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	01/18/2024

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00416352 and Residential Complaint IN00423410. Complaint IN00416352 - Federal/State deficiencies related to the allegations are cited at F684 and F689. Complaint IN00423410 - No deficiencies related to the allegations are cited. Survey dates: January 11, 12, 16, 17 and 18, 2024. Facility number: 000105 Provider number: 155198 Census Bed Type: SNF: 53 Residential: 67 Total: 120 Census Payor Type: Medicare: 20 Other: 33 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 29, 2024.	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.	
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr			

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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Bldg. 00	§483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the bed hold policy was provided to the resident and/or responsible party at the time of the hospital transfer for 1 of 1 resident reviewed for hospitalization. (Resident 54) Finding includes: The record for Resident 54 was reviewed on 1/18/24 at 2:34 p.m. Diagnoses included, but were	F 0625	I Resident #54 no longer resides in community and had no negative consequences from the alleged deficient practice. It is the practice of Marquette to provide the bed hold policy to the resident and/or responsible party at the time of the hospital transfer. II All residents, transferred to the hospital, have	02/15/2024

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	not limited to, acute respiratory failure, congestive heart failure (CHF), atrial fibrillation, atherosclerotic heart disease of native coronary artery (a narrowing of the artery), hypertensive heart, and chronic kidney disease. A nursing progress note dated 11/16/23 at 10:41 a.m., Licensed Practical Nurse (LPN) 2 indicated the resident had an oxygen saturation of 65 to 78 percent on 4 liters of oxygen. The resident was tired with rapid breathing, shaking, and back pain. The Nurse Practitioner was called, and an order was received to send the resident to the hospital for evaluation. The resident's daughter who was also the resident's power of attorney was called and updated on the resident's condition and the order to transfer the resident to the hospital. There was no bed hold policy or transfer documentation in the record. During an interview, on 1/18/23 at 3:30 p.m., the ADON (Assistant Director of Nursing) indicated she was unable to find any documentation the bed hold policy was provided to the resident or resident representative when the resident was hospitalized. She indicated when a resident transferred to the hospital a bed hold policy and resident information should be given to the resident/resident representative. A current policy, titled "Transfer or Discharge, Facility-Initiated," dated 10/2022 and received from the ADON on 1/18/24 at 5:25 p.m., indicated "...residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, the resident's return is generally expected...notice of transfer is provided to the resident/representative as soon as practicable before the transfer and to		the potential to be affected. III The Transfer or Discharge – Facility-Initiated Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on the Transfer or Discharge – Facility-Initiated Policy including providing the bed hold policy to the resident and/or responsible party at the time of the hospital transfer. IV The Director of Nursing or designee will: Audit all residents' documentation after transfer to a hospital to include the bed hold policy, daily after a hospital transfer has occurred 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.	

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	the long-term care (LTC) ombudsman when practicable (e.g. in a monthly list of residents that includes all notice content requirements)...notice of facility bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer...notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments...nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge...." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that 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 observation, interview and record review, the facility failed to ensure a resident with compression gloves had a physician's order, a care plan and staff were educated on the use of the compression gloves for 1 of 2 residents reviewed for edema (Resident B), and failed to ensure an unlicensed staff member did not move a resident before reporting an incident and having the resident assessed for 1 of 3 residents reviewed	F 0684	I Resident B has had no negative consequences from the alleged deficient practice. Resident C was affectedbut resolving without complications. It is the practice of Marquette to ensure a resident with compression gloves have a physician's order, care plan, and	02/15/2024

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	for accidents. (Resident C) Findings include: 1. During an observation, on 1/11/24 at 12:09 p.m., the Resident B was noted to have edema in his hands with compression gloves on both hands. During an observation, on 1/16/24 at 2:29 p.m., the resident did not have compression gloves on his hands. His bilateral hands are edematous. The clinical record for Resident B was reviewed on 1/16/24 at 11:23 a.m. The diagnoses included, but were not limited to, paroxysmal atrial fibrillation, type 2 diabetes mellitus with neuropathy, and idiopathic peripheral autonomic neuropathy. There was no physician's order for the compression gloves. A therapy progress note, dated 12/26/23, indicated the DON (Director of Nursing) and the NP (Nurse Practitioner) requested bilateral compression gloves for increased swelling in the resident's hands. The Occupational Therapy Assistant applied bilateral compression gloves with ¾ finger length to allow for monitoring of the fingertips. The resident was educated on the purpose of the compression gloves. There was no documentation the staff was educated on the use of the compression gloves. A review of the Medication Administration and Treatment Records, for 12/2023 through 1/17/24, indicated the compression gloves were not documented in the records.		staff education and that unlicensed staff members do not move a resident before reporting an incident and having the resident assessed. II All residents have the potential to be affected. An audit of all residents with compression garments conducted and physician's orders and care plans verified and added as indicated and staff education completed. III The Fall Prevention and Management Policy has been reviewed and found to meet clinical standards. Additionally, the Assistive Devices and Equipment Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff on the Fall Prevention and Management Policy and the Assistive Devices and Equipment Policy including that unlicensed staff members do not move a resident before reporting an incident and having the resident assessed and the education, care plan and physician's orders for compression gloves. IV The Director of Nursing or designee will: Audit all residents with falls for proper procedure with assessment and all residents with compression	

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	There was no care plan for the use of compression gloves. During an interview, on 1/18/24 at 1:24 p.m., the ADON (Assistant Director of Nursing) indicated the resident had the compression gloves for edema in his hands. The compression gloves were not documented on the medication or treatment records. She was not aware of how the information for donning and doffing the compression gloves were shared with staff.2. A facility reportable incident report, dated 6/24/23 at 11:01 p.m., indicated Resident C experienced a fall while showering in her restroom (assisted). Following the fall/shower, the resident was noted with increased pain/swelling to left knee and complaint of neck pain during the nursing assessment. The resident was transported to the hospital for further evaluation and treatment. A written statement of events, untitled, dated 6/24/23 and not timed, by Certified Nurse Aide (CNA) 4 indicated CNA 4 was giving Resident C a shower between 7:00 to 7:30 p.m. The resident was placed on the shower chair. The CNA turned around and took the soap off the paper towel dispenser. When the CNA turned around, the resident was slipping out of the shower chair. The CNA tried to rush to her and ended up slipping causing the chair to come off its legs and tilt backwards. The resident hit her head. CNA 4 placed her hand on the back of the resident's neck and the other under her thigh. The CNA positioned the resident back on the shower chair and noticed the resident had blood on the top of her head. CNA 4 continued to give the resident a shower and rinsed the blood from the resident's head. She then transferred the resident into her wheelchair and pushed the resident to the side of her bed. The CNA bumped the resident's knee on		garments, 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.	

