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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	09/17/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00361924. Complaint IN00361924 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, and F880. Survey date: September 17, 2021 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 1 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 21, 2021	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to ensure a resident's Responsible Party was notified of a change in condition related to a tracheostomy tube being removed/falling out for 1 of 3 residents reviewed for notifications. (Resident B) Finding includes: The record for Resident B was reviewed on 9/17/21 at 11:03 a.m. Diagnoses included, but were not limited to, acute respiratory failure, anoxic brain damage, and abnormal posture. An entry in the Respiratory Therapy progress notes, dated 9/2/21 at 7:50 a.m., indicated he was called to Resident B's room for suctioning prior to care, but when he arrived at bedside, he noted the tracheostomy tube was completely out of the resident's stoma and the stoma site was completely closed making it impossible to reinsert a new tracheostomy tube. The nursing progress notes for 9/2/21 were reviewed. There was no documentation to indicate the resident's family and/or Responsible Party were notified of the tracheostomy tube being removed and the stoma site closed. An interview with the Respiratory Therapist on 9/17/21 at 3:29 p.m. indicated there was a communication error on 9/2/21 and he thought the nurse on duty would notify Resident B's	F 0580	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 October 17, 2021 to the state findings of the Complaint Survey conducted on September 17, 2021. F - 580 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the responsible party of the resident identified as resident B has now been updated on the resident's current health conditions and will continue to be notified promptly of any and all changes in their condition and/or plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all clinical records has been completed to	10/08/2021

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	family/Responsible Party of the trach coming out, but the nurse did not notify the family. This Federal tag relates to complaint IN00361924. 3.1-5(a)(2) 3.1-5(a)(3)		identify any other residents with a change in condition and/or plan of care. There is documentation to support that any resident with a change of condition and/or plan of care has had their responsible party notified of those changes. The facility will continue to notify all responsible parties of any changes in their family member's condition and/or plan of care per facility policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility policy related to notifications. The nurses were re-educated on their responsibility to notify each resident's responsible party of any and all changes in condition and/or plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that each clinical record has documentation to support that the resident's responsible party has been promptly notified of any and all changes in condition and/or changes in the plan of care. 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	

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			three quarters. The outcome of this tool will be reviewed at the facility's QAPI meetings to determine if any additional action is warranted.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on observation and interview, the facility failed to ensure assistance was provided related to turning every 2 hours for residents who were dependent on staff for activities of daily living (ADLs) for 3 of 3 residents reviewed for ADLs. (Residents B, C, and D) Findings include: A continuous observation period for Residents B, C, and D was started on 9/17/21 at 11:03 a.m. The continuous observation period ended at 1:20 p.m. During the continuous observation, Residents B, C, and D were not turned in the 2 hour period and were in the same position for over 2 hours. An observation of RN (Registered Nurse) 1 was made on 9/17/21 at 1:24 p.m. RN 1 had entered Resident B's room to administer medications. Resident B's upper body was leaning over to his right side while his lower body was supine (lying on the back). RN 1 adjusted Resident B's upper body so that he was no longer leaning over to his right side. An interview with Resident B's family member	F 0677	F - 677 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the residents identified as resident B, C and D during the survey are now being turned and repositioned every two hours in accordance with their plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all residents has been completed to identify any dependent resident that requires assistance with the activities of daily living including turning and repositioning. All identified dependent residents who require assistance with turning and repositioning are now being turned and repositioned at least every two hours in accordance with their plan of care.	10/08/2021

