STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/20/2022				
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COD  3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION		
F 0000	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG	BEIGERGI		DATE		
Bldg. 00	IN00370649.  Complaint IN0037	he Investigation of Complaint  0649 Substantiated. No	F 00	000					
	deficiencies related to the allegations are cited.  Unrelated deficiencies are cited.								
	Survey date: January 20, 2022								
	Facility number: 0 Provider number: AIM number: 300	155857							
	Census Bed Type: SNF/NF: 26 Total: 26								
	Census Payor Type Medicare: 2 Medicaid: 21 Other: 3 Total: 26	e:							
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1							
	Quality review con	npleted on January 21, 2022							
F 0607 SS=D Bldg. 00	§483.12(b) The fa	ent Abuse/Neglect Policies acility must develop and a policies and procedures							
		phibit and prevent abuse, oitation of residents and							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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.

Event ID: C1B411 Facility ID: 014265 If continuation sheet Page 1 of 7

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2022 155857 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVENUE TRANQUILITY NURSING AND REHAB INDIANAPOLIS, IN 46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility F 0607 01/25/2022 The facility will ensure that all failed to implement its policies regarding prompt incidents, accidents or allegations reporting of an allegation of verbal and/or mental of abuse are reported within a abuse upon learning of the allegation to the State timely manner per regulations. Survey Agency within 2 hours or less. (Resident C) The issue identified during the State survey was reported via Findings include: gateway. In an interview with the Executive Director (ED) The facility reviewed current on 1-20-22 at 1:19 p.m., he indicated he had reportables to ensure timely received an allegation yesterday (1-19-22) and he notification. One issue identified had not reported it yet to Indiana Department of and corrected. No other issues Health's (IDOH) Division of Long Term Care noted. (LTC), but would do so immediately. In a continued interview with the ED on 1-20-22 at 1:36 The Administrator has been p.m., the ED indicated the resident declined to tell in-serviced on timely reporting the ED exactly what was said, other than CNA 5 protocols for incidents and used inappropriate language and was berating the accidents and allegations of Assistant Director of Nursing (ADON). The ED abuse. Two designees have been indicated he began an immediate investigation of assigned as backup in case the the situation and the alleged perpetrator, CNA 5. Administrator is not available to CNA 5 was immediately suspended at that time, report in a timely manner. pending results of investigation. The ED indicated the investigation was still in progress at Reportables will be reviewed the time of the interview. monthly for timeliness in reporting and accuracy. Results of the On 1-20-22 at 5:02 p.m., the ED provided a copy of reviews will be reported to QA the report he filed the afternoon of 1-20-22, to the team monthly for three months or IDOH-LTC, regarding the allegation of verbal until problem is considered and/or mental abuse. The report indicated on resolved.

1-19-20 at 9:01 a.m., Resident C indicated CNA 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED	
155857		B. WING		01/20/2022		
NAME OF F	ROVIDER OR SUPPLIEF	3		T ADDRESS, CITY, STATE, ZIP COD		
				N CENTRAL AVENUE		
TRANQU	IILITY NURSING A	ND REHAB	INDIA	ANAPOLIS, IN 46205		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTENTION	
TAG		R LSC IDENTIFYING INFORMATION  Omplaining about the ADON	TAG	BEFREEN	DATE	
		propriate language." It				
		byee, CNA 5, was suspended,				
	-	of the investigation.				
		5 a.m., the ED provided a copy				
		y entitled, "Abuse Prevention				
		licy indicated, "Our residents				
	have the right to be	sive policies and procedures				
	-	ed to aid our facility in				
	•	of our residents. Our abuse				
	prevention program	n provides policies and				
	-	vern, as a minimumThe				
	reporting and filing of accurate documents relative					
	to incidents of abus	se."				
	On 1-20-22 at 10:4	5 a.m., the ED provided a copy				
		y entitled, "Reporting Abuse				
		ment." This policy indicated,				
		lity of our employees, facility				
	consultants, Attend	ing Physicians, family				
		etc., to promptly report any				
	•	ed incident of neglect or				
		he Executive Director. 'Verbal				
		any use of oral, written or hat willfully includes				
		rogatory terms to residents or				
		ithin their hearing distance, to				
		regardless of their age, ability				
	· ·	disability'Mental abuse' is				
	· ·	ot limited to humiliation,				
		of punishment, or withholding				
	of treatment or servicesThe facility will report/respond to all allegations to all appropriate					
		the Indiana State Department				
	of Healthas warra	mea.				
	3.1-28(a)					
	3.1-28(e)					
l	l `´		i	i	i	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C1B411

