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	02/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00373411. Complaint IN00373411 - Substantiated. State deficiencies related to the allegations are cited at R27, R52 and R90. Survey date: February 24, 2022 Facility number: 000105 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 2, 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.	
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation, interview and record review, the facility failed to ensure the call light was in reach for 1 of 3 residents reviewed for accommodation of needs. (Resident C) Finding includes: During an observation of Resident C, on February 24, 2022 at 8:56 a.m., with CNA 8 in attendance, the resident was found to be in a low	R 0027	**R 027 410 IAC 16.2-5-1.2(b) Residents' Rights – Deficiency** I. Resident C experienced no harm. Call light was immediately placed within reach of Resident C. II. All residents who are able to utilize the call light have the potential to be affected. This is being addressed by the systems	04/01/2022

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

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	bed and her eyes were open. The call light was not observed to be close to the resident. At that time, CNA 8 located the call light to the left of the resident, on the floor, at the head of the bed. CNA 8 indicated Resident C probably could not reach the call light and it should have been within the resident's reach. During an interview, on February 24, 2022 at 8:57 a.m., QMA 9 indicated Resident C was able to use the call light. During an interview, on February 24, 2022 at 1:49 a.m., the Assistant Director of Nursing indicated it was her expectation for call lights to be within reach of residents who could use them. A current facility policy, titled "Answering the Call Light," dated as revised in March 2021 and provided by the Assistant Director of Nursing on February 24, 2022 at 2:22 p.m., indicated "...When a resident is in bed...be sure the call light is within easy reach of the resident. This State finding relates to Complaint IN00373411.		described. III. The "Answering the Call Light" policy was reviewed and found to meet clinical standards. Re-education provided to Reflections Memory Care Nursing Staff on policy for answering the call light including when a resident is in bed, be sure the call light is within easy reach of the resident. Additional systemic changes are being addressed through our quality assurance process described below. IV. Director of Nursing or designee will: Audit a random sample of 25% of residents on memory care unit for compliance with call lights within reach, Monday thru Friday for 8 weeks, 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: April 1st, 2022	

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R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when a resident exited the facility from a first floor window and was found eight feet below the window, on the ground, outside of the facility for 1 of 3 resident's reviewed for neglect. (Resident C) Findings include: During an observation of the facility, with Maintenance Staff 7 and Maintenance Staff 6, on February 24, 2022 beginning at 8:35 a.m., the windows of the second floor were observed to be Casement Windows (windows which open outward up to a 90 degree angle) which used a crank to open the window. During the observation, Maintenance Staff 7 indicated the cranks had been removed from the windows and they cannot be opened. When opened, there was about a 12-14 inch opening and it was possible to fall out. He further indicated there was an incident on the Reflections Unit located on the first floor, a memory care unit, and all cranks had been removed from those windows and other cranks were being removed from other areas as they are observed to still be in place. During the observation, an attempt was made to open a window which did not have a crank handle. The task was not accomplished. The windows in the memory care unit were also observed to be	R 0052	**R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights – Offense** I. Resident C was affected but resolving without complications. Resident C voices no concerns. It is the policy of Marquette to honor Residents Rights. II. All independently mobile residents with exit seeking behaviors have the potential to be affected. All memory care residents' charts reviewed, elopement assessments updated as indicated, and interventions in place. Casement Windows (windows which open outward up to a 90-degree angle) have been modified to remove cranks from all windows, to prevent opening to a 90-degree angle. III. Education provided to all Reflections Memory Care Staff on Casement Window modification and Behavior Management Program including applicable interventions for residents with exit seeking and/or other behaviors. Additional systemic changes are being	04/01/2022

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	without the crank mechanism needed to open the windows. During an independent observation of the activity room windows, on the memory care unit, Reflections, on February 24, 2022 at 8:51 a.m., it was noted to have multiple casement window without cranks and a larger picture window which did not open. The room was large. It contained a television and the nursing office as well. Another room behind a closed door was located adjacent to the activity room and the majority of the activity room was visible from the area. During an observation of the window, in the activity room, on the memory care unit, with Maintenance Staff 6, on February 24, 2022 at 9:15 a.m., the window was observed to be missing a crank handle. Maintenance Staff 6 opened the window, with the handle he had produced. The window was observed to open outward at approximately a 45 degree angle. The distance from the base of the window to the ground was accurately determined using the maintenance staff's tape measure. The measurement of the window provided by the Director of Nursing on February 24, 2022 at 2:16 p.m., was 58 inches by 32 inches. The record for Resident C was reviewed on February 24, 2022 at 10:26 a.m. Diagnoses included, but were not limited to, dementia, anxiety and depressive disorder. An elopement risk assessment, dated January 03, 2022, indicated the resident had expressed desire to go home, wandered aimlessly and the family/responsible party had voiced concerns to indicate the resident may have wandering tendencies or try to leave.		addressed through our quality assurance process described below. IV. Supervisor of Plant Operations or designee will: Audit all casement windows for security twice weekly for 8 weeks, weekly x 12 weeks, then monthly for a total duration of 12 months. Director of Social Services or designee will: Audit resident behaviors including documentation, exit seeking and appropriate interventions twice weekly for 8 weeks, 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: April 1st, 2022	

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A fall risk assessment, dated January 03, 2022, indicated the resident had intermittent confusion and was ambulatory (could walk).