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	the bathroom door frame. CNA 4 dressed the resident and transferred the resident into her bed. The resident was complaining of pain. The statement did not indicate the CNA notified the nurse before moving the resident or continuing the shower. A written statement of events, untitled, undated, and not timed, by LPN 5, indicated LPN 5 went into the pantry to get applesauce and found CNA 4 putting ice in a small trash bag. The CNA explained it was for Resident C and the CNA thought she bumped the resident's leg on the doorway. LPN 5 went into the resident's room and asked the resident what happened. The resident indicated she fell. The nurse asked the CNA if she fell, and the CNA stated she did not fall. When LPN 5 was completing her assessment, she noticed a small bag of ice on the resident's neck and the resident's forehead was bleeding with a small hematoma. The statement did not indicate how long after the shower the nurse was told the resident needed to be assessed. The clinical record for Resident C was reviewed on 1/16/24 at 10:06 a.m. The diagnoses included, but were not limited to, dementia, depression, and osteogenesis imperfecta (inherited disorder characterized by fragile bones). An admission Minimum Data Set (MDS) assessment, dated 3/23/23, indicated the resident was rarely/never understood. Her cognitive skills for decision making were severely impaired. She was dependent on staff for showering, bathing, and transfers.			

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	A care plan, initiated on 3/15/23, indicated the resident was at risk for falls. The interventions included, but were not limited to, alert the provider if a fall occurred, and initiate frequent neuro checks and bleeding evaluation per the facility protocol. A nursing progress note, dated 6/24/23 at 10:00 p.m., documented as a late entry, indicated the nurse was informed by CNA 4 she bumped the resident's knee on the bathroom door after completing a shower when exiting the bathroom. The CNA indicated Resident C needed ice. LPN 5 asked the resident if she was okay, and the resident stated she fell. LPN 5 noted the resident had pain to the left knee, a small skin tear to the right upper arm with a small amount of bleeding, and the left hand was discolored. The nurse did a head-to-toe assessment and noted the resident had a hematoma with a small laceration on the forehead. The progress notes did not indicate the time the head-to-toe assessment was completed. A hospital report, dated 6/25/23 at 12:27 a.m., indicated the resident arrived at the emergency department by the Emergency Medical Services (EMS), the resident sustained a fall at the nursing home, the resident's history was unclear, and the resident did not normally ambulate independently. A facility post event Interdisciplinary Team (IDT) note, dated 6/28/23 at 11:36 p.m., indicated the type of event was an intercepted fall. CNA 4 was assisting the resident with a shower. CNA 4 turned to the sink to grab soap and the resident started to slip out of the shower chair. CNA 4 was assisting the resident back in the shower chair and the chair tipped backwards. The CNA			

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	grabbed the resident around the back and neck area to prevent the resident from falling hard on the floor. The resident was assisted upright in the shower chair and the shower was completed. The CNA assisted the resident into her wheelchair. While exiting the bathroom, the CNA hit the resident's knee on the door frame. The resident was assisted into bed and complained of knee pain. A head-to-toe assessment found a hematoma, skin tear, and pain to the knee. The post fall note did not include how the time difference between the intercepted fall and the nursing head-to-toe assessment. There were no progress notes found in the resident's record to indicate the time the resident was sent out to the emergency department. A Certified Nursing Assistant (CNA) job description signed on 6/1/23 by CNA 4, indicated the essential job duties included, but were not limited to, assisting with resident with room moves, transfers, reports changes in condition or new concerns to the nurses, and other duties assigned by the nurse within the CNA scope of practice. A General Orientation Verification form, signed by CNA 4 on 6/6/23, indicated accidents were to be reported immediately to the supervisor. During an interview, on 1/17/24 at 9:18 a.m., the Director of Nursing (DON) indicated, on 6/24/23 at 10:00 p.m., the nurse on duty contacted her and indicated the CNA gave Resident C a shower. When CNA 4 was assisting the resident to her bed, CNA 4 bumped the resident's knee on the door frame. The DON asked the nurse if she had concerns with the resident and the nurse stated			

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	the resident was in bed. The nurse went to assess the resident and noticed something on her hand and on her head. The DON asked the nurse if the resident was in pain and talked to CNA 4 asking if the resident fell. CNA 4 indicated the resident did not fall. The CNA was giving the resident a shower and the resident was sitting on the shower chair. CNA 4 turned to get the soap. When CNA 4 turned around, the resident was slipping out of the chair. The CNA hurried over to help the resident and repositioned her back into the shower chair. CNA 4 then took the resident out of the bathroom and bumped her knee on the door. The DON asked the nurse to do a head-to-toe assessment and the nurse found a small laceration on top of her head and a small skin tear on the resident's right hand. The left knee had some swelling, and the resident was complaining of neck pain. The DON told the nurse to notify the physician and send the resident to the hospital. The DON called the daughter multiple times until she was able to talk to her and explained to the daughter, she was going to further investigate the incident. The resident was at the hospital from 6/24/23 to 7/7/23. During an interview, on 1/17/24 at 11:28 a.m., the DON indicated what was reported to her was the resident did not fall. During an interview, on 1/17/24 at 11:59 a.m., LPN 5 indicated around 8:30 p.m., she was getting pudding out of the pantry and saw CNA 4 putting ice in a plastic trash bag for Resident C. CNA 4 had bumped the resident's knee on the door coming out of the bathroom. LPN 5 and CNA 4 went to the resident's room and found the resident asleep in the bed. The nurse pulled down the blanket, did not see anything, and left the room to give medications. LPN 5 returned to the room			

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	around 9:00 p.m. She did a head-to-toe assessment and asked the resident what happened. Resident C indicated she fell and was in pain. LPN 5 called the DON who instructed her to call the physician and send the resident to the hospital. During an interview, on 1/20/24 at 2:50 p.m., a family member of Resident C indicated there was confusion on what had happened to the resident. The facility contacted the family member, on 6/24/23 at 10:58 p.m., by voice mail. The facility was sending the resident out to the hospital due to complaints of neck pain. At first, the family member was told by the facility staff a CNA was giving the resident a shower and, on the way, out of the bathroom bumped the resident's knee on the door frame. The resident at the time of the transfer should have been assisted by more than one staff member. When the resident was assessed in the emergency room, the resident was found to have a contusion on the front of her head and one on the back of the head, a C1 fracture, a left distal femur fracture, and a potential right femoral neck fracture. The resident had not been the same cognitively since the fall. A current policy, titled "Using a Mechanical Lifting Machine," received from the ADON on 1/18/24 at 11:23 a.m., indicated "...the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift ...at least two (2) nursing assistants are needed to safely move a resident with a mechanical lift...." A current policy, titled "Fall Prevention and Management," dated as revised 6/2021 and received from the Clinical Support Nurse on 1/16/24 at 11:47 p.m., indicated "...An intercepted fall occurs when the resident would have fallen if			

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	he or she had not caught him/herself or had not been intercepted by another person...An evaluation of all the causal factors leading to a resident fall should be completed...Head to toe evaluation by a licensed nurse is completed before the resident is moved... Documentation will include report/event report completion, the nurse's notes, and a fall investigation...." This Federal tag relates to Complaint IN00416352. 3.1-37(a)			
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 to prevent accidents. Based on observation, interview and record review, the facility failed to ensure dependent residents who required staff assistance with mobility and assistive devices, received adequate supervision and assistance to prevent falls and failed to ensure staff used a mechanical lift with assistance for 3 of 3 residents reviewed for accidents. (Resident C, B and H) This deficient practice resulted in Resident C being hospitalized for treatment of a blunt carotid artery occlusion injury and fractures of the neck, spine, left femur, and two fractures of the right foot. This deficient practice resulted in Resident B receiving a laceration with sutures to the right top of his head and to the right elbow.	F 0689	I Residents C and B were affected but resolving without complications. Resident H had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure dependent residents who require staff assistance with mobility and assistive devices receive adequate supervision and assistance to prevent falls and ensure staff utilize a mechanical lift with assistance. II All residents have the	02/15/2024

