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	03/04/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34850 Based on interview and record review, the facility failed to ensure grievances reported in resident council meetings were addressed with a resolution for 9 of 9 residents that attended resident council meetings. (Resident 12, Resident 23, Resident 19, Resident 18, Resident 7, Resident 20, Resident 11, Resident C, and Resident E) Findings include: The December 2024 resident council minutes indicated the following residents attended the meeting: Resident E, Resident 7, Resident 18, and Resident 19. During the meeting, the residents indicated nursing concerns with medications not administered timely. The January 2025 resident council minutes indicated the following residents attended the meeting: Resident 20, Resident 18, Resident 19, Resident C and Resident E. The residents indicated nursing concerns with medications not administered timely on night shift. The December 2024 and January 2025 resident council minutes did not include resolutions or follow up to their concerns addressed in resident council. An interview was conducted with the Administrator on 2/28/25 at 10:19 a.m. She indicated she was unable to provide documentation that grievances reported in resident council were addressed. A resident council meeting was conducted on 3/3/25 at 2:05 p.m. The following residents attended the meeting: Resident 12, Resident 23, Resident 19, Resident 18, Resident 7, Resident 20, Resident 11, and Resident E. During the council meeting, Resident E and Resident 7 indicated grievances reported in the resident council meeting were not addressed nor followed up with a resolution. Medications on night shift were not administered timely. It had previously been discussed in the resident council and nothing had changed. A resident council policy was provided by the Director of Nursing on 3/4/25 at 10:53 a.m. It indicated, Policy: Social Service and/or Activity Director will facilitate the gather together of residents' through assistance in planning, announcing the meeting, arranging for private space, and serving as a liaison between the Resident Council and the facility management. Procedures . 6. The Administrator will review reports submitted by the Council and will made recommendations and/or take appropriate action. All problem areas will be addressed on the Resident Council Minutes as well as the Resident Council Feedback . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A grievance policy was provided by the Director of Nursing on 3/4/25 at 10:53 a.m. It indicated, Policy: The facility shall both investigate and respond to complaints and grievances made by an individual resident, a resident group, a family member, family group, employee, or other individuals . 6. Once the corrective action is agreed upon by the administrator/grievance official and department head, a follow-up telephone call or visit shall be made by the department head to the person(s) lodging the concern, explaining the corrective action to be taken to resolve the concern. Said review of grievance, investigation, corrective action and follow up with the complainant should occur within three (3) days of notification of the Grievance Official, unless the nature of the concern requires further investigation warranting an extended timeframe. The facility shall keep the resident apprised of progress toward resolution as warranted . 3.1-3(l)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51984 Based on interview and record review, the facility failed to timely report an allegation of abuse for 1 of 2 residents reviewed for Preadmission Screening and Resident Review (PASRR). (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/28/25 at 2:45 p.m. The diagnoses included, but were not limited to, traumatic brain injury. A progress note, dated 12/10/24 at 12:23 p.m., indicated some dried blood on the front of his leg from scratching. Resident B indicated a nurse did it. An interview was conducted with the Executive Director (ED), Director of Nursing (DON), and Administrator on 2/28/25 at 2:57 p.m. The DON indicated the incident, on 12/10/24, was not reported and should have been. A reportable incident to the Indiana Department of Health (IDOH), dated 2/28/25, indicated, on 12/10/24 at 12:23 p.m., Resident B indicated he was scratched on the leg by a nurse. An abuse policy was provided by the DON on 3/3/25 at 8:50 a.m. The policy indicated the following, . Policy/Procedure . F. All reported incidents of alleged abuse, neglect or misappropriation of resident property are immediately investigated and reported per state and federal law typically within 24 hours of witness/identification . This citation relates to Complaints IN00453256, IN00453268, IN00453155, IN00454272, and IN00453057. 