 3:25 p.m., indicated she was the person responsible for explaining the [NAME] Trial Waiver section in the facility's admission agreement. ADM indicated, she explained the [NAME] Trial waiver as the resident/representatives were free to have an attorney and if they wanted to have an attorney present for the signing of the admission agreement, then they could, but by signing the [NAME] Trial waiver, it indicated they waived the right to have an attorney present at the time the admission agreement was being signed. An interview with Regional Nurse Consultant (RNC) was conducted on 8/8/245 at 3:42 p.m., indicated she was unsure of exactly when the admissions agreement had changed to include the [NAME] Trial Waiver, but the older admission agreements did not include a [NAME] Trial waiver.

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	155857	A. Building B. Wing	08/08/2024

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50826 Based on interview and record review, the facility failed to accurately submit the data for Licensed Nursing Coverage personnel that worked in the facility from January 1, 2024, through March 31, 2024 to CMS (The Centers for Medicare & Medicaid Services) for the Payroll Based Journal (PBJ) Daily Nurse Staffing report. This had a potential to affect 35 of 35 residents that reside in the facility. Findings include: The PBJ Staffing Data Report, that was generated from January 1, 2024 - March 31, 2024, indicated the facility failed to have Licensed Nursing Coverage (LNC) working in the building for 25 days out of 91 days in the first quarter. On 08/08/24 at 10:30 a.m., a quarterly facility schedule, from January 1, 2024 - March 31, 2024, of dates worked for all personnel was provided by the Executive Director (ED). The facility schedule indicated the facility did have LNC in the building for the following dates that were incorrectly reported as having no LNC. An interview was conducted, on 8/8/24 at 11:00 a.m., with the ED. He indicated several of the dates for LNC reported in the first Quarter 2024 PBJ were incorrect. On 08/08/24 at 02:49 p.m., a policy titled, Staffing Policy, was provided by the Regional Nurse Consultant. The policy indicated the following, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41129 Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during medication administration; disinfecting a glucometer; an electric razor was not shared between residents and ensure disinfection of such item after use; and initiation of enhanced barrier precautions that utilize personal protective equipment (PPE) during care for 8 of 10 residents observed during medication administration, 1 of 2 residents reviewed for wounds, and for 3 of 3 residents randomly observed. (Residents 8, 14, 23, D, E, F, J, K, L, M, P, and Q) Findings include: A medication administration observation was conducted, on 8/5/24, with Qualified Medication Assistant 7 (QMA 7). The following was noted: 1. At 9:49 a.m., QMA 7 was about to prepare Resident P's morning medications. QMA 7 had the plastic medication cups stacked on top of the medication cart, so the cups were facing upward. QMA 7 placed her long fingernails inside the cup and pinched the cup, so it was between her index finger and thumb to retrieve a single cup from the stack. QMA 7 then dispensed the medications into the plastic medication cup and administered the medications to Resident P. 2. At 10:25 a.m., QMA 7 was about to prepare Resident Q's morning medication. QMA 7 had the plastic medication cups stacked on top of the medication cart, so the cups were facing upward. QMA 7 placed her long fingernails inside the cup and pinched the cup, so it was between her index finger and thumb to retrieve a single cup from the stack. QMA 7 then dispensed the medication into the plastic medication cup and administered the medication to Resident Q. An interview with Regional Nurse Consultant (RNC), conducted on 8/6/24 at 11:48 a.m., indicated staff members who are administering medications should not place fingers and/or fingernails inside of a medication cup. 34850 3. An observation was made of Resident F on 8/5/24 at 11:25 a.m. Resident F was observed with a Foley catheter. During an interview with Resident F, he indicated the staff only donned gloves to provide care to his wounds and Foley catheter. An interview was conducted with Certified Nursing Assistant (CNA) 4 on 8/5/24 at 11:27 a.m. She indicated she only utilized gloves to provide care to Resident F. (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observations were conducted of medication administration with QMA 7 on 8/6/24 at 8:14 a.m., 8:30 a.m., and 8:40 a.m. QMA 7 was observed preparing and administering Resident K, L and M's medications. During the preparation of the residents' medications, QMA 7 had utilized hand hygiene prior to preparing their medications. After, she was observed touching the following items: the mouse of the computer, keys to unlock the medication cart, medication cart lock, and medication cards. She then utilized her long fingernails and placed her fingers inside the stacked medication cups and pulled apart to retrieve one medication cup from the pile. This occurred during all observations of Resident K, L and M's medication administrations. There was no hand hygiene prior to medication administrations or prior to placing her fingers inside of the medication cups. QMA 7 popped the pills from the medication cards inside the medication cups and administered the residents' medications. 