CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155857	B. WING		11/30/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
			3640 N	CENTRAL AVENUE		
TRANQL	JILITY NURSING A	ND REHAB	INDIAN	IAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
lg	This Visit was for t	the Investigation of Complaint	F 0000	By submitting the enclosed		
	IN00422135.	and investigation of complaint	1 0000	material, we are not admitting	the	
	11100422133.			_	uie	
	Complaint INIO042	2125 Endown!/State definions:		truth or accuracy of any		
	•	2135 Federal/State deficiencies		specific findings or allegations	I	
		ations are cited at F580, F684,		We reserve the right to contes	I	
	F690 and F776.			findings or allegations as part		
				any proceedings and submit the	nese	
	Survey dates: Nov	ember 29 and 30, 2023		responses pursuant to our		
				regulatory obligations. The		
	Facility number: 0	14265		facility request the the plan of		
	Provider number:	155857		correction be considered effect	tive	
	AIM number: 3000	029339		December 13, 2023 to the		
				complaint survey completed o	n	
	Census Bed Type:			November 30, 2023. The facili	I	
	SNF/NF: 34			also requests that our plan of	, I	
	Total: 34			correction be considered for p	aner	
				review. The facility would be h		
	Census Payor Type	·		to submit to you any	арру	
	Medicare: 2	•		additional paperwork that you		
	Medicaid: 32			would need for review.		
				would fleed for review.		
	Total: 34					
		a constitution in the				
		reflect State Findings cited in				
	accordance with 41	.0 IAC 16.2-3.1				
	01:6	npleted on December 4, 2023				
	Quality review con	ipleted on December 4, 2023				
F 0580	483.10(g)(14)(i)-(i	iv)(15)				
SS=D		s (Injury/Decline/Room, etc.)				
Bldg. 00		otification of Changes.				
Blug. 00						
		immediately inform the				
	resident; consult v					
		tify, consistent with his or				
		resident representative(s)				
	when there is-					
		volving the resident which				
	results in injury ar	nd has the potential for				
1	1		1	i e	1	

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

TITLE (X6) DATE

Pamela Nodley Regional Nurse 12/19/2023

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155857	B. W	ING		11/30/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			CENTRAL AVENUE		
TRANQU	IILITY NURSING A	ND REHAB			APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	requiring physicia	n intervention;					
	(B) A significant change in the resident's						
	physical, mental,	or psychosocial status					
	(that is, a deterior	ation in health, mental, or					
	psychosocial statu	us in either life-threatening					
		cal complications);					
	• •	r treatment significantly					
		discontinue an existing					
	form of treatment						
	•	to commence a new form					
	of treatment); or						
	(D) A decision to transfer or discharge the						
	resident from the facility as specified in						
	§483.15(c)(1)(ii).						
	, ,	notification under paragraph					
	1-11	ection, the facility must					
		rtinent information specified					
	- ,,,,	s available and provided					
	upon request to th						
	, ,	ust also promptly notify the					
	any, when there is	esident representative, if					
	(A) A change in ro						
	, ,	ecified in §483.10(e)(6); or					
	-	esident rights under Federal					
	, ,	gulations as specified in					
	paragraph (e)(10)	=					
		ust record and periodically					
	. ,	ss (mailing and email) and					
	phone number of	,					
	representative(s).						
	(-)-						
	§483.10(g)(15)						
	(0/(/	omposite distinct part. A					
		omposite distinct part (as					
	•) must disclose in its					
	admission agreen	•					
	_	uding the various locations					
	-	composite distinct part,					
	and must specify	the policies that apply to					
			- 1				

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Event ID:

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Facility ID: 014265

If continuation sheet

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PRINTED: 01/03/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION		E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	00	· /	LETED	
11112 12111	or condition,	155857	B. W.				0/2023	
						, 00		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
TDANOL	III ITV NILIDOINO AI	ND DELIAD			I CENTRAL AVENUE			
TRANQU	JILITY NURSING A	ND KEHAB		INDIAN	NAPOLIS, IN 46205			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	room changes bet	tween its different locations						
	under §483.15(c)((9).						
	Based on interview	and record review, the facility	F 0:	580	F580 Notification of Changes		12/14/2023	
	failed to notify the	attending physician of stat			(Injury/Decline/Room, etc)			
	(immediate) radiolo	ogy testing that had not been			It is the practice of this facility	to		
	conducted in a time	ely manner for 2 of 3 residents			assure that the resident's			
	reviewed for compl	etion of physician orders.			attending physician is			
	(Resident B and D)				notified when any (stat) radio	logy		
					testing has not been conducte			
	Findings include:				a timely			
					manner.			
	The clinical reco	ord of Resident B was reviewed			The correction action taken for	or the		
	on 11-29-23 at 10:5	50 a.m. Her diagnoses included,			residents found to be affected	d by		
	but were not limited	d to, acute and chronic			the deficient	•		
	respiratory failure v	with hypoxia, ventilator			practice include:			
	dependency and con	nstipation. Her most recent			Resident D - It would not be			
	Minimum Data Set	assessment, dated 9-24-23,			possible to correct the past			
	indicated she was so	everely cognitively impaired,			notifications for untimely			
	had no speech, was	dependent for all activities of			completion of radiology service	ces,		
		lized a ventilator to assist in			please refer to systems change			
	breathing.				and monitoring			
					below. Resident B has been			
	In an interview with	h a family member of Resident B			discharged from the facility or	า		
	on 11-29-23 at 10:3	37 a.m., indicated she was			10/17/23.			
	notified by an unna	med staff member on 10-14-23,			Other residents that have the			
	Resident B was sch	eduled for an xray of her			potential to be affected have	been		
	abdomen on a "stat,	" or immediate basis by the			identified by:			
		ontracted radiology company			All resident with (stat) radiolog	gy		
	would conduct the	xray at the facility, for the			testing could potentially be			
	purpose of checking	g out her bowels, due to no			affected. Please see			
		ments. She indicated this test			system changes below to pre	vent		
	was not conducted	until Monday, 10-16-23, after			reoccurrence.			
	she spoke with LPN	-			The measures or systematic			
					changes that have been put i	nto		
	In an interview with	h LPN 3 on 11-29-23 at 12:20			place to ensure that			
	p.m., she recalled o	n Monday, 10-16-23, the			the deficient practice does no	t		
	daughter of Resident B had contacted her about				recur include:			