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	Findings include: 1. A facility reportable incident report, dated 6/24/23 at 11:01 p.m., indicated Resident C experienced a fall while showering in her restroom (assisted). Following the fall/shower, the resident was noted with increased pain/swelling to left knee and complaint of neck pain during the nursing assessment. The resident was transported to the hospital for further evaluation and treatment. A written statement of events, untitled, dated 6/24/23 and not timed, by Certified Nurse Aide (CNA) 4 indicated CNA 4 was giving Resident C a shower between 7:00 to 7:30 p.m. The resident was placed on the shower chair. The CNA turned around and took the soap off the paper towel dispenser. When the CNA turned around, the resident was slipping out of the shower chair. The CNA tried to rush to her and ended up slipping causing the chair to come off its legs and tilt backwards. The resident hit her head. CNA 4 placed her hand on the back of the resident's neck and the other under her thigh. The CNA positioned the resident back on the shower chair and noticed the resident had blood on the top of her head. CNA 4 continued to give the resident a shower and rinsed the blood from the resident's head. She then transferred the resident into her wheelchair and pushed the resident to the side of her bed. The CNA bumped the resident's knee on the bathroom door frame. CNA 4 dressed the resident and transferred the resident into her bed. The resident was complaining of pain. A written statement of events, untitled, undated, and not timed, by LPN 5, indicated LPN 5 went into the pantry to get applesauce and found CNA		potential to be affected. Director of Nursing provided Education to all Licensed Nursing and C.N.A.'s related to Fall Prevention and Management Policy and Using a Mechanical Lifting Machine Policy including reporting to Licensed Nurse, post fall protocols, fall prevention and proper transfer procedure. Licensed Nurses and C.N.A.'s received re-education on transfer device policy and procedure, and mechanical lift competencies. III The Fall Prevention and Management Policy and Using a Mechanical Lifting Machine Policy have been reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff and **contracted Nursing Staff** on the Fall Prevention and Management Policy and Using a Mechanical Lifting Machine Policy including reporting events to a Licensed Nurse, post fall protocols, fall prevention, proper transfer procedure, and mechanical lift competencies. 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 proper notification of licensed staff, procedure post	

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	4 putting ice in a small trash bag. The CNA explained it was for Resident C and the CNA thought she bumped the resident's leg on the doorway. LPN 5 went into the resident's room and asked the resident what happened. The resident indicated she fell. The nurse asked the CNA if she fell, and the CNA stated she did not fall. When LPN 5 was completing her assessment, she noticed a small bag of ice on the resident's neck and the resident's forehead was bleeding with a small hematoma. The clinical record for Resident C was reviewed on 1/16/24 at 10:06 a.m. The diagnoses included, but were not limited to, dementia, depression, and osteogenesis imperfecta (inherited disorder characterized by fragile bones). An admission Minimum Data Set (MDS) assessment, dated 3/23/23, indicated the resident was rarely/never understood. Her cognitive skills for decision making were severely impaired. She was dependent on staff for showering, bathing, and transfers. A care plan, initiated on 3/15/23, indicated the resident was at risk for falls. The interventions included, but were not limited to, educate on the importance of maintaining a safe environment, evaluate fall risk on admission and when needed, educate the resident and representative regarding the proper use of mobility devices, alert the provider if a fall occurred, and initiate frequent neuro checks and bleeding evaluation per the facility protocol. A nursing progress note, dated 6/24/23 at 10:00 p.m., documented as a late entry, indicated the nurse was informed by CNA 4 she bumped the resident's knee on the bathroom door after		fall and use of transfer technique, five times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Additionally, mechanical lift competencies will occur with three random health center nursing staff weekly for a total duration of 6 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.	

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	completing a shower when exiting the bathroom. The CNA indicated Resident C needed ice. LPN 5 asked the resident if she was okay, and the resident stated she fell. LPN 5 noted the resident had pain to the left knee, a small skin tear to the right upper arm with a small amount of bleeding, and the left hand was discolored. The nurse did a head-to-toe assessment and noted the resident had a hematoma with a small laceration on the forehead. A hospital report, dated 6/25/23 at 12:27 a.m., indicated the resident arrived at the emergency department by the Emergency Medical Services (EMS), the resident sustained a fall at the nursing home, the resident's history was unclear, and the resident did not normally ambulate independently. The report indicated EMS staff were told the resident received a bath and 15 minutes later, the facility staff found the resident lying in bed in the fetal position, crying for help, and the resident indicated she had fallen. The facility staff reported to EMS the resident had sustained a forehead contusion, a scalp laceration, and left leg edema. A facility post event Interdisciplinary Team (IDT) note, dated 6/28/23 at 11:36 p.m., indicated the type of event was an intercepted fall. CNA 4 was assisting the resident with a shower. CNA 4 turned to the sink to grab soap and the resident started to slip out of the shower chair. CNA 4 was assisting the resident back in the shower chair and the chair tipped backwards. The CNA grabbed the resident around the back and neck area to prevent the resident from falling hard on the floor. The resident was assisted upright in the shower chair and the shower was completed. The CNA assisted the resident into her wheelchair. While exiting the bathroom, the CNA hit the resident's knee on the door frame. The resident			

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	was assisted into bed and complained of knee pain. A head-to-toe assessment found a hematoma, skin tear, and pain to the knee. A hospital report, dated 7/7/23 at 3:33 p.m., indicated the final discharge diagnoses included a C1 fracture (a bone which begins at the base of your skull and often caused by trauma to the back of the head), Dens fracture type II (a break which occurred through a specific part of the second bone in the neck), Biffl Gr 4 Rt VA occlusion (illustrates the spectrum of blunt cerebrovascular injury), L1 compression fracture (bottom part of the thoracic spine, occurs from too much pressure on the vertebral body), Left medial (towards the middle) and lateral (away from the middle) femoral condyle (ball-shape located at the end of the femur, thigh bone) fractures and right 5th proximal phalanx(bone located tip of foot) and metatarsal (large bone in the foot) shaft fracture. A Certified Nursing Assistant (CNA) job description signed on 6/1/23 by CNA 4, indicated the essential job duties included, but were not limited to, assisting with resident with room moves, transfers, reports changes in condition or new concerns to the nurses, and other duties assigned by the nurse within the CNA scope of practice. During an interview, on 1/17/24 at 9:18 a.m., the Director of Nursing (DON) indicated, on 6/24/23 at 10:00 p.m., the nurse on duty contacted her and indicated the CNA gave Resident C a shower. When CNA 4 was assisting the resident to her bed, CNA 4 bumped the resident's knee on the door frame. The DON asked the nurse if she had concerns with the resident and the nurse stated the resident was in bed. The nurse went to assess the resident and noticed something on her hand			

