| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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<br><br>Bldg. 00 | This visit was for a Post Survey Revisit (PSR) to the Recertification, State Licensure Survey and Complaint IN00359273 Investigation completed on August 19, 2021<br><br>This visit was in conjunction with a PSR to the Investigation of Complaint IN00361924 completed on September 17, 2021.<br><br>This visit was in conjunction with a PSR to the Investigation of Complaint IN00363933 completed on October 5, 2021.<br><br>Complaint IN00361924 - Not corrected.<br>Complaint IN00363933 - Not corrected.<br>Complaint IN00359273 - Corrected<br><br>Survey dates: November 9-10, 2021<br><br>Facility number: 014265<br>Provider number: 155857<br>AIM number: 300029339<br><br>Census Bed Type:<br>SNF/NF: 25<br>Total: 25<br><br>Census Payor Type:<br>Medicaid: 24<br>Other: 1<br>Total: 25<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 16, 2021 | F 0000 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 0656<br>SS=E<br>Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>Based on observation, interview and record review the facility failed to create a care plan for an assistive device (Resident E); a resident who required urinary catheter irrigation daily, changing urinary catheter monthly, or catheter care daily every shift (Resident C); and a resident who required bolsters on his bed related to seizure precautions (Resident B) for 3 of 3 residents reviewed for care plans.<br><br>Findings include:<br><br>1. The clinical record for Resident E was reviewed on 11/9/21 at 11:20 p.m. The Resident's diagnosis includes, but are not limited to, traumatic brain injury and post traumatic seizure disorder.<br><br>A physician's order, dated 10/25/21, indicated he was being seen by occupational therapy for self-care management.<br><br>On 11/9/21 at 9:25 a.m., Resident E was observed in the unit dining room sitting in his wheelchair with a lap tray in place.<br><br>On 11/9/21 at 2:35 p.m., he was observed in his room, sitting in his wheelchair with a lap tray in place. He was watching a movie on the television.<br><br>The clinical record did not contain a physician's order or a care plan addressing the use of the lap tray.<br><br>During an interview on 11/9/21 at 2:25 p.m., COTA (Certified Occupational Therapy Assistant) 11 | F 0656 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective November 11, 2021 to the state findings of the Post Survey Review along with a complaint survey conducted on November 10, 2021.<br>F - 656<br>*1.) 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 been re-evaluated related to the use of a lap tray. It has been determined that the lap tray is medically necessary to improve the resident's independence with meals. A physician's order has been obtained for the use of the lap tray and the care plan updated to reflect the use of the lap tray to promote resident independence.<br>*2,) The corrective action taken for those residents found to have been affected by the deficient* | 11/11/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 occupational therapy was working with him to improve his ability to feed himself. They had not issued the lap tray, but he had used it prior to his admission to the facility to enable his to feed himself. His wheelchair was taller than most and did not fit comfortably under the facility dining tables. The staff used the lap tray to put his food items on so that he could feed himself easier.<br><br>During an interview on 11/9/21 at 3:19 p.m., CNA (Certified Nursing Assistant) 12 indicated the staff usually put the lap tray on when he was eating a snack or a meal. They had used it off and on since he was admitted to the facility. He did not ask for it to be put on or taken off.<br><br>On 11/10/21 at 4:42 p.m., the Executive Director provided the current Care Plans- Comprehensive Policy which read "...Policy Statement An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident...6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require targeted and meaning to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making..."<br>2. Resident C's clinical record was reviewed on 11/9/21 at 2:11 p.m. Resident C's diagnoses included, but not limited to, disease of the spinal cord, neuromuscluar dysfunction of the bladder, and dependence on ventilator.<br><br>A physician's order dated 7/14/21 indicated for catheter care to be performed daily on each shift. | | *practice is that* the resident identified as resident C has been reviewed. Resident C's care plan has been reviewed and revised to include providing daily catheter care and daily catheter irrigation as ordered by the physician. The care plan also includes the monthly and/or prn changing of the urinary catheter as ordered by the physician.<br>*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B has been reassessed related to side rails. The resident has now been placed in a hi-low bed with an air mattress that has built in bed bolsters. A physician's order has been obtained for the use of these devices and the care plan has been up-dated to reflect the use of the hi-low bed with an air mattress that has built in bed bolsters.