STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 27, 28, 31, November 1, 2, and 3, 2022. Facility number: 000105 Provider number: 155198 Census Bed Type: SNF: 51 Residential: 69 Total: 120 Census Payor Type: Medicare: 19 Other: 32 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 15, 2022.	F 0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. Marquette is requesting a desk review of the following materials.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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.

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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record review, the facility failed to ensure residents were assisted to eat, in the dining room, with dignity, when staff stood over them during the meal for 1 of 11 randomly observed resident for meal service. (Resident 69) Finding includes:	F 0550	I. Resident #69 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure residents are assisted to eat, in the dining room, with dignity. II. All 10 residents who require assistance with meal	12/20/2022

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	On 10/31/22 from 11:35 a.m. to 12:13 p.m., during a random dining observation, 11 residents were observed to be seated in the dining room waiting for lunch to be served. Resident 69 was observed as she sat in a Broda (specialized high-back) chair at the dining table, in the second-floor main dining room. On 10/31/22 at 12:16 p.m., Licensed Practical Nurse (LPN) 2 was observed as she stood up next to the left side of Resident 69, were she was seated. The resident's meal tray was served to the table. LPN 2 opened the containers and prepped the meal by removing the lids and plastic wrap from the dishes, to assist the resident. LPN 2 then stood over Resident 69, when she placed bites of food in her mouth. At 12:22 p.m., LPN 2 sat down on the stool and finished assisting the resident with her meal. During an interview, on 10/4/22 at 2:14 p.m., the Director of Nursing (DON) indicated staff should sit down when feeding a resident for dignity reasons. A current policy, titled "Assistance with Meals," dated 3/22 and received from the DON on 11/1/22, indicated "...for residents who cannot feed themselves would be fed with attention to safety, comfort, and dignity..." The policy directed staff to not stand over the resident while assisting them with eating. 3.1-3(t)		consumption, in the second-floor dining room, have the potential to be affected. No residents have experienced any negative consequences. III. The Assistance with Meals Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff on the Assistance with Meals Policy including sitting while assisting residents to eat, providing dignity. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit compliance with dignified mealtime assistance, including sitting with resident while providing assistance, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for	

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			review. V. The facility will be in and remain in compliance by: December 20th, 2022.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information			

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	regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.			
	Based on interview and record review, the facility failed to complete the Comprehensive Annual 14-day Assessment in accordance with the Resident Assessment Instrument (RAI) for 2 of 11 residents reviewed for comprehensive assessments. (Resident 16 and 17) Findings include: 1. A review of the Minimum Data Set (MDS) Admission Assessment-14 day for Resident 16 indicated an ARD with a created date of 6/7/22, and submission date of 7/18/22. A review of the	F 0636	I. Residents ---#16 and #17 had no negative consequences from the alleged deficient practice. The identified MDS assessments are current and have been completed at this time. It is the practice of Marquette to complete MDS assessments in a timely manner that adheres to policy, procedure and to State and Federal Guidelines and Regulations. II. All residents have the	12/20/2022

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	medical record showed the Admission MDS Assessment for Resident 16 had not been completed or submitted in accordance with the RAI manual. 2. A review of the MDS Admission Assessment-14 day for Resident 17 indicated an ARD with a created date of 3/9/22, observation date of 3/29/22, and submission date of 5/2/22. A review of the medical record showed the Admission MDS Assessment for Resident 17 had not been completed or submitted in accordance with the RAI manual. During an interview, on 11/1/22 at 9:58 a.m., the MDS Coordinator indicated the 14-day annual assessment had not been completed or submitted on time. The facility got behind on submissions due to illness within the department. During an interview, on 11/1/22 at 2:09 p.m., the Director of Nursing (DON) indicated the facility would refer to the RAI for the timing of submissions. During an interview, on 11/01/22 at 2:46 p.m., the Administrator indicated he was not aware of any recent concerns in the last few months regarding late MDS submissions. The facility had not completed audits or reviewed MDS submission in the QAPI program. During an interview, on 11/1/22 at 4:33 p.m., the DON indicated the Corporate MDS Coordinator had identified a concern regarding late submission of the MDS. The facility policy, titled "MDS completion and submission Timeframes," dated as revised on 7/17, indicated the facility would conduct and		potential to be affected. A complete audit was performed of all resident comprehensive MDS assessments in the past 6 months. In addition to the 2 MDS' identified during the annual review, 24 additional comprehensive MDS assessments were identified as completed late. All MDS assessments are current and have been completed at this time. III. The completion of Minimum Data Set (MDS) Policy was reviewed and found to meet clinical standards. Education was provided to the MDS Nurse on the policy along with State and Federal guidelines. MDS nurse was also educated on how to utilize the electronic medical record (EMR) to build an MDS schedule and monitor status of assessments. In addition, MDS assessments have been created via the EMR calendar. The EMR calendar and MDS tracker and will be reviewed during our daily clinical meeting to further ensure compliance. Additional systemic changes are being addressed through our quality assurance process described below. IV. MDS Coordinator or designee will: Review all comprehensive MDS assessments for timely completion, weekly x 12 weeks, then monthly for a total duration of	

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	submit resident assessment in accordance with current federal and state submission timeframes. 3.1-31(b) 3.1-31(d)(1)		12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on interview and record review, the facility failed to complete and submit the Quarterly 14-day Assessment in accordance with the Resident Assessment Instrument (RAI) for 1 of 11 residents who were reviewed for Quarterly assessments. (Resident 17) Finding includes: A review of the Minimum Data Set (MDS) Quarterly Assessment-14 day for Resident 17, dated 6/20/22, was created on 5/31/22, and had a submission date of 7/25/22.	F 0638	I. Resident ---#17 had no negative consequences from the alleged deficient practice. The identified MDS assessments are current and have been completed at this time. It is the practice of Marquette to complete Quarterly MDS assessments in a timely manner that adheres to policy, procedure and to State and Federal Guidelines and Regulations. II. All residents have the potential to be affected. A	12/20/2022

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	A review of the MDS Quarterly Assessment-14 day for Resident 17, dated 9/13/22, was created on 10/3/22, and had a submission date of 10/18/22. During an interview, on 11/1/22 at 9:58 a.m., the MDS Coordinator indicated the 14-day quarterly assessment had not been completed or submitted on time. The facility got behind on submission due to illness within the department. During an interview, on 11/1/22 at 2:09 p.m., the Director of Nursing (DON) indicated the facility would refer to the RAI for the timing of submissions. During an interview, on 11/01/22 at 2:46 p.m., the Administrator indicated he was not aware of any recent concerns in the last few months regarding late MDS submissions. The facility had not completed audits or reviewed MDS submission in the QAPI program. During an interview, on 11/1/22 at 4:33 p.m., the DON indicated the Corporate MDS Coordinator had identified a concern regarding late submission of the MDS. A current facility policy, titled "MDS completion and submission Timeframes," dated as revised 7/17, indicated the facility would conduct and submit resident assessment in accordance with current federal and state submission timeframes. 3.1.-31(d)(3)		complete audit was performed of all resident Quarterly MDS assessments in the past 6 months. In addition to the 2 MDS' identified during the annual review, 16 additional Quarterly MDS assessments were identified as completed late. All MDS assessments are current and have been completed at this time. I. The completion of Minimum Data Set (MDS) Policy was reviewed and found to meet clinical standards. Education was provided to the MDS Nurse on the policy along with State and Federal guidelines. MDS nurse was also educated on how to utilize the electronic medical record (EMR) to build an MDS schedule and monitor status of assessments. In addition, MDS assessments have been created via the EMR calendar. The EMR calendar and MDS tracker and will be reviewed during our daily clinical meeting to further ensure compliance. Additional systemic changes are being addressed through our quality assurance process described below. III. MDS Coordinator or designee will: Review all Quarterly MDS assessments for timely completion, weekly x 12 weeks, then monthly for a total duration of 12 months.	