getting the test results from the weekend. "When

procedure of the abdomen, specifically of the

I reviewed the orders, the KUB [non-invasive xray

The nurses have all been

notification when (stat)

in-serviced related to MD/NP

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	ľ í	UILDING	onstruction 00	(X3) DATE COMPL 11/30/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
IAU	kidneys, ureters and structures to assist a abdominal pain] ha wasn't done. The rathes been having son healthcare business understaffed. So, I them to let them kn weekend that had n me they have been would get to it as so to them we had a rewith and needed that They were able to gwithin a matter of healthcare being don indicated she notificated she	I bladder and the supporting in determining causes of ad been ordered stat and still adiology company that we use me of the same problem other es have been having of being immediately reached out to ow we had a stat KUB from the ot been done yet. They told having staffing problems and oon as they could. I explained sident that we were concerned is done as soon as possible. Set to us and get the test done ours. They told me that fing problems, they were is stats and they would get to it. My thinking is that if all the indled as stats, then none of eas a stat order." She end the daughter she had begy company and they were the testing done. I did tell her est here soon, we could send the hospital and have the sound including stat orders. He was one of those affected by the had not personally spoken radiology company, but the done so. "My understanding roblems with having enough is done, especially stat orders, fing problems. I am not aware his when we order labs or			radiology services are not completed in a timely manner in-service also covers that a nurse progress note mube completed regarding the notification. The corrective action taken to monitor performance to assurate compliance through the quality assurance A Performance Improvement has been initiated that reviews residents with (stat) radiology services to assure the test is completed in a timely manner and if not, MD/NP will be notified and notification documented. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly Any issues identified will be immediately corrected. Quality Assurance Committee review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be completed: December 14, 2023	. The ust e is: Tool s all ne / x3. The will	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155857	B. W	ING		11/30	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	CENTRAL AVENUE		
TRANOI	JILITY NURSING A	ND REHAR			APOLIS, IN 46205		
1101100	·	TAD INCLUDE		II VDI/ (I V	711 OLIO, 11 1 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	ı	hey realize they are running					
	I	t get the test done in a timely					
		give the facility an opportunity					
		hysician or nurse practitioner					
	1 1	arrangements. "My definition					
		ely, usually for an xray, within a					
	few hours."						
	T !4!	- 4 FD 11 20 22 -4 1.05					
		th the ED on 11-30-23 at 1:05 his understanding of stat					
	1 ~	rm care facility for testing					
		would be within 4 hours of the					
		to the provider. "I can't speak					
		I not reach out to [name of					
		y provider] to find out why					
		up yet to do the tests. Maybe					
	they did, but didn't						
	uney ara, our aran r	document ii.					
	A review of the nur	rsing progress notes failed to					
		ntation by the facility staff of					
	I -	nedical provider of Resident					
		being conducted as ordered,					
	prior to 10-16-23.	-					
	2. The clinical reco	ord of Resident D was reviewed					
	on 11-29-23 at 2:25	p.m. His diagnoses included,					
	but were not limited	d to, acute respiratory failure					
	with hypoxia, pneu	monitis due to inhalation of					
	food and vomit, qua	adriplegia, ventilator					
	dependency, unspec	cified intracranial injury and					
	unspecified neck fra	acture. His admission					
	Minimum Data Set	assessment, dated 11-6-23,					
	indicated he is in a	coma.					
		h a family member on 11-29-23					
	_	dicated she did have some					
		e time ago in which the					
		ntracted for labs and xrays was					
		eing able to get the ordered					
	tests done in a time	ly manner. She recalled at one					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		155857	B. W	ING	_	11/30	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			CENTRAL AVENUE		
TRANQU	IILITY NURSING AI	ND REHAB			APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and some tests ordered and the					
		was very delayed in getting					
		und out it seemed to be a					
	-	kends and holidays, as far as					
		ke they were supposed to be					
	-	having to send [name of					
	_	nospital to get the tests done.					
		ould have made a difference in					
	the long run, but it	was a big issue at the time."					
	In an interview with	n LPN 3 on 11-30-23 at 10:10					
		"[Name of Resident D] was					
		t was impacted by the					
		not getting a stat chest xray					
		I have been done. It was					
		ne [name of Resident B] didn't					
		ne on time. When I came into					
	-	I found out that [name of					
		tat chest xray ordered on					
	_	sn't done yet. So, I got on the					
		ame of the contracted					
	-	to find out when they were					