<br>*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 residents with assistive devices, such as lap trays, catheters, side rails, bed bolsters, etc. has been completed. Each resident's care plans have been reviewed and revised to include the use of any medically warranted assistive devices as ordered by their physician. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 11/3/21 indicated for the urinary catheter to be changed monthly and as needed.<br><br>A physician's order dated 11/6/21 indicated for the urinary catheter to be irrigated with 60 ml (millimeters) of normal saline once each day.<br><br>Resident C's care plan dated 9/22/21 indicated, Resident C has a Foley catheter related to neurogenic bladder(inability to control the bladder). Interventions included, but not limited to, check tubing for kinks each shift, monitor intake and output, monitor/record/report to medical doctor signs and symptoms of infection, position catheter and tubing below the level of the bladder and away from the entrance door. The care plan did not address daily catheter care, daily irrigation of the catheter, nor the monthly and/or as needed changing of the urinary catheter.<br><br>3. Resident B's clinical record was reviewed on 11/9/21 at 9:32 a.m. Resident B's diagnoses included, but not limited to, anoxic(lack of oxygen) brain damage and acute respiratory failure.<br><br>A physician's order dated, 10/26/21 indicated to ensure bolsters are in place on the bed for seizure precautions.<br><br>An observation of Resident B was made on 11/9/21 at 10:56 a.m. Resident B was in bed with bilateral long side rails up with seizure pads attached to them. Resident B's bed had only one bed rail on each side of the bed. Resident B was on a specialty mattress.<br><br>Resident B's care plan dated 10/26/21 indicated Resident B has a seizure disorder. Interventions | | *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 members of the interdisciplinary team on the facility's policy related to the development and implementation of the comprehensive care plan. The team was instructed to ensure that each resident's care plan included all assistive devices that were deemed necessary in the resident's care plan including all appropriate interventions associated with the device.<br>*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 comprehensive care plans to ensure that the resident's care plans address the use of any and all assistive devices. The tool will also monitor to ensure that any additional interventions related to the use of the any assistive device is included in the care plan. 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 reviewed at the facility's Quality Assurance meeting 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<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | included, but not limited to, seizure precautions: do not leave resident alone during a seizure, protect from injury, don't attempt to restrain resident, and protect from onlookers. The care plan did not address the use of bilateral side rails to be in the up position all the time, the use of bolsters on a specialty mattress nor the risk of entrapment when using a specialty mattress with side rails up.<br><br>An interview with DON (Director of Nursing) was conducted on 11/10/21 at 1:03 p.m. She indicated, the bilateral side rails were utilized for seizure precautions. The resident had experienced a seizure at the facility and was sent to the hospital. After the hospital stay, Resident B was admitted with seizure medications. A side rail assessment was completed but had never included interventions related to the use of bilateral side rails, the bolsters, or the risk for entrapment.<br><br>A Care Plan policy was received on 11/10/21 at 4:24 p.m. from ED (Executive Director). It indicated, "3. Each resident's comprehensive care plan is designed to:<br>a. Incorporate identified problem areas;<br>b. Incorporate risk factors associated with identified problems;...<br>f. Identify the professional services that are responsible for each element of care;...<br>8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's conditions; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | This deficiency was cited on 8/19/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-35(b)(1)<br>3.1-35(a) | | | |
| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br><br>Based on interview and record review facility failed to administer medication as ordered for 1 of 3 residents reviewed for medication administration (Resident D) and failed to ensure a wound dressing was applied as per physician's orders for 1 of 3 residents residents reviewed for wound care (Resident B).<br><br>Findings include:<br><br>1. The clinical record for Resident D was reviewed on 11/9/21 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, pain in right shoulder and neuromuscular dysfunction of the bladder.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 9/9/21, indicated he was receiving scheduled pain medications. | F 0684 | F - 684<br>*1.) 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 all of their medications readily available for administration including Norco as ordered by their physician.