A document, titled "Follow Up Visit Note," dated January 03, 2022, indicated nurses reported increased anxiety/activity at night, often comes out of her room at night and roams halls, knocks on other resident's doors, takes others belongings and was difficult to redirect. Her behaviors were increasing.

A report from the hospital indicated Resident C "...apparently climbed out of ground-level window in her memory care unit...." she was complaining of right hip pain. Per the hospital records, the resident had sustained a fractured pelvis.

A partial statement of events, written by CNA 1 on January 8, 2022, indicated around 6:15 a.m., Resident C was peeking out of her room so CNA 1 dressed her for breakfast and left her in her room. The resident was looking out of her window, looking for someone. The CNA went to assist other residents. Resident C came out of her room and went to the activity room where she was looking out the window and tried to open them. She insisted someone was outside. The CNA moved the resident from the windows. The resident wandered into another resident's room. The CNA removed her from the room and assisted another resident to get dressed. She heard QMA 5 calling and ran out of the room. When CNA 1 asked what had happened, QMA 5 indicated Resident C "...jumped out of the window...."

The second half of the statement of events,

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	written by CNA 1, indicated Resident C had opened two windows and a chair was close to the window "...where she jumped from...." A statement of events, written by LPN 3, on January 08, 2022, indicated Resident C "...went out the window...This nurse saw fully clothed resident on the frosted covered ground...." A statement of events, written by LPN 4, on January 08, 2022, indicated around 6:55 a.m., QMA 5 rushed outside and Nurse 3 was in quick response regarding a "...jumped-out incident..." on the Reflections Memory Care Unit involving Resident C, who opened the windows in the activity area. A statement of events, written by QMA 5, indicated Resident C was last seen up and about wandering in the activity room. The resident was repeating "...I have to find the kids...." Resident C went over to the blinds and started to lift them up in search of her kids. She was redirected. The resident's behavior changed and she was seen entering another resident's room. The resident was redirected. The writer of the statement then left the nursing station and was out of direct eyesight of Resident C for approximately 10 minutes. When QMA 5 returned to the nursing station, she noticed the resident was not present in the activity area. When QMA 5 attempted to search for the resident, she noticed an open window in the activity room. Upon further investigation and calling out the resident's name, she did get a response. QMA 5 looked out the window and saw the resident on the ground. The resident "...had jumped outside from the window...." A nursing note, dated January 08, 2022 at 7:00			

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	a.m., indicated "QMA...heard yelling outside for help...window in activity area. She looked down...saw her sitting on the ground...." During an interview, on February 24, 2022 at 12:06 p.m., the Director of Nursing indicated she understood the window shifted open, and there was a latch which could be lifted up and if the window was not locked, it could be pushed open. She did not know if a resident in "that mental condition" could crank open the window, pressure needed to be applied and the window would open. It could be "punched out" for fire safety. Resident C had to open the window. All staff were to check the windows to ensure they were not open and staff had reported the window was not open. During a telephone interview, on February 24, 2022 at 12:42 p.m., the spouse of Resident C indicated he received a call from a lady at the facility wanting permission to send Resident C to the hospital. When he asked why, the lady told him Resident C had jumped out a window. He received a call the next day informing him, the issue had been taken care of. The windows could no longer be opened. During a telephone interview, on February 24, 2022 at 3:11 p.m., QMA 5 indicated when she received report that morning, nothing out of the normal was relayed except Resident C had been up that night. She did not observed the incident. She did see the resident in the activity room, around the windows, and redirected her. QMA 5 left the area and assisted with getting residents ready as there was only her and a CNA on the unit. Upon her return to the activity room, the room felt cold. She investigated the area, found an open window and the resident on the ground			

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	outside the window. QMA 5 indicated she had taken report, in the activity room, earlier that morning and would have noticed an open window. She did observe a chair by the window and the resident was outside on the ground. A current facility policy, titled "It is the practice...to promote...safety within the community population...Maintenance Services-Facility Safety," dated as reviewed October 10, 2021 and provided by the Director of Nursing on February 24, 2022 at 3:39 p.m., indicated "...personnel will conduct regular rounds of resident rooms, common areas, dining spaces, kitchens, offices, recreational spaces, etc.-to identify needed improvements, repairs, or adjustments to functionality...." This was the only policy provided for safety in the environment and to residents. This State finding relates to Complaint IN00373411.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;			

