STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00408696, IN00407833, IN00404697. Complaint IN00407833 - Federal/State deficiencies related to the allegations are cited at F0580 and F0677. Complaint IN00408696 - No deficiencies related to the allegations are cited. Complaint IN00404697 - No deficiencies related to the allegations are cited. Survey dates: June 12, 13, 14, and 15, 2023 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicaid: 28 Other: 1 Total: 29 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 19, 2023	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the the plan of correction be considered our allegation of compliance effective July 15, 2023 to the annual licensure survey completed on June 15, 2023. The facility request that the plan of correction be considered effective July 15, 2023 to the complaint survey completed on June 15, 2023. The facility also requests that our plan of correction be considered for paper review. The facility would be happy to submit to you any additional paperwork that you would need for review.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Kesler	Executive Director	06/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to timely notify a resident's representative of a new medication order for 1 of 1 resident reviewed for insulin (Resident B). Findings include: The clinical record for Resident B was reviewed on 6/13/23 at 2:36 p.m. The Resident's diagnosis included, but were not limited to, acute respiratory failure and diabetes. She was discharged from the facility on 5/4/23. A physician's order, dated 1/12/23, indicated to notify Resident B's sister of all medications, orders, physician or nurse practitioner visits, blood draws, concerns or updated each shift. An Admission MDS (Minimum Data Set) Assessment, completed 1/16/23, indicated she rarely or never made her needs or wants known and that she had a diagnosis of diabetes. A care plan indicated Resident B had diabetes. The goal was for her to have no complications related to diabetes. A physician's order, dated 4/12/23, indicated Resident B was to receive metformin (diabetes medication) 500 mg (milligram) daily for diabetes.	F 0580	**F580 Notification of Changes** **It is the practice of this facility to assure that the resident's representative is notified in a timely, concise and thorough manner with any change of medication.** 1. Resident B has been discharged from the facility on 5/4/23. 2. All resident with changes in medication could potentially be affected. Please see system changes below to prevent reoccurrence. 3. The policy for Notification has been reviewed. All nurses will be in-serviced related to assuring that resident's representative is being notified in a timely manner of changes in medication. The in-service also covers that when a family representative is notified a nurse progress note must be completed regarding the notification and must include the noted change. 4. A Performance Improvement Tool has been initiated that randomly reviews 5 residents with	07/15/2023

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	The clinical record did not contain information that Resident B's responsible party had been informed of the physician's order for the metformin. During a confidential interview, she indicated that the facility physician had informed her that Resident B had diabetes. She had no prior knowledge of Resident B being diabetic and that Resident B's blood sugar was not being checked. A physician's progress note, dated 5/3/23, indicated Resident B was being treated for diabetes due to her hemoglobin A1C (blood test for diabetes) had increased to 6.8 (high), so metformin was started in order to gain tight control and avoid complications. During an interview on 6/14/23 at 2:53 p.m., RN (Registered Nurse) 6 indicated when a new order was received the family or responsible party of the resident should be notified and the notification should be documented in the clinical record. Resident B's responsible party was very involved and there had been an order to inform her of all changes. RN 6 was unaware if Resident B's responsible party had been informed of the addition of the metformin. RN 6 could not locate a progress note which indicated Resident B's responsible party had been informed. On 6/15/23 at 9:29 a.m., the Director of Nursing provided the Notification of Change in Resident's Condition or Status Policy and Procedure, effective 11/28/2016, which read "...Unless otherwise instructed by the Resident, after notifying the Resident, the Nurse will notify the Resident's family or Resident Representative...Changes to the plan of		new and order dose changes to assure the family representative has been notified. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. 5. July 15, 2023	

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	care...Notification of the appropriate individuals will occur in a timely manner...The Nurse will record in the Resident's medical record information relative to changes in the Resident's medical/ mental condition or status, as well as notification of appropriate individuals..." This Federal tag relates to Complaint IN00407833. 3.1-5(a)(3)			
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.			

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	§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.			
	Based on interview and record review, the facility failed to complete and transmit MDS (Minimum Data Set) assessments timely for 11 of 11 residents reviewed for resident assessments. (Residents 3, 5, 7, 11, 15, 17, 18, 22, 24, 26, and 31) Findings include: The clinical records and MDS assessments for Residents 3, 5, 7, 11, 15, 17, 18, 22, 24, 26, and 31 were all reviewed on 6/15/23 at 1:15 p.m. Resident 3 was missing completion and	F 0640	**F640 Encoding/Transmitting Resident Assessments** **It is the practice of this facility to assure that the resident's Minimum Data Set (MDS) assessments are completed and transmitted in a timely manner.** 1. Resident 3, 5, 7, 11, 15, 17, 18, 22, 24, 26 and 31 MDS assessments have been reviewed and corrected, if	07/15/2023