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			The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV. The facility will be in and remain in compliance by: December 20th, 2022.	
F 0640 SS=E Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's			

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	assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.			
	Based on interview and record review, the facility failed to complete, encode and transmit a Discharge Minimum Data Set (MDS) assessment for 10 of 11 residents reviewed for resident assessment. (Resident 1, 2, 3, 4, 5, 6, 7, 8, 11 and 16)	F 0640	I. Residents ---#1, #2, #3, #4, #5, #6, #7, #8, #11, and #16 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to transmit MDS	12/20/2022

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	Findings include: 1. A review of the MDS Discharge Assessment-14 day for Resident 1 indicated a discharge date of 5/24/22, was created on 10/28/22, and had not been submitted at the time of the survey. A review of the medical record indicated the Discharge MDS for Resident 1 had not been submitted in accordance with the RAI manual. 2. A review of the MDS Discharge Assessment-14 day for Resident 2 indicated a discharge date of 6/29/22, was created on 10/28/22, and had not been submitted at the time of the survey. A review of the medical record indicated the Discharge MDS for Resident 2 had not been submitted in accordance with the RAI manual. 3. A review of the MDS Discharge Assessment-14 day for Resident 3 indicated a discharge date of 6/16/22, and submission date of 10/28/22. A review of the medical record indicated the Discharge MDS for Resident 3 had not been submitted in accordance with the RAI manual. 4. A review of the MDS Discharge Assessment-14 day for Resident 4 indicated a discharge date of 6/21/22, and submission date of 10/31/22. A review of the medical record indicated the Discharge MDS for Resident 4 had not been submitted in accordance with the RAI manual. 5. A review of the MDS Discharge Assessment -14 day for Resident 5 indicated a discharge date of 6/20/22, and submission date of 10/28/22. A review of the medical record indicated the Discharge MDS for Resident 5 had not been submitted in accordance with the RAI manual.		assessments in a timely manner that adheres to policy, procedure and to State and Federal Guidelines and Regulations. II. All residents have the potential to be affected. A complete audit was performed of all residents MDS assessment transmissions in the past 6 months. In addition to the 10 MDS' identified during the annual review, 0 additional MDS assessments were identified as transmitted late. I. The transmittal requirements of Minimum Data Set (MDS) Policy were reviewed and found to meet clinical standards. Education was provided to the MDS Nurse on the policy along with State and Federal guidelines. MDS nurse was also educated on how to utilize the electronic medical record (EMR) to build an MDS schedule and monitor status of assessments. In addition, MDS assessments have been created via the EMR calendar. The EMR calendar and MDS tracker and will be reviewed during our daily clinical meeting to further ensure compliance. Additional systemic changes are being addressed through our quality assurance process described below. III. MDS Coordinator or designee will:	

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	6. A review of the MDS Discharge Assessment-14 day for Resident 6 indicated a discharge date of 6/28/22, was created on 10/28/22, and had not been submitted at the time of the survey. A review of the medical record indicated the Discharge MDS for Resident 6 had not been submitted in accordance with the RAI manual. 7. A review of the MDS Discharge Assessment-14 day for Resident 7 indicated a discharge date of 8/15/22, and submission date of 10/28/22. A review of the medical record indicated the Discharge MDS for Resident 7 had not been submitted in accordance with the RAI manual. 8. A review of the MDS Discharge Assessment -14 day for Resident 8 indicated a discharge date of 9/6/22, and submission date of 10/20/22. A review of the medical record indicated the Discharge MDS for Resident 8 had not been submitted in accordance with the RAI manual. 9. A review of the MDS Discharge Assessment-14 day for Resident 11 indicated a discharge date of 7/7/22, and the discharge had not been submitted at the time of the survey. A review of the medical record indicated the MDS for Resident 11 had not been completed or submitted in accordance with the RAI manual. 10. A review of the MDS Discharge Assessment-14 day for Resident 16 indicated an ARD with a date of 6/24/22, was created on 10/31/22, and had not been submitted at the time of the survey. A review of the medical record indicated the MDS for Resident 16 had not been completed or submitted in accordance with the RAI manual. During an interview, on 11/1/22 at 9:58 a.m., the		Review all Discharge MDS assessments for timely transmission, weekly x 12 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV. The facility will be in and remain in compliance by: December 20th, 2022.	

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	155198	A. BUILDING 00 B. WING	11/03/2022

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	MDS Coordinator indicated the 14-day discharge assessment had not been completed or submitted on time. The facility got behind on submission due to illness within the department. During an interview, on 11/1/22 at 2:09 p.m., the Director of Nursing (DON) indicated the facility would refer to the RAI for the timing of submissions. During an interview, on 11/01/22 at 2:46 p.m., the Administrator indicated he was not aware of any recent concerns in the last few months regarding late MDS submissions. The facility had not completed audits or reviewed MDS submission in the QAPI program. During an interview, on 11/1/22 at 4:33 p.m., the DON indicated the Corporate MDS Coordinator had identified a concern regarding late submission of the MDS. During an interview, on 11/1/22 at 3:33 p.m., the Administrator indicated if the resident's discharges were submitted late, it could affect the facility census and cause an error on the Payroll Based Journal (PBJ) report. A current facility policy, titled "MDS completion and submission Timeframes," dated as revised 7/17, indicated the facility would conduct and submit resident assessment in accordance with current federal and state submission timeframes. 3.1-31(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview and record review, the facility failed to identify a change of condition, ensure the physician's order was followed, and ensure the physician was notified of a change of condition for 1 of 2 residents reviewed for quality of care. (Resident 28) Finding includes: The record for Resident 28 was reviewed on 10/27/22 at 3:09 p.m. Diagnoses included, but were not limited to, chronic kidney disease (disease of the kidneys leading to renal failure), congestive heart failure (when the heart can not pump enough blood), acute respiratory failure (when fluid builds up in the air sacs in your lungs), sepsis (complication of an infection), cardiogenic shock (when your heart cannot pump enough blood and oxygen to the brain and other vital organs), multiple myeloma (cancer of plasma cells) and bacteremia (presence of bacteria in the bloodstream). A care plan, with a printed date of 11/2/22 at 11:21 a.m., indicated to: a. Administer medications as ordered. b. Assess vital signs, labs, and weights as ordered and notify the physician as indicated. c. Observe for complications of chest pain, dyspnea, edema, wheezing, and consult the physician as indicated.	F 0684	I. Resident #28 no longer resides in community. It is the practice of Marquette to identify a change in resident's condition, ensure the physician's order is followed, and ensure the physician is notified of a change in condition. II. All residents have the potential to be affected. No residents experienced any negative consequences. An audit of blood pressures for the previous 30 days has been conducted for change in condition and notification of provider as indicated. III. The Acute Change of Condition – Clinical Protocol Policy has been reviewed and found to meet clinical standards. Education provided to nursing staff on the Acute Change of Condition – Clinical Protocol Policy including identifying a change in resident's condition, following a physician's order for parameters, and notification of provider upon change in condition. IV. The Director of Nursing	12/20/2022