3.1-28(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Tranquility Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N Central Avenue Indianapolis, IN 46205	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 an allegation of abuse for 1 of 5 residents reviewed for abuse. (Resident C) Findings include: 1. The clinical record for Resident C was reviewed on 2/28/25 at 9:36 a.m. The diagnoses included, but were not limited to, paranoid schizophrenia. The resident resided on the traumatic brain injury unit. A Quarterly Minimum Data Set (MDS) assessment, dated 2/1/25, indicated Resident C was moderately cognitively impaired. 2. The clinical record for Resident E was reviewed on 2/28/25 at 9:50 a.m. The diagnoses included, but were not limited to, traumatic brain injury. The resident resided on the traumatic brain injury unit. A Quarterly 2/19/25 MDS Assessment indicated Resident E was cognitively intact. A nursing progress note written by Licensed Practical Nurse (LPN) 9, dated 2/10/25 at 7:34 a.m., indicated Resident C had been transported by ambulance to the hospital's emergency room . Qualified Medication Aide (QMA) and Certified Nurse Aides (CNAs) reported to her Resident C was lethargic and had tremors. The resident was unable to communicate distress. A 2/9/25 daily staff work schedule included, but was not limited to, the following staff that worked the night of 2/9/25: LPN 9, QMA 8, CNA 5, and CNA 6. A reportable incident to the Indiana Department of Health, dated 2/10/25, indicated an incident had occurred on 2/9/25 at 11:20 p.m. The incident indicated the following, .Received call from hospital case manager on 2/10/25 stating that the fire department contacted them in reference to resident [C] stating that sexual misappropriate action had occurred. Case Manager stated she interviewed the resident [C] today and found intermitted confusion on the resident's part. He stated he did not have a roommate, he didn't stay in the facility, nor did he mention the incident .Follow up: 2/11/25 Investigation complete after interviewing staff and residents, care plans, nursing assessments and behavior health notes, the facility deemed allegation unsubstantiated. Indianapolis Police Department was notified and a report made against resident's roommate [Resident E]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident investigation file between Resident C and Resident E was provided by the Director of Nursing (DON) and the Executive Director (ED) on 2/28/25 at 9:50 a.m. The ED indicated the investigation was completed. It included, but was not limited to the following documents: Six staff written statements indicated, they had never seen Resident C's roommate (Resident E) exhibiting sexually inappropriate behaviors. The investigation file did not include statements from LPN 9, QMA 8, CNA 5, and CNA 6 that had worked the night of 2/9/25. During an interview with the ED and the Administrator (ADM), on 2/28/25 at 1:52 p.m., they indicated the Former DON had conducted the staff interviews during the investigation. The ED was unable to locate the staff interviews that included the staff that were working on the night of 2/9/25. The ED will be conducting the statements from the staff that worked the night of the incident on 2/9/25. Written staff statements from LPN 9, CNA 5 and CNA 6 were provided by the ED on 3/3/25 at 8:50 a.m. The statements from LPN 9, CNA 6, and CNA 5 were reviewed and did not include information about the night of the incident on 2/9/25. An interview was conducted with the Former DON on 3/3/25 at 9:30 a.m. She indicated she was the staff member that had conducted the staff interviews from the incident that had occurred, on 2/9/25, between Resident C and Resident E. She did not interview staff members that had worked on 2/9/25. An abuse policy was provided by the DON on 3/3/25 at 8:50 a.m. It indicated, .Standard: Residents will be free from misappropriation of resident property, verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion .L. The results of all investigations are reported to the administrator and or his/her designated representative. The outcome of investigations will be utilized to identify, correct, and intervene in precipitating factors that led to the allegation or the abuse, neglect, misappropriation of resident property or injury of known etiology. The facility's policies and procedures will be reviewed and revised as necessary . This citation relates to Complaints IN00453057, IN00454272, IN00453256, IN00453268, and IN00453155. 3.1-28(d)