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	and on her head. The DON asked the nurse if the resident was in pain and talked to CNA 4 asking if the resident fell. CNA 4 indicated the resident did not fall. The CNA was giving the resident a shower and the resident was sitting on the shower chair. CNA 4 turned to get the soap. When CNA 4 turned around, the resident was slipping out of the chair. The CNA hurried over to help the resident and repositioned her back into the shower chair. CNA 4 then took the resident out of the bathroom and bumped her knee on the door. The DON asked the nurse to do a head-to-toe assessment and the nurse found a small laceration on top of her head and a small skin tear on the resident's right hand. The left knee had some swelling, and the resident was complaining of neck pain. The DON told the nurse to notify the physician and send the resident to the hospital. The DON called the daughter multiple times until she was able to talk to her and explained to the daughter, she was going to further investigate the incident. The resident was at the hospital from 6/24/23 to 7/7/23. During an interview, on 1/17/24 at 10:16 a.m., the DON indicated the resident had a hematoma on the top of her head not on the forehead and the resident did not fall. The DON thought this was an isolated incident and would consider this an intercepted fall. The staff were not educated, only CNA 4. During an interview, on 1/17/24 at 11:28 a.m., the DON indicated what was reported to her was the resident did not fall. During an interview, on 1/17/24 at 11:59 a.m., LPN 5 indicated around 8:30 p.m., she was getting pudding out of the pantry and saw CNA 4 putting ice in a plastic trash bag for Resident C. CNA 4			

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	had bumped the resident's knee on the door coming out of the bathroom. LPN 5 and CNA 4 went to the resident's room and found the resident asleep in the bed. The nurse pulled down the blanket, did not see anything, and left the room to give medications. LPN 5 returned to the room around 9:00 p.m. She did a head-to-toe assessment and asked the resident what happened. Resident C indicated she fell and was in pain. LPN 5 called the DON who instructed her to call the physician and send the resident to the hospital. During an interview, on 1/20/24 at 2:50 p.m., a family member of Resident C indicated there was confusion on what had happened to the resident. The facility contacted the family member, on 6/24/23 at 10:58 p.m., by voice mail. The facility was sending the resident out to the hospital due to complaints of neck pain. At first, the family member was told by the facility staff a CNA was giving the resident a shower and, on the way, out of the bathroom bumped the resident's knee on the door frame. The resident at the time of the transfer should have been assisted by more than one staff member. When the resident was assessed in the emergency room, the resident was found to have a contusion on the front of her head and one on the back of the head, a C1 fracture, a left distal femur fracture, and a potential right femoral neck fracture. The resident had not been the same cognitively since the fall.2. An Indiana Department of Health Intake Information report indicated Resident B had been dropped after a staff member improperly secured him to a lift. The clinical record for Resident B was reviewed on 1/16/24 at 11:23 a.m. The diagnoses included, but were not limited to, paroxysmal atrial			

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	fibrillation, type 2 diabetes mellitus with neuropathy, idiopathic autonomic neuropathy, and ataxic gait. An Admission Minimum Data Set (MDS) assessment, dated 7/28/23, indicated the resident did not experience cognitive impairment. Section GG (functional abilities and goals) indicated the resident required partial/moderate assistance with toilet transfers and the helper did less than half of the effort. A nursing progress note, dated 8/12/23 at 10:00 a.m., indicated the CNA 3 notified LPN 2 the resident was on the floor in his bathroom. The CNA indicated while transferring him on the sit-to-stand lift from the toilet, the resident fell off the stand-up lift. The resident was laying on his right side with the back of his head against the door frame and his feet on the stand-up lift. The resident was alert, confused, stated he felt sleepy, and his head hurt. The resident sustained a laceration of the right temple area and a skin tear to the right upper arm. The resident was transported to the emergency room. An interdisciplinary team review of falls and skin events, dated 8/12/23 at 10:00 a.m., indicated CNA 3 noted the resident was starting to slip through the sit-to-stand lift sling. The CNA went immediately behind the resident and braced the resident's fall with her body. The resident hit his head and right elbow on the sit-to-stand lift when the resident was being assisted down to the floor. A hospital emergency room note, dated 8/12/23 at 10:51 a.m., indicated Resident D was alert and pleasant, received routine anti-coagulants, and had sustained a 3.0 cm (centimeter) head laceration which required four sutures and a 5.0			

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	cm right forearm laceration that required four sutures. A nursing progress note, dated 8/12/23 at 10:30 p.m., indicated the resident returned from the hospital. He had sutures to the right top of his head and a dressing to the right elbow. A nursing progress note, dated 8/13/23 at 5:32 a.m., indicated the resident was alert and oriented times 3, and denied pain and discomfort. The laceration to the right temple area had 9 sutures intact. The skin tear to the right forearm had 9 sutures intact. During an interview, on 1/18/24 at 11:54 a.m., the ADON (Assistant Director of Nursing) indicated the resident was assisted by one CNA and should have been assisted by 2. The resident did have a recommendation from therapy to transfer with a full body lift and not the sit-to-stand lift. He would refuse the full body lift and request the sit-to-stand lift. He had more syncopal episodes after his fall from the sit-to-stand lift. 3. During an observation, on 1/18/24 at 3:18 p.m., the Resident H was found sitting in a sling used for the mechanical lift. The resident was in the sling at the highest position with CNA 6 brushing her hair. During an interview, on 1/18/24 at 3:19 p.m., CNA 6 indicated she did not know the policy for using the facility mechanical lifts. CNA 6 was the resident's hospice CNA, and she did this all the time. LPN 8 indicated she asked if the staff could help, and CNA 6 indicated she did not need help. The clinical record for Resident H was reviewed on 1/16/24 at 3:13 p.m. The diagnoses included,			

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	but were not limited to, multiple sclerosis, anxiety disorder, depressive disorder, pain, and osteoporosis. A physician's order, dated 3/8/23, indicated to admit the resident to hospice. A facility document, titled "Resident Information Sheet," dated 1/16/24, indicated the resident transferred using a Hoyer lift (mechanical lift). A Quarterly Minimum Data Set (MDS) assessment indicated the resident was dependent (helper did all the effort) to move from a lying position to a sitting position. A hospice interdisciplinary care plan, dated 2/21/22, indicated to transfer the resident with a Hoyer lift and assist of 2 from bed to chair only. A facility care plan, dated as revised on 11/26/23, indicated the resident was at risk for falls. The interventions included, but were not limited to, educate the resident, family, and caregivers about safety reminders and what to do if a fall occurred. The Hoyer pad was to be removed from under the resident while up in the Broda chair. A facility care plan, dated as revised on 11/26/23, indicated the resident had a self-care performance deficit. The interventions included, but were not limited to, communicate any changes in status to hospice services and nurse and to promote dignity by ensuring privacy. During an interview, on 1/18/24 at 3:20 p.m., LPN 8 indicated the CNA who used the mechanical lift alone was from hospice. The facility policy stated when you use a mechanical lift you needed to have 2 staff assisting with the transfer to be safe.			

