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	08/19/2021

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 Complaint IN00359273. Complaint IN00359273 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: August 15, 16, 17, 18 and 19, 2021 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 1 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 25, 2021	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	08/19/2021

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
	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to maintain a resident's dignity during a staff-to-staff verbal altercation for 1 of 3 residents	F 0550	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We	09/22/2021

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	08/19/2021

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
	reviewed for abuse. (Resident G) Findings include: The clinical record for Resident G was reviewed on 8/15/21 at 1:30 p.m. The diagnosis for Resident G included, but was not limited to, schizoaffective disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 5/7/21, indicated Resident G was cognitively intact. An interview was conducted with Resident G on 8/15/21 at 1:12 p.m. He indicated he had witnessed Certified Nursing Assistant (CNA) 9 and CNA 13 get into a verbal argument. Last Friday evening, he was in his room talking on the telephone, and then started hearing CNA 9 and CNA 13 screaming at each other in the hallway. The isolation carts were pushed, and the argument was "very heated." License Practical Nurse (LPN) 8 had gotten involved. She grabbed CNA 9 and pushed her out the outside door. He did not feel CNA 9 deserved to be "man handled" by LPN 8. The incident was not appropriate and very concerning. An interview was conducted with LPN 8 on 8/18/21 at 3:38 p.m. She indicated around 7:00 p.m., on Friday evening during shift change CNA 9 and CNA 13 had gotten into a verbal altercation at the nurse's station on the vent unit. CNA 13 had said some "unfavorable" things and upset CNA 9. The conversation between the two CNA's became heated, and it escalated to screaming. Once they started getting loud and getting into each other's faces she then stepped in between them. At that time, LPN 8 had told them both to leave the premises. She grabbed CNA 9's arm and pushed		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 requests the plan of correction be considered our allegation of compliance effective 09/21/2021 to the state findings of the Recertification and State Licensure Survey as well as the complaint survey conducted on August 19, 2021. F - 550 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G has not suffered any negative outcome related to the identified event. Social Services has continued to follow the resident with no psychosocial issues identified. The staff members identified as CNA #9 and CNA # 13 have been disciplined and re-educated on residents' rights and dignity. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has been conducted of all alert and oriented residents related to ensuring that they are being treated with dignity and respect and free of abuse. All residents indicated that they are being treated with dignity and respect and free of any type of	

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	08/19/2021

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
	her outside the back door. Then, she called the police to escort CNA 13 out of the building due to her refusal to leave. All the residents were in their rooms at that time, but Resident G was the only resident that had overheard the commotion. An interview was conducted with CNA 9 on 8/18/21 at 3:47 p.m. She indicated she did have an argument with CNA 13 Friday evening. It was during shift change, and CNA 13 had come in to relieve her. CNA 13 had asked why a resident had not been placed in bed yet. During the conversation with CNA 13, things were said that was upsetting to her, and it turned into them screaming at each other. LPN 8 did get involved after we started getting into each other's faces. She grabbed her arm to remove her from the building. She was upset and just had a really bad day and needed to "cool" off. An interview was conducted with Resident G and the Executive Director on 8/18/21 at 4:10 p.m. Resident G indicated the incident was not appropriate behavior between the staff. He was on the phone, and the other person on the other end overheard them yelling. He did not feel it was abusive, but disrespectful. It was very loud, and he did not know what was going on. A Resident Rights policy was provided by the Executive Director on 8/18/21 at 4:55 p.m. It indicated "...Employees shall treat all residents with kindness, respect, and dignity...3. Our facility will support and assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity...." A Dignity policy was provided by the Executive Director on 8/18/21 at 4:55 p.m. "...It indicated Policy Statement...Each resident has a right to a		abuse. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policies related to residents' rights and dignity policy. All staff members were instructed on the importance of conducting themselves in a respectful and dignified manner in interacting with all residents, staff members and visitors to ensure a tranquil work environment for all as well as providing a safe, secure and peaceful living environment for our residents. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that all residents are being treated with dignity and respect provided a peaceful, secure environment. This tool will be completed by the Social Services Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	08/19/2021

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
	dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. Each resident will be treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of his or her quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of the resident...1. Residents shall be treated with dignity and respect at all times...." 3.1-3(t)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.			

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	08/19/2021

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
	§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review the facility failed to timely update preferences and to provide showers, as preferred, to 2 of 4 residents reviewed for ADL care (Residents H and E) Findings include: 1. The clinical record for Resident H was reviewed on 8/15/21 at 1:17 p.m. The Resident's diagnosis included, but were not limited to, quadriplegia and traumatic brain injury. An Annual MDS (Minimum Data Set) Assessment, completed 2/7/21, indicated it was very important to him to choose between a shower and a bed bath. A Quarterly MDS Assessment, completed 6/10/21, indicated he was cognitively intact and needed total assistance of 2 staff members for bathing. A care plan, last revised on 5/30/2019, indicated that he preferred a bed bath or a sponge bath. He also preferred to use his own shower chair. A Resident Preferences Evaluation, dated 5/13/2020, indicated his bathing preference was showers. During an interview on 8/18/21 at 2:01 p.m., Resident H indicated he was not receiving showers as he would like.	F 0561	F - 561 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H is now receiving showers in accordance with their personal preference and is allowed to utilize their own shower chair. The resident's care plan has been updated to reflect their preference of showers instead of bed baths. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E is continuing to receive showers in accordance with their personal preference. Resident E's care plan has been updated to reflect their preference for showers instead of bed baths. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all resident's personal preferences has been completed to identify each resident's personal preference as it relates to shower, bed bath, sponge bath, etc. Each resident's	09/22/2021

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	08/19/2021

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
	On 8/18/21 at 2:20 p.m., the DON (Director of Nursing) provided his July and August 2021 shower sheets, which indicated he had received bed baths instead of showers on the following days: 7/2/21, 7/6/21, 7/17/21, 7/20/21, 7/27/21, 7/30/21, 8/6/21, 8/13/21, and 8/17/21. During an interview on 08/18/21 at 3:25 p.m., CNA (Certified Nursing Assistant) 9 indicated that he preferred to have showers instead of bed baths. During an interview on 8/19/21 at 12:50 p.m., the Activity Director indicated completed the preferences assessments. She normally concentrated more on the activity preferences as that was her department. She was unsure how the nursing care preferences were updated. During an interview on 08/19/21 at 1:37 p.m., the DON indicated that she had not been informed of his preference for showers. Ideally, the resident would be asked about preferences and then the care updated to meet their preferences. 2. The clinical record for Resident E was reviewed on 8/18/21. Resident E's diagnoses included, but not limited to, cerebral infarction (Stroke), diabetes type II, need for assistance with personal care, and hypertension. A physician's order dated 8/6/21, indicated, Resident E was to receive a shower every Tuesday and Friday weekly on day shift. An interview with Resident E was conducted on 8/18/21 at 2:34 p.m. He indicated he preferred to receive a shower rather than bed baths. Resident E's care plan dated 7/1/21 was reviewed on 8/18/21. His care plan did not address his preference for showers.		care plan has now been updated to address the resident's current personal bathing preferences. Each resident was also advised that they may change their personal bathing preference at any time and that their personal bathing preference will be reviewed at least annually. The facility's shower schedules have been updated to address each resident's current bathing preferences/needs. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's policy related to each resident's right of self-determination and that each resident may choose the type and frequency of their bathing choices. The staff was re-educated on their responsibility to ensure that the resident's personal bathing preferences are being honored. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that each resident's personal bathing preferences are being honored. The tool will also monitor to ensure that the resident's personal preferences have been care planned and that	

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	08/19/2021

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
	Resident E's July and August shower sheets were provided on 8/17/21 by DON (Director of Nursing). Resident E received a bed bath on the following dates: 7/9/21, 7/17, 7/19, 7/20, 7/25, 7/27, 7/30, 8/10, 8/13, and 8/16/21. The 8/6/21 shower sheet for Resident E indicated, he had refused the bed bath and "wants to get in shower on Saturday" however, a shower sheet for Saturday, 8/7/21, was not provided. On 8/19/21 at 2:11 p.m., the ED (Executive Director) provided the current Quality of Life-Accommodation of Needs Policy which read "...1. The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered...3. The resident will also be assessed upon admission and periodically throughout their stay on their frequency and time of bathing preferences as it relates to showers, bed baths, etc. The resident has the right to change those preferences at any time by notifying nursing administration of the change in their preferences...." 3.1-3(v)(1)		there is supportive documentation to reflect that the resident's personal bathing preferences are being provided. This tool will be completed by Social Services and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0574 SS=B Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting			

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	08/19/2021

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
	personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act			

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	08/19/2021

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
	of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. Based on interview and observation, the facility failed to ensure the Ombudsman's contact information was accessible to the residents on the TBI (Traumatic Brain Injury) unit without assistance from staff for 15 of 15 residents residing on the TBI unit. Findings include: An interview with resident council members was held on 8/16/21 at 2:01 p.m. Residents in attendance were CC, W, S, and R, who are regular members. They indicated because they reside on the TBI unit, which was a locked unit, they did not have access to the Ombudsman information without having to ask staff for assistance in obtaining the information. An observation was made of the facility's	F 0574	F - 574 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the facility has now posted the Ombudsman's contact information on the secured traumatic brain injury unit allowing private access to this information for the residents identified as residents CC, W, S and R. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents on the secured traumatic brain injury unit now have access to the Ombudsman's contact information as well as the State contact information for	09/22/2021