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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. 51984 Based on interview and record review, the facility failed to invite resident and/or resident's representative to a quarterly care plan meeting for 2 of 2 residents reviewed for care plan meetings. (Resident 3 and Resident 23) Findings include: 1. The clinical record for Resident 3 was reviewed on 3/3/25 at 2:32 p.m. The diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage (bleeding between the brain and the tissue covering the brain). A Quarterly Minimum Data Set (MDS) assessment, dated 1/1/25, indicated Resident 3 was moderately cognitively impaired. A progress note, dated 8/22/24, indicated Resident 3's representative attended a care plan meeting by phone call. A progress note, dated 12/21/24, indicated that a voice mail was left with the resident's representative to schedule a care plan meeting. Resident 3's clinical record did not include documentation a quarterly care plan meeting had been conducted. An interview was conducted with the Director of Nursing (DON) on 3/4/25 at 9:15 a.m. The DON indicated this resident should have had a quarterly care plan meeting. 2. The clinical record for Resident 23 was reviewed on 2/27/25 at 2:00 p.m. The diagnoses included, but were not limited to, dementia. A progress note, dated 3/5/24, indicated a care plan meeting was conducted with the Administrator, Social Services, Admissions Director, Physical Therapist, Culinary Manager, and Resident 23's representative. During an interview with the DON on 3/4/25 at 9:15 a.m., she indicated Resident 23 should have a care plan meeting completed, since the last care plan meeting was on 3/5/24. The Care Planning Policy and Procedure was provided by the DON on 3/4/25 at 9:15 a.m. It indicated, .5. The Resident, the Resident's family and/or the Resident's representative are encouraged to participate in the development of and revisions to the Resident's care plan. The Resident, the Resident's family, and/or the Resident's representative will be invited to participate in the Resident's overall plan of care. Record of this invitation will be maintained in the Resident's clinical record and written justification if Resident, the Resident's family, and/or Resident's representative does not participate . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(d)(2)(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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 36942 Based on observation, interview, and record review, the facility failed to ensure a resident didn't have duplicate orders for gastrostomy tube (g-tube) feedings and ensure a resident received the correct amount of water flushes for 2 of 3 residents reviewed for feeding tubes. (Resident G and Resident F) Findings include: 1. The clinical record for Resident G was reviewed on 2/28/25 at 1:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, anoxic brain damage, and anemia. An Admission Minimum Data Set (MDS) assessment, dated 12/24/24, indicated Resident G had a feeding tube and received 51% or more of nutrition through the feeding tube. A care plan for activities of daily living (ADLs), dated 1/1/25, indicated Resident G was dependent on staff to maintain the continuous enteral feeding via a feeding tube. A care plan for feeding tube, revised 2/28/25, indicated Resident G required tube feeding and was dependent on staff with tube feeding and water flushes. A physician order, dated 2/18/25, indicated the use of Peptamen 1.5 (type of tube feeding) at 65 ml per hour with 30 ml per hour of water flushes. A physician order, dated 2/26/25, indicated the use of Glucerna 1.5 at 55 ml per hour with 35 ml per hour of water flushes. An observation conducted of Resident G on 2/27/25 at 11:20 a.m., noted Glucerna running at 55 milliliters (ml) an hour with 35 ml of water flushes per hour. During the record review, it was noted Resident G had two orders for g-tube feeding and flushes in the electronic health record. An observation and interview conducted with the Director of Nursing (DON), on 2/28/25 at 2:40 p.m., indicated there were duplicate g-tube feeding and water flush orders for Resident G. The DON indicated she clarified the g-tube feeding order and reflected the current g-tube feeding and water flush order in the electronic health record. 