STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00205359. Complaint: IN00205359: Substantiated. Federal/State deficiency related to the allegations is cited at F323. Survey dates: July 25 & 26, 2016 Facility Number: 000105 Provider Number: 155198 AIM Number: NA Census Bed Type: SNF: 71 Residential: 56 Total: 127 Census Payor Type: Medicare: 24 Other: 47 Total: 71 Sample: 6 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. QR completed on July 27, 2016 by 17934.	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to ensure safety measures were in place to prevent the possibility of an accident for 3 of 6 residents reviewed for accidents. (Resident D, E and G) Findings include: 1. The record for Resident D was reviewed on 7/26/16 at 3 p.m. Current diagnoses included, but were not limited to, lower extremity cellulitis, Congestive Heart Failure, Diabetes, and debility. A Fall risk care plan dated 7/12/16, indicated the resident was at risk for falls, with approaches that included, but were not limited to, clip for call light. Nursing notes dated:	F 0323	**F323: FREE OF ACCIDENT HAZARDS, SUPRVISION, DEVICES** It is the practice of Marquette to develop and implement policies and procedures that ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents from occurring. **THE COMMUNITY RESPECTFULLY REQUESTS INFORMAL DISPUTE RESOLUTION (IDR) ON THIS DEFICIENCY VIA PERSONAL APPEARANCE. ----- ---------- ---------- ---------- ---------- Plan of Correction - Request for Desk Review What corrective actions will be accomplished for those residents found to have been affected by the deficient**	07/27/2016

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	7/12/16 at 6:44 a.m., indicated the CNA heard the resident cry for help and found the resident on her knees on the floor at the foot of the bed with her wheelchair behind her with only one brake locked. The resident Indicated the call light had fallen on the floor and that is why she had not used it. The note indicated the staff would inquire about a clip for the call light to secure it. 7/19/16 the resident was readmitted and had a fall risk score of 15 indicating she was at high risk for falls. 7/21/16 IDT (Interdisciplinary Team) note for the 7/12/16 fall indicated interventions added were a clip for the call light and anti-roll back brakes for the wheelchair. During an observation of Resident D on 7/26/16 at 3:39 p.m., she was in her wheelchair in her room on the left side of her bed. The call light was laying on the bed and not secured with a clip. No clip was observed on the call light or call light cord. During an observation of Resident D, with the first floor Unit Manager on 7/26/16 at 3:44 p.m., she indicated the clip was not present to secure the call		**practice?** Resident D: Care plan reviewed for Resident D. In addition to the intervention keep call light clipped to bed there was also an intervention to “keep call light within reach of Resident”. At the time surveyor indicated observance, the Resident was not in bed, but was noted to be sitting in the wheelchair. The clip to secure the cord to the bed, was indeed located in the room as indicated, and would have been unclipped so the Resident would have the call light within reach while in the chair. Resident’s call light was noted to be within reach as surveyor indicated during the observation. Resident D BIMs score was reviewed and indicated a score of 6, showing cognition is severely impaired and Resident’s use of call light remained inconsistent. Keeping the call light in sight is anticipated to assist with cueing a resident with poor, but fluctuating cognition; but is not considered a strong intervention in the facility’s “3 C fall program”, therefore would be maintained as a secondary intervention. Another secondary intervention implemented post-fall was anti-rollbacks added to the w/c. The root cause of Resident’s fall on 7/12/2016 was deemed a toileting need with a primary intervention to increase frequency of observations x3d and urologist follow-up scheduled for 7/12/2016 due to Resident has a diagnosis of urine retention and	