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	08/19/2021

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
	Ombudsman contact information sign on 8/16/21 at 2:23 p.m. The Ombudsman information sign was located on the wall next to the front door. It did not contain the local Ombudsman's name. An interview with ED (Executive Director) was conducted on 8/17/21 at 11:58 a.m. He indicated the residents on the TBI unit are on a locked unit and do not have direct access to the name nor phone number of the Ombudsman. They would need to ask for someone to allow them out of the unit or have a staff member give them the numbers/names. 3.1-3(b)(2) 3.1-4(j)(3)(C)		reportables, as the facility has posted this information on the secured unit. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility administration on the required postings that must be readily available to all residents who reside in the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that all required postings are posted and readily accessible to all residents who reside in the facility including the secured unit within the facility. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and			

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	08/19/2021

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
	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 failed to ensure new-hire staff had criminal background checks conducted and abuse and resident rights in-servicing training was conducted for 3 of 10 personal files reviewed. (License Practical Nurse (LPN) 8, Certified Nursing Assistant (CNA) 13, Qualified Medication Aide (QMA) 14) Findings include: The 10 staff personnel files were provided by the Executive Director on 8/19/21 at 12:00 p.m. During the review, LPN 8 had a start date of 6/1/21, and was a full-time employee. The file did not include a criminal background check. The following staff files did not include resident rights and abuse in-servicing training: CNA 13 - start date 6/1/21 and was a full-time employee, and QMA 14 - start date 6/1/21 and was a full-time employee An interview was conducted with the Executive Director on 8/19/21 at 3:30 p.m. He indicated he was unable to provide a criminal background check that was conducted on LPN 8, and abuse or resident rights training that was completed for CNA 13 and QMA 14.	F 0607	F - 607 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by the deficient practice. The LPN identified as LPN 8 now has a completed criminal background check in their personnel file. The CNAs identified as CNA # 13 and CNA # 14 now have documentation to support that they have received training on abuse and resident's rights in their personnel files. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit has now been conducted on all current employee files. All employee files now contain a criminal background check and there is supportive documentation in each file that resident rights and abuse training has been provided for each	09/22/2021

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	08/19/2021

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
	The abuse prevention policy was provided by the Executive Director on 8/17/21 at 2:00 p.m. It indicated "...It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program: I. Background screening investigations. Our facility will not knowingly hire any individual who has a history of abusing other persons. This facility will conduct employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with this facility...Policy Interpretation and Implementation. 1. All employees are required to attend our facility's resident rights and abuse prevention program in-servicing training sessions prior to having any resident contact...." 3.1-28(a)		employee. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been provided for all department directors on the facility's policies related to hiring practices. The in-service included the instructions that all employees must have a clean criminal background check completed prior to being placed on the work schedule along with the completion of training on resident rights and the facility's abuse program. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the content of employee personnel files. The tool will monitor to ensure that criminal background checks have been completed along with training on resident's rights and the facility's abuse program prior to being placed on the facility's work schedule. The Administrator and/or their designee will complete this tool weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	08/19/2021

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 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review the facility failed to accurately complete an Annual Minimum Data Set Assessment for 1 of 1 resident reviewed for resident assessment (Resident DD) Findings include: The clinical record for Resident DD was reviewed on 8/15/21 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, anxiety disorder and major depression. The clinical record contained a PASRR (Preadmission Screening Resident Review) Level II outcome, dated 8/4/2020, which indicated he has a major mental illness and was appropriate for nursing home placement. An Annual MDS (Minimum Data Set) Assessment, completed 4/7/2021, did not indicate a Level II Assessment had been completed. During an interview on 8/19/2021 at 1:20 p.m., the Minimum Data Set Coordinator indicated that the Level II Assessment should have been captured on the Annual MDS Assessment. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 from October 2019 for Section A read, "Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental	F 0641	No Plan of Correction Required	09/22/2021

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	08/19/2021

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
	illness and/or ID/DD [Intellectual Disability/Developmental Disability] or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions."			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).			

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	08/19/2021

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
	§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on interview and record review, the facility failed to create a baseline care plan timely for 1 of 2 residents reviewed for care planning. (Resident P) Findings include: The clinical record for Resident P was reviewed on 8/16/21 at 2:30 p.m. The diagnosis for Resident P included, but was not limited to, coronary artery disease. The resident was admitted to the facility on 8/13/21. A nursing assessment dated 8/15/21 indicated Resident P was alert and oriented with some confusion. A baseline care plan was completed on 8/17/21. An interview was conducted with Resident P on 8/16/21 at 9:50 a.m. She indicated staff had not been in to tell her anything about her care. She had arrived on 8/13/21 and has had minimal care this whole weekend. An interview was conducted with the Social	F 0655	F - 655 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P did have their baseline care plan completed at the time of the survey process. Resident P has now been discharged from the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of admissions that have occurred within the past thirty days has been completed. All residents who have been admitted within the past thirty days have had a baseline care plan completed and there is documentation to support that the care plan has been reviewed with and a copy provided to the resident and/or their	09/22/2021

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	08/19/2021

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
	Services Director (SSD) on 8/17/21 at 10:52 a.m. She indicated Resident P arrived at the facility after 5:00 p.m., on 8/13/21. The nursing department was responsible to open and start the baseline care plan on arrival. It should be completed within 48 hours of the resident's arrival. SSD and the Director of Nursing (DON) would be conducting a baseline care plan meeting that morning. An interview was conducted with the DON on 8/17/21 at 11:02 a.m. She indicated the baseline care plan would be finished that day. She was unsure why the nursing department had not finished it already. A base line care plan policy was provided by the Executive Director on 8/18/21 at 11:10 a.m. It indicated "...The facility will develop and implement a baseline care plan for each resident...Policy Interpretation and Implementation. 1. Within 48 hours of admission the facility will develop and implement a baseline care plan for each resident...3. A summary of the baseline care plan will be provided to the resident and their representative within 48 hours of admission to the facility. 4. Documentation will be placed in the clinical record validating that the baseline care plan summary has been provided to the resident and their representative. 6. Care plan information is provided to the direct care staff through shift report and the use the CNA [Certified Nursing Assistant] assignment sheets and 24-hour report sheets...."		representative. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility's policy related to the development of a baseline care plan. The staff has been re-educated on their responsibility to ensure that a baseline care plan has been completed within 48 hours of admission and that there is documentation to support that the care plan has been reviewed with and a copy of the care plan summary provided to the resident and/or their representative. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that each resident has a completed baseline care plan developed within 48 hours of admission and that there is supportive documentation to indicate that the care plan has been reviewed with the resident and/or representative as well as a copy of the care plan summary provided to the resident. This tool will be completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

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	08/19/2021

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
			reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			

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	08/19/2021

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
	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview and record review the facility failed to ensure care plans were created that included interventions in place for a resident that was on an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medications; a resident that had tube feeding, intravenous [IV] therapy, a foley catheter and tracheotomy [trach] for 1 of 1 residents reviewed for IV therapy (Resident F and O); residents at risk for skin breakdown; risk for alteration of hydration status, and required tube feedings (Residents D and E); and a resident with a urinary catheter (Resident D). Findings include: 1. The clinical record for Resident F was reviewed on 8/16/21 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, anxiety and traumatic brain injury. The resident was admitted to the facility on 8/6/21. A physician order dated 8/6/21 indicated Resident F was to receive 30 milligrams of Lovenox twice a day. The resident's plan of care did not address or have interventions in place due to the resident on anticoagulant medication.	F 0656	F - 656 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F has now had their care plan updated. The care plan of resident F now has a care plan with appropriate interventions related to the use of an anticoagulant. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident O has now had their care plan updated. The care plan of resident O now has a care plan which addresses the use and care of their tracheostomy, including being on a ventilator, use of a Foley catheter and PICC line as well as the use of care of a g-tube with enteral feedings. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D has had	09/22/2021

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	08/19/2021

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
	2. The clinical record for Resident O was reviewed on 8/16/21 at 3:30 p.m. The diagnoses for Resident O included, but were not limited to, traumatic brain injury, protein calorie malnutrition, gastrostomy, and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on 6/21/21. A physician order dated 6/21/21 indicated Resident O was NPO [nothing by mouth]. A physician order dated 7/21/21 indicated "clean g-tube site every shift with warm soapy water, pat dry, and apply split gauze...." A physician order dated 6/25/21 indicated "provide foley cath [catheter] care every shift and prn [as needed]...." A physician order dated 6/21/21 indicated "Vent settings...Trach care Q [every] shift...." A physician order dated 6/21/21 indicated Resident O was to receive 87 milliliters of Jevity [feeding] an hour. A physician order dated 8/17/21 indicated staff was to remove Resident O's peripherally inserted central catheter [PICC] line. An observation of Resident O was made on 8/15/21 at 11:29 a.m. The resident was observed in bed breathing by a ventilator. He also had a foley catheter, PICC line in his right arm and tube feeding running through his g-tube. Resident O's care plan did not address his trach and ventilator, foley catheter, PICC line or his enteral feeding.		their care plan updated. The care plan of resident D now includes a care plan related to their risk for skin breakdown, alteration in their hydration status, use of tube feedings and the use of an indwelling urinary catheter. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E has had their care plan updated. The care plan of resident E now includes a care plan related to their risk for skin breakdown, alteration in hydration status and the use of tube feedings. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all comprehensive care plans has been conducted to identify each of the resident's needs/concerns. All care plans have been reviewed and revised to ensure that all of the resident's needs have been identified and the appropriate care plan developed and implemented with appropriate interventions put in place to address those needs/concerns. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	