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	was conducted on 9/17/21 at 2:45 p.m. She indicated she arrived at the facility at 1:30 p.m. and since she had arrived, no staff had been in to turn Resident B. The clinical record for Resident B was reviewed on 9/17/21. Resident B's diagnoses included, but not limited to, acute respiratory failure, anoxic brain damage, and abnormal posture. Resident B's Care Plan dated 7/30/21 indicated, he has an ADL self-care performance deficit related to disease process. The interventions included, but not limited to, the resident needs total turn/reposition at least every two hours, more often as needed. Resident B's admission MDS (Minimum Data Set) dated 8/5/21 indicated Resident B is totally dependent and requires assistance of 2 staff for bed mobility and transfers. Resident C's clinical record was reviewed on 9/17/21. Resident C's diagnoses included, but not limited to, focal traumatic brain injury, anoxic brain damage, and hypertension. Resident C's Care Plan dated 6/24/21 indicated, he had an ADL self-care deficit related to a traumatic brain injury. The interventions included, but not limited to, staff to assist with bed mobility. Resident C's admission MDS dated 6/28/21 indicated, Resident C required extensive assistance of 2 staff for bed mobility and transfers. Resident D's clinical record was reviewed on 9/17/21. Resident D's diagnoses included, but		*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on their responsibility to provide assistance in turning and repositioning of all dependent residents in accordance with their plan of care. The nursing staff was re-educated on the facility policy related to activities of daily living which includes providing the necessary assistance with all activities of daily living. *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 compliance in providing assistance in all activities of daily living for all dependent residents. 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 QAPI meetings to determine if any additional action is warranted.	

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	not limited to, dependence of ventilator, contracture, and hypertension. Resident D's Care Plan dated 7/16/21 indicated, she had an ADL self-care deficit. The interventions included, but not limited to, the resident requires staff to assist with bed mobility and staff to assist with transfers. Resident D's Quarterly MDS dated 8/15/21 indicated, she required extensive assistance of one staff member for bed mobility and extensive assistance of two staff for transfers. Resident D's BIMS (Brief interview for mental status) indicated she was cognitively intact. An interview with Resident D was conducted on 9/17/21 at 2:57 p.m. She indicated she had not yet been turned that day and wanted to be turned. An interview with RN 1 was conducted on 9/17/21 at 3:02 p.m. He indicated, the facility does utilize a specific turning schedule, but rather they turn residents when they are in the room or when they can. RN 1 stated turning residents was everyone's responsibility. This Federal tag relates to complaint IN00361924. 3.1-38(a)(3) 3.1-38(b)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and record review the facility failed to maintain an infection prevention and control program by improperly performing catheter care for 1 of 3 residents reviewed for catheter care. (Resident C) Findings included: An observation was made on 9/17/21 at 2:51 p.m. of RN (Registered Nurse) 1 performing catheter care for Resident C. RN 1 had gathered the supplies which included a wash basin, three wash cloths, and an alcohol wipe. RN 1 had wet down two wash clothes and applied soap to one of the wet wash cloths. With the soapy wash	F 0880	F- 880 *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 their catheter care in accordance with acceptable standards of practice. The nurse identified as RN 1 during the survey has been re-educated on the facility policy related to urinary catheter care and has successfully completed a return demonstration in accordance with	10/08/2021

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	cloth, he cleansed the urethral meatus (urinary opening) with a downward stroke motion and changed the position of the wash cloth with each stroke. He then used the other wet wash cloth to rinse off the soap. He then opened the alcohol swab, grabbed the catheter tubing about 4 inches from the insertion site and wiped the catheter tubing downward towards the urethral meatus. RN 1 had cleansed the catheter tubing going in the wrong direction. A Urinary Catheter Care policy was received on 9/17/21 at 2:40 p.m. from ED (Executive Director). It indicated, "Step in the Procedure...15. For the male: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans (head of the penis) using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique...16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward." This Federal tag relates to complaint IN00361924. 3.1-18(b)(1)		facility policy and acceptable standards of infection control practices. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has been conducted to identified residents with a urinary catheter. All residents with a urinary catheter are now receiving catheter care in accordance with facility policy and acceptable standards of infection control practices. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility policy related to urinary catheter care. Each nursing staff member has successfully completed a return demonstration on the completion of urinary catheter care in accordance with facility policy and acceptable standards of infection control practices. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the infection preventionist and/or the Director of Nursing will complete daily visual rounds to ensure that nursing staff members are providing urinary catheter care in accordance with facility policy and acceptable standards of infection control practices. These	

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			rounds will be completed daily for six weeks and until compliance is maintained. In addition, a Quality Assurance tool has been developed and implemented to monitor nursing staff's infection control practices related to providing urinary catheter care. 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 through the facility QAPI program. The Director Plan of Correction will be reviewed and updated with changes made to the plan as warranted to ensure substantial compliance is maintained for no less than six months.	