2. The clinical record for Resident F was reviewed on 2/28/25 at 10:57 a.m. The diagnoses included, but were not limited to, malnutrition, chronic kidney disease, congestive heart failure, and diabetes mellitus. An Admission MDS assessment, dated 2/5/25, indicated Resident F utilized a feeding tube. A physician order, dated 1/29/25, indicated the diet of nothing by mouth (NPO) for Resident F. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 2/5/25, indicated the utilization of Jevity (type of tube feeding solution) 1.5 at 70 ml per hour with water flushes of 40 ml per hour. A current care plan for feeding tube indicated Resident F utilized a feeding tube for g-tube feeding and water flushes. The interventions included, but were not limited to, provide formula and water flushes as ordered through the g-tube. The following observations were conducted of Resident F to where the feeding pump was set to administer tube feeding at 70 ml per hour and 80 ml per hour of water flushes: 2/27/25 at 12:04 p.m., 2/28/25 at 9:00 a.m., 2/28/25 at 11:20 a.m., and 2/28/25 at 12:40 p.m. An observation and interview with the DON, on 2/28/25 at 2:40 p.m., indicated the feeding pump was still set to 70 ml per hour of tube feeding and 80 ml per hour of water flushes. The DON clarified the order and indicated it was meant for 40 ml per hour of water flushes and not 80 ml per hour, that was noted on the feeding pump. The DON indicated the feeding pump was set incorrectly and she went back to Resident F's room to change the feeding pump settings. A policy entitled Enteral Tube Medication Administration, reviewed 5/31/24, was provided by the DON on 3/4/25 at 10:53 a.m. The policy indicated enteral formulas, equipment, route of administration, and flow rate are selected based on an assessment of the resident's condition and need. This citation relates to Complaint IN00453878. 3.1-44(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 36942 Based on interview and record review, the facility failed to ensure Registered Nurse (RN) coverage for 8 hours a day, 7 days a week with the potential to affect 25 of 25 residents that reside in the facility. Findings include: The daily nursing schedules were provided by the Scheduler on 2/27/25 at 11:24 a.m. The following date(s) were noted without an RN for 8 hours: - 2/1/25, - 2/2/25, - 2/15/25, - 2/16/25, - 2/22/25, and - 2/23/25. An interview conducted with the Director of Nursing (DON), on 3/3/25 at 1:40 p.m., indicated she worked on 3/1/25 and 3/2/25 as the RN coverage for the weekend. She found out, last week, that she was the only RN for coverage in the entire facility. The time clock reports were provided by the DON on 3/4/25 at 11:35 a.m. They indicated the following RN hours provided: - 2/1/25 for 7 hours and 36 minutes, - 2/2/25 for no hours, - 2/15/25 for no hours, - 2/16/25 for no hours, - 2/22/25 for no hours, and - 2/23/25 for no hours. An interview conducted with the DON, on 3/4/25 at 11:35 a.m., indicated she knew, on 2/23/25, there was no RN that worked in the facility. The facility didn't have a policy pertaining to RN coverage. The facility followed the regulation regarding RN coverage. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.1-17(b)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34850 Based on interview and record review, the facility failed to ensure a resident received a psychiatric evaluation timely to address a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications. (Resident 20) Findings include: The clinical record for Resident 20 was reviewed on 2/28/25 at 10:36 a.m. The diagnoses included, but were not limited to, traumatic brain injury and post-traumatic stress disorder. The resident resided on the traumatic brain injury unit. A January 2025 pharmacy recommendation indicated Resident 20 received the following medications: 7.5 milligrams of Zyprexa (antipsychotic medication) in the morning and 15 milligrams of Zyprexa at night, 25 milligrams of trazadone (antidepressant medication) nightly, 75 milligrams of Zoloft (antidepressant medication) daily, and 20 milligrams of Buspar (antianxiety medication) three times a day. The resident's trazadone was reduced six months ago, and the Zyprexa was reduced one year ago. The pharmacy was requesting the medications be evaluated for any reductions at that time. The recommendation was reviewed by the medical provider, but he indicated he was waiting for the resident to first receive a psychiatric evaluation. An interview was conducted with the Director of Nursing on 3/3/25 at 2:41 p.m. She indicated she was still in the process of getting with guardians to consent for residents to receive psychiatric services due to new psychiatric providers. Resident 20 had not received a psychiatric evaluation since the January 2025 pharmacy recommendation. 