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	08/19/2021

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
	An interview was conducted with the Director of Nursing on 8/17/21 at 3:51 p.m. She indicated the residents' care plans are needing to be updated. 3. The clinical record for Resident D was reviewed on 8/16/21. Resident D's diagnoses included, but not limited to, anoxic (lack of oxygen) brain damage, tracheostomy status, and acute respiratory failure. Resident D had a urinary catheter, cervical collar, and a feeding tube. Resident D's admission MDS (minimum data sheet) dated 8/5/21 indicated, he was total dependence with two-person assistance for bed mobility, transfers, dressing, and bathing. Resident D's care plan was reviewed. It did not contain a care plan regarding his risk for skin breakdown related to immobility, risk for alteration in hydration status, tube feedings, nor his indwelling urinary catheter. 4. The clinical record for Resident E was reviewed on 8/18/21. Resident E's diagnoses included, but not limited to, cerebral infarction (Stroke), diabetes type II, need for assistance with personal care, morbid obesity, and hypertension. Resident E's admission MDS dated 7/5/21 indicated, he was total dependence with two-person assistance for bed mobility, dressing, and bathing. Resident E's care plan was reviewed. It did not contain a care plan regarding his risk for skin breakdown, alteration in hydration status, nor tube feedings. A care plan policy was provided by the Executive Director on 8/18/21 at 11:10 a.m. It indicated		been provided for all members of the interdisciplinary team on the facility's policy related to the development and implementation of a comprehensive care plan for each resident. The interdisciplinary team was instructed on their responsibilities to identify resident's needs and to develop and implement the appropriate approaches to put in place to address those individualized needs of the residents.	

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	08/19/2021

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
	"...Policy Statement. An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident...Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems;...f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels...." 3.1-35(a) 3.1-35(b)(1)			
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. (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			

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	08/19/2021

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
	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 ensure a discharge summary was completed in a resident's medical chart for 1 of 1 resident reviewed for discharged to the community. (Resident ZZ) Findings include: The clinical record for Resident ZZ was reviewed on 8/19/21 at 9:30 a.m. The diagnoses for Resident ZZ included, but were not limited to, alcohol-induced disorder, bipolar, abnormalities of gait and mobility. The resident was admitted to the facility on 2/24/20 and discharged on 6/4/21. A progress note dated on 6/14/21 indicated Resident ZZ would not be returning to the building. The progress notes dated 6/5/21, 6/6/21 and 6/7/21 indicated Resident ZZ was not present in the building. A "Resident Personal Possessions Inventory" document indicated as of 7/9/21, Resident ZZ's belongings were released to a staff person from another facility. An interview was conducted with the Social Services Director on 8/19/21 at 9:33 a.m. She	F 0661	F - 661 *The corrective action taken for those residents found to have been affected by the deficient practice is that* a discharge summary has now been completed for the resident identified as resident ZZ and placed in the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all discharged residents have the potential to be affected by this deficient practice. A housewide audit has now been completed on all residents who have been discharged from the facility in the past thirty days. All other residents who were discharged within the past thirty days have a discharge summary documented in their respective clinical records. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all members of the interdisciplinary team on the facility's policy related to the	09/22/2021

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	08/19/2021

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
	indicated Resident ZZ had been living in the facility for a long time. Resident ZZ was removed from the facility by the authorities on 6/4/21. The resident was then discharged to another facility after his release from the authorities. The new facility came and picked up his belongings on 7/9/21. She indicated she had not entered a discharge summary due to the nature of the discharge. She felt at that time it was not appropriate to put what occurred in the resident's medical record. 3.1-36(a)(1) 3.1-36(a)(2)		completion of a discharge summary when a resident has been discharged from the facility. The team was re-educated on their responsibilities related to the completion of the discharge summary for all residents who have been discharged from the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that a discharge summary has been completed for all residents who have been discharged from the facility. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
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 observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of	F 0677	F - 677 *1.) The corrective action taken for those residents found to have been affected by the deficient*	09/22/2021

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	08/19/2021

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
	daily living related not shampooing hair when performing a bed bath for 2 of 4 residents reviewed for activities of daily living. (Residents D and E) Findings include: 1. The clinical record for Resident D was reviewed on 8/16/21. Resident D's diagnoses included, but not limited to, anoxic (lack of oxygen) brain damage, tracheostomy status, and acute respiratory failure. Resident D's admission MDS (minimum data sheet) dated 8/5/21 indicated, he was total dependence for bathing. An observation was made on 8/16/21 at 10:39 a.m. Resident D's face appeared greasy, his lips had a white, thick substance on them, and his hair appeared unkept. Resident D's shower sheets were reviewed. Resident D had bed baths on the following dates: 7/29/21, 8/2, 8/5, 8/9, 8/12, and 8/16/21. The shower sheets for those dates did not indicate Resident D received a shampoo. 2. The clinical record for Resident E was reviewed on 8/18/21. Resident E's diagnoses included, but not limited to, cerebral infarction (Stroke), diabetes type II, need for assistance with personal care, morbid obesity, and hypertension. Resident E's admission MDS dated 7/5/21 indicated, he was total dependence for bathing. An observation of Resident E was conducted on 8/15/21 at 12:46 p.m. His beard had food crumbs in it.		*practice is that* the resident identified as resident D is now getting their hair shampooed along with a complete bed bath in accordance with their plan of care. The resident's face is clean and their lips are properly moistened during oral care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E is now getting their hair shampooed along with cleaning/trimming of their facial hair in accordance with their plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all dependent residents are now receiving assistance with activities of daily living including the shampooing of their hair, care of facial hair and a thorough bath in accordance with their plan of care/needs. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's policies related to the care of a dependent resident. These instructions included providing assistance with bathing, shampooing of hair, care of facial hair, etc. in accordance with the resident's individualized plan of	

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	08/19/2021

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
	Resident E's shower sheets were reviewed. Resident E received bed baths on the following dates: 7/9/21, 7/17, 7/19, 7/20, 7/25, 7/27, 7/30, 8/10, 8/13, and 8/16/21. The shower sheets for those dates did not indicate Resident E received a shampoo. An interview was conducted on 8/17/21 at 3:36 p.m. with CNA (Certified Nursing Assistant) 6. She indicated, a bed bath does not include a shampoo or shave. Only when the shampoo section on the shower sheet is marked, does that indicate that a shampoo was completed. She further stated the shampoo, shave, clipping of finger and /or toenails should be offered with each bed bath/shower. This Federal tag relates to complaint IN00359273. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B)		care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the care and level of assistance with activities of daily living for the dependent resident. The tool will also monitor to ensure that assistance is being provided in the shampooing of the resident's hair and care of facial hair. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
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 comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to administer medications as ordered for 1 of 5 residents reviewed for unnecessary medications.	F 0684	F - 684 *The corrective action taken for those residents found to have been affected by the deficient*	09/22/2021

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	08/19/2021

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
	(Resident F) Findings include: The clinical record for Resident F was reviewed on 8/16/21 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, anxiety and traumatic brain injury. The resident was admitted to the facility on 8/6/21. A physician order dated 8/6/21 indicated Resident F was to receive 0.25 milligrams of clonazepam twice a day. A physician order dated 8/6/21 indicated Resident F was to receive 30 milligrams of lovenox twice a day. The August 2021 Mediation Administration Record (MAR) indicated the following days and times 0.25 milligrams of clonazepam and 30 milligrams of Lovenox was not available to administer: Clonazepam: 8/15/21 - 8:00 a.m., 8:00 p.m., 8/16/21 - 8:00 a.m., 8:00 p.m., and 8/17/21 - 8:00 a.m. Lovenox: 8/7/21 - 8:00 a.m., 8:00 p.m., and 8/11/21 - 8:00 p.m. The Narcotic count sheet was provided by the Director of Nursing on 8/18/21 at 4:29 p.m. It indicated the resident had zero dosages left of 0.25 milligrams of clonazepam on 8/14/21 at 8:00 p.m. An interview was conducted with License		*practice is that* the resident identified as resident F has now been discharged to home. The resident did receive their medications as ordered up until the time of discharge. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of the availability of all resident's medications has been conducted. All medications are now available for all residents as prescribed by their physician's and are being administered as ordered. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's procedure on securing resident medications in a timely manner to ensure that the residents receive their medications as ordered by their physicians. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor medication administration. The tool will monitor to ensure that all prescribed medications are readily available for administration as	