<br>*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B has now had their physician notified related to the orders for wound treatment. An appropriate treatment order is in place and is being provided as ordered by their physician. | 11/11/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 5/8/2020, indicated he was to receive Norco (narcotic pain medication) 5-325 mg (milligram) each day at bedtime.<br><br>An administration note, dated 11/2/21 at 9:59 p.m., indicated his Norco 5-325 mg was unavailable to administer and had been ordered.<br><br>The November 2021 MAR (Medication Administration Record) indicated he had not received his scheduled Norco from 11/1/21 through 11/9/21.<br><br>During an interview on 11/10/21 at 3:42 p.m., LPN 10 indicated that she had been told in shift report that he did not have Norco available and that the medication had been ordered. She was unsure why it had not been addressed earlier.<br><br>On 11/10/21 at 4:24 p.m., the Executive Director provided the current Medication Administration Policy which read "The facility will provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcome. The licensed nurse and/ or QMA [Qualified Medication Aide] shall administer each resident's medication in accordance with the physician's orders..."2. Resident B's clinical record was reviewed on 11/9/21 at 9:32 a.m. Resident B's diagnoses included, but not limited to, anoxic(lack of oxygen) brain damage and acute respiratory failure.<br><br>A physician's order dated 11/3/21 indicated, to cleanse the right ear's open area with wound cleanser, pat dry, apply collagen sheet, and cover with foam dressing daily and as needed for soilage. | | *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 medications and treatments has been conducted to ensure all medications and treatments are readily available and appropriate for each resident in accordance with their current physician's orders.<br>*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 medication administration policy as well as the facility's practice related to the reordering of medications. The staff was also instructed that if a treatment is no longer effective or applicable for the resident, they are to promptly notify the physician and request an appropriate treatment intervention.<br>*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 administration of medications and treatments in accordance with the current physician's orders. The tool will also monitor to ensure that if a treatment is no longer effective or applicable, that there is | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 11/9/21 at 10:56 a.m. with LPN (Licensed Practical Nurse) 3. Resident B had an open area to his right ear. The dressing in place was a band-aide with the date of 11/9/21.<br><br>An interview with LPN 3 was conducted on 11/9/21 at 10:56 a.m. LPN 3 indicated, she had changed the dressing to the right ear this morning and the foam dressing was not sticking so she just replaced it with a band-aid and a piece of tape. She indicated, she had not thought to inform the physician of the issue with applying the required foam dressing but rather thought as long as the wound was covered with something, that it would be good.<br><br>An interview with ADON (Assistant Director of Nursing) was conducted on 11/9/21 at 11:17 a.m. ADON indicated, the order should have been clarified with the physician prior to applying the bandaid.<br><br>This Federal tag relates to complaint IN00363933.<br><br>This deficiency was cited on 8/19/21 and 10/5/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-37(a) | | documentation to support that the physician has been notified and an appropriate treatment intervention has been promptly obtained. 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 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§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. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(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<br>(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.<br><br>§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.<br><br>2. The clinical record for Resident D was reviewed on 11/9/21 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, pain in right shoulder and neuromuscular dysfunction of the bladder.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 9/9/21, indicated he had an indwelling urinary catheter.<br><br>A physician's order, dated 10/7/21, indicated to | F 0690 | F - 690<br>*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C is now receiving catheter care in accordance with facility policy in an effort to prevent the development of a urinary tract infection. The LPN identified as LPN 3 has been re-educated on | 11/11/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | collect urine output every shift.<br><br>A care plan, dated 9/8/2019, indicated that he had a supra pubic catheter due to a diagnosis of neurogenic bladder. The goal was for him to remain free of catheter-related trauma and the intervention included, but were not limited to, observe and document intake and output.<br><br>A health status note, dated 11/2/21 at 5:36 p.m., indicated his urinary output was 500 ml (milliliters).