		[it] done. It ended up we had					
	to send him out to the	he hospital because they did					
	not get here like the	ey should have." She indicated					
		blogy provider did tell her					
	when she called abo	out when to expect them to be					
	in building that they	were short-staffed. "So now					
	what I do when I ha	ive a stat xray is to send the					
		, which is routine, then					
	follow-up with a ph	one call to let them know it is					
	stat and to request v	when to expect them."					
	A marriage - £41	aina muaamaa mata- f-!1-1 t-					
		sing progress notes failed to nation by the facility staff of					
		nedical provider of the stat D not being conducted as					
	_	•					
	ordered, prior to 10	-10-23.					
	In an interview with	the Executive Director (ED)					
	WILL	meeum (ED)					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/30/2023	
	PROVIDER OR SUPPLIER JILITY NURSING A		3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE IAPOLIS, IN 46205	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODER OF THE PROPERTY OF	O BE COMPLETION
TAG	on 11-30-23 at 9:2 the current contract been having issues in a timely manner, indicated he had no contracted radiolog nurse had done so. are having problem get the xrays done, of the staffing probi telling us this when when they realize th may not get the test would give the facil of the physician or so other arrangements. immediately, usuall hours." In an interview on Executive Director, understanding of sta for on-site testing sl test order being pro speak to why our st of contracted radiol they hadn't shown u they did, but didn't The ED provided an entitled, "Notificatic Condition or Status 12-1-23 at 10:02 a.1 be the policy currer This policy indicate notify the Resident, Physician/Physician and Resident Repre member of changes	n emailed copy of a policy on of Change in Resident's Policy and Procedure," on m. This policy was indicated to ttly utilized by the facility. id, "Our facility shall promptly his or her n Assistant/Nurse Practitioner, sentative/interested family	TAG	CROSS-REFERENCED TO THE APPRIC	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155857	B. W	'ING		11/30	/2023
NAME OF T	DOUDED OF CUERT TO		-	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C.		3640 N	CENTRAL AVENUE		
	IILITY NURSING AI	ND REHAB		<u> </u>	APOLIS, IN 46205		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	Nurse will notify th						
		n Assistant/Nurse Practitioner n (including, but not limited					
		the Resident's medical					
	· ·	itlyNotification of					
	-	uals will occur in a timely					
		will record in the Resident's					
		rmation relative to changes in					
		cal/mental condition or status,					
		on of appropriate individuals."					
		11 1					
	The ED provided an emailed copy of a contract						
	with the contracted radiology provider on 12-1-23						
	at 10:02 a.m., with	a signature date of 2-6-2019.					
	The contract did no	t specify time parameters for					
	obtaining stat xrays						
	0 11 20 22 . 2 2						
		3 p.m., the ED provided an					
		ut unsigned, "Standard					
		Conditions," document from					
		ed radiology provider. It					
		AT Imaging Exams. Every to complete Services within a					
		rvices are ordered. In the					
	-	is unable to complete Services					
		en the Service is ordered,					
	•	otified and the exam will be					
		uled. Special Services/On-Call					
	•	er Services. If requested by					
		e available, Provider shall be					
		a day, seven (7) days a week					
		ency) requests. A "STAT"					
	, -	for critical situations					
	-	lts, and "STAT" orders shall					
		ider only when requested by					
	•	n-physician practitioner.					
		its best efforts to limit "STAT"					
	orders to urgent situ	nations where the absence of					
		reasonably be believed to					
	place the Patient's h	ealth in serious jeopardy"					
1			- 1				I

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/30/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0684 SS=D Bldg. 00	IN00422135. 3.1-5(a)(2) 3.1-5(a)(3) 483.25 Quality of Care § 483.25 Quality of Care is a applies to all treat facility residents. It comprehensive as facility must ensure treatment and car professional stand comprehensive peand the residents' Based on interview failed to ensure phy administration of a ordered for 1 of 3 rephysician orders. (In a review of nursi assessment, dated 9 severely cognitively dependent for all acutilized a ventilator.	a fundamental principle that ment and care provided to Based on the sessment of a resident, the re that residents receive in accordance with Bards of practice, the reson-centered care plan, choices. and record review, the facility sician orders for the laxative were conducted as esidents reviewed for following	F 0684	F684 Quality of Care It is the practice of this facility assure that physician orders for administration of laxatives are administered a ordered. The correction action taken for residents found to be affected the deficient practice include: Resident B has been discharg from the facility on 10/17/23. Other residents that have the potential to be affected have be identified by: All residents with orders for laxatives and bowel medication have the potential to be affected. Please see system changes below to prevent	or as r the by ed			