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	08/19/2021

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
	Practical Nurse (LPN) 7 on 8/18/21 at 2:57 p.m. He indicated he reorders medications from the pharmacy when the residents' supply gets down to 14 pills. They are in process of switching pharmacies, and there have been a delay in getting medications. The pharmacy had sent Resident F's clonazepam on 8/18/21. After reviewing of the Emergency Drug Kit [EDK] staff had not documented removal of any medications for Resident F in the EDK. 3.1-37(a)		ordered by the resident's physician. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facilities Quality Assurance meetings to determine if any additional action is warranted.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure a resident's wound dressing was changed as ordered. (Resident O) Findings include:	F 0686	F - 686 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident O has had their wound treatment reviewed by the wound specialist. The	09/22/2021

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	08/19/2021

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
	The clinical record for Resident O was reviewed on 8/16/21 at 3:30 p.m. The diagnoses for Resident O included, but were not limited to, traumatic brain injury, protein calorie malnutrition, gastrostomy, and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on 6/21/21. A care plan dated 8/18/21 indicated "[Resident O] has a DTI [Deep Tissue Injury] noted to his right planter foot on 8/16/21...Interventions: Apply betadine to and around wound...." A physician order dated 8/17/21 indicated Resident O was to receive betadine to and around his right lateral plantar wound daily. An observation was made of Resident O with License Practical Nurse (LPN) 12 on 8/18/21 at 11:45 a.m. The resident's right planter wound was observed with a white dressing and secured with white tape. LPN 12 removed the dressing and indicated after observing the dressing, there was collagen and alginate on the dressing as well. The physician had ordered betadine. She indicated at that time there was no signs of betadine applied on the resident's wound, and the dressing applied on his right planter wound was incorrect. 3.1-40(a)(2)		resident is now receiving their wound treatment as ordered by the physician. The LPN identified as LPN 12 has been re-educated related to following the physician's orders related to wound treatments. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents with wounds have the potential to be affected by this deficient practice. A housewide audit of all pressure wounds has been conducted. All residents with pressure wounds are now receiving the appropriate treatment as prescribed by their physician. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility's policy related to pressure wound treatment. The nurses were reminded that only the prescribed treatments were to be provided as ordered by the physician and in accordance with the resident's plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the treatment of all pressure wounds. The tool will monitor to ensure that the	

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	08/19/2021

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
			appropriate treatments are being provided as ordered by the physician. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facilities Quality Assurance meetings to determine if any additional action is warranted.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for a resident who was at risk for falls for 1 of 2 residents reviewed for accidents. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/16/21 at 12 p.m. Resident C's diagnoses included, but not limited to, dementia, Parkinson's disease, dislocation of right shoulder, and epilepsy.	F 0689	F - 689 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C has been reassessed and additional fall interventions have been put in place in attempt to prevent future falls. No additional falls have occurred. *The corrective action taken for the other residents that have the potential to be affected by the*	09/22/2021

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	08/19/2021

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
	The Fall Risk Evaluation indicated, "if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan". Resident C's most recent fall risk evaluation, completed on 6/20/21, indicated, Resident C's score was 17. Resident C was at a high risk for falls. A nursing note dated 8/15/2021 at 11:20 a.m. indicated, "resident found on floor by staff. lac [sic, laceration] to right forehead.[sic] blood noted.[sic] area cleansed and three strips applied to approximated skin. [sic] scant blood continue [sic] but pa [sic] dressing applied. [sic] pupils reactive. VS [sic, vital signs] wnl [sic, within normal limits]. mumbles and answers with typical disorganized thought process.[sic] resident had recently been placed on bed. NP[sic, Nurse Practitioner] aware and stated to have sent out for ct [sic, computer tomography] eval [sic, evaluation].[sic, local hospital's name]...." An IDT (Interdisciplinary Team) note dated 8/16/2021 at 12:05 p.m. indicated, "IDT NOTE POST FALL ON 8/15/21: Patient was found on the floor in his room by a staff member. Patient noted to have laceration on his right forehead. Area cleaned, steri-strip and pressure applied. NP [sic] notified, patient transported to the ER [sic, emergency room] per order. Patient returns back to the facility with 8 sutures in place. Intervention: Patient to have floor mat on both side of his bed and no strip slip. IDT STAFF PRESENT: ED [sic, Executive Director], DON [sic, Director of Nursing], THERAPIST, ENVIROMENTAL [sic]...."		*same deficient practice is that* all residents at high fall risk have the potential to be affected by this deficient practice. A housewide audit has been conducted of all residents identified as being a high fall risk. Each resident identified as being a high fall risk has appropriate fall interventions in place to address their needs. In addition, observations have been made of all high fall risk residents to validate that fall risk interventions are in place in accordance with the resident's individualized plan of care. Fall follow up assessments are now being completed each shift for 72 hours post fall including the recording of neuro checks when applicable for all resident who have experienced a fall. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's fall prevention program. The in-service included a review of the required post fall documentation/assessments including neuro checks when applicable. The staff was also re-educated on their responsibility to ensure that all fall interventions are consistently in place in accordance with each resident's plan of care. *The corrective action taken to monitor to ensure the deficient*	

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	08/19/2021

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
	Resident C's care plan dated 5/22/21 was reviewed on 8/18/21. Resident C's care plan had the following interventions in place prior to his fall on 8/15/21 regarding the goal to keep him safe: Assist with toileting every 2 hours and as needed; remains in staff sight at all times except when sleep or taking a nap; remains on therapy caseload for strengthening and gait. The following care plans were initiated 8/16/21, which was after his last fall : Bilateral side rail for transfers and repositioning with a date initiated of 8/16/2021; Floor mat on both sides of patient bed with a date initiated on 8/16/2021; bed is in the lowest position with a date initiated of 8/16/2021, and Supportive footwear and anti-slip socks when patient is not in bed with a date initiated on 8/16/2021. An observation of Resident C was made on 8/19/21 at 12:39 p.m. Resident C was lying in his bed resting. His bed was not in the lowest position nor were there mats on the floor beside his bed. The mats were folded up and near the bathroom entrance. An interview with QMA (Qualified Medication Assistant) was conducted on 8/19/21 at 12:45 p.m. She indicated; she was unaware Resident C needed to have mats on the ground beside his bed. The Fall Management Program policy was received on 8/19/21 at 11:20 a.m. from ED. It indicated, "A score of 10 or above on the fall risk assessment places the resident at a high risk for falls and high-risk fall precautions may be initiated. The following interventions may be considered. Bed/chair alarms, Use of a low bed, Floor mats next to bed, Adaptive devices provided by OT [sic, Occupational Therapy],		*practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that residents identified at being at high fall risk have the appropriate fall risk interventions in place and that when a fall occurs that appropriate fall follow up assessments including neuro checks are completed in accordance with facility policy. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	08/19/2021

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
	Closer room placement to the nurse's station...Following Each Resident Fall...Complete the fall follow up assessment each shift for 72 hours post fall. Include any of the following information that is pertinent: 1. Redness 2. Swelling 3. Bruising 4. If there is any displacement/rotation 5. Pain 6. Change in cognitive status 7. Bleeding 8. Limited ROM [sic, range of motion]... Complete Neurological Checks per facility protocol for any un-witnessed fall or fall in which the resident hit their head...." The clinical record for Resident C did not contain the fall follow up assessments each shift for 72 hours, nor did it contain any neurological checks. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized			

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	08/19/2021

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
	unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident admitted with a Foley (indwelling) catheter had physician orders, plan of care and an appropriate clinical indication timely for 1 of 2 residents reviewed for catheters. (Resident P) Findings include: The clinical record for Resident P was reviewed on 8/16/21 at 2:30 p.m. The diagnosis for Resident P included, but was not limited to, coronary artery disease. The resident was admitted to the facility on 8/13/21. A nursing assessment dated 8/15/21 indicated Resident P was alert and oriented with some confusion.	F 0690	F - 690 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has had their Foley catheter removed and the resident has been discharged to home. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents with in indwelling urinary catheter have the potential to be affected by this deficient practice. A housewide audit has been conducted on all residents with a urinary catheter. Upon review of	09/22/2021

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	08/19/2021

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
	The nursing admission assessment dated 8/13/21 indicated Resident P was incontinent of bladder and used adult briefs. It did not indicate on the assessment Resident P had a Foley catheter. A nursing assessment note dated 8/15/21 indicated Resident P had 800 milliliters of urinary output. The clinical record for Resident P did not include any additional urinary outputs recorded. A physician order dated 8/16/21 indicated the staff was to "provide foley cath [catheter] care every shift and prn [as needed]." A physician order dated 8/16/21 indicated the staff was to record and document urinary outputs every shift. A baseline care plan dated 8/17/21 indicated Resident P had a Foley catheter. An interview was conducted with Resident P on 8/16/21 at 9:50 a.m. She indicated she was admitted with a Foley catheter on 8/13/21. As of today, the staff had not come in and told her anything about her care. She had received minimal care this whole weekend. An interview was conducted with the Director of Nursing (DON) on 8/17/21 at 3:30 p.m. The DON indicated Resident P was admitted on 8/13/21 with a Foley catheter. She was not sure why the nursing assessment on admission indicated the resident was incontinent and used briefs. She did get physician orders for the Foley catheter on 8/16/21. As of today, the catheter would be removed due to not appropriate diagnosis to have		each resident with a urinary catheter, there is documentation to support the medical justification for the use of the catheter, there are physician's orders for the urinary catheter along with a plan of care to address the appropriate interventions to be utilized in the care of the urinary catheter. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's policies related to the use and care of a urinary catheter. The staff was also re-educated on the required supportive documentation for a medical justification in the use of a urinary catheter as well as the required care and treatment of a urinary catheter in an attempt to prevent the development of an infection due to the use of this device. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor the use of urinary catheters. The tool will also monitor to ensure there is a supportive diagnosis for the use of the catheter, that a physician's order is in place for the use of the catheter as well as a plan of care/treatment in the use of a urinary catheter. This tool will be	