<br><br>A health status note, dated 11/6/21 at 2:55 p.m., indicated his urinary output was 600 ml.<br><br>A health status note, dated 11/7/21 at 5:25 p.m., indicated his urinary output was 500 ml.<br><br>The November 2021 TAR (Treatment Administration Record) did not have output record for the following days and shifts:<br>11/1/21 for the 7:00 a.m. and 7:00 p.m. shifts,<br>11/2/21 for the 7:00 p.m. shift,<br>11/3/21 for the 7:00 a.m. and 7:00 p.m. shifts,<br>11/4/21 for the 7:00 a.m. and 7:00 p.m. shifts, and<br>11/5/21 for the 7:00 a.m. and 7:00 p.m. shifts.<br><br>During an interview on 11/10/21 at 3:42 p.m., LPN (Licensed Practical Nurse) 10 indicated she was unsure why the output had not been documented on the November 2021 TAR.<br><br>During an interview on 11/10/21 at 4:07 p.m., CNA (Certified Nursing Assistant) 14 indicated that the nursing assistance empty the catheter bags each shift and report the output to the nurses for them to record.<br><br>On 11/10/21 at 9:20 a.m.., the Executive Director | | the facility policy related to catheter care and has successfully completed a return demonstration on catheter care per facility policy.<br>*2.) 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 having their urinary output recorded at the end of each shift. During shift change report, the on-coming nurse is verifying with the off-going nurse that the resident's urinary output has been record at this change.<br>*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 urinary catheters are now receiving catheter care and their urinary outputs are being recorded at the end of each shift. All nursing staff has been re-educated on the facility's catheter care policy and have successfully completed a return demonstration of this task. In addition, during each shift change report, the on-coming nurse is verifying with the off-going nurse that each resident with a urinary catheter has had their urinary output recorded in the clinical record at the end of the shift.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is* | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | provided the current Urinary Catheter Care Policy which read "...Input/ Output 1. Observe the resident's urine level for noticeable increases or decreases. If the level decreases, or increases rapidly, report to the physician or supervisor. 2. Maintain an accurate record of the resident's daily output..."<br><br>This Federal tag relates to complaint IN00363933.<br><br>This deficiency was cited on 8/19/21 and 10/5/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-41(a)(2)<br><br>Based on interview and record review, the facility failed to ensure a resident with a urinary catheter receives appropriate treatment and services to prevent urinary tract infections (Resident C) and to obtain and record urinary output, as ordered by the physician (Resident D) for 2 of 3 residents reviewed for indwelling catheters.<br><br>Findings include:<br><br>1. a. Resident C's clinical record was reviewed on 11/9/21 at 2:11 p.m. Resident C's diagnoses | | *that* a mandatory in-service has been provided for all nursing staff on the facility's catheter care policy and each nursing staff member has successfully completed a return demonstration of catheter care in accordance with acceptable standards of infection control practice. In addition, the facility has adopted a new practice in that at the end of each shift during shift change report the on-coming nurse will verify with the off-going nurse that each resident with a urinary catheter has had their urinary output recorded in the clinical record at the end of the shift.<br>*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 catheter care to ensure that the task is being successfully completed in accordance with facility policy. In addition, the tool will monitor to ensure that urinary outputs are being consistently recorded in the clinical record each shift for those residents with a urinary catheter. 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 meeting to determine if | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | included, but not limited to, disease of the spinal cord, neuromuscluar dysfunction of the bladder, and dependence on ventilator.<br><br>A physician's order dated 7/14/21 indicated for catheter care to be performed daily on each shift.<br><br>A physician's order dated 11/6/21 indicated for the urinary catheter to be irrigated with 60 ml (millimeters) of normal saline once each day.<br><br>An observation of urinary catheter care and urinary catheter irrigation was performed on 11/9/21 at 3:29 p.m. with LPN (Licensed Practical Nurse) 3. LPN 3 had washed her hands, donned clean gloves, filled a tub with warm water and soap. She grabbed the catheter tubing with her index finger and thumb of one hand and with the other hand, she took a clean, soapy wash cloth and just below labia, she wiped downward. She did this a total of 3 times while rotating the wash cloth each time. She then took another clean, soapy wash cloth and without separating the labia, wiped downward between Resident C's labia. A brown substance was observed on wash cloth when after she finished the wipe. She did not provide any further cleaning to the area between the labia, cleanse the urethral meatus per policy, and did not perform the procedure in the correct order as to not contaminate the catheter tubing.