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	During an interview, on 1/18/24 at 3:33 p.m., LPN 8 indicated the Director of Nursing (DON) had asked the hospice CNA if she was supposed to transfer a resident in a lift without help and CNA 6 indicated per the hospice policy she could. During an interview, on 1/18/24 at 3:47 p.m., the DON indicated she called the hospice supervisor, made hospice aware of the facility lift transfer, and if CNA 6 used a lift they should have assistance. A current policy, titled "Using a Mechanical Lifting Machine," received from the ADON on 1/18/24 at 11:23 a.m., indicated "...the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift ...at least two (2) nursing assistants are needed to safely move a resident with a mechanical lift...mechanical lifts maybe used for tasks that require lifting a resident from the floor, transferring a resident from bed to chair, lateral transfers, lifting limbs, toileting or bathing or repositioning...types of lifts that may be available in the facility are...floor-based full body sling lifts, overhead full body sling lifts and sit to stand lifts...." A current policy, titled "Fall Prevention and Management," dated as revised 6/2021 and received from the Clinical Support Nurse on 1/16/24 at 11:47 p.m., indicated "...It is the policy of our community to ensure a safe environment with lease restrictive measurers while promoting the highest possible level of independence and quality of life...An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person - this is still considered a fall. The fall risk evaluation will be completed upon			

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	admission, quarterly, annually, and/or if a change in condition requiring completion of a new MDS occurs (Significant Change MDS) and when a fall occurs. An evaluation of all the causal factors leading to a resident fall should be completed...Head to toe evaluation by a licensed nurse is completed before the resident is moved...Emergency care will be provided to the resident following appropriate procedures if necessary. Emergency care will be provided to any resident who has head trauma unless the physician, resident, or family refuses such treatment. Documentation will include report/event report completion, the nurse's notes, and a fall investigation...." This Federal tag relates to Complaint IN00416352. 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to notify the physician of a significant weight change and a 5 pound or more weight gain per the physician's orders for 2 of 3 residents reviewed for nutrition. (Resident D and 26) Findings include: 1. The record for Resident D was reviewed on 1/16/24 at 2:29 p.m. Diagnoses included, but were not limited to, muscle weakness, pain, anxiety disorder, and depression. A care plan indicated the resident was at nutrition risk. The interventions included, but were not limited to, monitor weights as ordered. The resident had the following weights: 1. On 10/22/23, the resident's weight was 109.0 pounds. 2. On 1/8/24, the resident's weight was 95.0 pounds. The resident had a 12.84% weight loss in 3 months. There was no documentation of the physician being notified of the significant weight loss. A nursing progress note, dated as a late entry on 1/16/24 at 1:00 p.m., indicated the Assistant Director of Nursing (ADON) discussed the resident's weight loss and no new orders were received. During an interview, on 1/16/24 at 4:35 p.m., the	F 0692	I Resident D and #26 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to notify the physician of a significant weight changes and a 5 pound or more weight gain per the physician's orders. II All residents with an order for daily weights with heart failure and who are at risk for weight loss have the potential to be affected. An audit has been conducted of all residents with an orders for daily weights and significant weight changes in the past 30 days for physician notification and documentation. Any discrepancies have been corrected. III The Weight Assessment and Intervention and Heart Failure-Clinical Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing staff on the Weight Assessment and Intervention and Heart Failure – Clinical Protocol Policy including physician notification, and documentation. Additional systemic changes are being addressed through our quality assurance process described	02/15/2024

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	ADON indicated she notified the Nurse Practitioner (NP) and the Registered Dietician (RD) of the weight change. When residents have a significant weight loss, the resident needed to be re-weighed and the physician notified. The ADON indicated she spoke with the NP, on 1/9/24, and did not chart the conversation until 1/16/24 at 1:00 p.m. 2. The record for Resident 26 was reviewed on 1/17/24 at 10:25 a.m. Diagnoses included, but were not limited to, unspecified CHF (congestive heart failure), unspecified dementia, and hypertension. A current order, with a start date of 11/28/23, indicated to weigh the resident every day at the same time of day with the same scale. Notify the physician of a 3-pound weight gain in 24 hours or a 5-pound weight gain in 1 week. A weight log indicated the following: 1. On 11/29/23, the resident's weight was 140.3 pounds. 2. On 12/1/23, the resident's weight was 145.0 pounds. 3. On 12/1/23, the resident's weight was 146.8 pounds. There was a greater than 5-pound weight gain in less than 1 week from 11/29/23 to 12/1/23 and no notification to the provider was found in the resident's electronic chart. During an interview, on 1/17/24 at 3:35 p.m., the DON (Director of Nursing) indicated the provider signed the CHF log when they came in and when they notified the provider. During an interview, on 1/18/24 at 9:52 a.m., the ADON (Assistant Director of Nursing) indicated		below. IV The Director of Nursing or designee will: Audit of all weights for significant weight loss or gain, including daily weights, 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.	

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	she could not find the CHF log for the time period the weight gain occurred. A current policy, titled "Weight Assessment and Intervention," dated as revised 3/2022 and received from the DON on 1/17/24 at 3:41 p.m., indicated "...Weights are recorded in each unit's weight record chart and in the individual's medical record. Any significant weight change since last weight assessment is retaken for confirmation. If the weight is verified, nursing will notify the dietitian. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria...1 month - 5% weight loss is significant; greater than 5% is severe. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. 6 months - 10% weight loss is significant; greater than 10% is severe...." A current policy, titled "Heart Failure-Clinical Protocol," dated as revised 11/2018 and received from the DON on 1/18/24 at 4:00 p.m., indicated "...Daily weight monitoring may be ordered for residents with heart failure. Notification of significant weight changes to be followed per physician's order. 3.1-46(a)(1)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated and a physician's order for oxygen was obtained for 4 of 5 residents reviewed for respiratory care. (Residents 6, 41, 206 and 10). Findings include: 1. During an observation, on 1/11/24 at 1:53 p.m., the oxygen tubing and humidifier bottle for Resident 6 was not dated. The record for Resident 6 was reviewed on 1/16/24 at 10:23 a.m. Diagnoses included, but were not limited to, shortness of breath, history of acute respiratory failure with hypoxia, and unspecified congestive heart failure. A current order, with a start date of 11/2/23, indicated to change and date oxygen tubing and humidifier bottle in the evenings every Wednesday. During an interview, on 1/11/24 at 2:46 p.m., the Clinical Support Nurse indicated the oxygen tubing was not dated. 2. During an observation, on 1/11/24 at 2:38 p.m., Resident 41 was wearing oxygen, and the oxygen tubing was not dated. The record for Resident 41 was reviewed on 1/16/24 at 9:22 a.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and anxiety disorder.	F 0695	I Resident # 41 no longer resides in the community. Residents #6, #41, #206, and #10 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure oxygen tubing is dated and a physician order for oxygen is obtained. II All residents receiving oxygen have the potential to be affected. No residents experienced any negative consequences. Audit completed for all residents who have oxygen, physician orders and dated oxygen tubing verified. III The Oxygen Administration Policy has been reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on the Oxygen Administration Policy including dating of oxygen tubing and order verification. Additional systemic changes are being addressed through our quality assurance process described below. IV The Director of Nursing or designee will: Audit of compliance of oxygen orders and oxygen tubing date, weekly x 12 weeks, then monthly	02/15/2024

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	There was no physician's order for the resident to wear oxygen or to change the oxygen tubing. During an interview, on 1/16/24 at 11:38 a.m., the DON (Director of Nursing) indicated there was not an order for the resident to wear oxygen. 3. During an observation, on 1/16/24 at 12:35 p.m., the oxygen tubing for Resident 206 was not dated. The record for Resident 206 was reviewed on 1/16/24 at 2:23 p.m. Diagnoses included, but were not limited to, sepsis, type 2 diabetes, and history of trans ischemic attack (TIA). A current order, with a start date of 1/9/24, indicated the resident wore oxygen at 2 liters per minute continuously. A current order, with a start date of 1/9/24, indicated to change the oxygen tubing weekly every Wednesday night. During an interview, on 1/11/24 at 2:48 p.m., the Clinical Support Nurse indicated the resident's oxygen tubing was not dated. 4. During an observation, on 1/11/24 at 2:38 p.m., Resident 10 was not wearing oxygen and the oxygen tubing and humidifier bottle was not dated. The record for Resident 10 was reviewed on 1/12/24 at 9:22 a.m. Diagnoses included, but were not limited to congestive heart failure, atrial fibrillation, and obstructive sleep apnea. A physician's order, dated 10/3/23, indicated oxygen at 2 liters per nasal cannula during the day as tolerated.		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.	