Facility ID: 014265

If continuation sheet

Page 3 of 7

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 01/20/2022	
	PROVIDER OR SUPPLIEI JILITY NURSING A		3640 N	ADDRESS, CITY, STATE, ZIP COD I CENTRAL AVENUE NAPOLIS, IN 46205	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	- , ,	ged Violations conse to allegations of exploitation, or mistreatment,			
	violations involvin exploitation or mis injuries of unknow misappropriation reported immedia hours after the all events that cause or result in serious than 24 hours if the allegation do not i result in serious be administrator of the officials (including Agency and adult state law provides	streatment, including on source and of resident property, are tely, but not later than 2 egation is made, if the the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the the facility and to other to the State Survey protective services where is for jurisdiction in long-term accordance with State law			
	investigations to the designated reofficials in accordincluding to the State of the	port the results of all the administrator or his or presentative and to other ance with State law, tate Survey Agency, within the incident, and if the s verified appropriate must be taken.			
	Based on interview failed to report of a mental abuse upon	and record review, the facility n allegation of verbal and/or learning of the allegation to gency within 2 hours or less.	F 0609	The facility will ensure that all incidents, accidents or allegati of abuse are reported within a timely manner per regulations.  The issue identified during the	
	Findings include:			State survey was reported via	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C1B411

Facility ID: 014265

If continuation sheet

Page 4 of 7

02/09/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2022 155857 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVENUE TRANQUILITY NURSING AND REHAB INDIANAPOLIS, IN 46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE gateway. In an interview with the Executive Director (ED) on 1-20-22 at 1:19 p.m., he indicated he had The facility reviewed current received an allegation yesterday (1-19-22) and he reportables to ensure timely had not reported it yet to Indiana Department of notification. One issue identified Health's (IDOH) Division of Long Term Care and corrected. No other issues (LTC), but would do so immediately. In a noted. continued interview with the ED on 1-20-22 at 1:36 p.m., the ED indicated the resident declined to tell The Administrator has been the ED exactly what was said, other than CNA 5 in-serviced on timely reporting used inappropriate language and was berating the protocols for incidents and ADON. The ED indicated he began an immediate accidents and allegations of investigation of the situation and the alleged abuse. Two designees have been perpetrator, CNA 5 was immediately suspended at assigned as backup in case the that time, pending results of investigation. The Administrator is not available to ED indicated the investigation was still in report in a timely manner. progress at the time of the interview. Reportables will be reviewed On 1-20-22 at 5:02 p.m., the ED provided a copy of monthly for timeliness in reporting the report he filed the afternoon of 1-20-22, to the and accuracy. Results of the IDOH-LTC, regarding the allegation of verbal reviews will be reported to QA and/or mental abuse. The report indicated on team monthly for three months or 1-19-20 at 9:01 a.m., Resident C indicated CNA 5 until problem is considered "was in his room complaining about the ADON resolved. and was using inappropriate language." It indicated the employee, CNA 5, was suspended, pending the results of the investigation. In an interview with Resident C on 1-20-22 at 12:20 p.m., he indicated he recently had a staff member speak to another employee while providing care to him, who used "inappropriate language" while she was talking about being upset with the ADON. Resident C declined to repeat the terms the employee was using as it was "foul language and would rather not repeat what she said." He indicated the facility management were very prompt to respond to his concerns regarding this and "they fired her yesterday over it."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C1B411

Facility ID: 014265

If continuation sheet

Page 5 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
155857		B. WING		01/20/2022	01/20/2022	
		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIER	<b>L</b>		N CENTRAL AVENUE		
TRANQL	JILITY NURSING AI	ND REHAB	INDIA	ANAPOLIS, IN 46205	<u> </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		MPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		10 a.m., the ED provided a copy				
		Resident C had given him the				
		22) of his concerns/allegations				
		ntal abuse. The document				
		2, while CNA 5 and CNA 6				
		e to him, CNA was using very				
		alking badly about the ADON. very inappropriate to be using				
	in a resident's room					
	in a resident's roull	•				
	On 1-20-22 at 10·4	5 a.m., the ED provided a copy				
		y entitled, "Abuse Prevention				
		licy indicated, "Our residents				
	have the right to be free from					
	abuseComprehens	sive policies and procedures				
	have been develope	d to aid our facility in				
	preventing abusec	of our residents. Our abuse				
	prevention program provides policies and					
		procedures that govern, as a minimumThe				
		of accurate documents relative				
	to incidents of abus	e."				
	On 1-20-22 at 10:45 a.m., the ED provided a copy					
		y entitled, "Reporting Abuse				
		nent." This policy indicated,				
	_	lity of our employees, facility				
		ing Physicians, family				
		etc., to promptly report any				
	1	ed incident of neglect or				
		he Executive Director. 'Verbal				
	abuse' is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability'Mental abuse' is defined as, but is not limited to humiliation, harassment, threats of punishment, or withholding					
	of treatment or servicesThe facility will report/respond to all allegations to all appropriate					
	1	6				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C1B411 Facility ID: 014265

If continuation sheet Page 6 of 7

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
155857		155857	B. WING		01/20/2022		
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD  3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
	agencies, including of Healthas warra 3.1-28(e)	the Indiana State Department nted."					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: C1B411 Facility ID: 014265 If continuation sheet Page 7 of 7