5. A medication administration observation for Resident J was conducted, on 8/6/24 at 10:18 a.m., with Registered Nurse (RN) 9. RN 9 prepared Resident J's medications and took the medications to Resident J's room. RN 9 preformed hand hygiene, donned gloves, and administered Resident J's medications through the g-tube. There was no additional PPE donned for a resident that received medications through a g-tube. 6. An observation was conducted, on 8/6/24 at 11:04 a.m., of obtaining blood sugar readings utilizing a glucometer with QMA 7. QMA 7 was observed removing a glucometer out of the medication cart. QMA 7 indicated, at that time, the glucometer was utilized for all diabetic residents on the traumatic brain injury unit. She then pulled some gloves from a box and entered Resident D's room. QMA 7 was observed obtaining the resident's blood sugar utilizing the glucometer. She then left Resident D's room. At 11:17 a.m., QMA 7 was observed obtaining Resident 14's blood sugar reading utilizing the same glucometer. She then left the resident's room and returned to the cart. There was no observation of QMA 7 disinfecting the glucometer prior or after being utilized for Resident D and Resident 14. An interview was conducted with QMA 7 on 8/6/24 at 11:14 a.m. She indicated the glucometers were disinfected utilizing bleach wipes. If bleach wipes were not accessible, then she utilized alcohol wipes. An interview was conducted with the Regional Nurse Consultant on 8/6/24 at 12:00 p.m. She indicated she was unaware of initiating enhanced barrier precautions to the residents with internal medical devices. QMA 7 should not be putting her artificial nails inside medication cups. The glucometers should be disinfected with germicidal bleach wipes between resident use. The Caring for your System policy for the glucometers was provided by the Regional Nurse Consultant on 8/6/24 at 1:55 p.m. The policy indicated the following, .The meter should be cleaned and disinfected after use on each patient. The Blood Glucose Monitoring System may only be used for testing multiple patients with Standard Precautions and the manufacture's disinfection procedures are followed .We have validated Clorox Healthcare Bleach Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, CaviWipes 1, and PDI Super Sani-Cloth Germicidal Disposable Wipe for disinfection the Assure Prism multi meter . 36942 (continued on next page)

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	155857	A. Building B. Wing	08/08/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. An observation conducted, on 8/4/24 at 3:05 p.m., of Resident E looking through his door and asking for a razer so he can shave himself. Certified Nurse Aide (CNA) 2 was coming out of Resident 8's room and Resident E inquired about needing a razor to shave. CNA 2 went back into Resident 8's room and came back out with a box that indicated an electric razor. Resident E indicated the electric razor belongs to his roommate, Resident 23, and they share the electric razor. An interview conducted with CNA 2, during the observation, indicated Resident 8's facial hair grows quickly and it's easier to shave him with the electric razor. Resident 23 and Resident E are very close. An interview conducted with Resident 23, on 8/5/24 at 10:10 a.m., indicated he utilized an electric razor, and the electric razor was his own personal one. He indicated it had broken on 8/4/24, and he took it apart to see if he could fix it, but he couldn't. An interview conducted with CNA 4, on 8/5/24 at 10:15 a.m., indicated Resident E and Resident 23 are very close and they share everything. They are like brothers. An interview conducted with Regional Nurse Consultant, on 8/5/24 at 10:21 a.m., indicated Resident 8 does have spasticity and utilizing an electric razor was more appropriate for him but the staff should not be sharing an electric razor between multiple residents. A policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, revised July 2014, was provided by Regional Nurse Consultant on 8/6/24 at 9:47 a.m. The policy indicated the resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection. 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(b)(5) 3.1-18(j)(1) 3.1-18(l)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41129 Based on interview and record review, the facility failed to ensure residents were offered the COVID-19 vaccine unless the immunization was medically contraindicated, or the resident had already been immunized for 2 of 5 residents reviewed for COVID-19 vaccinations. (Residents G and O) Findings include: A review of 5 residents' clinical records were reviewed on 8/5/24 at 10:51 a.m. for COVID-19 vaccination status. 