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	11/29/2022

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00395442. Complaint IN00395442 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F580. Survey dates: November 28 and 29, 2022. Facility number: 000105 Provider number: 155198 Census Bed Type: SNF: 56 Total: 56 Census Payor Type: Medicare: 56 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 8, 2022.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;			

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

Jeffrey Cox | Administrator | 12/23/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	11/29/2022

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
	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations			

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	11/29/2022

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
	under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician and resident representative of an unwitnessed fall until six (6) day after the event had occurred for 1 of 3 residents reviewed for notification of change. (Resident C) Finding includes: The record for Resident C was reviewed on 11/28/22 at 2:04 p.m. Diagnoses included, but were not limited to, unspecified dementia severe with anxiety, unspecified dementia severe with mood disturbance and age-related physical debility. There was no documentation in the record to indicate the physician or resident representative had been notified of the fall on the day of the incident, 10/29/22. During an interview, on 11/29/22 at 8:42 a.m., the Director of Nursing indicated the facility was not aware Resident C had fallen until during an investigation related to an injury to the resident's right shoulder. They interviewed LPN 2 and found out Resident C had fallen. They had an event report filled out by LPN 2 and the interdisciplinary team did make a note of the fall. LPN 2 informed the facility of the fall during the interview, on 11/04/22, via telephone. LPN 2 should have written a progress note and notify the physician, as well as the family. During an interview, on 11/29/22 at 9:59 a.m., the Director of Nursing indicated the event report was not completed by LPN 2, until 11/04/22, and it should have been completed on the day of the fall. The family and physician were notified on 11/03/22; they should have been notified the day	F 0580	I. Resident C was affectedand is resolving without complications. Physician and responsible party were notified on 11/4/22. It is the practice of Marquette to notify the physician and resident representative when there has been an accident or incident involving the resident. II. All residents have the potential to be affected. No residents experienced any negative consequences. An audit of all falls in the past 30 days has been conducted for notification of provider/physician and resident representative. III. The Change in Resident's Condition or Status Policy has been reviewed and found to meet clinical standards. Education provided by Director of Nursing to Health Center Licensed Nurses on the Change in Resident's Condition or Status Policy including notification of providers/physician and resident representative. IV. The Director of Nursing or designee will: Audit all resident related accidents and incidents during daily clinical stand-up, five times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months.	01/16/2023

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	11/29/2022

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
	of the fall. During a telephone interview, on 11/29/22 at 10:18 a.m., LPN 2 indicated Resident C had an un-witnessed fall on 10/29/22. She indicated she did not notify the physician or family because she was busy, and the day got away from her. She forgot to document a progress note. Her responsibility was to do an assessment, do the neurological checks and to make a note. She did go to the facility on 11/04/22 to complete the event report. The resident fell on a Saturday (10/29/22) and she did not report it. The first notification of the fall, to the facility, was on 11/04/22. A facility policy, titled "Change in a Resident's Condition or Status," dated as revised in February 2021 and provided by the Director of Nursing on 11/29/22 at 10:54 a.m., indicated "...The nurse will notify the resident's attending physician or physician on all when there has been a(an)...accident or incident involving the resident...." This Federal tag relates to Complaint IN00395442. 3.1-5(a)(1)		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: Jan. 16, 2023	
F 0689 SS=G 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			