3.1-25(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 36942 Based on observation, interview, and record review, the facility failed to ensure a medication was not administered in an excessive dose and not crushed for an extended release (ER) medication for 1 of 3 residents observed for medication administration. (Resident F) Findings include: An observation of medication administration was conducted with Licensed Practical Nurse (LPN) 3 on 3/3/25 at 8:50 a.m. LPN 3 prepared potassium 20 milliequivalents (mEq) tablet and placed two tablets into the medication cup which LPN 3 proceeded to crush to administer through Resident F's feeding tube. The clinical record for Resident F was reviewed on 3/3/25 at 10:30 a.m. The diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and gastrostomy (procedure where a tube is inserted through the abdominal wall and into the stomach) status. A pharmacy recommendation document, dated 2/17/25, indicated Resident F was receiving potassium ER as a 20 mEq tablet. This should not be crushed. The pharmacy recommended changing the order to potassium 10 mEq capsules which could be opened and dissolved. A physician order, dated 2/18/25, was noted for potassium chloride extended release (ER) 10 mEq; take two capsules via feeding tube daily for chronic kidney disease. The observation of LPN 3 administering potassium 20 mEq; two tablets crushed through Resident F's feeding tube was incorrect regarding the dose of 40 mEq administered, instead of 20 mEq, and crushing the ER medication instead of opening the capsules and letting them dissolve to administer through Resident F's feeding tube. An interview conducted with LPN 3, on 3/3/25 at 10:58 a.m., indicated she did administer two potassium tablets via crushing them and administering them through Resident F's feeding tube. LPN 3 stated she did not have potassium capsules, 10 mEq, in the medication cart for Resident F. A policy entitled Medication Errors, dated 10/2014, was provided by the Director of Nursing on 3/4/25 at 9:40 a.m. The policy indicated the facility would be free of medication error rates of five percent or greater along with being free of significant medication errors. 3.1-48(c)(2)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 36942 Based on interview and record review, the facility failed to ensure follow up regarding a urinalysis (UA) and a sputum culture for 1 of 3 residents reviewed for antibiotic use. (Resident G) Findings include: The clinical record for Resident G was reviewed on 3/3/25 at 2:23 p.m. The diagnoses included, but were not limited to, chronic respiratory failure, diabetes mellitus, anemia, constipation, and fistula of vagina to large intestine (abnormal connection between the vagina and large intestine that allows gas or stool to pass through the vagina, leading to fecal incontinence). A physician order, dated 12/18/24, indicated all lab draws may be completed the next available lab day unless otherwise specified. A physician note, dated 1/8/25, indicated Resident G had elevated white blood cells and worsened lung sounds. The orders were listed to start an antibiotic, change Foley catheter (indwelling urinary catheter) and send urine for a UA with culture and sensitivity, and conduct a chest x-ray for possible pneumonia. A progress note, dated 1/9/25 at 11:25 p.m., indicated Resident G had a chest x-ray completed on such date. An antibiotic was started and a request for a sputum culture. The electronic health record (EHR) did not include any results for a UA nor a sputum culture for Resident G in January of 2025. There was no follow up in the EHR regarding the order for the UA and the notation for a sputum culture. A physician note, dated 1/15/25, indicated Resident G's Foley catheter was clogged but was replaced by nursing staff. The physician did not have access to imaging regarding the follow up for the prescribed antibiotic, on 1/8/25, but Resident G had improvement. Resident G had a fistula of vagina to large intestine and placed her at an increased risk of developing a urinary tract infection (UTI). An interview conducted with the Director of Nursing (DON), on 3/3/25 at 2:09 p.m., indicated she could not locate any laboratory results for Resident G regarding the UA or sputum culture. A policy entitled Laboratory and Clinical Testing Services, undated, was provided by the DON on 3/3/25 at 8:46 a.m. The policy indicated the facility will provide and/or maintain laboratory services or other clinical testing, such as X-rays, scan, dopplers, etc. to meet the needs of its residents. The facility was responsible for the quality and the timeliness of the services. 3.1-49(a)