1. The clinical record for Resident G did not indicate they had been offered the COVID-19 vaccination since his admission to the facility. Resident G's clinical record did not indicate he refused/accepted the COVID-19 vaccination, nor did it provide evidence to support if Resident G had been educated about the COVID-19 vaccine. An interview with the Regional Nurse Consultant (RNC), conducted on 8/8/24 at 3:12 p.m., indicated brand new doses of the COVID-19 vaccine were administered at the facility in May 2024. RNC indicated, in the time frame in which the COVID-19 vaccinations were offered, Resident G was hospitalized and since then, had not been offered the vaccine. 2. The clinical record for Resident O did not indicate they had been offered the COVID-19 vaccination since his admission to the facility. Resident O's clinical record did not indicate he refused/accepted the COVID-19 vaccination, nor did it provide evidence to support if Resident O had been educated about the COVID-19 vaccine. An interview with the RNC, conducted on 8/8/24 at 3:23 p.m. indicated, she was unable to locate evidence in Resident O's electronic health record (EHR) of being offered/denied the COVID-19 vaccination nor that Resident O was provided education about the COVID-19 vaccine. RNC indicated the facility was unable to locate a COVID-19 vaccination policy for residents. A Vaccines PowerPoint from Indiana Department of Health was provided by the RNC on 8/8/24 at 3:59 p.m. The document indicated, Current boosters (bivalent formulation) .Recommendation is that everyone over the age of 6 should get one bivalent vaccine .People aged [AGE] years and older may get 1 additional dose of COVID-19 vaccine 4 or more months after the 1st updated COVID-19 vaccine. People who are moderately or severely immunocompromised may get 1 additional dose of [sic, the] updated COVID-19 vaccine 2 or more months after the last updated COVID-19 vaccine.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 50826 Based on observation, interview and record review, the facility failed to ensure the call light system was audible to the staff on the Ventilator unit (Vent). This had the potential to affect 11 of 35 residents that reside on the Vent unit. Findings include: A random observation was made of the Vent unit nurse's station, on 8/4/24 at 10:39 a.m., of Resident 287's call light, on the ceiling in the hallway outside her door, was lit requesting assistance. There was no sound heard at the nurse's station or the surrounding area indicating the resident's call light had been turned on. A random observation was made of the Vent unit nurse's station, on 8/6/24 at 9:10 a.m., of Resident 1's light fixture that was lit in the hallway outside of her door. Registered Nurse (RN) 9 indicated Resident 1 had pushed her call light for assistance. There was no sound heard in the surrounding area indicating the resident's call light had been turned on. On 8/8/24 at 11:10 a.m., an observation and interview was conducted with the Maintenance Director (MD) for an environmental tour of the facility. He indicated that the call light system was not audible at the desk on the Vent unit at the time of the tour. Observations were made with call lights for Resident 11 and Resident 34 being lit in the hall but no sound being audible at the nurse's station to notify staff that a call light had been initiated for resident assistance. The MD corrected the call light system by turning the audible back on and the call lights were then heard at the nurses' station. An interview was conducted, on 8/8/24 at 11:15 a.m., with the MD. He indicated the call light system was checked daily by him. On several dates he had found the audible volume turned down or off manually, or the audible volume had been turned off in the application on the computer, or a cord had been unplugged. All eliminated the call light system from being audible and being heard by staff at the nurse's station. The MD indicated he had reported to the Executive Director (ED) each date the system was inaudible. On 08/08/24 at 1:05 p.m., an interview was conducted with the ED and the Regional Nurse Consultant (RNC). The ED indicated that the call light system was a constant problem in the facility with staff turning the audible ring off or lowering the sound, so it was not easily heard. He also indicated the ventilators are directly connected into the call light system. He indicated if a ventilator alarms in the resident's room, it was also heard at the nurses' station through the call light system. The ED indicated the MD does report back to him when the audible has been turned off or disconnected at the nurse's station for the call light system. The RNC indicated the call light system should be fully operational with an audible sound so that residents can be assisted when they utilize their call light. On 8/8/24 at 1:55 p.m., an interview was conducted with Respiratory Therapist 13. She indicated that there are 4 residents on the ventilator unit that actively use support ventilators all day and night or a fraction of each day/night. (continued on next page)

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	08/08/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at 2:40 p.m., a policy titled Call Lights Policy and Procedure, with the effective date of June 1, 2021, was provided by the RNC. The policy indicated, To assure each resident will have a readily accessible means to obtain needed assistance. The call light communication system will be a direct link to a centralized staff location. 3.1-19(u)