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	light to the bed. She looked under the bed and found the clip and applied it to the call light. She indicated the CNA's have assignment sheets that would have fall interventions. She then went to her office to get her computer to look at the assignment sheets. She indicated there were no specific instructions for the CNA's regarding the clip on the call light. During an interview with CNA # 1 on 7/26/16 at 3:50 p.m., she retrieved her assignment sheet from her pocket and indicated the resident was a fall risk and was an assist to for transfers and toileting. She indicated the special instruction area was blank. She indicated she was not aware the resident was to have a clip on her call light cord to keep it secure. 2. During an interview on 7/26/16 at 1:14 p.m., Resident E indicated she used her call light to call for assistance and demonstrated how to use the light. She indicated staff were not always timely and she has had to wait up to 30 minutes to go to the bathroom. She indicated she had also gotten up by herself even though they do not want her to because she felt she could not wait. The record for Resident E was reviewed on 7/26/16 at 1:48 p.m. Diagnoses		had admitted from the hospital with a foley catheter on 7/6/2016. The indwelling catheter was discontinued on 7/9/2016 and bladder scans and a toileting program was initiated at that time. Resident D remains in the facility and has continued to be accident free. Resident E's call light report was reviewed from the date of admission on 7/1/2016 through 8/2/2016. Resident had activated her call light 412 times during the time frame reviewed. Resident's average call light response time was 2 minutes and 35 seconds. Resident had not issued any previous concerns, complaints, or grievances to the facility. Resident's BIMs score was reviewed, indicating a score of 9, showing moderate cognition level, with short term memory impairments. Resident E remains in the facility free of accidents and hazards. Resident G's call light report was reviewed from the date of admission on 6/30/2016 through 8/1/2016. Resident had activated her call light 336 times during the time frame reviewed. Resident's average call light response time was 3 minutes and 2 seconds. Resident had not issued any previous concerns, complaints, or grievances to the facility. Resident's BIMs score was reviewed, indicating a score of 13. Resident remained free of accidents and hazards during her stay at the facility. Resident G had a successful discharge to	

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	included, but were not limited to, fracture of pelvis. A July 2016 careplan indicated she was a fall risk and was to have her call light within reach. Nursing notes indicated: 7/2/16 the resident had been placed in the Healthcare portion of the facility 4 times since Christmas due to falls in her apartment. 7/8/16 the resident had a BIM (Brief Interview of Mental Status) score of 13/15, indicating she was cognitively intact. 3. During an interview with Resident G on 7/26/16 at 1:03 p.m., she indicated she needed assist to get up and used her call light for help. She indicated on 2 occasions her call light was on the back of bed at the headboard and she was unable to reach it. She stated "this really needs to be addressed." The record for Resident G was reviewed on 7/26/16 at 3 p.m. A July 2016 care plan indicated the resident was a fall risk, with interventions that included, but were not limited to		Assisted Living on 8/1/2016. **How other residents having the potential to be affected by the same deficient practice will be identified and What corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. Resident Concern Logs were reviewed. No concerns voiced related to call light response times. All concerns voiced were appropriately addressed, resolved, and follow-up with the responsible party completed. Resident council concerns were reviewed, again no concerns with call light response times voiced. Call light reports were reviewed for June 2016, July 2016 and August 2016 with the following average call light response times: * June 1st Floor = 2 minutes and 49 seconds * June 2nd Floor = 3 minutes and 17 seconds * July 1st Floor = 2 minutes and 40 seconds * July 2nd Floor = 3 minutes and 40 seconds * August 1st Floor = 3 minutes and 36 seconds * August 2nd Floor = 3 minutes and 9 seconds Resident information sheets and care plans were reviewed to ensure consistency and accuracy related to potential for hazards and accidents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Call Light policy reviewed. The policy	

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	keep call light in reach. This Federal Tag relates to Complaint IN00205359. 3.1-45(a)(2)		and procedure has been maintained upon review. The "3 C's" developing strong action plans material was reviewed for identifying root causes of accidents and implementing interventions based on a hierarchy of actions classified as weak, intermediate, and strong interventions. The hierarchy of actions has been maintained and proven to be a success. No concerns identified with current policy and procedures requiring additional staff education. Upon review it is determined that the facility has maintained appropriate identification of hazards, evaluation and analysis of hazards, proper implementation of interventions based on hierarchy of actions, and adequate monitoring for effectiveness. **How will the corrective actions will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place?** A hazards and accident audit will be completed to ensure ongoing compliance with identification of hazards, evaluation and analysis of hazards, implementation of interventions, and monitoring for effectiveness of interventions. A call light response time audit will completed to ensure ongoing compliance with call light policy and procedure. Both audits will be conducted weekly x4 weeks, bi-weekly x2 months, and monthly	

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			x3 months. The results of the audits will be reviewed monthly in the Quality Assurance and Performance Improvement meeting. Date of Compliance? July 27, 2016	