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

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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 complete and accurate documentation regarding the electronic medication and treatment administration records (MAR and TAR) for 1 of 3 closed records reviewed, 1 of 5 residents reviewed for unnecessary medications, and 1 of 3 residents reviewed for pressure ulcers. (Resident D, Resident 27, and Resident 8) Findings include: 1. The clinical record for Resident D was reviewed on 2/28/25 at 11:31 a.m. The diagnoses included, but were not limited to, respiratory failure, diabetes mellitus, depression, quadriplegia, and pressure ulcer of sacral region. A Quarterly Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident D had two stage 4 pressure ulcers marked along with skin tears. The TAR, dated January of 2025, noted a total of 22 pages with a total of 56 holes noted throughout the TAR. The TAR, dated February of 2025, noted a total of 17 pages with over 100 holes noted throughout the TAR. 2. The clinical record for Resident 27 was reviewed on 3/3/25 at 2:29 p.m. The diagnoses included, but were not limited to, respiratory failure, hypertension, diabetes mellitus, and pressure ulcer of sacral region. The MAR, dated February of 2025, noted a total of 13 pages and 23 holes noted throughout the MAR. The TAR, dated February of 2025, noted a total of 18 pages with over 100 holes noted throughout the TAR. 34850 3. The clinical record for Resident 8 was reviewed on 2/28/25 at 11:00 a.m. The diagnoses included, but were not limited to, schizophrenia. The resident resided on the traumatic brain injury unit. A physician order, dated 11/26/24, indicated Resident 8 was to receive 300 milligrams of Depo-Provera injections once a week for sexual behavior. The February 2025 MAR for Resident 8 indicated the resident was to receive 300 milligrams of Depo-Provera every Tuesday at 8:00 a.m. and 8:00 p.m. The MAR was documented on the following dates and times he had received a dosage at 8:00 a.m. and 8:00 p.m. of the 300 milligrams of Depo-Provera: 2/3/25 and 2/25/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 2/28/25 at 3:15 p.m. She indicated after reviewing Resident 8's Depo-Provera dosage supply; the resident had not received two dosages of 300 milligrams of Depo-Provera on 2/3/25 and 2/25/25. The MAR was set up as two timeframes; one time to administer the Depo-Provera, and the other timeframe was for the nurse to double check to make sure he received it. She will remove the second timeframe on the MAR. A charting and documentation policy was provided by the Director of Nursing on 3/4/25 at 10:53 a.m. It indicated, .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . 3.1-50(a)(1) 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36942 Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE) was donned during medication administration through a gastrostomy (g-tube/feeding tube) for a resident on enhanced barrier precautions (EBP) for 1 of 3 residents reviewed for medication administration, and maintain infection control by not performing hand hygiene before and after cleaning residents' rooms for 2 of 2 random observations of infection control practices. (Resident F and Resident G) Findings include: 1. An observation was conducted of medication administration for Resident F with Licensed Practical Nurse (LPN) 3 on 3/3/25 at 8:50 a.m. Resident F's medications were retrieved, placed in a medication cup, crushed, mixed with water, and administered through Resident F's feeding tube. LPN 3 went in and out of Resident F's room to retrieve medications from the medication cart. LPN 3 did not don PPE upon administering medications through Resident F's feeding tube. The clinical record for Resident F was reviewed on 3/3/25 at 10:30 a.m. The diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and gastrostomy (procedure where a tube is inserted through the abdominal wall and into the stomach) status. A physician order, dated 1/29/25, indicated Resident F was on enhanced barrier precautions for high-contact care. The order indicated gown and gloves must be worn when . following device care: feeding tube. An interview conducted with LPN 3, on 3/3/25 at 10:58 a.m., indicated she was informed she should wear PPE when administering medications through a feeding tube. 51750 2a. The clinical record for Resident F was reviewed on 3/3/25 at 8:45 a.m. The diagnoses included tracheostomy and chronic respiratory failure. 