<br><br>A Urinary Catheter Care policy was received on 11/9/21 at 9:20 a.m. from ED (Executive Director). It indicated, " Steps in Procedure...13. With non-dominant hand separate the labia of the female resident...Maintain the position of this hand throughout the procedure. 14. Assess the urethral meatus. 15. For the female: Use a washcloth with warm water and soap to cleanse | | 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<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus...16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertions site to approximately four inches downward..."<br><br>b. LPN 3 performed the urinary catheter irrigation immediately following the observation of catheter care. She had donned clean gloves, opened the container of normal saline and opened the sterile piston syringe. LPN 3 dunked the piston syringe into the container of normal saline and drew up 60 ml (milliliters) of normal saline. She then with two hands pulled the catheter apart from the drainage tubing and began instilling the normal saline into the end of the catheter. Meanwhile, the tip of the drainage tubing was lying on the residents bed. After instilling the normal saline and allowing it to drain, LPN 3 wiped the tip of the drainage tube with an alcohol pad and reattached the drainage tubing back to the end of the catheter. LPN 3 did not don sterile gloves for the procedure nor did she secure a sterile protector cap to the end of the drainage tubing.<br><br>A Open System Catheter Irrigation policy was received on 11/10/21 at 4:26 p.m. from ED. It indicated, "Steps in the Procedure...6. Put on sterile gloves. 7. Place the sterile drape under the catheter...10. Disconnect the catheter from the drainage tubing. Cover the open end of the drainage tubing with the sterile protector cap. Position capped tubing so that it remains coiled on the bed surface...13. Remove the protector cap, clean the end of the drainage tubing with an alcohol wipe, and reconnect tubing to the catheter..." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 0700 SS=D Bldg. 00 | 483.25(n)(1)-(4)<br>Bedrails<br>§483.25(n) Bed Rails.<br>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.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§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.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>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 representative for bed rail use, and to assure manufactures guidelines were reviewed for installing bed rails for 1 of 1 residents reviewed for bed rails (Resident B).<br><br>Findings include:<br><br>Resident B's clinical record was reviewed on 11/9/21 at 9:32 a.m. Resident B's diagnoses included, but not limited to, anoxic(lack of oxygen) brain damage and acute respiratory failure. | F 0700 | F - 700<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident has now been reviewed related to bed rail usage. The resident no longer has bed rails, but has been placed in a hi-low bed with an air mattress that has built in bolsters.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a | 11/11/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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, 10/26/21 indicated to ensure bolsters are in place on the bed for seizure precautions.<br><br>An observation of Resident B was made on 11/9/21 at 10:56 a.m. Resident B was in bed with bilateral long side rails up with seizure pads attached to them. Resident B's bed had only one bed rail on each side of the bed. Resident B was on a specialty mattress.<br><br>A physician's order dated 11/9/21 indicated for bilateral side rails related to seizure precautions.<br><br>Resident B's care plan did not address the use of bilateral side rails to be in the up position all the time, the use of bolsters on a specialty mattress nor the risk of entrapment when using a specialty mattress with side rails up.<br><br>An interview with Resident B's mother was conducted on 11/10/21 at 1:41 p.m. She indicated, she was never asked for consent for the use of the beds side rails nor was she informed of the risks and/or benefits associated with use of side rails.<br><br>An interview with DON (Director of Nursing) was conducted on 11/10/21 at 1:03 p.m. She indicated, the bilateral side rails were utilized for seizure precautions immediately following his return to the facility from a hospitalization which was at the end of October. A side rail assessment was completed on 10/26/21. The DON was unable to locate a signed consent form from Resident B's representative nor could the DON locate in the clinical record that a verbal consent was received from Resident B's representative. DON indicated, she had not called the company which supplied Resident B's specialty mattress to ascertain if the specialty mattress could/should be used with side | | housewide audit of all residents with bed rails has been conducted to ensure the need for bed rails. Other bed safety devices have been put in place if warranted. Residents who have been