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daughter had provided a bed bath to the resident

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reoccurrence.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155857	B. W	NG		11/30	/2023
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
TDANOLI	II ITV NILIDOINO AI	ND DELIAD			CENTRAL AVENUE		
TRANQU	ILITY NURSING A	ND REHAB		INDIAN	APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and had observed th	ne resident's right and left			The measures or systematic		
	lower quadrants of	the abdomen felt "firm and			changes that have been put in	ito	
	moderately distended," and the last bowel				place to ensure that		
	movement had been on 10-12-23. The				the deficient practice does not		
	documentation refle	ected the nurse auscultated			recur include:		
	Resident B's abdom	en and denoted the presence			All nurses have been in-servic	ed	
	of bowel sounds. A	notation indicated at 4:30			on administering and charting		
	p.m., the daughter in	nformed the nurse Resident B			laxatives and other		
	had vomited, to whi	ich the nurse responded by			bowel medications in accorda	nce	
	raising the resident's	s head of the bed, turned the			with the MD orders.		
	resident onto the side and suctioned the				The corrective action taken to		
	resident's tracheotomy. At 4:37 p.m., the notes				monitor performance to assure	Э	
	reflect the nurse notified the on-call NP (nurse				compliance		
	practitioner) of the	resident's status with her vital			through the quality assurance		
	signs and emesis in	which estimated suctioned			A Performance Improvement		
	less than 100 millili	ters of emesis. New orders			has been initiated that all		
	were provided by th	ne NP for a chest xray, a KUB			resident's who have		
	and to administer th	ne resident's as needed order			laxatives and other bowel		
	for Miralax (a laxat	ive) and to hold/stop the enteral			medications are being adminis	ster	
	feedings for one hor	ur and then to verify any			in accordance with the MD		
	gastric residual and	to resume the enteral feeding			order. The Director of Nursing	, or	
	for one hour and the	en recheck the gastric residual.			designee, will complete this to	ol	
					weekly x3, monthly		
		ne clinical record failed to			x3, and then quarterly x3. Any		
	locate any documen	ntation in the narrative portion			issues identified will be		
	or the medical admi	inistration record (MAR) the			immediately corrected. The		
	resident had receive	ed the Miralax. Resident B's			Quality Assurance Committee	will	
	physician orders did	d include an order for			review the tools at the schedu	led	
	"polyethylene glyco	ol [generic form of Miralax]			meetings with		
	3350 Powder 17 gra	ams per scoop, give 17 grams			recommendations as needed		
	via G-tube every 24	hours as needed for			based on the outcomes of the		
	-	medication was not			tools.		
	documented as adm	inistered on the MAR or in			The date the systemic change	s	
		ss notes at any time during			will be completed:		
	the October, 2023 ti	ime frame.			December 14, 2023		
	This Federal tag rela	ates to Complaint IN00422135.					
	3 1 37(a)		1				I

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

Event ID:

Y5EE11 Facility ID: 014265

If continuation sheet Page 10 of 23

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155857			A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/30/2023	
	PROVIDER OR SUPPLIER			3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205			
					7 (I OLIO, IIV +0200			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Ε	(X5) COMPLETION DATE	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) Incont §483.25(e) Incont §483.25(e)(1) The resident who is co bowel on admissic assistance to main or her clinical con- that continence is §483.25(e)(2)For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling cath unless the resider demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possib clinical condition of catheterization is (iii) A resident who receives appropriat to prevent urinary restore continence §483.25(e)(3) For incontinence, bas comprehensive as ensure that a resid bowel receives ap services to restore function as possib	continence, Catheter, UTI inence. In facility must ensure that continent of bladder and con receives services and intain continence unless his dition is or becomes such not possible to maintain. In resident with urinary end on the resident's essessment, the facility must enters the facility without enter is not catheterized in a catheterization was enteres the facility with an error subsequently receives for removal of the catheter in the catheter is enterested in the catheter in the cat			F600 Powel/Pladder In confi			
	Based on interview	and record review, the facility	F 06	590	F690 Bowel/Bladder Inconti	nence.	12/14/2023	