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	A physician's order, dated 11/2/23, indicated to change the oxygen tubing twice a week. During an interview, on 1/11/24 at 1:32 p.m., LPN 2 indicated she did not know why the resident was not wearing his oxygen and the oxygen tubing was not dated. The oxygen tubing was changed by the night shift nurse and should be dated and initialed. A current policy, titled "Oxygen Administration," dated as revised 10/2010 and received from the Clinical Support Nurse on 1/11/24 at 3:38 p.m., indicated "...The purpose of this procedure is to provide guidelines for safe oxygen administration...Verify that there is a physician's order for this procedure. Review the resident's care plan to assess of any special needs of the resident. Assemble the equipment and supplies as needed...Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. Tubing will be changed routinely and as needed/indicated...." 3.1-47(a)(6)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Residential Complaint IN00423410 and Nursing Home Complaint IN00416352. Complaint IN00423410 - No deficiencies related to the allegations are cited.	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	

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	Complaint IN00416352 - Federal/State deficiencies related to the allegations are cited at F684 and F689. Survey dates: January 11, 12, 16, 17 and 18, 2024 Facility number: 000105 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 29, 2024.		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 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 interview and record review, the facility failed to protect cognitively impaired residents on the memory care unit from abuse, related to sexual behaviors from a male resident who had previously displayed sexual behaviors for 3 of 3 residents reviewed for sexual abuse. (Resident 300, 700 and 500) Finding includes: The clinical record for Resident 300 was reviewed on 1/17/24. The diagnoses included, but were not limited to, dementia with behavior disturbance, liver cell carcinoma, and secondary malignant neoplasm of other digestive organs.	R 0052	I Resident #300, #700, and #500, had no negative consequences from the alleged deficient practice. Resident #300 no longer resides in the community. It is the practice of Marquette to protect cognitively impaired residents from abuse including sexual behaviors. II All Reflections Memory Care residents have the potential to be affected. All memory care residents with identified behaviors charts reviewed, behavior monitoring	02/15/2024

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	The resident admitted to the facility in 2022 and had been sent out for geriatric psychiatric stays since his admission for sexual behaviors. His last return from a psychiatric stay was 9/7/23. A nursing note, dated 9/7/23 at 8:30 p.m., indicated Resident 300 was to receive medroxyprogesterone acetate (Depo-Provera) (a female hormone when given to a man inhibits the production of testosterone reducing sexual drive) intermuscular (IM) suspension 100 mg(milligram)/ml(milliliter). Inject 1 ml IM in the morning every 28 days. Next dose due on 10/2/23. A nursing note, dated 9/7/23 at 8:31 p.m., indicated Resident 300 returned to the facility from a behavior rehabilitation center. He was alert and oriented times 3 and denied pain and discomfort. He returned with new prescriptions for escitalopram (an antidepressant medication) 10 mg and Depo-Provera and an order to discontinue paroxetine (an antidepressant medication). A nursing note, dated 9/8/23 at 2:11 p.m., indicated a CNA reported the resident was in the dining room and he pulled his penis out of his pants and exposed himself. Staff have been directed to ask the resident to pull up his pants. No nursing progress notes related to behaviors were documented on 9/9/23 and 9/10/23. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/11/23, indicated Resident 300 pulled out his penis all the time, displayed unacceptable sexual behavior, was grabbing others, he was asked to stop, and interventions were not working.		updated and interventions in place. III The Abuse Prevention Policy was reviewed and found to meet clinical standards. Education provided to Reflections Memory Care Staff on the Abuse Prevention Policy including behavior documentation, behavior interventions and sexual behaviors. Additional systemic changes are being addressed through our quality assurance process described below. IV The Assisted Living Director or designee will: Audit resident behaviors including documentation, sexual behaviors, 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.	

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	There was no documentation a new intervention was implemented. A nursing note, dated 9/11/23, indicated Physician 29 was consulted regarding the resident still exhibiting inappropriate sexual behaviors since his return from the behavior psychiatric hospital. The physician wrote new orders for Depo-Provera 150 mg intramuscularly times 2 and then every month. The initial dose was to be given on 9/12/23. A document, titled "Follow Up Visit Note," dated 9/11/23, indicted the resident was readmitted after a brief stay in an inpatient geriatric psych for inappropriate sexual behavior. He returned with new orders to discontinue Paxil, started escitalopram 10 mg daily and Depo Provera 150 mg IM every four weeks. The note indicated the last dose of Depo Provera was given 9/4/23. Since readmitting his inappropriate sexual behaviors have continued. He had been noted multiple times to have his pants down in public areas, rubbing other residents' shoulders, etc. He had also been resistant to care. The unit manager had contacted Physician 29, who had ordered Depo Provera shot to be given early in an attempt to stop the behaviors. The patient denied any concerns, he did not discuss the behaviors. The visit note was not signed. A nursing note, dated 9/12/23 at 2:43 p.m., indicated the resident was seen in the sunroom, putting a female resident's hand in his pants. He was not wearing under pants. He was taken to his room, underpants were put on him, and his pants were changed. There was no documentation a new intervention was implemented.			

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	A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/12/23, indicated Resident 300 pulled out his penis all the time, was verbally aggressive, had unacceptable sexual behavior and "...It's getting really bad with him, he thinks he can talk to anyone any kind of way...." There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/13/23, indicated Resident 300 pulled out his penis all the time and had unacceptable sexual behavior. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/14/23, indicated Resident 300 would not stop pulling out his penis and had unacceptable sexual behaviors. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/15/23, indicated Resident 300 had unacceptable sexual behaviors. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/16/23, indicated Resident 300 displayed verbal aggression and unacceptable sexual behaviors.			