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	08/19/2021

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
	one. An interview was conducted with Resident P on 8/17/21 at 3:43 p.m. She indicated she wanted the catheter removed. "It really hurts." An interview was conducted with Qualified Medication Aide (QMA) 2 on 8/17/21 at 3:45 p.m. She indicated there was an order to remove the resident's catheter. She was waiting for the nurse to entered it into the system, and then the nurse would remove. A urinary catheter policy was provided by Executive Director on 8/18/21 at 11:10 a.m. It indicated "...The purpose of this procedure is to prevent catheter-associated urinary tract infections...1. Review the resident's care plan to assess for any special needs of the resident. Input and Output...1. Observe the resident's urine level for noticeable increases or decreases. 2. Maintain an accurate record the resident's daily output, per the facility's policy and procedures....Complications 1. Observe the resident for complications associated with urinary catheters...The following information should be recorded in the resident's medical record: 26. Initial the MAR [Medication Administration Record] on the date and shift that the catheter care was provided. 27. All assessment data obtained when giving catheter care. 28. Character of urine such as color...clarity...and odor...29. Any problems noted at the catheter-urethra junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain...." A base line care plan policy was provided by the Executive Director on 8/18/21 at 11:10 a.m. It indicated "...The facility will develop and implement a baseline care plan for each		completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	08/19/2021

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
	resident...Policy Interpretation and Implementation. 1. Within 48 hours of admission the facility will develop and implement a baseline care plan for each resident...6. Care plan information is provided to the direct care staff through shift report and the use the CNA [Certified Nursing Assistant] assignment sheets and 24-hour report sheets...." 3.1-41(a)(1)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview and record review, the facility failed to change a resident's Peripherally Inserted Central Catheter [PICC] line dressing timely for 1 of 1 resident reviewed for intravenous therapy. (Resident O) Findings include: The clinical record for Resident O was reviewed on 8/16/21 at 3:30 p.m. The diagnoses for Resident O included, but were not limited to, traumatic brain injury, protein calorie malnutrition, gastrostomy, and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on 6/21/21. A physician order dated 7/21/21 indicated staff was to administer "10 milliliters of sodium chloride every 12 hours for flush. Flush PICC if fluids not	F 0694	F - 694 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident O has had their PICC line pulled and no longer is receiving intravenous medications/fluids. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents with any type of intravenous line have the potential to be affected by this deficient practice. A housewide audit of all residents with intravenous lines has been conducted. All residents with an intravenous line	09/22/2021

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	08/19/2021

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
	in use and/or before/after secondary infusion if ordered." A physician order dated 7/26/21 indicated staff was to administer "2 grams of cefepime intravenously every 12 hours for UTI [Urinary Tract Infection] for 10 days." A physician order dated 8/17/21 indicated staff was to remove Resident O's PICC line. The clinical record did not have a plan of care for Resident O's PICC line. An observation was made of Resident O on 8/15/21 at 11:29 a.m. The resident was observed in bed. Resident O had a PICC line in his right arm with a dressing date of 8/9/21. An observation was made of Resident O on 8/16/21 on 3:22 p.m. Resident O's right arm had a PICC line with a dressing date of 8/9/21. An observation was made of Resident O with License Practical Nurse (LPN) 12 on 8/17/21 at 1:41 p.m. Resident O's right arm was observed with a PICC line. The dressing was dated 8/9/21. An interview was conducted with LPN 12 on 8/17/21 at 1:45 p.m. She indicated the PICC line dressing should be changed every 7 days. The dressing should have been changed on 8/16/21. An interview was conducted with the Director of Nursing on 8/17/21 at 3:51 p.m. She indicated Resident O's PICC line would be pulled that day. The doctor was notified. He ordered to remove the PICC line, because the resident did not need it. The Intravenous Therapy policy was provided by		are receiving dressing changes in accordance with their plan of care. In addition, all residents with an intravenous line have a care plan developed and implemented to address the appropriate care of the intravenous line. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility's policies related to the care/treatment of intravenous lines. The nurses were re-educated on their responsibilities related to the care of intravenous lines, including assessment, treatment/dressing changes, administration of IV medications/flushes, etc. The nurses were also reminded that a care plan must be developed and implemented for all residents with any type of intravenous lines with appropriate interventions for the care of this device. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure the appropriate care and treatment is being provided for those residents with any type of intravenous line. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then	

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	08/19/2021

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
	the Executive Director on 8/18/21 at 11:10 a.m. It indicated "...The purpose of this procedure is to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters...Surveillance. 1. Observe the insertion side (and sutures if present) on every shift, on admission, and with dressing changes. 2. Observe visually or by palpation through the intact dressing...Catheter Site Dressing Regimens...2. Change TSM [Transparent Semi-permeable membrane] dressings every 7 days or PRN [as needed] if wet, dirty, or not intact...Documentation. The following information should be recorded in the resident's medical record: 1. Objective information regarding appearance of insertion site, catheter, and dressing. 2. Any interventions that were done (dressing change, cultures, etc.)..." 3.1-47(a)(2)		monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's			

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	08/19/2021

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
	dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview, and record review, the facility failed to review the risks and benefits of bed rail use and obtain informed consent from a resident's power of attorney prior to bed rail use, and to assure manufactures guidelines were reviewed for installing bed rails for 1 of 2 residents reviewed for accidents (Resident J). Findings include: The clinical record for Resident J was reviewed on 8/16/21 at 11:47 a.m. The Resident's diagnosis included, but were not limited to, traumatic brain injury and seizure disorder. He was admitted to the facility on 8/2/2021. A progress note, dated 8/6/2021 at 10:24 a.m., indicated that he had fallen out of bed. He had history of interment confusion and decreased cognitive ability. His family member informed the facility that he sometimes forgot that he could not walk and requested that the bed be in low position and that side rails be added to his bed for extra protection. The bed was placed in low position and the management staff would follow up with the resident's family about the side rail request. On 8/12/21 at 10:05 a.m., Resident J was observed in his room sitting in his wheelchair next to his bed. His bed appeared to be a queen-sized bed. There were metal side rails present on each side of the bed which extended half the length of the bed.	F 0700	F - 700 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J has had the risk versus benefits of the use of bed rails explained to their representative and a signed consent for the use of the bed rails has been obtained. In addition, a physician's order has been obtained for the use of the bed rails. The resident's care plan has been updated to include a care plan related to the use of bed rails for the resident's safety. The maintenance department has assessed the bed rails to ensure they are in good functioning condition and are not considered a safety hazard for the resident. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents utilizing bed rails are potentially at risk to be affected by this deficient practice. A housewide audit of all residents utilizing bed rails has been conducted. There is now documentation to support that the risks versus the benefits in the	09/22/2021

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	08/19/2021

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
	During an interview on 8/17/21 at 10:11 a.m., LPN (Licensed Practical Nurse) 8 indicated the bed in his room had been brought in sometime after his admission to the facility and she had seen the side rails being used while he was in bed. During an interview on 08/17/21 at 10:54 a.m., the Maintenance Director indicated he had not installed the bed rails. The rails ran under the mattress and were not attached to the frame. They could move from side to side under the bed. He did not have any manufactures information about the bed rails since they had been brought in by his family. The clinical record did not contain a physician's order for bed rail use or an informed consent form for bed rail use. The clinical record did not contain a care plan addressing bed rail use. On 8/18/21 at 4:09 p.m., Resident J was observed laying in the middle of the bed with the bed rails up. The rails extended approximately 2 inches above the mattress. He was pulling on the top of the mattress with his left arm and moving his body to his right side. During an interview on 8/18/21 at 4:15 p.m., LPN 7 indicated he needed total assistance to get up out of bed and staff used a mechanical lift to transfer him to and from bed. Staff assisted him with turning and repositioning while he was in bed. During an interview on 8/18/21 at 4:30 p.m., the DON (Director of Nursing) indicated she had a conversation with his family member about the larger bed and the side rails. They had been		use of bed rails has been provided to the resident and/or their representative and a signed consent has been obtained for their use. There is a physician's order in place for the use of the bed rails as well as a care plan in place. All bed rails have been inspected to ensure that they have been applied in accordance with the manufacturer guidelines and are in good condition. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff as well as all maintenance staff on the facility's policies related to the use of bed rails. The staff has been re-educated on the required education that must be provided for the resident and/or their representative along with a signed consent prior to the use of bed rails. The staff was also reminded of the required physician's order and care plan for the use of bed rails. The maintenance staff was also re-educated on following the manufacturer guidelines on the installation and maintenance of bed rails to ensure resident safety. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the use of bed rails. The tool will monitor to ensure that the	