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

Event ID:

failed to routinely document the bowel elimination

for 2 of 3 non-verbal and dependent residents

Y5EE11

Facility ID: 014265

Catheter, UTI

If continuation sheet

It is the practice of this facility to

Page 11 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155857	B. W	ING		11/30	/2023
		<u>l</u>	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CENTRAL AVENUE		
TRANO	JILITY NURSING A	ND REHAR			IAPOLIS, IN 46205		
HANGE	HEITT NURSING A	IND INCLIND		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reviewed for consti	pation. (Residents B and C)			assure that all bowel elimination	ons	
					are routinely		
	Findings include:				documented for all residents.		
	1 701 11 1	1.00 11.00			The correction action taken fo		
	1. The clinical record of Resident B was reviewed on 11-29-23 at 10:50 a.m. Her diagnoses included,				residents found to be affected	by	
		_			the deficient		
		d to, acute and chronic			practice include:	1	
		with hypoxia, ventilator			Resident B has been discharg	jea	
		nstipation. Her most recent			from the facility on 10/17/23.		
		assessment, dated 9-24-23, everely cognitively impaired,			Resident C past bowel		
		dependent for all activities of			documentation is unable to be		
	_	lized a ventilator to assist in			corrected, however the facility assuring that all bowel	' IS	
		st recent Minimum Data Set			_		
	_	9-24-23, indicated she was			eliminations are being appropriately documented ever	on/	
		y impaired, had no speech, was			shift.	≠ı y	
		ctivities of daily living,			Other residents that have the		
		needs. It indicated she was			potential to be affected have b	oon	
	incontinent of her b				identified by:	Deen	
	incontinent of her o	owers.			All residents have the potentia	al to	
	A review of Reside	nt R's records for			be affected. Please see system		
		owel elimination was			changes below to		
		ember and October, 2023.			prevent reoccurrence.		
		days for September had no			The measures or systematic		
		ducted regarding bowel			changes that have been put ir	nto	
		re (12) of 17 days for October			place to ensure that	=	
		ion conducted regarding			the deficient practice does not	t	
	bowel elimination.				recur include:		
					All nurses and CNAs have been	en	
	In an interview with	h the Executive Director (ED)			in-serviced on documenting be		
		p.m., he indicated he would			eliminations		
		ntation for bowel and bladder			appropriately every shift.		
	elimination would b	be conducted routinely.			The corrective action taken to		
					monitor performance to assure	е	
	2. The clinical reco	ord of Resident C was reviewed			compliance		
		0 p.m. Her diagnoses included,			through the quality assurance	is:	
	but were not limited	d to acute respiratory failure			A Performance Improvement	Tool	
	with hypoxia, venti	lator dependency, cognitive			has been initiated that random	nly	
	communication def	icit, anoxic brain			reviews 5 residents		
	damage,moderate protein-calorie malnutrition and				point of care charting to ensur	·e	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155857	B. W	ING		11/30/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			CENTRAL AVENUE		
TDANOL	JILITY NURSING A	ND DELIAR					
TRANQC	JILIT NUKSING A	IND REHAB		INDIAN	APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	postviral fatigue sy	ndrome. Her most recent			that bowel eliminations are be	ing	
	Minimum Data Set	assessment, dated 11-9-23,			documented every		
	indicated she is severely cognitively impaired.				shift. The Director of Nursing,	or	
	Her care plans indi-	cated she is dependent for			designee, will complete this to	ool	
	activities of daily living, including toileting.				weekly x3, monthly		
					x3, and then quarterly x3. Any	1	
	In an interview with	h a family member on 11-29-23			issues identified will be		
	at 11:40 a.m., he in	dicated Resident C has diarrhea			immediately corrected. The		
	on a regular basis.				Quality Assurance Committee	will	
					review the tools at the schedu	led	
	A review of Reside				meetings with		
	documentation of b	owel elimination was			recommendations as needed		
	conducted for Nove	ember, 2023. Eight (8) of 27			based on the outcomes of the		
	days for November	had no documentation			tools.		
	conducted regardin	g bowel elimination.			The date the systemic change	es	
					will be completed:		
	In an interview wit	h the Executive Director (ED)			December 14, 2023		
		5 p.m., he indicated he would					
	_	ntation for bowel and bladder					
	elimination would	be conducted routinely.					
		3 p.m., the ED provided a copy					
		, "Effective Bowel Elimination					
		re." This policy was identified					
	_	y in use by the facility and did					
		ve date. It indicated, "It is the					
		y nursing personnel to					
		and implement appropriate					
		o the management of bowel					
		el function regimen will be					
		ensed Nurse with the approval					
		Physician as indicated. All					
		sessed upon admission and at					
		ed on the Resident Assessment					
		e and PRN [as needed] for					
		If a problem is identified,					
		tions will be determined by the					
		problem e.g., constipation or					
		ed, orders for intervention will					
	be determined by the	he physician. Certified Nursing					

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

Event ID: Y5EE11 Facility ID: 014265

If continuation sheet Page 13 of 23

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	(X2) MULTI A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 11/30/	ETED
	PROVIDER OR SUPPLIER		36	640 N (DDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IC PRE: TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0776 SS=D Bldg. 00	movement daily in the recordDocumental number of bowel mented. Observation include color, consistion of motification as indication as indic	tion should reflect sizeThe overments should also be of bowel movements should stency, size or presence of eport any abnormalities to the ocumentation and physician ated. The Nurse will review [activities of daily living] gard to bowel movements" ates to Complaint IN00422135. Diagnostic Services ogy and other diagnostic services of its residents. The ole for the quality and ervices. Ovides its own diagnostic ces must meet the ons of participation for d in §482.26 of this services from a er that is approved to provide	F 0776		F776 Radiology/Other Diagnos Services It is the practice of this facility		12/14/2023