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	transmission of a Quarterly MDS assessment after his 2/4/23 Quarterly MDS assessment. Resident 5 was missing completion and transmission of a Quarterly MDS assessment between his 7/14/22 Admission MDS assessment and his 1/11/23 Quarterly MDS assessment, as well as a Quarterly MDS assessment after his 1/11/23 Quarterly MDS assessment. Resident 7 was missing completion and transmission of a Quarterly MDS assessment between his 8/5/22 Annual MDS assessment and his 1/18/23 Quarterly assessment, as well as a Quarterly MDS assessment after his 1/18/23 Quarterly MDS assessment. Resident 11 was missing completion and transmission of a Quarterly MDS assessment after their 1/10/23 Quarterly MDS assessment. Resident 15 was missing completion and transmission of a Quarterly MDS assessment between his 6/9/22 Annual MDS assessment and his 2/1/23 Quarterly assessment, as well as a Quarterly MDS assessment after his 2/1/23 Quarterly MDS assessment. Resident 17 was missing completion and transmission of a Quarterly MDS assessment between his 10/31/22 Admission MDS assessment and his 2/8/23 Quarterly assessment, as well as a Quarterly MDS assessment after his 2/8/23 Quarterly MDS assessment. Resident 18 was missing completion and transmission of a Quarterly MDS assessment after his 1/6/23 Quarterly MDS assessment. Resident 22 was missing completion and		applicable. 2. All residents residing at the facility had the potential to be affected Please see the system changes below to prevent reoccurrence. 3. An in-service has been conducted and included the MDS coordinator all persons who complete MDS sections to ensure that the assessments are being completed and transmitted in accordance with the regulations. 4. A Performance Improvement Tool has been initiated that reviews all residents Minimum Data Set (MDS) to ensure that the assessments are being completed and transmitted in accordance with the regulations. The MDS Coordinator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. 5. July 15, 2023	

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	transmission of a Quarterly MDS assessment after his 1/10/23 Quarterly MDS assessment. Resident 24 was missing completion and transmission of a Quarterly MDS assessment after his 1/11/23 Quarterly MDS assessment. Resident 26 was missing completion and transmission of a Quarterly MDS assessment after his 1/11/23 Quarterly MDS assessment. Resident 31 was missing completion and transmission of a Quarterly MDS assessment after his 1/19/23 Quarterly MDS assessment. An interview was conducted with the MDSC (Minimum Data Set Coordinator) on 6/15/23 at 1:20 p.m. After reviewing several of the above residents' history of MDS assessments, she indicated she began doing MDS assessments in March, 2023, as the staff member previously responsible was missing assessments. She'd been learning different sections of the MDS weekly and printed the RAI Manual to learn how to complete MDS assessments. They knew there was a problem with MDS assessments and she was responsible for fixing it. They had to sort out who was responsible for which sections and discussed it in morning meetings. They used the RAI manual as a policy and guide for completing MDS assessments.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that			

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	includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview, and record review, the facility failed to revise a resident's hearing care plan to reflect the current plan to address his hearing for 1 of 1 resident reviewed for communication and sensory services. (Resident 12) Findings include: The clinical record for Resident 12 was reviewed on 6/13/23 at 10:30 a.m. His diagnoses included, traumatic brain injury. The 9/16/22 hearing care plan, revised 4/17/23, indicated he had over the counter hearing devices	F 0657	**F657 Care Plan Timing and Revision** **It is the practice of this facility to assure that resident needs are met and the care plan reflects appropriate interventions.** 1. Resident 12 hearing care plan has been reviewed and has been revised to reflect that the resident is to wear sensory devices as tolerated. 2. All resident with sensory devices could potentially be	07/15/2023

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	and was not able to put them in or take them out of his ears. The goal was for him to have his hearing devices in daily to attempt to assist with his hearing. Interventions were to place devices in his ears daily and remove each night; to check him periodically to place the device in his ear as it comes out of his ear at times; and to assure he was on the list to see the audiologist. The 3/13/23 audiology consultation note indicated he was scheduled for a hearing aid check, but he was not wearing his aid, so that service was not provided this day. The note read, "RECOMMENDATIONS: Regular use of hearing aid and recheck x [times] 3 months." An observation and interview was conducted with Resident 12 in the dining room on 6/13/23 at 10:34 a.m. After introduction, Resident 12 indicated he was deaf and couldn't hear well. He was not wearing any hearing devices at this time. Resident 22 was present in the dining room and observed this interaction. An interview was conducted with Resident 22 on 6/13/23 at 10:36 a.m., per his request. He indicated if Resident 12 was not wearing his "earbud" in his hear, he couldn't hear anything. "You could be this far away (Resident 22 put his hands up in the air to represent one foot of space) from him and he can't hear you." An observation of Resident 12 was made in the dining room on 6/13/23 at 11:17 a.m. He was not wearing any hearing devices at this time. An interview and observation was conducted with the SLP (Speech Language Pathologist)/Unit Director on 6/13/23 at 2:46 p.m. She indicated Resident 12 had hearing aids, but she wasn't sure		affected. Please see system changes below to prevent reoccurrence. 3. The QA team, or designee is responsible for assuring any updates are in place on the care plan including all sensory devices. An in-service has been conducted with QA team related to updating the care plans for sensory devices. The nurses have been in-serviced on completing progress notes and notifying QA regarding any changes noted with sensory devices. 4. A Performance Improvement Tool has been initiated that reviews all residents care plans that involve sensory devices. Care plans are updated to reflect all sensory devices. The MDS Coordinator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	

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	what happened to them, as she hadn't seen them "in a while." The TD (Therapy Director) joined the interview and indicated his hearing devices were frequently left in, so when he was in bed he would roll over them, and they'd get tossed around. The next morning, Resident 12 wouldn't remember to put them back in. The TD last saw his hearing devices a couple of days ago. An interview and observation of Resident 12's room was made with the SLP/Unit Director and TD on 6/13/23 at 2:53 p.m. in an attempt to locate Resident 12's hearing devices. The TD was able to locate one hearing device by the television. The TD indicated he may only have one device. An interview was conducted with the ED (Executive Director) and DON (Director of Nursing) on 6/13/23 at 3:05 p.m. The ED indicated Resident 12 normally would not wear his hearing device in common areas, such as the dining room, due to overstimulation. The DON indicated Resident 12's hearing care plan shouldn't say to put in his hearing device daily and to remove at night, but rather state "as tolerated." 3.1-35(d)(2)(B)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.			