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	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to report the full details of an incident which resulted in a fractured hip when the resident dropped eight feet to the ground, outside of the facility, from a first floor window for 1 of 3 residents reviewed for accidents. (Resident C)	R 0090	**R 090 410 IAC 16.2-5-1.3(g)(1-6) Administration and Management – Deficiency** I. Resident C was affected but resolving without complications. Resident C voices no concerns.	04/01/2022

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	Finding includes: During an observation of the window, in the activity room, on the memory care unit, with Maintenance Staff 6, on February 24, 2022 at 9:15 a.m., the window was observed to be missing a crank handle. Maintenance Staff 6 opened the window, with the handle he had produced. The window was observed to open outward at approximately a 45 degree angle. The distance from the base of the window to the ground was accurately determined using the maintenance staff's tape measure. The measurement of the window provided by the Director of Nursing on February 24, 2022 at 2:16 p.m., was 58 inches by 32 inches. A partial statement of events, written by CNA 1 on January 8, 2022, indicated around 6:15 a.m., Resident C was peeking out of her room so CNA 1 dressed her for breakfast and left her in her room. The resident was looking out of her window, looking for someone. The CNA went to assist other residents. Resident C came out of her room and went to the activity room where she was looking out the window and tried to open them. She insisted someone was outside. The CNA moved the resident from the windows. The resident wandered into another resident's room. The CNA removed her from the room and assisted another resident to get dressed. She heard QMA 5 calling and ran out of the room. When CNA 1 asked what had happened, QMA 5 indicated Resident C "...jumped out of the window...." The second half of the statement of events, written by CNA 1, indicated Resident C had opened two windows and a chair was close to the		II. Residents who have reportable incidents have the potential to be affected. This is being addressed by the systems described. III. Education to be provided to Administrator and Director of Nursing on process for reporting incidents. All Reflections Memory Care Nursing Staff educated on current reportable guidelines. Additional systemic changes are being addressed through our quality assurance process described below. IV. Executive Director or designee will: Audit all resident unusual occurrence reportable events upon submission of initial and follow up review 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: April 1st, 2022	

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	window "...where she jumped from...." A statement of events, written by LPN 3, on January 08, 2022, indicated Resident C "...went out the window...This nurse saw fully clothed resident on the frosted covered ground...." A statement of events, written by LPN 4, on January 08, 2022, indicated around 6:55 a.m., QMA 5 rushed outside and Nurse 3 was in quick response regarding a "...jumped-out incident..." on the Reflections Memory Care Unit involving Resident C, who opened the windows in the activity area. A statement of events, written by QMA 5, indicated Resident C was last seen up and about wandering in the activity room. The resident was repeating "...I have to find the kids...." Resident C went over to the blinds and started to lift them up in search of her kids. She was redirected. The resident's behavior changed and she was seen entering another resident's room. The resident was redirected. The writer of the statement then left the nursing station and was out of direct eyesight of Resident C for approximately 10 minutes. When QMA 5 returned to the nursing station, she noticed the resident was not present in the activity area. When QMA 5 attempted to search for the resident, she noticed an open window in the activity room. Upon further investigation and calling out the resident's name, she did get a response. QMA 5 looked out the window and saw the resident on the ground. The resident "...had jumped outside from the window...." A nursing note, dated January 08, 2022 at 7:00 a.m., indicated "QMA...heard yelling outside for help...window in activity area. She looked			

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	down...saw her sitting on the ground...." An incident report, filed with the Indiana State Department of Health, indicated "...Description added...1/8/2022... Resident was ambulating in the activity room of her residential care unit when she lost her balance and experienced a fall. Staff reported that resident appeared to be looking out the window when she fell. During her fall, resident scraped her knee on the window sill. Resident was immediately assisted and assessed by facility staff. Resident family and physician immediately notified...." The description of the incident did not include the resident had exited the facility through a window. A copy of the facility's incident report was requested and provided by the Director of Nursing on February 24, 2022 at 12:15 p.m. The incident report included additional information which indicated "resident suffered an injury from her unobserved fall. When staff assisted the resident, she was position toward the outside of the window on the first floor...." During an interview, on February 24, 2022 at 12:59 p.m., the Director of Nursing indicated the additional follow up added to the incident report provided was "possibly" done the next day. That information was not provided to the Indiana State Department of Health. During an interview, on February 24, 2022 at 12:06 p.m., the Director of Nursing indicated she had "no idea" why the facility did not disclose, on the incident report filed with the Indiana State Department of Health, the resident exited the facility through a first floor window which resulted in the fracture. She indicated it was the way the report was written.			

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy, titled "Accidents and Incidents-Investigating and Reporting," dated as revised in July 2017 and provided by the Director of Nursing on February 24, 2022 at 2:22 p.m., indicated "...The following data...shall be included on the Report of Incident/Accident form...The circumstances surrounding the accident or accident...." This State finding relates to Complaint IN00373411.			