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	The vital signs for Resident 28 were reviewed and indicated the following: a. On 10/20/22 at 8:45 p.m., her blood pressure was 119/68. b. On 10/21/22 at 10:22 p.m., her blood pressure was 104/55. c. On 10/21/22 at 8:45 p.m., her blood pressure was 107/72. d. On 10/22/22 at 10:22 p.m., her blood pressure was 104/55. e. On 10/22/22 at 12:51 p.m., her blood pressure was 99/56. f. On 10/23/22 at 8:23 p.m., her blood pressure was 99/58. g. On 10/23/22 at 2:53 p.m., her blood pressure was 76/46. h. On 10/23/22 at 7:51 p.m., her blood pressure was 77/44. A nurse progress note, dated 10/22/22 at 5:31 a.m., indicated Resident 28 had no complaints of pain, discomfort, or distress. A condition change nurse progress note, dated 10/23/22 at 10:23 p.m., indicated Resident 28 had a change of condition. Her blood pressure was 77/50, heart rate was 60 and respirations were 16. Resident 28 had a history of renal failure, was very pale and was not eating or drinking. The physician and health representative were notified and she was sent to the hospital for evaluation. A review of Resident 28's record indicated the physician was not notified on 10/23/22, until eight hours after her blood pressure was first recorded low at 76/46 at 2:53 p.m. A Hospital Discharge Summary, dated 11/1/22 at 11:00 a.m., indicated Resident 28 was brought to the Emergency Department by Emergency		or designee will: Audit all resident blood pressures for acute change in condition and notification of provider, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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	Medical Services for weakness and had shortness of breath for the past few days which worsened on 10/28/22. The Discharge Summary indicated Resident 28 had been admitted to the hospital for septic shock presumably due to a complicated urinary tract infection with a history of extended spectrum beta-lactamase (ESBL). The resident did present to the Emergency Department with hypotension (low blood pressure) and required intravenous (IV) fluids and antibiotics. The urine culture had no growth to the date of discharge date. The diltiazem (antihypertensive drug) was changed from an immediate release to an extended release since her blood pressures were on the lower side. A nurse note, dated 11/1/22 at 3:29 p.m., indicated Resident 28 had an admitting diagnosis of hypotension and acute renal failure. During an interview, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/2/22 at 9:26 a.m., they indicated Resident 28 had multiple hospital admission during the stay at the facility. The DON indicated Resident 28 was a risk for hospitalization related to her kidney failure. When Resident 28 had a change in condition, her blood pressure and pulse were affected. During an interview, on 11/2/22 at 4:55 p.m., the DON indicated Resident 28 had an order for staff to monitor her blood pressure and hold her diltiazem when her systolic blood pressure was below 90. During an interview, on 11/3/22 at 10:53 a.m., the DON indicated the physician was not notified when Resident 28 had a blood pressure of 76/46 recorded at 2:53 p.m., and a blood pressure of			

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	77/44 at 7:51 p.m. Her expectation for staff would be to notify the physician with changes of condition and document in the resident's progress note. A current facility policy, titled "Acute Condition Change - Clinical Protocol," with a revised date of 8/18, indicated nursing staff would make a detailed observation and collect pertinent information to report to the physician. The nursing staff would contact the physician based on the urgency for the situation. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure residents at risk for development of pressure ulcers received the necessary care, treatment and services, consistent with professional standards of practice, to prevent worsening of a pressure ulcer and promote healing for 1 of 3 residents reviewed	F 0686	I. Resident #73 was affectedbut resolving without complications. It is the practice of Marquette to ensure residents at risk for development of pressure ulcers receive the necessary care, treatment and services, consistent	12/20/2022

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	for pressure ulcers. (Resident 73) Resident 73 had developed a pressure ulcer at the facility and wound was discovered as a stage 2. Finding includes: During the initial tour of the facility, on 10/27/2022 at 1:00 p.m., Resident 73 was observed sitting, in a reclining Broda chair, in her room. A pressure reducing cushion was in the seat of the chair and a low air mattress was on the resident's empty bed. The resident did not respond to her name being called or a knock on the room door. The CNA (Certified Nursing Assistant) care sheet, on this date, was obtained from the unit nurse which indicated the resident was a mechanical lift transfer and required turning and repositioning every 2 hours. The record for Resident 73 was reviewed on 10/28/2022 at 3:32 p.m. Diagnosis included, but were not limited to, dementia, hemiplegia following a cerebral infarction (stroke) affecting the left side, age related physical debility, sacral pressure ulcer stage 3, abnormality of gait and contracture of the left hand. Admission physician's orders, included, but were not limited to, "Weekly Visual Skin Assessment - Complete a Head-to-toe Visual Skin Assessment with the resident shower 1 (time) every Week - Note Intact Skin IF THE RESIDENT HAS ANY NOTED OPEN AREAS, SKIN BREAKDOWN, BRUISES, OR IF SKIN INTEGRITY IS COMPROMISED..." The resident's skin care regime, at the time of admission, indicated a physician's order to "Cleanse perineum with soap et (and) water. Rinse. Dry et apply calazime (a skin protectant		with the professional standards of practice, to prevent worsening of a pressure ulcer and promote healing. II. All residents have the potential to be affected. An audit of all active inpatient residents was completed for risk of pressure ulcer development, any current impaired skin integrity and treatments as indicated. Skin assessments have been updated. Skin treatments and skin care plans were updated to reflect the current skin condition of the resident as indicated. III. The Pressure Ulcer Prevention and Skin Management Policy was reviewed and found to meet clinical standards. Re-education provided to Health Center Licensed Nursing Staff on the policy. This re-education includes identifying residents at risk for development of pressure ulcers receive the necessary care, treatment and services, consistent with the professional standards of practice, to prevent worsening of a pressure ulcer and promote healing. In addition to the re-education, nursing assistant shower sheets have been revised and will be reviewed daily, Monday through Friday, in morning clinical meeting, for any skin integrity concerns by nursing management.	

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	paste) bid (twice a day) et prn (when necessary) after incont (incontinent) episodes." A "Nursing Evaluation," dated 06/17/2022, indicated the condition of the resident's skin at the genitals, perineal and buttock areas had "some redness" and described the area as follows: Type - rash Body part - groin/pubic area Location - back Appearance - healing Odor - none Drainage - none Drainage appearance - clear Length - 2 cm (centimeters) Width - 1 cm Depth - 0.1 cm Shower sheets completed on the date of discovery of the pressure ulcer, and the week following, titled "Care giver Body Check Worksheet", indicated the following: On 06/17/2022, to the question of any rashes?, the staff completing the worksheet answered "yes", with the location being the "butt". On 06/21/2022, to the question of "Any open lesions, cuts, lacerations, or skin tears?", staff completing the worksheet answered "yes", and to the question of "Any open ulcers?", staff completing the worksheet answered "no". The first full description of the pressure ulcer, dated 06/24/2022, 7 days following the discovery of the initial stage 2 pressure ulcer, described the wound as a "stage 3" with tissue type as "Pale Pink Non-granulating = 10%" and "Slough White Fibrinous = 90%". The current plan and		IV. Director of Nursing or designee will: Audit a random sample of 10% of residents via visual skin observation, ensuring skin assessment accuracy and potential identification and treatment of impaired skin integrity. This will occur weekly x 12 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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comments included, " ...New area noted to buttocks ..." The pressure ulcer measured, on this date, 2 cm by 1.5 cm with a depth of 0.2 cm and a scant amount of serosanguinous drainage.

The first physician's order related to the pressure ulcer was dated 06/22/2022 and indicated to "Cleanse area to sacrum with normal saline, pat dry, apply skin prep to periwound, apply saline moistened hydrofera blue (a bacteriostatic foam dressing), ring out excess saline and to cover with bordered foam..."

On 11/02/2022 at 11:31 a.m., the pressure ulcer was observed. Resident 73 was lying in bed and turned to her left side. When the resident's brief was removed by the wound nurse, a stage 3 pressure ulcer was seen at the sacral/coccyx area. The wound, when measured at this time by the wound nurse, measured 1 cm in length with a width of 0.5 cm and a depth of 0.3 cm. The wound edges were clean and well approximated with dark brown to black tissue covered the wound base. No drainage was noted at the time of the observation.

During an interview, on 10/28/2022 at 11:00 a.m., the wound nurse reviewed the images of the pressure ulcer and indicated Resident 73 had developed the pressure ulcer at the facility and wound was discovered as a stage 2 on 06/17/2022. The resident was totally dependent on staff for activities of daily living and was incontinent of bowel and bladder. At the time of discovery, the wound measured to be 2 cm (centimeter) in length by 1 cm in width and 0.1 cm in depth.