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	(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on interview and record review, the facility failed to prepare a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care for 1 of 1 resident reviewed for discharge. (Resident 33) Findings include: The clinical record for Resident 33 was reviewed on 6/15/23 at 9:41 a.m. His diagnoses included, but were not limited to, traumatic brain injury, hypertension, and anxiety disorder. He was admitted to the facility from the hospital on 3/7/23 and discharged home on 3/28/23. The 3/7/23 nurse's note read, "Client arrived at approximately 1130 am, accompanied by family,	F 0661	**F661 Discharge Summary** **It is the practice of this facility to assure that a discharge summary is completed on resident's that discharge to the community.** 1. Resident 33 was discharged from the facility on 3/28/23 2. All residents that discharge to home/community have the potential to be affected. Please see system changes below to prevent reoccurrence.	07/15/2023

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	able to walk in on his own, admitted to room [room number,] orders verified by [name and title of Nurse Practitioner,] she gave the order to d/c [discontinue] Nicotine patches and Nicotine gum." The 3/28/23 Discharge Summary, found in the progress notes of the electronic health record, read, "Res [Resident] alert and oriented this am [morning] family present today to dc [discharge] patient home with all meds [medications,] pharmacy notified. Skin warm dry intact no open, lungs clear bi [bilaterally,]...Res discharge home with family via car ad lib no issues will continue to monitor." There was no recapitulation of the resident's stay, final summary of the resident's status, reconciliation of pre and post discharge medications, or discharge plan of care in Resident 33's clinical record beyond the above 3/28/23 Discharge Summary note. An interview was conducted with the DON (Director of Nursing) on 6/15/23 at 9:50 a.m. She indicated she did not think the facility completed discharge summaries for residents. She'd seen progress notes, but no actual summary. An interview was conducted with the MDSC (Minimum Data Set Coordinator) on 6/15/23 at 9:55 a.m. She indicated she didn't think the facility had been completing discharge summaries, just writing a note, and did not think their electronic health record system had the ability to create them. An interview was conducted with the DON on 6/15/23 at 10:21 a.m. She indicated there was no discharge summary for Resident 33, and the facility had no policy on discharge summaries.		3. All nursing staff have been in-serviced on completing resident discharge summaries, which includes a recapitulation of resident's stay, final status, medications and discharge plan of care. 4. A Performance Improvement Tool has been initiated that reviews any applicable resident discharge summaries to ensure all areas mentioned above are noted. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	

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	3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(a)(3)(b)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide a shower or complete bed baths twice weekly for 1 of 2 residents reviewed for ADL (Activities of Daily Living) (Resident B). Finding include: The clinical record for Resident B was reviewed on 6/13/23 at 2:36 p.m. The Resident's diagnosis included, but were not limited to, acute respiratory failure and diabetes. She was discharged from the facility on 5/4/23. An Admission MDS (Minimum Data Set) Assessment, completed 1/16/23, indicated she rarely or never made her needs or wants known and that she needed total assistance of 2 staff members for personal hygiene. The clinical record did not contain a care plan addressing ADL care or preferences. A health status note, dated 4/30/23 at 2:17 p.m., indicated Resident B had received a shower on 4/30/23. On 6/14/23 at 10:37 a.m., the MDSC (Minimum	F 0677	**F677 ADL Care Provided for Dependent Residents** **It is the practice of this facility to assure that showers or compete bed baths are completed twice weekly.** 1. Resident B was discharged from the facility on 5/4/23 2. All resident have the potential to be affected. Please see system changes below to prevent reoccurrence. 3. All nursing staff have been in-serviced on completing and documenting showers and bed baths twice weekly for all residents. 4. A Performance Improvement Tool has been initiated that randomly reviews 5 residents showers and bed baths. The Director of Nursing, or designee,	07/15/2023