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

Event ID:

Y5EE11 Facility ID: 014265

If continuation sheet Page 14 of 23

PRINTED: 01/03/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		155857	B. WI	NG		11/30	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹			CENTRAL AVENUE		
TRANQU	JILITY NURSING A	ND REHAB			IAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		a timely manner for 2 of 3			assure that all MD/NP ordered		
		for radiology services.			radiology		
	(Residents B and D	9)			services are conducted in a tin	nely	
					manner.		
	Findings include:				The correction action taken for		
					residents found to be affected	by	
		ord of Resident B was reviewed			the deficient		
	on 11-29-23 at 10:5	50 a.m. Her diagnoses included,			practice include:		
	but were not limited	d to, acute and chronic			Resident B has been discharg	ed	
	respiratory failure v	with hypoxia, ventilator			from the facility on 10/17/23.		
	dependency and co	nstipation. Her most recent			Resident D past		
	Minimum Data Set	assessment, dated 9-24-23,			radiology service is unable to I	be	
	indicated she was s	everely cognitively impaired,			corrected, however the facility	is	
		dependent for all activities of			assuring that all		
	daily living and util	lized a ventilator to assist in			radiology services are being		
	breathing.				conducted in a timely manner.		
					Other residents that have the		
	In an interview with	h a family member of Resident B			potential to be affected have b	een	
	on 11-29-23 at 10:3	37 a.m., she indicated she was			identified by:		
	notified by an unna	med staff member on 10-14-23,			All residents that have ordered	t	
	Resident B was sch	eduled for an xray of her			radiology services have the		
	abdomen on a "stat	" or immediate basis by the			potential to be affected.		
	physician and the c	ontracted radiology company			Please see system changes		
	would conduct the	xray at the facility, for the			below to prevent reoccurrence).	
	purpose of checking	g out her bowels, due to no			The measures or systematic		
	recent bowel move	ments. She indicated this test			changes that have been put in	to	
	was not conducted	until Monday, 10-16-23, after			place to ensure that		
	she spoke with LPN	N 3.			the deficient practice does not		
					recur include:		
	In an interview with	h LPN 3 on 11-29-23 at 12:20			All nurses have been in-servic	ed	
	p.m., she recalled o	on Monday, 10-16-23, the			on ensuring that all radiology		
	daughter of Resider	nt B had contacted her about			services are being		
	getting the test resu	llts from the weekend. "When			conducted in a timely manner.		
	I reviewed the orde	rs, the KUB [non-invasive xray			The corrective action taken to		
	procedure of the ab	domen, specifically of the			monitor performance to assure		
	kidneys, ureters and	d bladder and the supporting			compliance		
	1	in determining causes of			through the quality assurance	is:	
	abdominal pain] ha	ad been ordered stat and still			A Performance Improvement		

wasn't done. The radiology company that we use

has been having some of the same problem other

residents with

has been initiated that reviews all

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/30/	ETED
	PROVIDER OR SUPPLIER		•	3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
IAU	healthcare business understaffed. So, I them to let them kn weekend that had n me they have been would get to it as so to them we had a re with and needed this They were able to gwithin a matter of health because of the staff treating all orders as soon as possible. orders are being don indicated she notificated she notificated she notificated she notificated she notificated working on getting that if they didn't get her mother out to the testing done." LPN being very involved knowledgeable regardler in an interview with on 11-30-23 at 9:2 the current contract been having issues in a timely manner, added Resident B "this." He indicated with the contracted corporate nurse had is they are having p staff to get the xray because of the staff of them telling us the updating us when the behind and may not	es have been having of being immediately reached out to ow we had a stat KUB from the of been done yet. They told having staffing problems and oon as they could. I explained sident that we were concerned s done as soon as possible. Set to us and get the test done ours. They told me that fing problems, they were so stats and they would get to it. My thinking is that if all the hadled as stats, then none of set as a stat order." She ed the daughter she had one soon, we could send the hospital and have the set here soon, we could send the hospital and have the set in her care and seemed very arding healthcare in general. In the Executive Director (ED) If a.m., he indicated he is aware ed radiology company, but the done so. "My understanding roblems with having enough so done, especially stat orders, fing problems. I am not aware his when we order labs or ney realize they are running to get the test done in a timely give the facility an opportunity		IAU	radiology services are being conducted in a timely manner Director of Nursing, or designee, will complete this to weekly x3, monthly x3, and the quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee review the tools at the schedu meetings with recommendation as needed based on the outcomes of the tools. The date the systemic change will be completed: December 14, 2023	. The pol en	DATE

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Event ID:

Y5EE11 Facility ID: 014265

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING NC	00	COMPI	
		155857	B. WI	NG		11/30	/2023
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					CENTRAL AVENUE		
IKANQU	JILITY NURSING A	IND KEHAR		INDIAN	APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		hysician or nurse practitioner					
		arrangements. "My definition ely, usually for an xray, within a					
		ared the daughter of Resident B					
		in her mother's care and has					
	· ·	n regarding any of these					
	concerns.						
	In an interview wit	h the ED on 11-30-23 at 1:05					
	p.m., he indicated h	nis understanding of stat					
		erm care facility for testing					
		would be within 4 hours of the					
	_	to the provider. "I can't speak					
	1	d not reach out to [name of					
		gy provider] to find out why					
		up yet to do the tests. Maybe					
	they did, but didn't	document it."					
	In a review of nurs	ing progress notes, dated					
		m., indicated Resident B's had					
	_	h to the resident and had					
	l ~	ent's abdomen right and left					
		the abdomen felt "firm and					
	_	ed," and the last bowel					
	I	n on 10-12-23. The					
	documentation refl	ected the nurse auscultated					
	Resident B's abdon	nen and denoted the presence					
		A notation indicated at 4:30					
	p.m., the daughter	informed the nurse Resident B					
		nich the nurse responded by					
	_	's head of the bed, turned the					
		de and suctioned the					
		omy. At 4:37 p.m., the notes					
		tified the on-call NP of the					
		th her vital signs and emesis in					
		ectioned less than 100 milliliters					
		ders were provided by the NP					
	1	KUB and to administer the					
		d order for Miralax (a laxative)					
	I and to hold/stop the	e enteral feedings for one hour	ı		I		I

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

Event ID:

Y5EE11 Facility ID: 014265

If continuation sheet Page 17 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155857	B. W	ING		11/30/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE		
TDANOL	III ITV NI IDOINO AI	ND DELIAD					
TRANQU	IILITY NURSING A	ND REHAD		INDIAN	APOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	and then to verify a	ny gastric residual and to					
	resume the enteral f	feeding for one hour and then					
	recheck the gastric residual.						
	No additional entries were noted, prior to a late						
		vn date and time, dated					
		m., indicated the chest xray nor					
		ducted. It indicated the					
		was "minimally distended and					
		vith bowel sounds described as					
		drant of the abdomen with the					
	_	quadrants having being					
	hypoactive and dist	ant.					
	A second lote entmy	, for an unknown date and					
	-						
		3 at 7:00 a.m., indicated a faxed					
	_	xray and KUB had been sent he facility staff were					
		the medical provider. The					
		resident's daughter was					
		results being received on					
		m. and the medical provider was					
		results on 10-17-23 at 11:37 a.m.					
		tes reflect the nurse was					
		t B having mustard-colored					
		ions, which she shared with					
	_	turn, ordered for the resident					
		al emergency room for					
		e nurse updated the daughter					
	_	that time and was in					
	agreement with the						
	In a phone interview	w with a customer service					
		e contracted radiology					
	_	23 at 3:34 p.m., she indicated the					
		y provider defines the					
	-	lfil a stat order as within 4					
		the order, dependent upon					
	·	traffic conditions. She					
	indicated it is policy	y their staff will attempt to					

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Event ID:

Y5EE11 Facility ID: 014265

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPL	
		155857	B. WING			11/30/	2023
NAME OF T	NOTABLE OF CLIEBY AND		S	TREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER				CENTRAL AVENUE		
	IILITY NURSING AI	ND REHAB	IN	NDIAN	APOLIS, IN 46205		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
		facility to update them on an					
	expected arrival time for test performance if there is a delay or to re-schedule. She indicated her						
	-	t B's show "the chest xray and					
		completed on 10-16-23, after					
		orders on 10-15-23." She					
	-	a notation their staff had					
		the facility on 10-15-23 around					
	11:00 p.m., but ther	e was no answer. The					
		report reflected the chest xray					
		ducted on 10-16-23 at 7:54 p.m.,					
		adiologist on 10-16-23 at 8:13					
	p.m. and reported or	n 10-16-23 at 8:13 p.m.					
	2. The clinical reco	ord of Resident D was reviewed					
		p.m. His diagnoses included,					
		I to, acute respiratory failure					
		nonitis due to inhalation of					
	food and vomit, qua	driplegia, ventilator					
		rified intracranial injury and					
		acture. His admission					
		assessment, dated 11-6-23,					
	indicated he is in a	coma.					
	In an interview with	a family member on 11-29-23					
		dicated she did have some					
	concerns from some	e time ago in which the					
		tracted for labs and xrays was					
	~ ·	ing able to get the ordered					
		y manner. She recalled at one					
	-	ad some tests ordered and the					
		was very delayed in getting					
		und out it seemed to be a					
	-	kends and holidays, as far as					
		ke they were supposed to be					
		having to send [name of asspital to get the tests done.					
		ould have made a difference in					
		was a big issue at the time."					
	and forig run, out it	mas a org issue at the time.					