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	11/29/2022

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
	to prevent accidents. Based on observation, interview and record review, the facility failed to report a fall on the date of the fall, failed to document assessments and neurological checks after a fall and failed to transfer a resident using the correct transfer equipment after a fall for 1 of 3 residents reviewed for accidents. (Resident C) Resident C did not receive fall follow up monitoring for side effects related to a fall and was found to have a fracture to the right clavicle six (6) days after the fall. Finding includes: On 11/28/22 at 11:36 a.m., Resident C was observed in a Broda chair, slightly reclined, alone in her room. She appeared clean and dry, with her call light in reach. The resident did not respond to conversation. The record for Resident C was reviewed on 11/28/22 at 2:04 p.m. Diagnoses included, but were not limited to, unspecified dementia severe with anxiety, unspecified dementia severe with mood disturbance and age-related physical debility. The Minimum Data Set assessment, dated 06/10/22, indicated Resident C had a Brief Interview for Mental Status score of 01. (BIMS-screening tool used to assist with identifying a resident's current cognition, scores close to 0 indicate severe cognitive impact). An undated care plan indicated Resident C was as risk for falling due to impaired balance/mobility, vision, and cognition. An intervention indicated "...Assist with mobility as needed. 3/18/21 Use Hoyer (full body mechanical lift) ...as indicated...Status: Active (Current)...."	F 0689	I. Residents C was affected and is resolving without complications. It is the practice of Marquette to report falls at the time of the fall, initiate assessments including neurological checks, utilize the correct transfer device and conduct fall monitoring after a resident's fall. Director of Nursing provided one on one with LPN #2 on 11/4/22 related to Fall Prevention and Management Policy and Procedure including post fall documentation requirements, neurological check procedure and fall monitoring post fall. II. All residents have the potential to be affected. Director of Nursing provided Education to all Licensed Nursing staff related Fall Management Policy and Procedure including post fall documentation requirements, neurological check procedure and fall monitoring post fall. Licensed Nurses and C.N.A's received re-education on transfer device policy and procedure. III. The Fall Prevention and Management Policy, Neurological Assessment Policy and the Abuse Prevention Program Policy have been reviewed and found to meet clinical standards.	01/16/2023

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	11/29/2022

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
	There was no progress note related to the resident's fall on 10/29/22. There was no assessment of Resident C found in the record on the date of the fall on 10/29/22. There were no fall follow-up checks related to the fall on 10/29/22, 10/30/22 or 10/31/22. There was no initial neurological check for the fall, found in the record. There were no neurological rechecks related to the fall on 10/29/22 or the following 72 hours. The vital signs charted into the record on 10/29/22, was a blood pressure at 12:59 p.m., a heart rate at 12:15 p.m., a temperature at 12:59 p.m., an oxygen saturation at 12:59 p.m., and pain at 11:29 a.m. A progress note, dated 11/03/22 at 3:35 p.m., written by LPN 1 indicated "...Writer was called down to resident's room by CNA staff. Writer went to room and upon assessment writer noticed skin discoloration and swelling to resident's right shoulder, right humerus, and right clavicle. Writer noticed resident facial grimacing occurring as writer was completing skin assessment...informed DON (Director of Nursing) ...Hospice and NP (Nurse Practitioner) ...family made aware...received new order for x-rays...to right shoulder, right humorous and right clavicle...V/S WNL (vital signs within normal limits)...." A progress note, dated 11/04/22 at 4:00 p.m., and entered on 11/28/22 at 11:32 a.m., titled "IDT Review" (Interdisciplinary Review), written by the Assistant Director of Nursing indicated "...LATE ENTRY ...Type of Event: Trauma to right shoulder		Education provided to Health Center Licensed Nurses on the Fall Prevention and Management Policy, Neurological Assessment Policy and the Abuse Prevention Program Policy including reporting a fall at the time of the fall, completing assessments and neurological checks of resident post fall, utilizing the proper transfer device in accordance with the resident's plan of care, and conducting fall monitoring after a resident's fall. Licensed Nurses and C.N.A's received re-education on transfer device policy and procedure. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit all falls for completed documentation at time of fall, completed post fall monitoring, proper use of transfer technique and completion of assessments including neurological checks, five 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	