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	Data Set Coordinator) provided Resident B's shower records for April and May 2023. The Shower Sheets indicated Resident B had received 5 bed baths or showers in the month of April. She had received a bed bath on 4/4/23, a shower on 4/10/23, a shower on 4/17/23, and a bed bath on 4/29/23. The MDSC indicated there were no Shower Sheets for May. During an interview on 6/14/23 at 2:52 p.m., CNA (Certified Nursing Assistant) 5 indicated when a shower or bed bath was completed, a shower sheet was filled out and put into the shower binder. Refusals of showers or bed baths are documented on the shower sheet and the nurse is notified. On 6/14/23 at 10:20 a.m., the Director of Nursing indicated the facility did not have a policy for ADL care. During an interview on 6/14/23 at 3:45 p.m., the Executive Director indicated the shower schedule had not been accurately created by a former member of management. This Federal tag relates to Complaint IN00407833. 3.1-38-(a)(3)		will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to administer medications as ordered; follow through on a pharmacy recommendation; timely schedule a vascular surgeon appointment; and timely address a skin condition on a resident's right great toe for 1 of 1 resident reviewed for skin conditions and 2 of 5 residents reviewed for unnecessary medications. (Residents 4, 24, 25) Findings include: The clinical record for Resident 4 was reviewed on 6/14/23 at 2:15 p.m. His diagnoses included, but were not limited to: type 2 diabetes mellitus, traumatic brain injury, major depressive disorder, anxiety, and chronic pain. 1. a) The 5/4/23 Note To Attending Physician/Prescriber read, "[Name of Resident 4] has current orders for Acetaminophen and Norco. The recommended maximum of acetaminophen is 4000mg/24 hours but may need to be lower for residents with impaired kidney and/or liver dysfunction. Please review then check off if one of the following may be added to all orders containing acetaminophen." The options in the note were a maximum of 4000mg/24 hours of acetaminophen from all sources, a maximum of 3000 mg/24 hours of acetaminophen from all sources, or other with a blank to indicate such. The 5/10/23 physician/prescriber response section indicated a maximum of 4000mg/24 hours was selected by the physician/prescriber. The current physician's orders included an order for Acetaminophen 500 mg, 2 tablets by mouth every 8 hours as needed and an order for Hydrocodone-Acetaminophen tablet 7.5-325 mg,1	F 0684	**F684 Quality of Care** **It is the practice of this facility to assure that medications are administer as ordered, pharmacy recommendations are completed, resident appointments are scheduled and skin conditions are addressed timely.** 1. Resident 4 pharmacy recommendation and vascular appointed was corrected during annual survey. Resident 4 and 25 are receiving medication administration in accordance with MD orders and are being documented appropriately. Resident 24 skin condition has been addressed by MD and orders were in place during annual survey. 2. All residents have the potential to be affected. Please see system changes below to prevent reoccurrence. 3. All nurses have been in-serviced on administering and charting medications in accordance with the MD orders, assessing, documenting and assuring MD orders are in place for skin issues, and ensuring that all outside the facility MD	07/15/2023

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	tablet by mouth, every 6 hours as needed for pain. Neither order included an Acetaminophen maximum of 4000mg/24 hours, nor was there an additional order for an Acetaminophen maximum of 4000mg/24 hours. An interview was conducted with the DON (Director of Nursing) on 6/14/23 at 3:00 p.m. She reviewed Resident 4's orders and indicated she did not see the 5/4/23 pharmacy recommendation to include an Acetaminophen maximum, approved by the physician, was added to the current orders. The Pharmacy Recommendation - Facility Communication Policy and Procedure was provided by the MDSC (Minimum Data Set Coordinator) on 6/15/23 at 2:25 p.m. It read, "The DON, or his/her designee, will track the physician's response to the pharmacist recommendations." 1. b) The 5/31/23 physician's order for Resident 4 indicated to refer to vascular surgeon for pain every day shift and to discontinue the order when the appointment was made, starting 6/1/23. The June, 2023 TAR (treatment administration record) indicated the order was signed off on the following dates and never discontinued: 6/1/23 6/2/23, 6/5/23, 6/7/23, 6/8/23, 6/10/23, 6/11/23, and 6/14/23. There was no information in Resident 4's clinical record indicating a vascular surgeon appointment was made after the 5/31/23 order to do so. An interview was conducted with the DON (Director of Nursing) on 6/15 at 2:25 p.m. She indicated they just now scheduled the vascular surgeon appointment. There was an agency nurse		appointments are made and documented. 4. A Performance Improvement Tool has been initiated that randomly reviews 5 residents medications are being administer in accordance with the MD order. A Performance Improvement Tool has been initiated to review all residents with outside appointment to ensure appointment is made in a timely manner. A Performance Improvement Tool has been initiated that randomly reviews 5 residents skin assessments to ensure all skin conditions are documented and treatment in place. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	

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	who was working the day of the order and she missed it. 1. c) The physician's orders for Resident 4 indicated for 1 vial of Bydureon Pen-injector 2 mg to be injected subcutaneously one time a day every 7 days, starting 6/7/23; 40 units of Insulin Detemir Solution Pen-injector 100 UNIT/ML to be administered at bedtime, starting 3/23/23; 5 units of HumaLOG Solution 100 UNIT/ML (Insulin Lispro) to be administered after meals, starting 3/24/23; and humaLOG Solution 100 NIT/ML to be administered per sliding scale for blood sugar readings between 150 and 350 before meals and at bedtime, starting 3/23/23; for blood sugar checks to be conducted before meals and at bedtime, starting 3/23/23; for OcuSoft Lid Scrub Original External Liquid (Eyelid Cleansers) to be applied to eyelids topically three times a day, starting 6/6/23; for Paxil Tablet 30 MG to be administered one time a day, starting 1/12/23; and busPIRone HCl Oral Tablet 10 MG tablet to be administered two times a day, starting 4/12/23; - The June, 2023 MAR (medication administration record) indicated the Bydureon was not administered on 6/13/23, as ordered; the Insulin Detemir Solution was not administered on 6/2/23 and 6/9/23, as ordered; the HumaLOG was not administered 3 times on 6/2/23, one time on 6/6/23, 2 times on 6/9/23, and 2 times on 6/13/23; the sliding scale HumaLOG was not administered for blood sugar readings between 150 and 350 three times on 6/2/23, once on 6/3/23, and once on 6/9/23; and the blood sugar checks were not done once on 6/6/23, twice on 6/9/23 and once on 6/13/23; the OcuSoft Lid Scrub was not applied 2 times on 6/9/23 and 2 times on 6/13/23; the Paxil was not administered on 6/9/23; and the busPIRone was not administered once on 6/9/23			