identified in need of bed rails for bed safety have been educated on the risks versus the benefits of bed rails and have a signed bed rail usage consent on file in their medical record. If the resident is uncapable of understanding the risks versus benefits, then their assigned representative has been provided the bed rail safety information and they have signed the consent form for the use of the bed rails. In addition, the facility has obtained the manufacturer guidelines on the use of bed rails and the facility environmental services department has ensured that all bed rails have been applied in accordance with the manufacturer guidelines. The environmental services department has also added monthly monitoring of all bed rails to ensure that the bed rails continue to be secure and are functioning properly in accordance with the manufacturer guidelines. This task will be a part of the facility's on-going preventative maintenance program.<br>*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<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | rails in the up position.<br><br>Resident B's clinical record did not indicate the facility's attempts of other alternatives to side rails nor did it contain documentation for monitoring and/or supervision during the use of the side rails.<br><br>On 11/10/21 at 4:24 p.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."<br><br>This deficiency was cited on 8/19/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-41(a)(2)<br>3.1-45(2) | | been provided for all nursing staff as well as the members of the environmental services on their responsibilities related to the use of bed rails. The nursing staff was reminded of their responsibility to ensure that prior to the application of any bed rails that the risks versus benefits of bed rail usage must be provided to the resident and/or their representative and a signed consent form obtained. The nursing staff was also re-educated on their responsibility to complete a bed rail assessment periodically in accordance with the regulations. In addition, the environmental services department was re-educated on their responsibility to ensure that bed rails were installed in accordance with the manufacturer guidelines and the bed rails were to be monitored monthly to ensure on-going safety in the use of the bed rails as far as safe condition and functioning.<br>*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 bed rails are medically warranted for the residents' safety, risks versus benefits provided along with a signed consent for their use, as well monitoring to ensure that the bed rails have been applied in | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | | | accordance with the manufacturer guidelines and continued to be monitored monthly for on-going safe condition and functioning. 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 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, 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<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not wearing eye protection within 6 feet of a resident for a high risk for transmission rate in the county for 25 of 25 residents in the facility and handling medications with bare hands for 1 of 1 residents observed during a random observation.<br><br>Findings include:<br><br>1. An observation was made on 11/9/21 at 9:35 a.m. of LPN (Licensed Practical Nurse) 3 inside Resident C's room. LPN 3 was less than 6 feet from Resident C. LPN 3 was not wearing any eye protection and her facemask was below her nose, leaving her nose exposed.<br><br>An interview with LPN 3 was conducted on 11/9/10 at 9:37 a.m. LPN 3 indicated she had her facemask down below her nose because she needed a break from the mask to breathe.<br><br>An observation was made on 11/9/21 at 9:35 a.m. of CNA (Certified Nursing Assistant) 4 inside Resident C's room. CNA 4 was less than 6 feet from Resident C as she was washing Resident C's face with a washcloth. CNA 4 did not have on eye protection.<br><br>An interview with CNA 4 was conducted on 11/9/21 at 9:40 a.m. CNA 4 indicated she did not | F 0880 | F - 800<br>*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C is now receiving care and services by staff members who are properly wearing eye protection and facial masks in accordance with acceptable standards of infection control practices. The staff members identified as LPN 3 and CNA 4 have been re-educated on the proper wearing of facial masks and eye protection in accordance with acceptable standards of infection control practices. Staff members LPN 3 and CNA 4 have also been re-educated on ensuring that the proper personal protective equipment is utilized based on the county's risk for transmission rate.<br>*2.) 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 receiving their medications by nursing staff that are adhering to acceptable standards of infection control practices in the administration of medication. The | 11/11/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 |
|---|---|---|---|---|