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	08/19/2021

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
	brought to the facility for him to use on 8/9/21. He had used the same bed and the side rails while he was at home. She had not educated her about the side rail risks because the family member had previously used them at home. On 8/18/21 at 11:10 a.m., the ED (executive Director) provided the Bed Rail Information and/ or Consent Form policy which read "...Prior to applying any type of side rail to a resident bed, the facility will attempt to utilize other interventions to meet the resident's bed positioning, bed transfer and safety needs. Prior to signing consent for the use of side rails it is important that you {sic} the residents {sic}, and/ or resident representative understand the risk factors of using side rails...Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Although not all bed rails create a risk for entrapment, injury may still occur." 3.1-45(a)(1) 3.1-45(a)(2)		risks versus the benefits of the use of bed rails has been provided to the resident and/or their representative along with a signed consent for the use of the bed rails. The tool will also monitor to ensure the appropriate physician's order for bed rails along with an appropriate care plan is in place. The tool will also include an observation of the bed rails to ensure proper installation has been completed to ensure resident safety. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0732 SS=A Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State			

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	08/19/2021

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
	law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily staff posting was posted daily in a visible area. This had a potential to affect 26 of 26 residents that reside in the facility. Findings include: Observations were made of the facility on the following days daily staffing was not posted: 8/15/21, 8/16/21, and 8/17/21. An interview was conducted with License Practical Nurse (LPN) 7 on the locked Traumatic	F 0732	No Plan of Correction Required	09/22/2021

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	08/19/2021

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
	Brain Injury (TBI) unit on 8/18/21 on 3:14 p.m. He indicated the daily staff posting was not posted on that unit. It usually was hung up on the vent unit on the other side of the building. The Director of Nursing (DON) hung it on her door. An observation was made of the DON's door on the vent unit on 8/18/21 at 3:10 p.m. There was no observation of the daily staff posting on her door. An interview was conducted with the DON on 8/18/21 at 3:15 p.m. She indicated she normally hung the staff daily posting on her door, but had not hung it up.			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	08/19/2021

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
	Based on observation, interview and record review, the facility failed to ensure food items stored in the kitchen were labeled, dated and disposed after expiration. This had a potential to affect 22 of 22 residents that eat food prepared in the kitchen. Findings include: A kitchen tour was made with Dietary Aide (DA) 19 on 8/15/21 at 10:30 a.m. The following food items were observed in the kitchen unlabeled, dated or expired: Stand up refrigerator 1: 2 loaves of bread - not labeled or dated, 1 package of hamburger buns - not labeled or dated, 3 packages of sub buns - not labeled or dated, 1 package of hot dog buns - not labeled or dated, 1 bag of salad mix that was a quarter full of lettuce appearance of brown and wilted - not labeled or dated, 1 full bag of salad mix with lettuce appearance of brown and wilted - not labeled or dated, and 1 container of carrot parson salad - open date of 7/21/21. Stand up refrigerator 2: 4 small bowls of Cole slaw with plastic tops - dated 8/5/21. The dry storage area: 3 cans of corn - not labeled or dated, 1 bag 1/4 full folded over - not dated, 2 jars of grape jelly - not dated, 1 bag of rotini noodles - not dated, and 1 plastic bag of rice - not dated.	F 0812	F - 812 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all twenty-two residents who are provided meals from this kitchen have the potential to be affected by this deficient practice. All food items that were identified during the survey have been discarded. All food items are now being labeled and dated when opened and all food items dated beyond 72 hours are being discarded. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all twenty-two residents who are provided meals from this kitchen have the potential to be affected by this deficient practice. All food items that were identified during the survey have been discarded. All food items are now being labeled and dated when opened and all food items dated beyond 72 hours are being discarded. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all dietary staff on the facility's policies related to food storage, dating and labeling. All dietary staff was reminded of their responsibility to label and date all food items and to discard any food item that is dated beyond	09/22/2021

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	08/19/2021

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
	The walk-in refrigerator: 1 six inch best wishes cake - not labeled or dated & 5 prepackaged turkey breast lunch meat - not labeled or dated. The walk-in freezer: 1 bag fries - not labeled or dated, 1 box of packages of buns - not labeled or dated, 1 bag of peas - not labeled or dated, 1 bag of corn and black beans - not labeled or dated, 1 bag of spinach - not labeled or dated, and 1 bag of broccoli medley opened to air and dry in appearance - not labeled and dated 2/17/21. An interview was conducted with the DA 19 on 8/15/21 at 11:00 a.m. He indicated all food items should be labeled and dated. The broccoli medley, Cole slaw, and carrot parson salad should be discarded, because they have expired. The bags of salad mix will be also discarded due to the lettuce turning brown. An interview was conducted with the Dietary Manager on 8/18/21 at 11:05 a.m. He indicated prepared food by staff should be discarded after 3 days. A Food Receiving and Storage policy was provided by the Executive Director on 8/18/21 at 11:10 a.m. It indicated "...7. All foods stored in the refrigerator or freezer will be covered, labeled and dated...15. All food items will be dated upon receipt...." 3.1-21(i)(2) 3.1-21(i)(3)		the 72-hour time frame. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the labeling/dating of food items. The tool will also monitor to ensure that any food item dated greater than 72 hours is being promptly discarded. This tool will be completed by the Food Service Manager and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	08/19/2021

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 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, 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;			

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	08/19/2021

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
	(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 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 properly prevent and/or contain COVID-19 related to staff not wearing appropriate PPE (Personal Protective Equipment) inside a resident's room which was under contact precautions (Resident N and J), housekeeping stepping out of a room on contact	F 0880	F - 880 *1a.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident N is no longer in contact precautions. There have been no negative	09/22/2021

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	08/19/2021

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
	precautions with potentially contaminated PPE to grab items off her cleaning cart (Resident Q), disposing of used PPE inappropriately, not performing hand hygiene after doffing gloves during tracheostomy care (Resident D), urinary catheter bag touching the ground (Resident D), not monitoring unvaccinated residents daily for signs/symptoms of COVID-19 (Residents D, E, F, and P), visitors in contact precaution rooms without proper PPE, bringing 2 residents who were in Droplet Plus TBP (Transmission Based Precautions) to the unit dining room; using a pen to open multiple medications packages and using bare hands place food in a resident's mouth while assisting him to eat for 2 residents randomly observed for infection control (Resident F and J), 1 of 8 residents randomly observed for medication administration (Resident M), and 1 of 4 residents reviewed for ADL care (Resident H). Findings include: 1a. An observation was made on 8/15/21 at 12:50 p.m. of CNA (Certified Nursing Assistant) 3. CNA 3 was standing inside Resident N's room without an isolation gown or gloves on. The clinical record for Resident N was reviewed on 8/16/21. Resident N was on contact precautions for possible close contact with someone who tested positive for COVID-19. Resident N's room was clearly marked with a "yellow stop sign" and information regarding the type of PPE that was required prior to entering her room. 1b. An observation was made on 8/15/21 at 12:59 p.m. of CNA 21. CNA 21 was inside Resident J's room without an isolation gown or gloves on.		outcomes related to resident N and COVID-19 exposure. The CNA identified as CNA # 3 has been re-educated on contact precautions and personal protective equipment usage. *1b.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J is no longer on contact precautions. There have been no negative outcomes related to resident J and COVID-19. The CNA identified as CNA # 21 has been re-educated on contact precautions and personal protective equipment usage. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident Q is no longer on contact precautions. There have been no negative outcomes related to resident Q and COVID-19 exposure. The housekeeper identified as HK 1 has been re-educated on contact precautions and personal protective equipment usage. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents on the ventilator unit have the potential to be affected by this	

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	08/19/2021

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
	The clinical record for Resident J was reviewed on 8/16/21. Resident J was on contact precautions related to being newly admitted to the facility on 8/2/21. Resident J was to remain in contact precautions for 14 days after admission to facility. Resident J had not been vaccinated against COVID-19. 2. An observation was made on 8/16/21 at 10:30 a.m. of HK (Housekeeping) 1. HK 1 had been inside Resident Q's room with her PPE on when she stepped out of his room into the hallway where her housekeeping cart was positioned in front of Resident Q's door. HK 1 rifled through the top of her cart with the possibly contaminated gloves still on, then went back into Resident Q's room. The clinical record for Resident Q was reviewed on 8/16/21. Resident Q was on contact precautions for possible close contact with someone who tested positive for COVID-19. Resident Q's room was clearly marked with a "yellow stop sign" and information regarding the type of PPE that was required prior to entering his room. Resident Q was not vaccinated for COVID-19. 3. An observation was made on 8/16/21 at 10:32 a.m. of used isolation gowns in medication cart's trash bin. The medication cart was in the hallway on the ventilation unit. The trash can did not have a lid and the gowns were popping out of the top of the bin. An interview with ED (Executive Director) was conducted on 8/16/21 at 10:43 a.m. He indicated, used PPE should be disposed of inside the resident's room and should not be disposed in such a manner as to potentially contaminate other		deficient practice. All soiled personal protective equipment including isolation gowns are now discarded in the appropriate receptacles inside each resident's isolation room. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is no longer in isolation and is now receiving tracheostomy care in accordance with acceptable standards of infection control practices. The respiratory therapist identified as RT 5 has been re-educated on hand hygiene, glove usage and trach care. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D now has their catheter bag positioned so that the urinary drainage bag does not touch the floor. *6a.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is now being monitored daily for signs and symptoms of COVID-19. *6b.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E is now	