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	and once on 6/13/23. An interview was conducted with the DON on 6/15/23 at 2:25 p.m. She indicated one of the QMAs (Qualified Medication Aids) at the facility informed her the medications were administered as ordered, but could not provide any verification of they were administered. The Medication Administration General Guidelines was provided by the MDSC (Minimum Data Set Coordinator) on 6/14/23 at 2:34 p.m. It read, "After medication administration is completed, licensed personnel reviews the MAR/eMAR to ensure all necessary doses were administered and documented."2. The clinical record for Resident 25 was reviewed on 6/15/23 at 9:40 a.m. The diagnoses included, but were not limited to, tachycardia (fast heartbeat) cardiomyopathy (heart muscle problems that makes it difficult to pump blood). A physician order dated 11/29/22 indicated Resident 25 was to receive 5 milliliters of metoprolol 4 times a day. The staff was to hold blood pressure medication if systolic was less than 100 or diastolic was less than 60. A physician order dated 11/30/22 indicated Resident 25 was to receive 50 milligrams of eplerenone daily. The staff was to hold blood pressure medication if systolic was less than 100 or diastolic was less than 60. A physician order dated 12/19/22 indicated Resident 25 was to receive 2.5 milligrams of lisinopril on Mondays, Wednesdays, and Fridays. The staff was to hold blood pressure medication if systolic was less than 100 or diastolic was less than 60.			

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	The June 2023 Medication Administration Record (MAR) for Resident 25 indicated the following days and times the resident had received the metoprolol, the eplerenone, and the lisinopril medications out of the parameters of the orders: 5 milliliters metroprolol: 6/2/23 at 8:00 a.m., blood pressure reading 92/59; at 2:00 p.m. blood pressure reading 91/63, 6/3/23 at 9:00 a.m., blood pressure reading 97/59; 6/4/23 at 2:00 a.m., blood pressure reading 92/63; 6/5/23 at 8:00 a.m., blood pressure reading 89/56; at 2:00 p.m., 89/56; 10:00 p.m., 96/60; 6/6/23 at 2:00 a.m., blood pressure reading 98/72; 6/12/23 at 2:00 a.m., blood pressure reading 92/58; at 2:00 p.m., 92/58; and 6/13/23 at 2:00 a.m., blood pressure reading 90/66; at 8:00 a.m., 90/66; 2.5 milligrams of lisinopril: 6/2/23 at 12:00 p.m., 91/63; and 6/5/23 at 12:00 p.m., 89/56; 50 milligrams of eplerenone: 6/2/23 at 8:00 a.m., 92/59; 6/5/23 at 8:00 a.m., 89/56; 6/12/23 at 8:00 a.m., 92/58; and 6/13/23 at 8:00 a.m., 90/66; An interview was conducted with the Director of Nursing on 6/15/23 at 9:34 a.m. She indicated the nursing staff was not administering medications as ordered. In-servicing had been provided to address staff not administering the blood pressure medications as ordered. Registered Nurse (RN) 6 had recognized Resident 25's blood pressure was running low a few weeks ago. RN 6 had spoken to the medical provider to address and do a medication review. The DON indicated she was			

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	unable to provide nursing notes nor medical provider notes the blood pressure medications had been reviewed. As of today, the medical provider would be reviewing. 3. The clinical record for Resident 24 was reviewed on 6/13/23 at 10:40 a.m. The Resident's diagnosis included, but was not limited to seizures and cellulitis of right great toe. A Quarterly MDS (Minimum Data Set) Assessment, completed 1/11/23, indicated he was cognitively intact and needed extensive assistance of 1 staff member for dressing and total assistance of 2 staff members for bathing. A Weekly Skin/ Shower Assessment, dated 5/30/23 at 9:27 a.m., indicated Resident 24's skin was clean, dry, and intact. There were no new skin issues. A Health Status Note, dated 6/5/23 at 9:35 a.m., indicated Resident 24 had been sent to an acute care hospital due to having seizure like activity. The acute care hospital history and physical, dated 6/5/23, which read "... On arrival to the emergency room, the patient was noted to have a wound on his right toe...Assessment and Plan...Right toe wound...We will continue vanc[sic] and Zosyn (antibiotic)..." Resident 24 was readmitted to the facility from an acute care hospital on 6/11/23. An Admission Summary, dated 6/11/23 at 6:28 p.m., indicated Resident 24 had returned from the acute care hospital. A total skin assessment was done, and his right great toe had a mepilex (type of dressing) dry bandage which was removed. The area under the bandage was beefy red with			