A current facility policy, titled "Pressure Ulcer Prevention and Skin Management," dated as last revised June 2021 and received from the Assistant

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	Director of Nursing on 11/01/2022 at 12:25 p.m., indicated "...Program Overview - Each health center is to implement a pressure ulcer prevention and management program. The program shall emphasize prevention of pressure ulcers. All pressure ulcers will be managed to promote optimal healing...." 3.1-40(a)(2)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview and record review, the facility failed to ensure staff followed fall interventions and completed a root cause analysis for 4 of 4 residents reviewed for accidents. (Resident 17, 32, 35 and 69) Findings include: 1. During an observation, on 10/21/22 at 9:31 a.m., Resident 17 was found seated, in her Broda chair, leaning over to her left side of the arm rest. During an observation, on 10/28/22 at 10:34 a.m., Resident 17 was observed lying, in bed, facing the wall covered with a blanket. At the foot end of the blanket, the call light was attached to her blanket. The fall mat was standing up on its side next to the wall away from Resident 17.	F 0689	I. Residents #69 and #35 were affected but resolving without complications. Residents #32 and #17 had no negative consequences from the alleged deficient practice. Resident #17 no longer resides in facility. It is the practice of Marquette to ensure staff follow fall interventions and complete a root cause analysis. II. All residents who are at risk for falls have the potential to be affected. An audit has been conducted of all residents with falls in the previous 30 days for evidence of fall interventions present, care plan updated, care	12/20/2022

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	The record for Resident 32 was reviewed on 10/31/22 at 10:30 a.m. Diagnoses included, but were not limited to, dementia and a history of falls. An Event report, dated 8/29/22 at 12:20 p.m., indicated Resident 17 had an unwitnessed fall and was found on the floor in front of the closet in her room. Immediate interventions were implemented to provide 30-minute checks for days. A Unit Manager Event Review report, dated 8/29/22, indicated Resident 17 was confused and had a fall. The report indicated the root cause for the fall was staff performance and a new intervention was for staff education to be provided. An Event report, dated 10/15/22 at 7:00 p.m., indicated Resident 17 had an unwitnessed fall and was found on the floor. Immediate interventions were implemented to provide one to one supervision, promptly lay down after meals and frequent checks. A Unit Manager Event Review report, dated 10/15/22, indicated Resident 17 was confused and had a fall. The report lacked indication a root cause was completed, or a new intervention was placed after review. A fall risk assessment was completed, on 10/17/22, and indicated Resident 17 was a high risk for falls. A care plan, with a print date of 11/3/22, indicated Resident 17 had a risk for falls related to impaired balance, impaired cognition and a history of falling. The care plan indicated: a. Not to leave the resident alone in her room when up in her wheelchair.		plan interventions initiated and in place and root cause analysis for each incident. Any discrepancies have been corrected. III. The Falls and Fall Risk Managing Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff on the Falls and Fall Risk Policy including the initiation of interventions, care plan updating, interventions being in place and root cause analysis being performed with each incident. In addition, the event reporting procedure has been updated to include a revised root cause analysis form. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit all resident falls for initiation of interventions, care plan updating, interventions being in place and root cause analysis being performed, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time	

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	155198	A. BUILDING 00 B. WING	11/03/2022

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MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	b. Assist with mobility as needed. c. Assist to walk as desired. d. Obtain a soft touch call light. e. Keep the bed in a low position. f. Do not leave her alone in the bathroom. g. Anticipate needs as indicated and give frequent cues. h. Identify specific interventions to aid in prevention of falls. i. Place the call system and most frequently used items within reach of the resident. j. Bed against the wall and a fall mat beside the bed. k. Check and change each round and toilet as needed. l. Promptly lay down after meals. During an interview, with Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/3/22 at 9:30 a.m., the DON indicated she was not sure if a call light to the end of a blanket would work for alerting the staff if Resident 17 was to attempt to get out of bed. The fall mat should be placed next to Resident 17 while she was in bed and staff would provide checks throughout the day to ensure she was safe. 2. During an observation, on 11/1/22 at 10:19 a.m., Resident 32 was observed, in the hallway, directly in front of the nursing station. A hospice nurse was observed standing in front, to the left side of the nursing station, just past the wall and out of view of the resident. No staff were observed in either hallway which had direct view of the resident. Resident 32 was in her wheelchair, her wheels were unlocked when she attempted to stand and hit her head on the sling attachment bar of the Hoyer lift. The stabilizing leg was stuck between the wheels. She sat back down in her wheelchair and continued to push the wheel but		consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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was unable to move the chair free. Resident 35 stood back up and attempted to step away unsteadily from the wheelchair. Resident 35 was prompted to sit down and staff were prompted to intervene and assist the resident.

The record for Resident 32 was reviewed on 11/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, dementia, aphasia (a loss of ability to understand or express speech).

A Quarterly Minimum Data Set (MDS) assessment, dated 10/17/22, indicated Resident 32 had a severe cognitive impairment with inattention, disorganized thinking, had two falls and impaired vision. She required extensive physical assistance of one staff for assistance with transfers and locomotion on the unit.

A care plan indicated Resident 32 was at risk for falls due to impaired balance, impaired cognition, history of falling, and impaired vision. The care plan indicated:
a. Provide cues and supervision while ambulating.
b. Obtain a soft touch call light.
c. Encourage activities in the afternoon.
d. Provide Resident 32 orientation to the room and call system.
e. Use fall mat at bedside.
f. Keep bed in low position.
g. Bed against the wall.
h. Dycem in recliner.
i. Offer to toilet after meals.

A Unit Manager Event Review report, dated 5/20/22, indicated Resident 32 had a fall. She was found on the floor by housekeeping staff playing with hats. The root cause determined Resident 32 had a diagnosis of dementia and was reaching, forgets limitation and had poor safety judgement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	A wheelchair evaluation was added as an intervention. A nurse progress note, dated 6/6/22 at 1:45 p.m., indicated Resident 32 had an unwitnessed fall and was found in her room, on the floor. Interventions added for Resident 32 was for the staff to place the call light in reach. A nurse progress note, dated 7/3/22 at 7:45 a.m., indicated Resident 32 had an unwitnessed fall and was found down, on the floor, in the hallway. Interventions added for Resident 32 was for the staff to place the call light in reach. An Event report, dated 8/25/22 at 2:05 p.m., indicated Resident 32 was found on the floor, in her room, asleep with her blanket over her. A Unit Manager Event Review report, dated 8/25/22, indicated Resident 32 had a fall. A new intervention was added to offer Resident 35 a coca cola and to assist to toilet at bedtime and early morning. The review lacked indication a root cause was completed. A post fall follow up progress note, dated 10/29/22, indicated Resident 32 had a fall in the second-floor hallway, on 10/28/22 at 6:00 p.m., when she was found lying on her left side in front of her wheelchair yelling out for help. The progress notes further indicated 15-minute checks was initiated. Resident 32's care profile, undated, indicated she was a fall risk, put the bed in the low position and against the wall, fall mat at bedside, a soft touch call light, wheelchair within reach of the bed, dycem to recliner and a nightlight in her room. The care profile lacked indication staff were to offer a			

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	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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coca cola, provide cues and supervision while ambulating.

A root cause analysis was requested and not provided for the falls on 6/6/22, 7/3/22 and 8/25/22.

During an interview, on 11/1/22 at 10: 22 a.m., Nursing Assistant (NA) indicated Resident 32 had her wheelchair stuck in the Hoyer lift leg and could have fallen if staff did not intervene.

During an interview, on 11/1/22 at 10:25 a.m., the Assistant Director of Nursing (ADON) indicated Resident 32 was at risk for falls and had fallen in the past. Resident 32 was able to ambulate at times but used the handrails for support. Resident 32 could have fallen and sustained an injury when she got her wheelchair stuck in the Hoyer lift and attempted to free it on her own. The Hoyer lift should have been stored in the appropriate resident's bathroom instead of in the hallway.

During an interview, on 11/3/22 at 9:30 a.m., the DON and ADON indicated Resident 32 was a fall risk and required assistance from staff for transfers. The staff should keep the call light within reach for Resident 32 to use and staff should be providing checks throughout the day for safety.

3. During an observation, on 10/27/22 at 12:42 p.m., Resident 35 was found sitting up with the head of the bed up. She was observed, above her left eye, to have a one and half inch bruise and down past her left cheek was red and bruised. She had an abrasion on the bridge of her nose. Above her left eye were five steri-strips, soaked through with blood, which covered a wound.

During an observation, on 10/28/22 at 9:36 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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Resident 35 was heard yelling out "please, please, help, help." Upon entering Resident 35's room, she was observed seated in her reclining chair, in her room, with the feet elevated. The call light was hanging over the bedrail of her bed more than 9 feet away from the resident. No staff were observed near her room.