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	11/29/2022

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
	on 11/3/22...ROOT CAUSE: Trauma related to possible unwitnessed fall/advanced age and frailty...." A CNA work list, provided by the Director of Nursing on 11/29/22 at 12:05 p.m., indicated Resident C was to be transferred using a full body lift. A document, provided by the Director of Nursing on 11/29/22 at 9:59 a.m., titled "Skilled Nursing Visit Note (name of company) Hospice" indicated "...Date of Visit 10/31/22...Integumentary (skin)...Pallor...Warm...Dry ...Loose/Lacks tone...." An untitled document, provided by the Director of Nursing on 11/28/22 at 4:30 p.m., indicated "...Appt. Date/Time 11/03/22 11:46 a.m...female...is being seen today for reports of new onset right arm pain this am...Nurse was called to room when pt (patient) was moaning this morning during cares c/o (complaint of) her right arm hurting...On assessment nurse found scattered bruising to right shoulder and right upper back...The right shoulder was also noted to be swollen...No known falls or injuries have been reported...Will obtain XR (x-ray) of right humerus, right shoulder and right clavicle...Differentials include trauma related to unwitnessed fall, transfer trauma or spontaneous injury due to advance frailty...." The document was signed by the Nurse Practitioner 5 on 11/03/22 at 12:22 p.m. An x-ray result, provided by the Director of Nursing on 11/29/22 at 10:55 a.m., indicated "Date of Service 11/03/22...Conclusion: Fractured Clavicle...." A document, dated 11/04/22, provided by the Director of Nursing on 11/29/22 at 9:59 a.m., titled		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: Jan. 16, 2023	

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	11/29/2022

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
	"Event Report (Quality Assurance/Confidential)" indicated Resident C fell on 10/29/22 at 7:30 a.m. There was no injury noted, neuro (Neurological) checks were within normal limits for the resident and range of motion was within normal limits. Resident C's vital signs were documented on the sheet. The physician and responsible party were notified on 11/03/22. A head-to-toe assessment was completed. The immediate intervention was the resident was moved to the nurse's station. The document had LPN 2's printed name on the signature line. The resident was unable to state if she was "alright". The form was signed by the Director of Nursing on 11/04/22. A document, provided by the Director of Nursing on 11/28/22 at 4:30 p.m., titled "Investigation Conclusion Statement" indicated "Interviewed Nurses/CNAS assigned to resident 11/3, 11/4... (CNA 4) called 11/3/22 via phone with other members of management present. Asked...if she had noticed any changes...CNA stated she had not seen anything on the resident when initially asked. CNA was asked to confirm how resident was to be transferred and CNA stated she sometimes use the stand-lift, sometimes picks up resident or use (name of full body lift) by herself. CNA was asked if resident had anything on right side of her forehead and CNA stated, "yes where she picked a mole off, I told the nurse". I informed CNA she needed to come in on 11/4/22 to discuss...regarding the resident. CNA agreed. CNA did not come in but placed a letter under DON (Director of Nursing) door...." On the same document it was noted LPN 2 was called on 11/04/22 and she was asked if there were any changes with Resident C "...she was not aware of anything. Asked nurse did resident have a fall and nurse stated yes. She stated fall was on 10/29 and that CNA came to report that resident			

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	11/29/2022

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
	slid down from her chair. Nurse stated she completed assessment and vitals. No visual skin changes...." During a telephone interview, on 11/28/22 at 2:59 p.m., the family member of Resident C indicated he believed the last fall was when the resident injured her shoulder and the Director of Nursing had investigated the fall. He indicated the resident did get really agitated and it had been happening a lot lately. During an interview, on 11/28/22 at 3:40 p.m., LPN 1 indicated CNA 3 informed her Resident C had bruising. LPN 1 went to the resident's room and performed an assessment and found bruising at the right shoulder area. She notified the Director of Nursing. LPN 1 indicated the resident did not fall on her shift. The resident was still in bed when she was notified of the injury and went to assess her. During a telephone interview, on 11/28/22 at 3:49 p.m., CNA 4 indicated she was walking in the hall when she observed Resident C on the floor. She reported the resident on the floor to LPN 2. She did assist LPN 2 to get the resident off the floor and into the Broda chair (a wheelchair which tilts, reclined and had footrests). She did not observed LPN 2 to assess Resident C's vital signs. CNA 4 indicated LPN 2 asked her not to say anything and CNA 4 informed LPN 2 she did what she was supposed to do, she reported it to the nurse. During an interview, on 11/29/22 at 8:42 a.m., the Director of Nursing indicated the facility was not aware Resident C had fallen until they began interviewing staff. They have an event report filled out by LPN 2 and the interdisciplinary team did make a note of the fall. Upon investigation			