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	no drainage from it. The area was redone with a hydrofera (type of dressing) pad. He had been treated for a history of seizure activity and cellulitis while at the hospital. Augmentin had been ordered and the first dose had been received from the pharmacy. A physician's order, dated 6/12/23, indicated Resident 24 was to receive Amoxicillin- Potassium Clavulanate (antibiotic) 875 mg every 12 hours until 6/19/23 for an infection. The clinical record did not contain a physician's order for a treatment to the right great toe. A care plan, initiate 6/14/23, indicated Resident 24 had returned from the hospital on an antibiotic for cellulitis. The goal was for him to be free of complications related to the infection. The interventions were to administer antibiotics as ordered by the physician, monitor and document and report to physician symptoms of cellulitis, monitor and document healing of cellulitis. A Weekly Skin/ Shower Assessment, dated 6/14/23, indicated a new area of concern. Toenail on right big toe not present. He has an order for a podiatry consult. On 6/15/23 at 10:01 a.m., Resident 24's right great toe was observed with QMA (Qualified Medication Aide) 3. There was an undated dressing present on his right great. The toe was missing the toenail and there was a "pea sized" amount of blood-tinged drainage present on the proximal side of the toenail area. During an interview on 6/15/23 at 10:01 a.m., QMA 3 indicated a dry dressing was being applied to the toe and that Resident 24's right great toe had			

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	been that way since before he went to the hospital on 6/5/23. QMA 3 would let the nurse know about the drainage on the right toe. During an interview on 6/15/23 at 2:25 p.m., the MDSC (Minimum Data Set Coordinator) indicated that as a general rule there should be a physician's order to apply a dressing. On 6/15/23 at 1:22 p.m., the MDSC provided the current Weekly Skin Check policy which read "...All areas of the Resident's skin shall be inspected by his or her nurse and documented at least weekly on the Weekly Skin Assessment...If skin impairment has been identified the nurse shall complete the Weekly Skin Assessment form indicating any new area of abnormality (to include measurements, appearance, drainage, etc.) and obtain a treatment order from the attending MD [sic] immediately...The nurse shall complete the ...Non-Pressure form weekly to track the area of skin impairment identified..." 3.1-37(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments			

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TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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	under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to remove discontinued medications from the medication cart and failed to timely label medications with a date opened for 1 of 3 medications carts reviewed for medication storage. Findings included: On 6/15/23 at 1:48 p.m., the primary medication cart on the TBI (Traumatic Brain Injury) unit was observed with QMA (Qualified Medication Aide) 3. The top drawer of the primary medication cart contained the following: 1. A plastic bag labeled with Resident 23's name, which contained 29 individually packaged doses of Remeron (anti-depressant medication) 30 mg(milligram) tablets. The date filled was 8/19/22. QMA 3 was unsure if Resident 23 was still receiving the medication. The clinical record for Resident 23 indicated the	F 0761	**F761 Label/Store Drugs and Biologicals** **It is the practice of this facility to assure that medications are removed when discontinued, and labeled timely when opened.** 1. No specific residents were identified. The unlabeled medications have been removed and destroyed. New medications were dated with opening date. All discontinued medications were removed from medication carts. 2. All residents that have medications discontinued and medications that require an open date have the potential to be affected. Please see system changes below to prevent reoccurrence.	07/15/2023

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	Remeron 30 mg tablets had been discontinued on 11/8/22. 2. A cardboard box which was labeled with Resident 17's name and contained Moxifloxacin eye drops. The date filled was 3/14/23. QMA 3 indicated Resident 17 had received the eye drops after he had eye surgery, but he was done receiving them. The clinical record for Resident 17 indicated the Moxifloxacin eye drops had been discontinued on 4/24/23. 3. A plastic medication bottle labeled with Resident 15's name and a fill that of 10/24/22, that contained a small glass bottle of Nitroglycerin tablets with the seal broken. There was not a date opened present on either of the bottles. QMA 3 indicated she was unsure when the nitroglycerin had been opened. 4. A Lantus Solostar Solution Pen-injector labeled with Resident 15's name. A sticker was present on the pen which indicated it was good for 28 days after the open date. There was no date indicating when the insulin pen had been opened. QMA 3 indicated the Lantus insulin pen had been open for about 2 weeks. She was unsure why it had not been labeled with an open date. During an interview on 6/15/23 at 2:20 p.m., QMA 3 indicated when she knew that a medication had been discontinued, she would remove it from the cart and give it to the nurse to be returned or destroyed. On 6/15/23 at 2:24 p.m., the MDSC (Minimum Data Set Coordinator) provided the Storage of Medications and Biologicals Policy, last reviewed		3. All nurses and QMAs have been in-serviced on removing discontinued medications from med carts and correct labeling of all medications that require an open date. 4. A Performance Improvement Tool has been initiated that reviews residents discontinued medications to ensure that medications are being removed from med cart on the date of discontinuation. A Performance Improvement Tool has been initiated that reviews medications that require an open date to ensure that all medications are labeled correctly. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	