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	There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/17/23, indicated Resident 300 displayed verbal aggression and unacceptable sexual behaviors. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/18/23, indicated Resident 300 was pulling on another resident so he could put his penis on her from the back, pulled out his penis all the time, he was verbally aggressive, grabbed others, and displayed unacceptable sexual behavior. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/19/23, indicated Resident 300 was threatening to hit employees, was verbally aggressive, grabbing others, displayed unacceptable sexual behavior, and pulled out his penis all the time. The interventions were not working. There was no documentation a new intervention was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/20/23, indicated Resident 300 displayed verbal aggression, unacceptable sexual behavior, would grab others and pulled out his penis all the time. There was no documentation a new intervention			

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	was implemented. A facility document, titled "ALL STAFF BEHAVIOR TRACKING RECORD," dated 9/21/23, indicated Resident 300 was pulling residents by the side and putting his penis out on her butt, he was verbally aggressive, displayed unacceptable sexual behaviors, grabbed others, made negative statements and staff "...told him not to do that. Pulls out his penis in the dining room and hallways...." There was no documentation a new intervention was implemented. A document, titled "Indiana State Department of Health Survey Report System," dated 9/23/23 at 10:14 p.m., indicated the resident was observed, by staff, sitting on a couch in the memory care unit. Minutes later, staff observed the resident had ambulated out of the living room and into another resident's room. Upon entering the room, the resident was found standing inside the bathroom of a neighboring room with his pants unfastened. The resident was immediately assisted and redirected to his own room/restroom. Facility staff escorted the resident safely to his own room on the unit. A nursing note, dated 9/23/23 at 1:08 p.m. (late entry), indicated the staff began 1:1 supervision for Resident 300 following the incident, on 09/23/23. A nursing note, dated 9/24/23 at 8:35 a.m. and written by the Assisted Living Director, indicated she spoke with the CNA who worked 9/23/23 on the evening shift. The CNA reported, at 9:35 p.m., she noticed Resident 300 sitting alone on the couch in the common area. The CNA went to			

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	assist a resident to bed and when she exited the room Resident 300 was gone. She walked towards his room and noticed the door to Resident 700's room was open. Resident 700 was sitting on the toilet in her bathroom and Resident 300 was also standing in the bathroom with his pants down and his penis exposed. The CNA reported Resident 300 was not touching Resident 700. During an interview, on 1/12/24 at 3:03 p.m., the Executive Director indicated Resident 500, and Resident 300 were a couple in the community and went through different levels of care together. He believed Resident 500 was transferred to the memory care unit prior to Resident 300. He indicated after the first instance of sexual behavior, by Resident 300, the physician was consulted. He felt people with dementia go down that path and with multiple incidents; there was always hindsight. During an interview, on 1/16/24 at 11:28 a.m., QMA 28 indicated Resident 300 had behaviors. He would go to Resident 500's room to visit. He exposed his penis to Resident 500 and Resident 700. He would expose his penis in the hall and move up close to Resident 500. He would take Resident 500 out to the sunroom from the dining room and remove his penis and rub it on her butt. QMA 28 indicated she had observed it many times. She would tell Resident 300 he could not do that, and Resident 500 was going to fall. During an interview, on 1/16/24 at 11:40 a.m., the Assisted Living Director indicated Resident 300 was on 1-on-1 supervision. He did have 2 psychiatric stays. He admitted for a psychiatric stay in August 2023 and was there for a little over a week. Resident 300 was put on Lexapro and Depo Provera. She indicated Physician 29 was			

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	involved after the first sexual incident occurring on 5/25/23. She indicated she felt Resident 500 couldn't remember what her feelings were, she was confused. You could ask Resident 500 again and get a different answer every time. Resident 500 thought Resident 300 was her boyfriend or husband. She indicated she was not saying Resident 500 consented to a sexual relationship in memory care, she felt that exposing a penis was offensive and if someone put their hands down another's pants that was sexual. Physician 29 and Physician 30 were following Resident 300 and eventually the resident was evicted from the facility. During an interview, on 1/17/23 at 3:51 p.m., the Assisted Living Director indicated Resident 300, and Resident 500 were very affectionate with each other. They would hold hands. He would walk to her room and pick her up for breakfast. They would walk together. The first sexual incident was on 5/25/23. Residents 300 and 500 were separated, and staff kept an eye on them. Physician 30 and the family were notified right away. Physician 30 and the family were notified again the second time there was a [sexual] incident between Resident 300 and Resident 500 that same day. Physician 30 came and seen Resident 300, on 6/1/23, ordered labs and started him on citalopram. He began the medication, on 6/2/23, and the resident was referred to Physician 29, the psychiatrist. Physician 29 came on 6/9/23, assessed the resident, discontinued the citalopram, and ordered paroxetine 20 milligrams at bedtime. Between 6/10/23 and 7/20/23, there was improvement. The resident had no sexual behaviors, no exposures (of the penis). On 6/30/23, a note indicated the resident was more lethargic, tired, and had a decreased appetite. The resident was seen by Physician 30, on 7/20/23. She ordered labs and			

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	noted the lethargy, decreased appetite, tiredness, and the resident's gait was less steady. On 7/25/23, Physician 29 saw the resident again. He decreased the paroxetine to 10 milligrams at bedtime. He thought that was why the resident had a decreased appetite and was tired. On 7/28/23, there was improvement in mood and the resident came out of his room for meals and activities. On 8/7/23, Physician 29 saw the resident again and had no changes or recommendations. The medications seemed to be working. On 8/30/23, there was a reportable incident, the resident was found in bed with Resident 700. She was dressed, his pants were down. He was immediately put on 1:1 supervision after getting him out of the female's room. The families and physician were notified. On 8/31/23, Physician 30 came and did a head-to-toe assessment on Resident 700 first thing in the morning and had no findings. There was an assessment completed by the nurse on 8/30/23 and an attempt to contact the daughter was made, but the daughter did not answer. On 8/31/23, as soon as they could get Resident 300 out, he was sent to a geriatric psychiatric facility. He returned one week later, on 9/7/23, with new medications. Lexapro and Depo-Provera. Then on 9/8/23, he began to expose himself again. He was directed to his room to do that. Physicians 29 and 30 were notified. Physician 29 saw him, on 9/18/23, followed up on the psychiatric stay and clarified specific orders for the Depo-Provera injections. There was a reportable incident, on 9/23/23, when he was found in the bathroom. Staff reported seeing him on the couch and then he was gone. Resident 700 was on the toilet and Resident 300's pants were down, he was not touching her. He was put back on 1:1 supervision and the next morning there was a care plan meeting with the family. They notified the family Resident 300 no longer met criteria for			

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	the memory care unit. The family requested he go back to the geriatric psych facility. He was kept on 1:1 supervision until the next day when he was transferred out. He did not return. They did reach out to the physicians, on 9/8/23. They kept redirecting the resident hoping the Depo-Provera would kick in. During an interview, on 1/18/23 at 2:46 p.m., the Assisted Living Director indicated they did not have any documentation the resident was on 1:1. They just put him on 1:1 monitoring. They had no documentation. A facility policy, titled "Abuse Prevention Policy," dated as revised on 7/19/18 and received from the Director of Nursing on 1/11/24 at 12:00 p.m., indicated "...It is the policy of this community to provide each resident with an environment that is free from...sexual...abuse...Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault...."			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure documentation for the attempts to hold fire and disaster drills in conjunction with the local fire department at least every six months were available. (January 2023) Finding includes: A copy of a text message to the local fire department, dated 7/13/23, indicated in blue pen across the top of the paper, it was an invite for 7/19 or 7/26. The body of the text message contained the email address of a staff member at the facility. The text indicated it was read on 7/13/23. A response indicated "...Got it thanks...." and at the bottom of the page in blue pen indicated "...No Response...." During an interview, on 1/11/24 at 2:38 p.m., the Plant Operations Manager indicated the facility did not have documentation to show the fire department had been invited to attend a fire/disaster drill in January 2023. The facility did follow the state regulations. A facility policy, titled "Fire and Life Safety Training and Drills," dated as revised in 1/2019 and received from the Corporate Support Nurse on 1/11/24 at 3:43 p.m., indicated "...The area fire	R 0092	I No residents were affected nor had any negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure documentation for attempts to hold fire and disaster drills in conjunction with the local fire department at least every six months is available. II All residents have the potential to be affected. No residents have experienced any negative consequences from the alleged deficient practice. III The Fire and Life Safety Training and Drills Policy was reviewed and found to meet clinical standards. Education provided to Plant Operations Staff on Fire and Life Safety Training and Drills Policy including documentation of scheduling with local fire department. Additional systemic changes are being addressed through our quality assurance process described below.	02/15/2024