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	11/29/2022

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
	related to an injury to the right shoulder, they interviewed LPN 2, due to lack of documentation, to find out if Resident C had fallen. LPN 2 did inform the facility of the fall during the interview. The interview took place on 11/04/22, via telephone. The facility could not determine if the shoulder/clavicle fracture was a result of the fall. The hospice provider was in around 11/01/22 and assessed the resident. They did not find any bruising or signs of injury. On 11/03/22, CNA 3 reported to LPN 1 of bruising she found. LPN 2 requested the Director of Nursing observed the injury and the Director of Nursing noted the bruising. She did interview a CNA and found the CNA reported using a stand-up lift. The resident was to be transferred using a full body lift, not a stand-up lift. The improper transfer may have been a cause of the injury. The CNA had provided a written statement and then later verbally spoke of the fall. The CNA was asked to come into the facility and write a statement, instead she slid a written statement under the Director of Nursing's door. The Director of Nursing indicated LPN 2 should have written a progress note and notify the physician, as well as the family. During an interview, on 11/29/22 at 9:59 a.m., the Director of Nursing indicated the event report was not completed by LPN 2 until 11/04/22 and should have been completed on the day of the fall. The neurological checks and fall follow-up monitoring should have been completed for 72 hours after the fall. The family and physician were notified on 11/03/22; they should have been notified the day of the fall. Neurological checks were not completed because they were not aware of the fall until after the 72 hours had passed. The facility had an Interdisciplinary Team meeting around 11/06/22, but the documentation was not entered into the record until 11/28/22 because they were			

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	11/29/2022

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
	working on a plan of correction until 11/28/22. During a telephone interview, on 11/29/22 at 10:18 a.m., LPN 2 indicated Resident C had an un-witnessed fall on 10/29/22. The CNA came and informed her the resident fell. The resident was found on her back perpendicular to the Broda chair, and it looked like she slid out of the chair. She assessed the resident's vital signs, did the initial neurological check and then both her and the CNA transferred the resident into the Broda chair by lifting the resident. She lifted Resident C from under her arms and the CNA lifted the resident at the knees. She believed the resident was a fully body mechanical lift but there was no lift pad in the chair and the resident only weighed about 80 pounds. She did complete the initial neurological check on the resident but was unable to indicate where the documentation could be found and believed it was documented on paper. She did not notify the physician or family because she was busy, and the day got away from her. She did forget to document a progress note. Her responsibility was to do an assessment, do the neurological checks and to make a note. She did go to the facility, on 11/04/22, to complete the event report. The resident fell on a Saturday (10/29/22) and she did not report it. The first notification of the fall, to the facility, was on 11/04/22. A facility policy, titled "FALL PREVENTION AND MANAGEMENT," dated as last reviewed June of 2021, and provided by the Director of Nursing on 11/28/22 at 4:30 p.m., indicated "...Steps following a fall...Head to toe evaluation by a licensed nurse if completed before resident is moved...If the fall is unwitnessed neurological assessments will be conducted according to the neurological assessment policy...Documentation will include			

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	11/29/2022

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
	incident report/event report completion, the nurse's notes, and a fall investigation...Follow up resident assessment and documentation for seventy-two (72) hours will be completed in the medical record...." A facility policy, titled "ABUSE PREVENTION PROGRAM," dated May 2017 and provided by the Director of Nursing on 11/29/22 at 12:05 p.m., indicated "...Neglect...failure of the facility, its employees or service providers, to provide...services necessary to avoid physical harm, pain, mental anguish or emotional distress...." A facility policy, titled "Neurological Assessment," dated as reviewed in May 2018 and provided by the Director of Nursing on 11/29/22 at 10:54 a.m., indicated "...The purpose of this procedure is to provide guidelines for a neurological assessment...when following an unwitnessed fall...Neurological assessments are indicated...Following an unwitnessed fall...assessments will be documented on the neurological assessment tool...and completed as follows...Every 15 minutes for 60 minutes (1 hour)...Every 30 minutes for 60 minutes (1 hour)...Every 60 minutes for 120 minutes (2 hours)...Every shift for 72 hours...." This Federal tag relates to Complaint IN00395442. 3.1-45(a)(1) 3.1-45(a)(2)			