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	08/19/2021

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
	residents or staff who could come in contact with potentially contaminated PPE. 4. An observation was made on 8/17/21 at 9:08 a.m. of tracheostomy care with RT (Respiratory Therapist) 5. RT 5 had donned an isolation gown and gloves prior to entry into Resident D's room. RT 5 suctioned the resident. After suctioning the resident, she removed her gloves and donned new pair of gloves. She proceeded and removed the gauze from around the tracheostomy tube, then doffed gloves and donned another new pair of gloves. RT 5 had not performed hand hygiene prior to donning the gloves when entering the resident's room. She also failed to perform hand hygiene each time she doffed a pair of gloves nor prior to donning the clean pairs of gloves. A Hand washing/Hand hygiene policy was received on 8/18/21 from ED at 11:10 p.m. It indicated, "5. Employees must wash their hands for at least forty-sixty (40-60) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...u. After removing gloves or aprons...6. In most situations, the preferred method of hand hygiene is with and an alcohol-based hand rub. If hands are not visibly soiled, use and alcohol-based hand rub containing 60-95% ethanol or isopropanol...This hand cleansing method can be utilized for all the following situations...k. After removing gloves..." 5. An observation was made on 8/16/21 at 10:39 a.m. of Resident D's urinary catheter collection bag. The bag was touching the floor. An observation was made on 8/16/21 at 3:30 p.m. of Resident D's urinary catheter collection bag. The bag was touching the floor.		being monitored daily for signs and symptoms of COVID-19. *6c.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F is now being monitored daily for temperature and signs and symptoms of COVID-19. *6d.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has been discharged to home with no signs or symptoms of COVID-19. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the family members of the resident identified as resident D have been re-educated on the required use of personal protective equipment. The resident identified as resident D is no longer in contact precautions. *8a.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F is no longer in transmission-based precautions however is still required to wear a facial mask when out of their room. *8b.) The corrective action taken for those residents found to have been affected by the deficient*	

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	08/19/2021

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
	An observation was made on 8/17/21 at 2:22 p.m. of Resident D's urinary catheter collection bag. The bag was touching the floor. A Urinary Catheter Care policy was received on 8/18/21 at 11:10 a.m. from ED. It indicated, "Infection Control...2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag...b. Be sure the catheter tubing and drainage bag are kept off the floor. 6a. The clinical record for Resident D was reviewed on 8/17/21. Resident D was admitted to the facility on 7/29/21. Resident D was not vaccinated for COVID-19. Resident D's August 2021 MAR (Medication Administration Record) was received on 8/18/21 at 10:31 a.m. from DON (Director of Nursing). It indicated Resident D had not been assessed for signs and symptoms of COVID-19 on 8/1/21, 8/2/21, and 8/3/21. Resident D's COVID-19 monitoring did not start until 8/4/21. 6b. The clinical record for Resident E was reviewed on 8/17/21. Resident E was admitted to the facility on 6/30/21. Resident E was not vaccinated for COVID-19. Resident E's July 2021 MAR and TAR (Treatment Administration Record) were received on 8/18/21 at 10:31 a.m. from DON. It indicated, no monitoring for COVID-19 signs or symptoms had been done for the entire month. Resident E's August 2021 MAR and TAR were received on 8/18/21 at 10:31 a.m. from DON. The MAR indicated, monitoring for signs and symptoms of COVID-19 began on 8/4/21.		*practice is that* the resident identified as resident J is no longer in transmission-based precautions. The LPN identified as LPN 7 has been re-educated on infection control practices related to transmission-based precautions. *9.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident M is no longer in droplet plus isolation precautions. Resident M is now receiving their medications in accordance with acceptable standards of infection control practices as it related to medication administration. The LPN identified as LPN 12 has been re-educated on medication administration practices as well as infection control practices and is now administering medication in accordance with acceptable standards of practice. *10.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H is now receiving assistance with meals by staff members that are practicing acceptable standards of infection control practices related to meal service. The CNA identified as CNA 11 has been re-educated on infection control practices as it related to meal	

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	08/19/2021

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
	6c. The clinical record for Resident F was reviewed on 8/16/21 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, anxiety and traumatic brain injury. The resident was admitted to the facility on 8/6/21 and placed in droplet precautions. The clinical record for Resident F did not include monitoring of temperature and signs or symptoms of COVID-19. 6d. The clinical record for Resident P was reviewed on 8/16/21 at 2:30 p.m. The diagnosis for Resident P included, but was not limited to, coronary artery disease. The resident was admitted to the facility on 8/13/21 and was placed in droplet precautions. The August 2021 Medication Administration Record (MAR) indicated as of 8/14/21, Resident P's temperature and respirations were being monitored every 4 hour for 14 days. The clinical record for Resident P did not include monitoring for signs or symptoms of COVID-19. An interview was conducted with the Executive Director on 8/19/21 at 9:17 a.m. He indicated Resident F and Resident P were not vaccinated and new admissions. He was unable to provide monitoring for signs and symptoms of COVID-19 for either resident. The COVID-19 LTC [Long Term Care] Infection Control Guidance Standard Operating Procedure dated 7/23/21 indicated "...Unvaccinated residents require once-daily assessment for COVID-19...Unknown COVID-19 status (Yellow): All residents in this category warrants (droplet		service. CNA 11 is now assisting residents with their meals utilizing acceptable standards of practice as it related to meal service and infection control practices. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All residents are now being provided care and services in accordance with acceptable standards of infection control practices. These practices include the appropriate use of transmission-based precautions, monitoring daily for temperature and signs and symptoms of COVID-19, the use of appropriate PPE, which includes face masks, eye protection, isolation gowns, glove usage and hand hygiene. Residents are now having their indwelling catheters cared for in a manner to prevent the possibility of infection. Residents are also receiving their medication administration in a manner to prevent the possible contamination of medication. Residents are now being provided meal service without risk of contamination of food service items and residents are being provided tracheostomy care in accordance with correct infection control practices and procedures. In addition, all visitors are now receiving proper	

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	08/19/2021

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
	and contact.) HCP [Healthcare Personnel] will wear single gown per resident, glove, N95 [respirator] mask and eye protection (face shield/ or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed...Residents in yellow status who do not undergo testing can be transferred to the COVID-19 negative areas of the facility if they remain afebrile and without symptoms for 14 days after exposure or admission..." 7. An observation was made on 8/17/21 at 2:19 p.m. of Resident D's mother and grandmother inside Resident D's room. Resident D's mother was wearing an isolation gown, a cloth mask, and no gloves. His grandmother was only wearing a surgical mask. The clinical record for Resident D was reviewed on 8/16/21. Resident D was admitted to the facility on 8/5/21 and had not received the COVID-19 vaccination. Resident D's room was on contact precautions and required staff and visitors to don the appropriate PPE for a contact precaution rooms, which was an isolation gown, N95 mask, gloves, and eye protection. An interview with ED was conducted on 8/17/21 at 2:23 p.m. He indicated; he previously has had a discussion with Resident D's family concerning the need to adhere to the contact precautions that were in place for Resident D. He stated if visitors continue to not follow rules, they will no longer be able to visit. 8a. The clinical record for Resident F was reviewed on 8/16/21 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, anxiety and traumatic brain injury. The resident was admitted to the facility on 8/6/21.		instruction on infection control practices that must be adhered to during any and all visits to the facility or they will forfeit their ability to visit the residents. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all facility staff on the facility's infection control practices. Re-education along with successful return demonstration has been provided to all staff on the following practices; identification of what residents require transmission-based precautions and ensure that all staff members have knowledge of which residents require transmission-based precautions, proper posting of personal protective equipment required for care, application of and removal of required personal protective equipment, including proper disposal of contaminated equipment, hand hygiene, proper infection control practices related to the care and handling of indwelling catheters, proper infection control practices related to medication administration, proper infection control practices during tracheostomy care, proper infection control practices related to meal services and in the assistance of feeding a resident. The Director of Nursing and/or their designee will provide this	

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	08/19/2021

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
	A physician's order, dated 8/6/21, indicated he was to have a private room, staff were to encourage resident to stay in his room for meals, therapy, and activities for 14 days. On 8/15/21 at 11:40 a.m., he was observed in his room, lying in bed. There was an isolation cart present outside of his room door and a sign on the door indicating he has in Transmission Based Precautions. On 8/15/21 at 12:42 p.m., Resident F was observed sitting at a dining table in the unit dining room. He did not have a mask on and was sitting within 6 feet of 1 other resident. He was leaning over and attempting to pick up an item on the floor. There were 3 staff members present in the dining room. During an interview on 8/15/21 at 12:45 p.m., CNA (Certified Nursing Assistant) 13 indicated he was in the dining room for lunch. She was unsure if he was in transmission-based precautions, but she would check. On 8/15/21 at 12:50 p.m., CNA 13 was observed assisting him from the dining room back to his room for lunch. 8b. The clinical record for Resident J was reviewed on 8/16/21 at 11:47 a.m. The Resident's diagnosis included, but were not limited to, traumatic brain injury and seizure disorder. He was admitted to the facility on 8/2/2021. A physician's order, dated 8/2/21, indicated he was to have a private room, staff were to encourage resident to stay in his room for meals, therapy, and activities for 14 days.		education along with ensuring successful return demonstrations are completed. The Director of Nursing and/or their designee will also be responsible for on-going continued education in all areas of infection control practices. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor all facets of the facility's infection control practices. This tool will be completed by the Director of Nursing and/or their designee weekly x3, monthly x3, and quarterly x3. In addition, daily rounds will be completed to monitor for infection control practices for at least six weeks or longer to ensure on-going consistent compliance. The facility through the QAPI program will review these outcomes and revise and update any changes related to the Directed Plan of Correction until substantial compliance is achieved.	