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	department will be invited to participate in fire and life safety drills annually...." During an interview, on 1/11/24 at 3:55 p.m., the Administrator in Training indicated the policy was updated, on 1/11/24, to indicate the area fire department will be invited to participate in fire and life safety drills at least every 6 months.		IV The Director of Plant Operations or designee will: Audit documentation on attempts to hold fire and disaster drills in conjunction with the local fire department at least every six months, on a monthly basis, 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.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			

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	Based on interview and record review, the facility failed to identify and assess a resident for self-administration of a medication for 1 of 2 residents reviewed for self-administration of medications. (Resident 500) Finding includes: The record for Resident 500 was reviewed on 1/12/23 at 10:23 a.m. Diagnoses included, but were not limited to, dementia, speech disturbance, and aphasia (loss of the ability to understand speech or express oneself). A physician's order, dated 4/3/23, indicated Melatonin oral tablet 3 mg (milligram), to give one tablet by mouth at bedtime. Give with a 5 mg tablet to equal 8 mg. A physician's order, dated 4/3/23, indicated Melatonin oral tablet 5 mg, to give one tablet by mouth at bedtime, unsupervised self-administration. Give with a 3 mg tablet to equal 8 mg. Resident 500 did not have an assessment to self-administer Melatonin. The Medication Administration Record (MAR), from 4/4/23 to 1/15/24, showed documentation of self-administration of 5 mg of Melatonin. A service plan for Resident 500, dated 2/1/23, indicated nursing was to order, store, and administer medications. A current service plan for Resident 500, dated 8/11/23, indicated nursing was to order, store, and administer medications.	R 0216	I Resident #500 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to identify and assess a resident for self-administration of a medication. II All Reflections Memory Care residents have the potential to be affected. All residents' charts have been reviewed and verified no residents on the Reflections Memory Care are self-administering medications and no other data entry errors of self-administrations noted on medications. III The Self-Administration of Medications Policy was reviewed and found to meet clinical standards. Education provided to Assisted Living Licensed Nursing Staff on the Self-Administration of Medications Policy including assessment of residents' ability to self-administer medications and physician's order entry for self-administering medications. Additional systemic changes are being addressed through our quality assurance process described below. IV The Assisted Living Director or designee will: Audit of all Reflections Memory Care residents' charts and orders for self-administration, documentation, and updated plan	02/15/2024

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	During an interview, on 1/16/24 at 4:13 p.m., the Assisted Living Director indicated Resident 500 could not self-administer medications. The resident did not have the cognition to self-administer medications. Resident 500 was not getting 8 mg of melatonin, she thought she was receiving 3 mg. The 5 mg Melatonin dose was entered incorrectly by an agency nurse when the facility was transcribing medications from a paper Medication Administration Record (MAR) to the electronic record. She indicated she "guesses" it was her job to review the medications for accuracy, but she was not a nurse. The nurse entered the medications and should be looking at the medications for errors. She indicated she did check the resident's room and the resident did not have any medication in her room. During an interview, on 1/17/24 at 8:13 a.m., the Assisted Living Director indicated self-administration for medication did not show up on the administration record when staff administered medications. The self-administration was a data entry error. A facility policy, titled "Self-Administration of Medications," dated as last reviewed in 2/2011 and received from the Assisted Living Director on 1/17/23 at 2:01 p.m., indicated "...As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assess each resident's cognitive and physical abilities to determine whether self-administration of medication is safe and clinically appropriate for the resident...."		of care as indicated, weekly for 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.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment			

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	records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to document medication administration in the Medication Administration Record (MAR) for 1 of 5 residents reviewed for medication administration. (Resident 200) Finding includes: The record for Resident 200 was reviewed on 1/12/24 at 12:05 p.m. Diagnoses included, but were not limited to, anemia, pain, and constipation. a. A physician's order, initiated 11/10/23, indicated to give Melatonin oral tablet 3 milligram (mg) times 2 tablets at bedtime. The MAR, for 11/24/23, was not documented to show the medication had been administered at bedtime. The MAR, for 12/12/23, was not documented to show the medication had been administered at bedtime. b. A physician's order, initiated 12/6/23, indicated to give trazodone (an antidepressant) 50 mg at bedtime to help with sleep. The MAR, for 12/12/23, was not documented to show the medication had been administered at bedtime. c. A physician's order, initiated 12/1/23, indicated to give Colace (a medication for constipation) 100	R 0243	I Resident #200 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure medication administration is documented in the Medication Administration Record. II All residents have the potential to be affected. No residents experienced any negative consequences from the alleged deficient practice. III The Documentation of Medication Administration Policy was reviewed and found to meet clinical standards. Education provided to Assisted Living Licensed Nurses and Qualified Medication Aide Staff on the Documentation of Medication Administration Policy including accurate and timely documentation. 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 Medication Administration Record, three times weekly for 8 weeks, then	02/15/2024

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	mg twice a day. The MAR, for 11/24/23, was not documented to show the medication had been administered in the evening. The MAR, for 12/12/23, was not documented to show the medication had been administered in the evening. d. A physician's order, initiated 11/10/23, indicated to give Percocet (a narcotic pain reliever) 5-325 mg four times a day for pain. The MAR, for 11/17/23, was not documented to show the medication had been administered at 1:00 p.m. The MAR, for 11/24/23, was not documented to show the medication had been administered at 7:00 p.m. The MAR, for 12/12/23, was not documented to show the medication had been administered at 7:00 p.m. The MAR, for 12/13/23, was not documented to show the medication had been administered at 1:00 a.m. The MAR, for 12/17/23, was not documented to show the medication had been administered at 1:00 a.m. During an interview, on 1/12/24 at 8:44 a.m., QMA 27 indicated nursing staff should document on the Medication/Treatment Administration Record (MAR/TAR) right after administration of medications. They should document when residents took their medications or if they refused		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.	

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	the medication. Staff should not leave a hole in the MAR/TAR on purpose. A facility policy, titled "Documentation of Medication Administration," dated as last revised in 11/2022 and received from the Director of Nursing on 1/11/2024 at 3:55 p.m., indicated "...A nurse or certified medication aid...documents all medication administered to each resident on the resident's medication administration record (MAR) ...Administration of medication is documented immediately after it is given...."			