During an observation, on 10/28/22 at 10:46 a.m., Resident 35 was found lying in her bed with her eyes closed. Her call light was found lying on the floor near the top right wheel of the exit side of the bed. The bed was in the low position.

During an observation, on 11/1/22 at 9:45 a.m., Resident 35 was heard calling out "help, help me" and was found in her room seated in the reclining chair with the footrest elevated. The over the bed table was positioned over her lower legs. She had both her legs over the left side of her footrest. Her call light was tucked inside the cushion on the left side of the reclining chair beneath her left hip. Resident 35 indicated she was tired and wanted to go to bed.

The record for Resident 35 was reviewed on 10/31/22 at 9:30 a.m. Diagnoses included, but were not limited to, dementia and repeated falls.

A Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated Resident 35 had a severe cognitive impairment and demonstrated no behaviors. She required extensive physical assistance of one staff person to assist with bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. She had falls with injuries and used a wheelchair for locomotion.

A care plan indicated Resident 35 was a fall risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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and indicated to:
a. Apply anti-rollbacks to wheelchair.
b. Keep bed against the wall
c. Place Fall mat at bedside.
d. On 12/4/21, staff were to keep her wheelchair within reach when she was in bed.
e. On 11/26/21, staff were to obtain a soft touch call light.
f On 11/28/21, staff were to offer and assist resident to lay down after meals.
g. On 11/27/21, staff were to assist her to wear hipsters to aide in prevention of hip injury and apply in a.m.
h. Place the call system and most frequently used items within resident's reach.
i. Provide resident orientation to room and call system.
j. On 1/17/21, staff were to offer and assist with toileting a minimum of every two hours while awake.
k. On 12/10/21, staff were to encourage and assist resident to sit in her recliner after dinner.
l. On 12/13/21, therapy was to provide dycem for wheelchair.
m. On 11/29/21, staff were to ensure bed controls are secured in appropriate and safe place while resident was in bed.
n. On 12/15/21, staff were to supervise resident during meals.
o. On 10/1/22, staff were to offer, Resident 35, 15-minute checks until management review and allow to sleep as long as possible before meals.

Resident 35's care profile, undated, indicated she was a fall risk and needed antiroll backs to the wheelchair, bed in the lowest position, fall mat at bedside, a soft touch call light, wheelchair within reach of the bed, and dycem to the wheelchair. Staff were to place the call light and items used frequently within reach, encourage activities,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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supervise during meals, lay down after meals, offer early bedtime, offer to get up if awake and not to leave the resident alone in the bathroom.

A review of the facility's falls, in the past 6 months, indicated Resident 35 had 11 falls from May to October 2022.

A Resident Incident Assessment indicated Resident 35 had an unwitnessed fall on 5/25/22 at 4:00 p.m., when she was found sitting, in her bathroom, on the floor. She sustained skin tears to her left knee and elbow. Post fall interventions included to have the resident, in her wheelchair, at the nurse's station and to have a call light in reach when in her room.

A Resident Incident Assessment indicated Resident 35 had an unwitnessed fall on 6/2/22 at 10:10 a.m., when she was found lying on the left side, on her floor, near her bed. Post fall, the facility added interventions to place her bed against the wall and the aide was too standby when the resident was toileting.

A Resident Incident Assessment indicated Resident 35 had a fall on 7/16/22 at 10:00 a.m., at the nurse's station. The resident pushed against the wall, tilted her wheelchair and fell on her left side. She hit the outer left side of her eye and sustained a skin tear to her left knee. Post fall 30-minute checks were added to Resident 35 interventions.

A Resident Incident Assessment indicated Resident 35 had a fall, in the hallway, on 8/4/22 at 2:30 p.m. The resident was incontinent of loose stool at the time of fall. She sustained a 1.0 cm laceration to her left forehead and her left knee was skinned. Post fall additional interventions of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	15-minute checks for 15 days were added. She was also sent to the Emergency Room for evaluation. A Unit Manager Event Review report, dated 8/4/22, indicated Resident 35 had a fall with injury. The report indicated the root cause was related to toileting, weakness, poor safety judgement and wheelchair not dumped. The report indicated a new intervention was initiated by the facility for staff to offer to lie down after activities and provide 15 minute checks. An occupational therapy (OT) initial assessment, dated 7/28/22, indicated they had completed a wheelchair evaluation due to the history of frequent falls. The assessment indicated Resident 35 was a fall risk and had precautions for falls, cognitive impairment and she was hard of hearing. OT indicated the resident to have 24/7 nursing assistance. An OT daily treatment note, dated 8/10/22, indicated Resident 35 had an unwitnessed fall on 8/2/22, when she attempted to stand from her wheelchair. Her leg rests were not in place at the time of the fall. Staff were educated on the importance of leg rest for fall prevention. A Resident Incident Assessment indicated Resident 35 had a fall, on 8/23/22 at 4:00 p.m., where she was found in her room on floor. Post fall additional interventions of frequent checks, with nurse, and spoke to son were added. A Unit Manager Event Review report, dated 8/23/22, indicated Resident 35 had a fall. The report indicated a lack of a root cause. A new intervention for staff to encourage short sleep cycles (naps) during the daytime hours. A Resident Incident Assessment indicated			

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	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	Resident 35 had a fall, on 9/1/22 at 8:00 p.m. She was found by a Certified Nursing Assistant (CNA) on the floor in her room. Resident 35 had sustained an abrasion to her left elbow. Post fall interventions added for Resident 35 were one-to-one supervision, frequent checks, bed in low position with a fall mat in place, call light in reach and toilet every two hours. A Unit Manager Event Review report, dated 9/1/22, indicated Resident 35 had a fall with a head injury. The report indicated the root cause was related to staff performance. The report lacked a new intervention was initiated by the facility. A Resident Incident Assessment indicated the resident had a witnessed fall in her bathroom, on 9/16/22 at 7:30 a.m., when she fell off the toilet after she had bent down to pull up her pants. She sustained a 2.5 cm (centimeter) by 5 cm laceration to the left side of her forehead and a skin tear to the bridge of her nose. the resident had steri-strips and dressing applied to her injuries. Post fall interventions added for Resident 35 were one-to-one supervision, frequent checks, bed in low position with a fall mat in place, call light in reach and toilet every two hours. The assessment lacked indication Resident 35 had been evaluated at the Emergency Room after she sustained a head injury. A Unit Manager Event Review report, dated 9/16/22, indicated Resident 35 had a fall with injury. The report indicated the root cause was related to toileting, balance and staff performance. A new intervention of staff education was indicated for Resident 35. A Resident Incident Assessment indicated Resident 35 had a fall, on 10/1/22 at 11:15 a.m., in a room when she had propelled herself and flipped the wheelchair over on top of herself. Post fall, the facility placed an intervention to take resident to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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bed per her request. A Unit Manager Event Review report, dated 10/1/22, indicated Resident 35 had a fall with injury. The report lacked indication of a root cause.

A Resident Incident Assessment indicated Resident 35 had a fall at the nurse's station, on 10/27/22 at 7:00 a.m. Resident 35 was up in her wheelchair when she attempted to get out of the chair and landed on her face. She sustained a 0.1 cm by 0.1 cm by 0.1 cm laceration to her forehead. The facility added the intervention for staff to clean wound and apply steri -strips. A root cause analysis was requested and not provided for the fall on 10/27/22.

4. During an observation, on 10/27/22 at 2:05 p.m., Resident 69 had significant amount of bruising to her right side of her face which covered from her jaw line up past her forehead. A large black colored bump was just above her right eyebrow. She had her right hand up to her forehead rubbing the black colored bump.

During an observation, on 10/28/22 from 9:25 a.m., to 9:53 a.m., Resident 69 was seated in a reclining Broda chair at the nursing station, rubbing her forehead and eye. She had facial grimacing while she was rubbing her head. No staff were observed at the nurse's station until 9:53 a.m., when an aide came up to take Resident 69 back to her room.

The record for Resident 69 was reviewed on 10/31/22 at 9:30 a.m. Diagnoses included, but were not limited to, dementia, subdural hemorrhage, muscle weakness, macular degeneration and repeated falls.