| | need to wear eye protection because all of the residents in the facility are on "green zones", indicating, they are not in any contact precautions at this time.<br><br>The CDC's (Center for Diseases and Control) website for County transmission rates for COVID-19 last accessed on 11/9/21 indicated, Marion County's transmission rate was high or substantial for transmission for COVID-19.<br><br>The Indiana Department of Health's COVID-19 Infection Control Guidance in Long-term Care Facilities last updated, 9/28/21, indicated, for green zones, eye protection is to be worn by all healthcare providers for resident care when community transmission is substantial or high.<br><br>2. A random observation of LPN 3 was made on 11/9/21 at 9:59 a.m. LPN 3 was preparing Resident F's medications for administration. After placing Resident F's medications into a medication cup and placing the medication cards back into the medication cart, she reached into the medication cup and pulled out a capsule with her bare hands and opened it so its contents spilled into the medication cup. Once she was done with the capsules, she poured the medications into a plastic sleeve and crushed the medications. LPN 3 used her bare finger to reach inside the plastic sleeve to separate the two side of the plastic sleeve so the crushed medications could be dumped into the plastic cup. LPN 3 did not perform hand hygiene after putting the medication cards back into the medication cart nor prior to touching the medication capsules with her bare hands. She also did not perform hand hygiene after using the medication crusher nor prior to sticking her bare finger into the plastic crush sleeve. | | LPN identified as LPN 3 has been re-educated on the facility's policy related to acceptable standards of infection control practices in the administration of medication. This includes instruction on proper hand hygiene as well as refraining from touching any medication with their bare hands.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* random observations have been conducted to ensure that all residents are now receiving their medications in accordance with acceptable standards of infection control practices as it related to medication administration. Random observations were also conducted to ensure the proper wearing of personal protective equipment by all staff based on the county's transmission rate and acceptable standards of infection control practices. No other concerns were identified during these random observations.<br>*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 infection control practices as it relates to the proper wearing of personal protective equipment based on the county's transmission rate and acceptable standards of infection control | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 Medication Administration policy was received on 11/10/21 at 4:24 p.m. from ED (Executive Director). It indicated, "Preparation 1. The nurse and/or QMA (sic, Qualified Medication Assistant) shall administer all medications in accordance with the physician's orders and in conjunction with the facility's established medication administration schedule. The nurse/QMA should sanitize their hands in accordance with acceptable standards of infection control practices prior to preparing each residents' medications...4. Medications are to be removed from the packaging and/or medication card and placed into the med cup without touching the medication with the bare hand."<br><br>An Infection Control policy was received on 11/10/21 at 4:24 p.m. from ED. It indicated, "General Guidelines 7. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use and alcohol-based hand rub:...d. Before handling medications;... h. After handling used dressings, contaminated equipment..."<br><br>This Federal tag relates to complaint IN00361924.<br><br>This deficiency was cited on 8/19/21 and 9/17/21. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-18(b)(1) | | practices. All staff members were required to successfully complete a return demonstration on the wearing of facial masks and eye protection as well as hand hygiene (both water/soap hand hygiene and alcohol-based hand sanitizer). In addition, a mandatory in-service was provided for all licensed nurses and QMAs on the facility's policy related to acceptable standards of infection control practices as it relates to medication administration. All licensed nurses and QMAs were required to conduct a return demonstration on the acceptable standards of infection control practices as it related to medication administration.<br>*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 staff's infection control practices as it relates to the proper wearing of personal protective equipment, hand hygiene and the administration of medication utilizing appropriate infection control practices in an effort to prevent the possible spread of infection and/or contamination of medication. 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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155857 | A. BUILDING 00<br>B. WING | 11/10/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANQUILITY NURSING AND REHAB | 3640 N CENTRAL AVENUE<br>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 outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |
| F 9999<br>Bldg. 00 | | F 9999 | F9999 is not listed on the 2567 | 11/11/2021 |