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	08/19/2021

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
	On 8/15/21 at 12:50 p.m., LPN (Licensed Practical Nurse) 7 was observed pushing Resident J in his w/c in the hallway, he did not have a mask on. He brought him into the dining room and was told by CNA 13 to take him back to his room because he was on TBP. LPN 7 then left the dining room with him. 9. The clinical record for Resident M was reviewed on 8/18/21 at 8:15 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and diabetes. On 8/18/21 at 8:15 a.m., LPN 12 was observed administering medications to Resident M. She performed hand hygiene and gathered his medications from the medication cart. She used the end of her pen to poke the foil of each medication card and then put the pills into a plastic medication cup. The door of his room had a sign indicating he was in Droplet Plus Isolation Precautions and that a N95 mask, eye protection, isolation gown and gloves were required to enter the room. She was wearing a N95 mask and a face shield and donned a disposable isolation gown and entered his room. She did not have on disposable gloves. She administered his medication to him and assisted him with positioning his blankets. She then removed her isolation gown and left the room. She performed hand hygiene and went back to the medication cart. During an interview on 8/15/21 at 8:45 a.m., LPN 12 indicated she should not have used to her pen to poke the foil of each medication card and that she should have worn gloves while when entering the TBP room.			

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	08/19/2021

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
	10. The clinical record for Resident H was reviewed on 8/15/21 at 1:17 p.m. The Resident's diagnosis included, but were not limited to, quadriplegia and traumatic brain injury. On 8/17/21 at 1:17 p.m., CNA 11 was observed assisting him to eat lunch in the unit dining room. She picked up a piece of a sandwich with her bare hands and placed it in his mouth. She then laid her hands into her lap. She asked him if he was ready for another bite and then placed her bare hand into a bag of potato chips, removed a couple of chips from the bag and placed them in his mouth. On 8/18/21 at 11:10 a.m., the ED (Executive Director) provided the current Meal Service Policy which read "...Residents shall be served their meals in accordance with dignity and acceptable standards of infection control practices.... (4) Bare hands are never to touch any resident food or beverages..." 3.1-18(b)(1)(A) 3.1-18(l)			
F 0885 SS=E Bldg. 00	483.80(g)(3)(i)-(iii) Reporting-Residents,Representatives&Families §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—			

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	08/19/2021

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
	(i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. Based on interview and record review, the facility failed to inform residents, their representatives, and families of the occurrence of a confirmed COVID-19 infection in a timely manner related to a staff member testing positive for COVID-19 who had worked and potentially exposed the 11 residents residing on the ventilator unit. Findings include: An interview with ED (Executive Director) was conducted on 8/16/21 at 9:57 a.m. He indicated, on 8/13/21, CNA (Certified Nursing Assistant) 19 tested positive for COVID-19 during the facility's required bi-weekly testing based on County Positivity Rates. CNA 19 had reported to work on 8/13/21 and already started working on the ventilator unit when the facility performed her test. CNA 19 was sent home and the facility placed all the residents who reside on the ventilator unit on "yellow" precautions related to the possible exposure for a period of 14 days. Yellow precautions indicated; the resident is on	F 0885	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The Administrator is now communicating with all resident representatives at least weekly of any confirmed COVID-19 cases and or if any three residents and/or staff members who are experiencing any COVID-19 signs and symptoms within a 72-hour period of each other.	09/22/2021

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	08/19/2021

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
	Contact Precautions. ED stated, he did not send out notification to the residents, representatives, and/or families as of yet. An interview was conducted with FM (Family member) 20 on 8/16/21 at 11:57 a.m. She indicated she had not been made aware of the current COVID-19 status in the facility. She was not aware that her son, who was on a ventilator, had potentially been exposed to COVID-19 on 8/13/21. A copy of the family/representative and resident notification email was provided by ED on 8/17/21. The notification indicated all residents and staff were COVID-19 tested per outbreak testing and no new cases were identified in staff or residents. It mentioned the quarantine of all residents on the ventilation unit and noted visitation was discouraged but allowed in certain situations.		*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Administrator on the required notification of residents and/or representative related to COVID-19 infections and/or signs and symptoms within the facility per regulation. The Administrator was re-educated on their responsibility for communicating to the residents and their families on the facility's COVID-19 status. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation of the communication of the facility's COVID-19 status at least weekly to all residents and/or representatives. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including			

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	08/19/2021

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
	individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate			

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	08/19/2021

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
	to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to document that testing for COVID-19 was completed for staff and the results of each staff tested for COVID-19 for 10 staff reviewed for COVID testing and documentation. Findings include: An interview with ED (Executive Director) was conducted on 8/16/21 at 9:57 a.m. He indicated, the employee who was responsible for recording/documenting the results following staff COVID-19 testing, as required based on County Positivity rates, had been overwriting the current results over the previous COVID-19 testing	F 0886	F - 886 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by the deficient practice. The facility is now testing all staff members in accordance with the regulation and is documenting the findings into the required system correctly. *The corrective action taken for the other residents that have the*	09/22/2021

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	08/19/2021

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
	results. In essence, each time they recorded current COVID-19 testing information, they erased the previous testing results and dates. A list of COVID-19 staff testing results was provided on 8/16/21 by the ED. The testing results were from the 8/14/21 employee COVID testing. A list of COVID-19 staff testing results was provided on 8/18/21 by the ED. The testing results were from the 8/17/21 employee COVID testing. ED was unable to provide any employee COVID-19 testing results prior to 8/14/21.		*potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility is now testing all staff members in accordance with the regulation and is documenting the findings into the required system correctly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility receptionist on the required documentation of all staff testing for COVID-19 in accordance with the regulations. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation of the COVID-19 staff testing to ensure the results are being recorded accurately into the State required system. This tool will be completed by the Administrator and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.	
F 0887 SS=E	483.80(d)(3)(i)-(vii) COVID-19 Immunization			

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	08/19/2021

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
Bldg. 00	§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and			

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	08/19/2021

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
	(B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on interview and record review, the facility failed to maintain documentation related to staff's COVID-19 vaccination status of 10 staff reviewed for COVID testing and documentation. Findings include: An interview with ED (Executive Director) was conducted on 8/18/21 at 11:01 a.m. ED indicated; he did not individually know the vaccination status for each staff member nor did the facility have documentation of each staff member's COVID-19 vaccination status. A review of employee records was conducted on 8/19/21. The employee records did not contain documentation of their COVID-19 vaccination status.	F 0887	F - 887 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All employee files have now been updated to reflect each employee's COVID-19 immunization status. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide audit of all employee files has been conducted. All employee	09/22/2021

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	08/19/2021

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
			files have been updated to include the employee's COVID-19 immunization status. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Human Resource Director on their responsibility for maintaining the employee files related to the employee's COVID-19 immunization status. The Human Resource Director will now be responsible for ensuring that all employee files contain information related to the employee's COVID-19 immunization status. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the employee files to ensure COVID-19 immunization status is present in the employee files. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 9999 Bldg. 00				

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	08/19/2021

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
	PERSONNEL Sec.14 (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5TYU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure new-hire staff had credentials and obtained tuberculin skin test or risk assessments	F 9999	9999 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The CNA identified as CNA # 13 has now had a PPD skin test completed. The Social Service Director's file now contains a copy of the credentials. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all personnel files have been conducted. All personnel files now contain all required documents such as tuberculin skin test, and/or risk assessment, certifications/ licensures, etc., criminal background checks, etc. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Human Resource Director on the required employee documents that must be obtained and maintained in each employee file. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a	09/22/2021

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	08/19/2021

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
	for 2 of 10 staff employee files reviewed. (Certified Nursing Assistant (CNA) 13 and Social Services Director Findings include: The 10 staff personnel files were provided by the Executive Director on 8/19/21 at 12:00 p.m. The Social Services Director was full time and start date 6/1/21. The Social Services Director's file did not include proof of her credentials. The file for CNA 13 indicated she had a start date of 6/1/21 and was full time. CNA 13's file did not include a tuberculin skin test or risk assessment that was obtained. An interview was conducted with the Executive Director on 8/19/21 at 3:30 p.m. He indicated he was unable to provide Social Service Director's credentials nor a tuberculin skin test or risk assessment to rule out of tuberculosis for CNA 13.		Quality Assurance tool has been developed and implemented to monitor the completeness of employee files. This tool will monitor to ensure that all required employee documents are maintained accurately and in a timely manner. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	