Resident 69's care profile, undated, indicated she was a fall risk and staff were to keep the bed in the

lowest position, use a fall mat at bedside, place in recliner when in room and the resident was not to be in her wheelchair alone when she was in her room. The staff were to use Dycem to the wheelchair when she was in her room alone, offer activities, put the bed next to the wall and use a soft touch call light.

A Physical Therapy (PT) Discharge Summary, dated 3/30/22, indicated Resident 69 had dementia with memory impairment and was a fall risk. She had a right arm fracture on 2/24/22.

A physician progress note, dated 9/9/22 at 9:49 a.m., indicated Resident 69 was hospitalized from 5/23/22 to 5/28/22, for an unwitnessed fall resulting in right temporal and tentorial subdural hematomas. She sustained a left maxillary fracture and a left periorbital hematoma. Resident 69 had fractures of the first and second vertebral body and a right first rib fracture.

An Event Report, dated 10/18/22, indicated Resident 69 had an unwitnessed fall with a right side hematoma. The resident was found face down, on the floor of the room, in front of the Broda chair. The root cause indicated the resident scooted forward. Interventions added to Resident 39 was for staff to provide 15-minute checks for three days.

A Unit Manager Event Review report, dated 10/19/22, indicated Resident 69 had a fall with injuries. The report indicated the root cause was related to decreased safety awareness. The report lacked indication new interventions were added after the manager review.

An Event Report, dated 10/19/22 at 8:10 a.m., indicated Resident 69 had an unwitnessed fall and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(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

was found lying on her right side on the floor near her chair. She had a 4 cm by 4 cm hematoma to her right side of head and bruising to her forehead and under her right eye. Interventions prior to the fall included to assess for pain, use specialized call light and keep the call light within reach. Immediate interventions implemented were for the staff to get the resident up right before meals and neuro checks were initiated.

A Unit Manager Event Review report, dated 10/19/22, indicated Resident 69 had a fall with injuries. The report indicated the root cause was related to decreased safety awareness. The report lacked indication new interventions were added after the manager review.

An Occupational Therapy evaluation, dated 11/1/22, indicated Resident 69 was a fall risk, had an overall decrease in overall strength and functional activity tolerance. She received daily assistance with all self-care task and functional mobility.

During an interview, on 11/3/22 at 10:45 a.m., the ADON indicated the Administrator was the person at the facility to report incidents related to falls and fractures. The incident investigation report lacked indications Resident 69 sustained fractures after her fall on May 23, 2022. Resident 69 was a fall risk and sustained a hematoma on 10/19/22.

During an interview, on 11/3/22 at 10:45 a.m., the DON indicated her expectation for staff would be to follow the residents care plan and provide the supervision and assistance as directed for each resident.

During an interview, on 11/4/22 at 4:30 p.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	Administrator indicated the facility had identified resident falls as a concern and was currently reviewed in the quality assurance and performance improvement (QAPI) meetings. A review of the falls in the last six months for second floor report, undated, indicated a total of 87 falls had occurred from 4/2/22 to 10/27/22. A current facility policy, titled "Falls and Fall Risk, Managing," dated 3/18, indicated staff were to identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. 3.1-45(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to ensure the physician was notified when a medication was not filled by the pharmacist upon their admission as ordered to help address pain for 1 of 1 new resident reviewed for pain management. (Resident 193) Finding includes: During the initial tour of the facility, on 10/27/2022 at 11:38 a.m., alert and oriented Resident 193 was found in her room, sitting in a wheelchair. During an interview, at this time, the resident indicated	F 0697	I. Resident #193 was affected but resolving without complications. Resident #193's pain medication was restarted to aide with pain management. It is the practice of Marquette to ensure the physician is notified when a medication is not filled by the pharmacist upon admission to help address pain. II. All newly admitted residents receiving pain management therapy have the	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	she was new to the facility. She had recently suffered a stroke which had affected her left arm and leg, leaving her without movement to the left side of her body. During the interview, Resident 193 continually adjusted her left arm, rubbed her arm and attempted to hold her arm in place while she grimaced in pain. When questioned, the resident indicated she had increasing pain to her left shoulder and arm following her stroke which caused her to be unable to sit up in her chair for long periods of time. The record for Resident 193 was reviewed on 10/31/2022 at 10:02 a.m. Diagnosis included, but were not limited to, hypertension, obesity, seizures, hemorrhagic cerebral vascular event (stroke) with residual deficits and left side hemiplegia. Resident 193's baseline plan of care was received and reviewed on 11/03/2022 at 9:31 a.m. A problem of "Pain Management" with a goal of "Experience less pain" was observed. Interventions to this goal included, but were not limited to, drug interventions, assess pain tolerance and non-drug interventions. At the time of her admission, initial physician orders included an order for baclofen (a muscle relaxant) 20 mg (milligrams) three times a day for muscle spasms. A physician progress note, dated 10/28/2022 at 2:44 p.m., indicated "...Left frontal hemorrhagic CVA (stroke) with left sided neglect, hemiparesis, spasticity, and contracture to the left hand. Baclofen 20 mg tid (three times a day) stopped on admission by pharmacist and hasn't had for a week so will restart 5 mg tid x 3 days, then 10 mg po (by mouth) tid x 3 days, then 20 mg po tid.		potential to be affected. An audit was conducted of active inpatient residents admitted in the past 30 days for receipt of pain medications ordered upon admission. No other residents identified as not receiving pain management medication from pharmacy. III. The Change in a Resident's Condition or Status Policy has been reviewed and found to meet clinical standards. Education provided to Licensed Nursing Staff on the Change in a Resident's Condition or Status Policy including notification of the physician when a medication is not filled by the pharmacy to help address pain. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit all new admissions for receipt of pain medications ordered upon admission, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/03/2022

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	Called and left message for pharmacist that she is to be on both due to significant spasticity..." During an interview, on 11/02/2022 at 2:06 p.m., the ADON indicated discharge orders from the hospital, at the time, the resident was admitted to the facility included baclofen 20 mg three times a day, however this medication was not filled by the pharmacy due to an interaction with another muscle relaxant the resident was also prescribed. Documentation lacked the physician was aware the resident was not receiving the baclofen as ordered from the time of admission until reordered by the physician on 10/28/2022. A current facility policy regarding development of initial baseline plans of care was requested on 11/02/2022 at 3:34 p.m., however the policy and procedure was not received prior to, or at the time of exit from the facility on 11/04/2022 at 5:05 p.m. 3.1-37(a)		Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications			

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	for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on interview and record review, the facility failed to monitor a resident's blood pressure as ordered by the physician when administering a mediation used to treat high blood pressure for 1 of 5 residents reviewed for unnecessary medications. (Resident 87) Finding includes: The record for Resident 87 was reviewed on 10/31/22 at 2:43 p.m. Diagnoses included, but were not limited to, high blood pressure and heart failure. A current care plan, undated, indicated the resident had a diagnoses of hypertension and heart failure. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 10/14/22, indicated the resident was to receive Hydrochlorothiazide (a medication used to treat high blood pressure and heart failure) 12.5 milligrams every day for heart failure and to hold the medication if the resident's systolic blood pressure (the top number of a blood pressure which measures the amount of pressure in your arteries) was less than 100. The MAR (Medication Administration Record) was reviewed, for 10/22, and there were not any documented blood pressure readings correlated to	F 0757	I. Resident #87 had no negative consequences from the alleged deficient practice and no longer resides in facility. It is the policy of Marquette to monitor a resident's blood pressure as ordered by the physician when administering a medication to treat high blood pressure. II. All residents receiving cardiovascular medications, with parameters to hold medication, have the potential to be affected. A comprehensive audit has been completed of all residents receiving cardiovascular medications, three additional residents identified as having orders to hold medication without documentation available. Areas for additional documentation to be recorded, blood pressure and pulse, have been updated and verified present on all cardiovascular orders with parameters to hold. III. The Administering Oral Medications Policy has been reviewed and found to meet clinical standards.	12/20/2022