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	5/12/21, which read "...Disposal of medication(s) should be completed for medication(s) that are...outdated...Disposal needs to be timely...Removed medication(s) immediately from stock..." 3.1-26(k)(6) 3.1-25(o)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to timely obtain labs, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 6/14/23 at 2:15 p.m. His diagnoses included, but were not limited to: type 2 diabetes mellitus, traumatic brain injury, major depressive disorder, anxiety, and chronic pain. The 6/1/23 physician's order indicated to collect the following labs on the next lab draw day: CBC w/diff [complete blood count with differential,] CMP [complete metabolic panel,] Mag [Magnesium] level, Phosphate level, A1C [blood test that measures average blood sugar levels over the past 3 months,] and TSH [thyroid	F 0770	**F770 Laboratory Services** **It is the practice of this facility to assure that residents laboratory services are completed in a timely manner.** 1. Resident 4 labs were ordered and reviewed by MD. 2. All residents that have lab orders have the potential to be affected. 3. All nurses have been in-serviced to ensure that labs are ordered, collected and completed in a timely manner and MD notified.	07/15/2023

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	stimulating hormone.] The results to the above 6/1/23 lab order indicated the specimen was collected on 6/8/23. The 6/1/23 physician's order indicated to collect a UA (urinalysis) and send to lab for protein, microalbumin, creatinine one time only, starting 6/1/23. There was no UA result on or after 6/1/23 in Resident 4's clinical record. An interview was conducted with the DON (Director of Nursing) on 6/15/23 at 2:25 p.m. She indicated they missed doing the UA lab. The agency nurse who wrote the order for the other labs did not include the UA on the order. The lab comes almost daily to draw labs, so she was unsure why it took 7 days for the other labs to be drawn. The Laboratory and Clinical Testing Services Policy and Procedure was provided by the DON on 6/15/23 at 2:45 p.m. It read, "The facility will provide and or obtain laboratory services/clinical testing to meet the needs of its residents. The facility is responsible for the quality and the timeliness of the services." 3.1-49(a)		4. A Performance Improvement Tool has been initiated that reviews residents with ordered laboratory services to ensure that they are being ordered, collected and completed in a timely manner and MD notified. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information			

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	for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the			

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	individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to submit the data for license personnel that worked in the facility from January 2023 through March 2023 to CMS (The Centers for Medicare & Medicaid Services) for the Payroll Based Journal Daily Nurse Staffing (PBJ) report. This had a potential to effect 29 of 29 residents that reside in the facility. Findings include: The PBJ Staffing Data Report that was generated from January 1, 2023 - March 31, 2023 indicated the facility had not submitted data for the quarter. An interview was conducted with the Director of Operations on 6/14/23 at 3:18 p.m. He indicated the staff person that was suppose to submit the staffing data last quarter had not reported the data. The facility did have the appropriate nursing staff working in the facility in January, February, and March. A random review of the January, February, March 2023 staff work schedules were reviewed. The facility did have license staff personnel working in the facility that included Registered Nurses during	F 0851	**F851 Payroll Based Journal** **It is the practice of this facility to assure that PBJ Staffing Data is submitted to CMS to ensure the facility has the appropriate nursing staff in place.** 1. No residents were identified. The facility was noted to have the appropriate nursing staff working in the facility during the first quarter (Jan, Feb and Mar). 2. All residents that have the potential to be affected with any staffing issues. 3. The HR coordinator has been in-serviced to ensure that proper submission of the facility staffing is being submitted to CMS for the Payroll Based Journal Daily Nurse Staffing (PBJ).	07/15/2023

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	that time.		4. A Performance Improvement Tool has been initiated that reviews daily staffing and ensures that submission is being done in accordance with the PBJ report guidelines. The HR coordinator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control that included: touching pill medications with bare hands, not utilizing hand hygiene during the medications administrations and prior and after donning and doffing of gloves, and disinfecting of an insulin pen hub with alcohol prior to attaching the needle for 3 of 8 residents observed during medication administration and 2 of 2 randomly observed residents for infection control. (Residents' 1, 15, 19, 22, 28) Findings included: 1. An observation was made of medication administration with License Practical Nurse (LPN) 2 on 6/14/23 at 8:24 a.m. LPN 2 was observed at the medication cart with a cup of pill medications sitting on top of the cart. She indicated the medication was for Resident 28. LPN 2 at that time was observed pulling 0.5 milligrams of Lorazapam out of the narcotic box and placed it in the cup of pill medications. She then using her bare hands removed three capsules from the cup of pills and placed them on top of the medication cart. After, she pulled apart the capsules and emptied the contents in an additional medication cup. She then crushed the remaining pill medications, poured the contents back into the medication cup	F 0880	**F880 Infection Prevention & Control** **It is the practice of this facility to assure that nurses/QMAs are conducting all services in a manner that is in accordance with infection control guidelines this includes: not touching medications with bare hands, not utilizing hand hygiene during medication administration and prior to and after donning and doffing gloves, disinfecting insulin pen hub with alcohol prior to attaching needles.** 1. Resident 1, 15, 19, 22, 28 were affected at the time of survey and the facility is unable to go back and correct the areas of concern at that time. Moving forward all residents receiving medications and insulin services are handled with all precautions in a manner that promotes acceptable infection control.	07/15/2023