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155857	A. BUILDING 00 B. WING		COMPL	COMPLETED 11/30/2023	
	PROVIDER OR SUPPLIER		3640	T ADDRESS, CITY, STATE, ZIP COD N CENTRAL AVENUE ANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	a.m., she indicated, another resident tha radiology company done when it should around the same timget her stat xray dor work on 10-16-23, I Resident D] had a state 10-14-23 and it was phone and called [nadiology provider] going to be getting a send him out to the get here like they she contracted radiology she called about who building that they was what I do when I had order electronically, follow-up with a photon state and to request was a suctioning obtained of fluids that appear feeding and 30 mills. The nurse notified to who ordered a state (notes reflect the comprovided a confirmation nudated 10-15-23 at 10 xray "planned for 12 dated 10-15-23 at 40 Respiratory Therapis" pinkish bloody" se	"ILPN 3 on 11-30-23 at 10:10 "[Name of Resident D] was t was impacted by the not getting a stat chest xray thave been done. It was the [name of Resident B] didn't the on time. When I came into thould out that [name of that chest xray ordered done on n't done yet. So, I got on the tame of the contracted to find out when they were thone. It ended up we had to thospital because they did not toould have." She indicated the ty provider did tell her when ten to expect them to be in the entry is so send the ty which is routine, then tone call to let them know it is ty hen to expect them." Is notes for Resident D the to the facility from a hospital the open the total approximately 150 milliliters the on-call medical provider, the on-call medical provider, the on-call medical provider, the on-call medical provider the on-cal					

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Event ID:

Y5EE11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155857	B. WI	NG		11/30/	2023
				CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE		
TDANOL	IILITY NURSING A	ND DELIAD			APOLIS, IN 46205		
TRANQU	ILIT NURSING A	ND REHAB		INDIAN	APOLIS, IN 40205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	rder for stat chest x-ray placed					
		ne of contracted radiology					
		ssible bleeding and aspiration					
	per RN. Writer contacted [name of contracted						
		unable to give ETA [expected					
		stat order at this time due to					
		d decrease in mobile techs.					
		ory therapist] removing					
		f thick red secretions and temp					
		call NP [nurse practitioner].					
		resident to ER [emergency in state chest x-ray and					
		reflected Resident D's mother					
	-	change in the resident's status					
		s sent to a local emergency					
		at 1:46 p.m. Resident D					
	returned to the facil	-					
	returned to the rach	nty on 10-27-23.					
	In an interview with	n the Executive Director (ED)					
		1 a.m., he indicated he is aware					
		ed radiology company has					
		with getting xrays conducted					
		including stat orders. He					
	indicated he had no	t personally spoken with the					
	contracted radiolog	y company, but the corporate					
		"My understanding is they					
	are having problem	s with having enough staff to					
	-	especially stat orders, because					
	~ ·	lems. I am not aware of them					
	telling us this when	we order labs or updating us					
	-	ney are running behind and					
		done in a timely manner," as					
	_	lity an opportunity to get hold					
		nurse practitioner to make					
	_	. "My definition of stat is					
	_	y for an xray, within a few					
	hours."						
		11 20 22 71 05					
		11-30-23 at 1:05 p.m., with the					
	Executive Director,	(ED), he indicated it was his					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155857	B. W	ING		11/30/	/2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t .			CENTRAL AVENUE		
TRANOL	JILITY NURSING A	ND DEHAR			APOLIS, IN 46205		
IIIAIIQU	TETT NORSING A	ND INLIND		INDIAN	AI OLIO, IN 40205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	understanding of sta	at testing for a long term care					
	for on-site testing sl	hould be within 4 hours of the					
	test order being pro	vided to the provider. "I can't					
	speak to why our st	aff did not reach out to [name					
	of contracted radiol	ogy provider] to find out why					
	they hadn't shown to	up yet to do the tests. Maybe					
	they did, but didn't	document it."					
	_	w with a customer service					
	1 -	e contracted radiology					
	1 ~	23 at 3:34 p.m., she indicated the					
		y provider defines the					
	_	fil a stat order as within 4					
		he order, dependent upon					
		traffic conditions. She					
		y their staff will attempt to					
		g facility to update them on an					
	_	ne for test performance if there					
	1	chedule. She indicated her					
		t D reflect a staff member had					
	_	ne at the facility on 10-15-23					
	_	amed staff member and					
	rescheduled his test	ing for 10-16-23.					
	_	emailed copy of a contract					
		radiology provider on 12-1-23					
		a signature date of 2-6-2019.					
		t specify time parameters for					
	obtaining stat xrays	•					
		3 p.m., the ED provided an					
		ut unsigned, "Standard					
		Conditions," document from					
		ed radiology provider. It					
		AT Imaging Exams. Every					
		to complete Services within a					
	1 -	rvices are ordered. In the					
		is unable to complete Services					
	I -	en the Service is ordered,					
	Customer will be no	otified and the exam will be					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155857	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/30/2023	
NAME OF PROVIDER OR SUPPLIER TRANQUILITY NURSING AND REHAB				3640 N	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVENUE APOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Emergency Provide Customer and wher available 24 hours a for "STAT" (emerg services is provided requiring rapid resu be honored by Prov the physician or non Customer shall use orders to urgent situ such an order could place the Patient's h	uled. Special Services/On-Call or Services. If requested by the available, Provider shall be a day, seven (7) days a week ency) requests. A "STAT" of critical situations alts, and "STAT" orders shall ider only when requested by an encyphysician practitioner. The interest of the absence of the reasonably be believed to the ealth in serious jeopardy"					

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