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	when the resident received the Hydrochlorothiazide. During an interview, on 10/31/22 at 2:30 p.m., the Director of Nursing indicated there was not any documentation the resident's blood pressure was taken at the time when the medication was administered but it was her assumption nursing would take the resident's blood pressure prior to giving the medication. A current policy, titled "Administering Medications," dated as revised 12/2012 and provided by the Director of Nursing on 11/01/22 at 2:30 p.m., indicated "...3. Medications must be administered in accordance with the orders...8. The following information must be checked/verified for each resident prior to administering medications: b. Vital signs, if necessary...." 3.1-48(a)(3)		Education provided to Health Center Licensed Nursing Staff on the Administering Oral Medications Policy including to perform any pre-administration assessments, including but not limited to blood pressure and pulse, as ordered for medication administration parameters. Additional systemic changes are being addressed through our quality assurance process described below. IV. Director of Nursing or designee will: Review cardiovascular orders with parameters to hold medication, for supplemental documentation present, weekly x 12 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on interview and record review, the facility failed to ensure the diagnoses were appropriate for the use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications (Residents 69 and 75). Findings include: 1. The record for Resident 69 was reviewed on 10/27/22 at 1:34 p.m. Diagnoses included, but were not limited to, depression (a mood disorder which causes a persistent feeling of sadness and loss of interest), vascular dementia (decline in thinking skills caused by conditions which block or reduce blood flow to various regions of the brain), bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and anxiety. Physician's orders indicated Resident 69 had orders for: a. Depakote Sprinkles (used to treat mental, mood conditions (such as manic phase of bipolar disorder) 125 mg (milligram) capsule, delayed release (2 capsules (250 mg)) by mouth twice a day. b. Buspirone (used to treat anxiety disorders) 7.5 mg tablet (1 tab) tablet by mouth twice a day. c. Oxycodone 5 mg tablet (2.5 mg (1/2 tablet)) every four hours as needed for pain.	F 0758	I. Residents #69 and #75 had no negative consequences from the alleged deficient practice. It is the policy of Marquette to ensure the diagnoses are appropriate for the use of psychotropic medications. II. All residents receiving psychotropic medications have the potential to be affected. A comprehensive audit has been completed of all residents receiving psychotropic medications for appropriate approved diagnoses. In addition, all residents' records have been reviewed for psychotropic medication consents identifying the risk and benefits associated with the medication usage and found to be in compliance. III. The Antipsychotic Medication Use Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on the	12/20/2022

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	d. Aripiprazole (an antipsychotic) 2 mg tablet (1) tablet. e. Lorazepam (an anti-anxiety) 2 mg/mL oral concentrate (0.5 mL) two times a day and as needed every four hours for anxiety and restlessness. A care plan indicated the resident had: a. Resident 69 was at risk for side effects from psychotropic medications. The care plan indicated to monitor for side effects, complete AIMS, pharmacy consult, GDR all psychotropic medications, monitor targeted behaviors and obtain consents for psychotropic medications. b. A mood disorder and manic episodes, bipolar disorder, anxiety and insomnia. The care plan indicated she had anxious expressions at times displayed by biting her nails, yelling out, garbled verbal noises, crying and combative with care. She took an anti-convulsant (Depakote) and lorazepam. Staff were to give the medications as ordered and to observe and notify the physician as needed for potential side effects. During an interview, with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Consulting Pharmacist (CP), on 11/2/22 1:15 p.m., the DON and ADON indicated no risk and benefits was completed for Resident 69 who had taken antipsychotics. 2. The record for Resident 75 was reviewed on 11/02/22 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, restlessness and agitation and senile degeneration of the brain. A care plan indicated the resident had anxiety and directed staff to administer medication per physician's order and for staff to monitor for		Antipsychotic Medication Use Policy including appropriateness of diagnosis for all psychotropic medications. Additional systemic changes are being addressed through our quality assurance process described below. IV. Director of Nursing or designee will: Audit all psychotropic physician orders for appropriate diagnosis and consent present, weekly x 12 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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potential side effects and report to the physician.

Physician's orders, dated 7/7/22, indicated Resident 75 was prescribed:
a. Seroquel (an antipsychotic) 25 mg tablet by mouth daily for restlessness and agitation.
b. Fentanyl (a narcotic) 12 mcg/hour patch for anxiety disorder.

A Medication Management Review (MMR) report, dated 9/21/22, had recommended a gradual dose reduction of the Seroquel for Resident 75.

During an interview, on 11/2/22 1:15 p.m., the Pharmacist indicated the Seroquel was being used for restlessness and agitation and was an off label use for Resident 75. Anxiety was the wrong diagnosis used for Fentanyl.

During an interview, with the DON, ADON and the CP, on 11/2/22 1:15 p.m., the CP indicated the Seroquel was being used for restlessness and agitation and was an off label use for Resident 75. The anxiety was the wrong diagnosis for Fentanyl. The DON and ADON indicated no risk and benefits was completed for Resident 75 who had taken antipsychotics.

During an interview, the hospice Nurse Practitioner (NP) indicated she had seen Resident 75 in September for a recertification visit. The resident did not make eye contact or communicate with her during the visit. No medication changes had been made since March of 2022. The family had requested to not have a reduction in Resident 75's medication.

A recent publication of "PDR.net" indicated "...Seroquel (quetiapine) was indicated for the treatment of bipolar disorder, including mania,

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	bipolar depression and major depressive disorder...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Seroquel in this population should be avoided if possible due to an increase in morbidity and mortality..." A recent publication of "PDR.net" indicated "...Depakote was indicated for the treatment of bipolar disorder including mania...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Depakote in this population should be avoided if possible due to an increase in morbidity and mortality...." A current policy, titled "Antipsychotic Medication Use," with a revision date of 12/16, indicated antipsychotic medications would be prescribed at the lowest possible dosage for the shortest period of time and or subject to a gradual dose reduction and review. Additionally, antipsychotic medication would not be used for symptoms of restlessness, impaired memory, anxiety, insomnia, crying alone, nervousness and uncooperativeness. 3.1-48(a)(4)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication	F 0759	I. Residents #146, #143, and #86 had no negative	12/20/2022

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	error rate of less than 5 percent, based on medication errors observed during 3 of 31 opportunities for errors, during a random medication administration observation, resulting in a medication error rate of 9.68 percent. (Residents 146, 143 and 86) Findings include: 1. During a random medication administration observation, beginning on 11/1/2022 at 8:30 a.m., Licensed Practical Nurse (LPN) 3 was observed to prepare levothyroxine (a thyroid hormone) 100 mcg (microgram) tablet and punched it out into a medication cup for Resident 146. LPN 3 poured a cup of water, locked the medication cart and computer, picked up the medication up containing Resident 146's medication, and walked into her room were Resident 146 was seated in her recliner. On 11/1/22 at 8:31 a.m., LPN 3 gave Resident 146 her levothyroxine medication and held a cup of water for her to drink. At 8:33 a.m., Resident 146's breakfast tray had been delivered into her room and was set up for her to eat. Resident 146 was observed, at 8:39 a.m., to be eating her breakfast. During an interview, at this time, LPN 3 indicated she was unsure Resident 146 had a specific time to administer her levothyroxine medication. Her breakfast had been delivered. Resident 146's order did not have a specific time for administration of medication, because she had a window from 6:00 a.m., to 10:00 a.m. The record for Resident 146 was reviewed on 11/1/22, at 8:35 a.m. A physician's order indicated the resident was to receive levothyroxine 100 mcg tablet one time daily for hypothyroidism. A Medication Summary document from electronic		consequences from the alleged deficient practice. Residents #143 and #86 no longer reside in the community. It is the policy of Marquette to be free from medication rates of 5% or more. II. All residents receiving medications have the potential to be affected. Additionally, all residents receiving levothyroxine have been reviewed for appropriate timing with meals. Records have been updated as appropriate for administration time and resident preference. No residents currently receiving insulin injection via pen. III. The Administering Medications Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on the Administering Medications Policy including administering medications in accordance with the order and any required time frame. Observations on medication administration, including medication administration time and insulin injection via pen, have been completed with all Health Center Licensed Nursing Staff. Additional systemic changes are being addressed through our quality assurance process described below.	