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	and placed chocolate pudding on the crushed medications. After, she administered the medication to Resident 28. There was no hand hygiene observed prior to the administration to Resident 28. 2. An observation was made of medication administration with LPN 2 on 6/14/23 at 8:55 a.m. LPN 2 was observed pulling and prepping to administer Resident 22's pill medications. During that time, she had touched the computer mouse, her hair, medication cart, multiple pill medication cards and boxes of eyes drops. She then pulled a pair of gloves and walked to Resident 22 with pill medications. LPN 2 was observed administering the pill medications, donned on the pair of gloves and administer refresh tears to Resident 22. There was no hand hygiene utilized prior to the administration of the pill medications nor donning on the gloves. 3. An observation was made of medication administration with LPN 2 on 6/14/23 at 9:00 a.m. LPN 2 was observed pulling and preparing Resident 15's pill medications and lantus insulin from a flex pen. During that time, LPN 2 had pulled the cap off the flex pen and placed the needle on the hub of the flex pen. There was no observation of disinfection of the hub of the flex pen prior to the placement of the needle. After, she then walked to Resident 15's room and administered the pill medication to Resident 15. During that time, she donned on a pair of gloves and administered 37 units of lantus to Resident 15. There was no observation of hand hygiene prior or after the medication administration nor prior to donning or doffing of the gloves. An interview was conducted with the Director of Nursing on 6/14/23 at 2:30 p.m. She indicated the		2. All residents that receive medications/insulins have the potential to be affected. 3. All nurses/QMAs have been in-serviced to ensure that medications and insulins are being administered in accordance with the infection control guidelines. 4. A Performance Improvement Tool has been initiated to ensure that medications and insulins are being administered in accordance with the infection control guidelines. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. **5. July 15, 2023**	

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	staff should use hand hygiene before and after administration of medications. 4. On 6/14/23 at 10:39 a.m., Resident 1 was randomly observed for tracheostomy care. RT (Respiratory Therapist) 4 gathered the tracheostomy care supplies from the respiratory cart and entered Resident 1's room. She cleared the bedside table and opened the trach care kit. RT 4 then donned a pair of non-sterile gloves and removed the old dressing from Resident 1's tracheostomy site. RT 4 did not perform hand hygiene prior to donning the non-sterile gloves. RT 4 then removed the glove from her right hand and donned a new glove. RT 4 did not perform hand hygiene prior to donning the new glove. Tracheostomy care was performed. During an interview, RT 4 indicated she always washed her hands with soap and water prior to leaving a room. She did sometimes forget to do hand hygiene prior to starting trach care. 5. On 6/14/23 at 11:29 a.m., LPN 2 was randomly observed administering insulin to Resident 19. LPN 4 obtained the insulin pen from the medication cart and verified the order for the amount of insulin to administer. She obtained a needle for the insulin pen from the medication cart and then entered Resident 19's room to administer the insulin. She removed the cap from the insulin pen and attached the needle to the insulin pen. She did not cleanse the hub of the insulin pen prior to attaching the needle. She then administered the insulin as ordered to Resident 19. During an interview, LPN 3 indicated she would sometimes cleanse the hub of the insulin pen prior to attaching the needle. On 6/14/23 at 11:11 a.m., the Executive Director provided the current Tracheostomy Care policy			

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	which read "...Gather the necessary equipment and proceed to the patient's room...Wash your hands and utilizing aseptic technique prior to setting up equipment..." On 6/14/23 at 2:38 p.m., the MDSC provided the Insulin Preparation and Administration policy, last reviewed 5/12/21, which read "...Procedure of insulin pen...Remove cap from pen and wipe needle attachment area with alcohol swab..." A "Handwashing/Hand Hygiene" policy was provided by the Minimum Data Set (MDS) Coordinator on 6/14/23 at 2:34 p.m. It indicated "...This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation..7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...b. Before and after direct contact with residents; c. Before preparing or handling medications;...f. Before donning sterile gloves;...m. After removing gloves..." 3.1-18(l)			
F 9999 Bldg. 00	Based on interview and record review, the facility failed to ensure annual or new hire dementia in-service training was provided for 7 of 10 staff personnel files reviewed. (Qualified Medication Aide (QMA) 16, Certified Nursing Assistant (CNA) 17, Respiratory Therapist (RT) 22, CNA 23, Activities Director (AD) 24, CNA 25, and License Practical Nurse (LPN) 26) Findings include:	F 9999	**F9999 Final Observations** **It is the practice of this facility to ensure that annual or new hire dementia in-service training is provided.** 1. AD 24, CNA 25, LPN 26, QMA 16, CNA 17, RT 22 and CNA 23	07/15/2023

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TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The staff personal files for 10 staff members were provided by the Executive Director (ED) on 6/15/23 at 2:45 p.m. The following staff members files did not include dementia in-service training: AD 24 had a start date of 2/28/23, CNA 25 had a start date of 8/5/21, LPN 26 had a start date of 1/16/23, QMA 16 had a start date of 2/22/23, CNA 17 had a start date of 5/8/23, RT 22 had a start date of 8/1/21 and CNA 23 had a start date of 5/31/23 During the exit conference on 6/15/23 at 5:30 p.m., the ED indicated she was unable to provide documentation annual or new hire dementia in-service training was provided to AD 24, CNA 25, LPN 26, QMA 16, CNA 17, CNA 23 and RT 22.		2. Staff files have been reviewed to assure that they have proper in-servicing related to the required dementia training. Any issues are being addressed. 3. The HR Coordinator has been in-serviced related to assuring that staff complete all new and annual assigned in-service material including the required dementia training. 4. A Performance Improvement Tool has been initiated that randomly reviews employee file to assure that required scheduled in-services are complete including dementia training. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. 5. **July 15, 2023**	