2b. The clinical record for Resident G was reviewed on 3/3/25 at 9:00 a.m. The diagnoses included chronic respiratory failure and diabetes. An observation was conducted, on 3/3/25 at 9:34 a.m., of Housekeeper 17 cleaning resident rooms on the vent unit. Housekeeper 17 entered and exited Resident F's room without performing hand hygiene, she then entered and exited Resident G's room without performing hand hygiene. An interview with the Director of Nursing (DON) was conducted on 3/3/25 at 10:19 a.m. She indicated housekeeping staff should be performing hand hygiene prior to entering a resident's room and upon exit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Handwashing/Hand Hygiene Policy, with a revision date of August 2015, was provided by the DON on 3/03/25 at 2:17 p.m. It indicated .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: I. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident . 3.1-18(b)(2) 3.1-18(l)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 51750 Based on interview and record review, the facility failed to ensure implementation of antibiotic stewardship by not tracking and monitoring infections for antibiotic use from October of 2024 through December of 2024 with the potential of affecting 25 of 25 residents. Findings Include: On 2/28/25 at 8:46 a.m., the Director of Nursing (DON) provided Infection Control documentation demonstrating antibiotic stewardship for the months of January and February of 2025. At that time, the DON indicated she was unable to provide infection control tracking and monitoring from September through December of 2024, but would continue tracking and monitoring moving forward. On 3/3/25 at 8:25 a.m., the DON and Executive Director (ED) provided Infection Control documentation demonstrating antibiotic stewardship for the month of September 2024. The DON indicated tracking was not completed for October through December of 2024. The DON provided the Antibiotic Stewardship Policy on 3/3/25 at 8:40 a.m., with a revision date of December 2016. It indicated, .Policy Interpretation and Implementation 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36942 Based on observation, interview, and record review, the facility failed to ensure a homelike environment for 3 of 25 residents observed for homelike environment. (Resident L, Resident F, and Resident E) Findings include: 1. An observation was conducted of Resident L's room on 2/27/25 at 11:43 a.m. There was a light fixture with no cover and one out of the two lightbulbs were not working. An observation was conducted of Resident L's room on 2/28/25 at 8:58 a.m. The light fixture remained the same without a cover and one lightbulb not working. An observation was conducted of Resident L's room on 2/28/25 at 11:20 a.m. The light fixture remained the same without a cover and one lightbulb not working. 2. An observation was conducted of Resident F's room on 2/27/25 at 12:04 p.m. There was a brown substance on the wall by the outlet where Resident F's head was facing. An observation was conducted of Resident F's room on 2/28/25 at 9:00 a.m. There continued to be a brown substance on the wall by the outlet where Resident F's head was facing. An observation was conducted of Resident F's room on 2/28/25 at 11:20 a.m. There continued to be a brown substance on the wall by the outlet where Resident F's head was facing. An observation was conducted of Resident F and Resident L's room on 3/3/25 at 2:55 p.m. The environmental concerns remained the same. 3. An observation was conducted of the kitchen with the Dietary Manager on 2/27/25 at 9:45 a.m. The dishwasher did not reach the appropriate temperature. The Dietary Manager indicated the dishwasher hasn't been functioning for a while and the facility utilized paper products for that reason. An interview conducted with Resident E, on 2/27/25 at 11:45 a.m., indicated the facility was utilizing Styrofoam cups and paper plates for meal service. He indicated he would like to have regular cups and plates to eat on. An interview conducted with the Director of Nursing (DON), on 3/3/25 at 2:09 p.m., indicated the dishwasher had been broken and the kitchen staff were utilizing the three compartment sink for pots and pans. The dietary department utilized paper products for the dishwasher not reaching proper temperature. A policy entitled Resident Rights, dated 11/28/16, was provided by the DON on 3/4/25 at 9:37 a.m. The policy indicated You have the right to a clean, safe, comfortable, and home-like environment. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-19(f)(5)