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	medical record, dated 10/22, indicated Levothyroxine should be taken by mouth as directed by the doctor, on an empty stomach, and 30 minutes to 1 hour before breakfast. The summary further indicated, the absorption of levothyroxine in the stomach was decreased when taken at the same time as calcium, iron, some foods and other drugs. 2. During a medication observation, beginning on 11/1/22 at 8:52 a.m., LPN 3 was observed to prepare 10 medications for Resident 143. LPN 3 reviewed the orders for Resident 143 and punched the medications into a medication cup. One of the order's indicated she was to take Methotrexate three 2.5 mg (milligram) tablets. LPN 3 was unable to locate the medication in the med cart and she indicated she would have to contact the pharmacy because the medication was not available. The record for Resident 143 was reviewed on 11/1/22 at 10:00 a.m. A physician's order indicated the resident was to receive Methotrexate three 2.5 mg tablets for rheumatoid arthritis (a chronic inflammatory disorder affecting many joints). A Medication Summary document from electronic medical record, dated 3/22, indicated Methotrexate was used to treat rheumatoid arthritis During an interview, on 11/2/22 at 1:00 p.m., the Director of Nursing (DON) indicated staff should administer medication as ordered by the physician and pharmacy recommendations. The DON would not indicate her expectation for administering Levothyroxine and food intake when asked. 3. During a medication administration observation, on 10/31/22 at 12:22 p.m., LPN 1 dialed the amount of insulin needed to cover the resident's blood sugar from the resident's Kwik pen (a pre filled		IV. Director of Nursing or designee will: Observe medication administration for accuracy and medication errors, weekly x 12 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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	cartridge of insulin which is attached to a needle for administration) and indicated she was ready to give the resident her insulin. She was not observed to prime (remove the air) from the insulin needle. During an interview, at that time, LPN 1 indicated she was not aware she needed to prime the needle and she was never educated on the process. The record for Resident 86 was reviewed on 10/31/22 at 3:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension (high blood pressure) and pain. A physician's order, dated 10/30/22, indicted the resident was to receive insulin at 7:30 a.m., 12:30 a.m., and 5:30 p.m., dependent upon the resident's blood sugar at that time. A current policy, titled "Insulin Pen Administration," dated as revised on 08/2017 and provided by the Director of Nursing on 11/01/22 at 2:30 p.m., indicated "...9. Attach the needle to the end of the pen and prime pen. 10. Prime pen by dialing the dose knob to select 2 units. Then hold pen upright and tap cartridge to remove any air bubbles. Net depress the dose knob until "0" is seen in the dose window and hold doses knobby for 5 seconds. You should see insulin at the tip of the needle. A current policy, titled "Administering medications," dated 12/12, indicated medications must be administered in accordance with the order including any required time frame. 3.1-48(c)(1)			
F 0812 SS=D	483.60(i)(1)(2) Food			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview and record review, the facility failed to ensure proper hand hygiene was completed with the distribution of food and assistance with feeding in accordance with the professional standards for food service safety for 2 of 2 staff members randomly observed during food service. (An unidentified staff member and LPN 2) Findings include: 1. During an observation, on 10/31/22 at 12:06 p.m., an unidentified staff member walked into the dining room, up to the food service window. She used her right hand to sweep over her bangs and tucked hair behind her right ear. The staff member grabbed a tray with a resident's lunch and left the	F 0812	I. No residents had any negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure proper hand hygiene is completed with the distribution of food and assistance with feeding in accordance with the professional standards for food service safety. II. All 27 residents in the second-floor dining room, have the potential to be affected. No residents have experienced any negative consequences. III. The Assistance with Meals Policy has been reviewed and found to meet clinical	12/20/2022

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	dining room to carry to the room. She did not perform hand hygiene at no time after she touched her hair and before she grabbed the resident's tray. 2. During an observation, on 10/31/22 at 12:15 p.m., Licensed Practical Nurse (LPN) 2 was observed to walk next to Resident 69 with a glove on her right hand, bent over and picked up a knitted blanket off the floor behind her. At 12:16 p.m., LPN 2 touched her N95 mask with her right gloved hand. LPN 2 then started to remove the lids and plastic wrap from the food items, picked up the spoon and started to feed Resident 69. LPN 2 did not perform hand hygiene at any time after she picked up the blanket off the floor. During an observation, on 10/31/22 at 12:29 p.m., Resident 69's blanket had fallen on the floor behind her. At 12:30 p.m., LPN 2 reached down to the floor with her right hand and placed the blanket on the back of Resident 69's chair. LPN 2 did not perform hand hygiene at any time after she picked up the blanket off the floor. During an interview, on 10/4/22 at 2:14 p.m., the Director of Nursing (DON) indicated staff should perform hand hygiene before they assisted Resident 69 with meals, when they picked up an object off the floor or when touching their hair or mask. A current policy, titled "Assistance with Meals," dated 3/22, indicated employees would engage in hand hygiene after contact with objects or after personal contact with hair, face, or personal protective equipment. 3.1-21(i)(3)		standards. Education provided to Health Center Nursing Staff on the Assistance with Meals Policy including proper hand hygiene completion with the distribution of food and assistance with feeding in dining room. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit compliance with proper hand hygiene during mealtime, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 27, 28, 31, November 1, 2, and 3, 2022 Facility number: 000105 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 15, 2022.	R 0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. Marquette is requesting a desk review of the following materials.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the			

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	resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to provide signed service plans for 5 of 7 residents reviewed for service plans. (Resident 1, 2, 4, 5 and 6) Findings include: 1. The record for Resident 1 was reviewed on 11/03/22 at 11:03 a.m. Diagnoses included, but were not limited to, mild cognitive impairment, high blood pressure and constipation. The record for Resident 1 had a current service plan although it was not signed by the resident or resident's representative. 2. The record for Resident 2 was reviewed on 11/03/22 at 1:04 p.m. Diagnoses included, but were not limited to, atherosclerosis (hardening of the arteries), artificial heart valve and coronary artery bypass. The record for Resident 2 had a current service plan although it was not signed by the resident or	R 0217	**R0217 410 IAC 16.2-5-2(e)(1-5) Evaluation** I. Resident #1, #2, #4, #5, and #6, had no negative consequences from the alleged deficient practice. These residents have had their service plans signed. It is the practice of Marquette to provide signed service plans for all residents. II. All residents have the potential to be affected. 50 Resident charts have been audited for Service Plan signature of resident or representative. 47 additional residents found to be lacking signatures. Marquette has ensured all Assisted Living residents service plans have a signature of resident or representative. III. The Resident Care Individual Service Plan Policy was reviewed and found to meet	12/20/2022

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	resident's representative 3. The record for Resident 4 was reviewed on 11/03/2022 at 1:23 p.m. Diagnoses included, but were not limited to, dementia, insomnia and high blood pressure. The record for Resident 4 had a current service plan although it was not signed by the resident or resident's representative. 4. The record for Resident 5 was reviewed on 10/25/2022 at 1:35 p.m. Diagnoses included, but were not limited to, edema (swelling), confusion and heart failure. The record for Resident 5 had a current service plan although it was not signed by the resident or resident's representative. 5. The record for Resident 6 was reviewed on 11/03/22 at 1:05 p.m. Diagnoses included, but were not limited to, muscle weakness, chronic kidney disease and low back pain. The record for Resident 6 had a current service plan although it was not signed by the resident or resident's representative. During an interview, on 11/03/22 at 1:49 p.m., the Assisted Living Director indicated she was unaware the resident's service plans needed to be signed by the resident or resident's representative. A current policy, titled "Resident Care Individual Service Plan," undated and provided by the Assisted Living Director on 11/3/22 at 3:43 p.m., indicated " ...The Resident and/or responsible party/family will sign and date the Individualized		clinical standards. Education provided to Assisted Living Licensed Nursing Staff on the Resident Care Individual Service Plan Policy including resident or resident representative signature. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Assisted Living Director or designee will: Audit 20% of all residents for completed service plans with signature, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: December 20th, 2022.	

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